WEDNESDAY, 13 JULY 2011

ESTIMATES—HEALTH AND DISABILITIES COMMITTEE—DISABILITIES AND MENTAL HEALTH

Estimates Committee Members

Ms LH Nelson-Carr (Chair)
Mrs EA Cunningham
Ms TE Davis
Ms AA Johnstone
Mr MF McArdle
Mrs CA Smith

In Attendance

Hon. CW Pitt, Minister for Disability Services, Mental Health and Aboriginal and Torres Strait Islander Partnerships

Department of Communities

Ms L Apelt, Director-General

Mr T Hayes, Associate Director-General, Regional Service Delivery Operations

Mr J Marsh, Assistant Chief Finance Officer

Mr M Kelly, Director, Finance Programs, Disabilities and Aboriginal and Torres Strait Islander Services (Acting)

Committee met at 9.30 am

CHAIR: Good morning, everyone. I declare the estimates hearing of the Health and Disabilities Committee now open. Following recent reforms to the committee system of this parliament, estimates hearings are now conducted by portfolio committees and this is the first estimates hearing by the Health and Disabilities Committee. On behalf of the committee, I would like to welcome the Minister for Disability Services, Mental Health and Aboriginal and Torres Strait Islander Partnerships. I would like to also welcome departmental officers and members of the public at this hearing.

I am Lindy Nelson-Carr, the member for Mundingburra and chair of this committee. Mr Mark McArdle, the member for Caloundra, is the deputy chair. The other committee members are Mrs Liz Cunningham MP, the member for Gladstone; Ms Tracy Davis MP, the member for Aspley; Ms Mandy Johnstone MP, the member for Townsville; and Mrs Christine Smith MP, the member for Burleigh. We do have other members who are present in the chamber today, and I would like to welcome Kerry Shine, the member for Toowoomba North.

The committee will examine the proposed expenditure contained in the Appropriation Bill 2011 for the portfolio areas of health, mental health and disabilities as required by chapter 31 of the standing orders of the Legislative Assembly. This morning the committee will examine the Minister for Disability Services, Mental Health and Aboriginal and Torres Strait Islander Partnerships on the disabilities and mental health portfolios. Following lunch the committee will examine the portfolios of the Minister for Health.

The committee will suspend proceedings for the following breaks: morning tea from 11 am to 11.30 am; lunch from 1 pm to 2.30 pm; afternoon tea from 4 pm to 4.30 pm; and dinner from 6.30 pm to 7.30 pm. I would like to remind all those participating in the hearings today that these proceedings are similar to parliament to the extent that the public cannot participate in the proceedings. In this regard, I

remind members of the public that under the standing orders the public may be admitted to or excluded from the hearing and that is entirely at the discretion of the committee. The committee has resolved that the whole of the proceedings of the committee may be broadcast in line with the media broadcasting rules, which are available from one of the parliamentary attendants in this room. I would ask that all mobile phones or pagers be either switched off or switched to silent mode. Also, I should remind you that food and drink are not permitted in the chamber.

Changes to the standing orders and rules of the Legislative Assembly have removed the strict time limits for questions and answers during an estimates hearing. This will ensure that exploration of relevant issues is not artificially curtailed by the time limits and that questions on a particular issue can continue if appropriate. However, it is important that questions and answers remain relevant and succinct. I intend to guide proceedings today so that relevant issues can be explored without imposing any artificial time limits and to ensure there is adequate opportunity to address questions from government and non-government members of the committee. Where necessary I will remind ministers and their departmental advisers that their answers to questions should be finalised so that other issues can be examined.

The committee has resolved that non-committee members be given leave to attend and ask questions during the hearing. For the benefit of Hansard, I ask departmental officers to identify themselves before answering a question referred to them by the minister or by the director-general.

I now declare the proposed expenditure for the portfolio areas of disability services and mental health open for examination. The time allocated is three hours. The question before the committee is—

That the proposed expenditure be agreed to.

Minister, if you wish you may make an opening statement, and I remind you that there is a limit of three minutes for your statement.

Mr PITT: Thank you very much, Madam Chair. Firstly I acknowledge the traditional owners of the land on which we meet today—the Turrbal people to the north of the Brisbane River and the Jagera people to the south of the river—and I pay my respects to their elders past and present. I recognise Aboriginal and Torres Strait Islanders as our First Australians, and we are fortunate indeed to have two of the world's oldest continuing living cultures right here in our country.

Since taking on the disability services and mental health portfolios, I have had many conversations with many Queenslanders and many service providers right across the state. The one thing they have in common, whether they be Blue Care clients in Mackay, residents of a group home in Cairns or workers at a social enterprise like Espresso Train cafe in Nundah, is that they are all looking to make their way in the world. I believe this budget is a budget that will help them to achieve their goals. In fact, Queenslanders with a disability or the frail aged, people with a mental illness, their families, their carers or their advocates will benefit from a record investment of $1.775 billion for disability and community care services. This represents an increase of 10 per cent—an extra $163 million more than last year. This includes $16.7 million in new funding and nearly $140 million in growth funds. That amounts to an extra $367 million in the last two years. In Queensland under Labor, state funding alone for disability services has increased more than 495 per cent. In 2011-12 disability services funding will be almost $1 billion more than it was in 1997-98. That is 14 years of sustained growth.

This budget, though, is not about the dollars; it is about people. Our summer of natural disasters has demonstrated the resilience, strength and generosity of Queenslanders. It has had a dramatic impact on people, families and communities across Queensland. It has had an impact on our non-government and government disability and community care service providers and in some places for a time on the delivery of some services. I commend our non-government partners and our departmental staff who have worked tirelessly before, during and after the disasters to help people and communities recover, and their work is ongoing. The disasters also had a major impact on the state's economy. The response to the disasters underpins the Bligh government's budget. It is all about rebuilding Queensland and restoring wellbeing.

This year's budget has delivered new disability funding of $7.36 million and $5.3 million in growth funding to expand support for young people with a disability leaving school or care with an extra 474 places in 2011-12. All up we will have almost $80 million in 2011-12 to support young adults with a disability leaving school or the care of the state. That is $12.7 million more than last year and $17 million more than the year before that. We are giving young people the life skills, the personal supports, the links and for some the accommodation they will need once they leave school. On top of this I am pleased to outline today a new initiative—$1 million for My Future, My Life that will for the first time make assistance available next year to 1,000 young people with a disability in years 11 and 12 to plan and prepare for their future. The second component of the new disability funding is an extra $4.34 million, which, along with $22 million in growth funding, will expand long-term accommodation support options for people with a disability so they can continue to lead active lives in our community. This takes the total for accommodation support funding to non-government organisations to $299.6 million.

This year's budget includes $11.2 million over three years from the Queensland and Australian governments for the Mental Health Disaster Recovery Package. Funding will deliver more community based support and services such as one-to-one counselling, grief counselling, mental health advice and referrals, social supports and tailored group counselling. Services are already being provided on the ground where they are needed. It is a clear demonstration that Operation Queenslander is helping to rebuild people's lives. The Bligh government has a long-term vision. It has policies and plans for the future. The Mental Health Disaster Recovery Package is a downpayment on our forthcoming mental health community services plan and the forthcoming COAG discussions on a new national mental health roadmap. We will deliver a new 10-year plan for Queenslanders with a disability. In partnership with the federal government, we will deliver major reforms to the delivery of Home and Community Care services, and this record budget will deliver on our commitment to provide better access and more services for as many Queenslanders as possible.

CHAIR: Thank you, Minister. I call the member for Aspley.

Ms DAVIS: Minister, in opening I would like to say that I was very disappointed to learn this morning that there would not be an Auslan interpreter available here to make the proceedings today more accessible for those people with hearing impairments. Could you advise why?

Mr PITT: We have worked very closely, as you have seen over the summer, with Auslan interpreters through our natural disasters and disaster recovery, so of course it is something that we as a government have been very supportive of. We have spoken at length on the need for Auslan translators in support of the deaf community and for the hearing impaired community. This is a matter that we have raised with the Clerk of the Parliament and we have sought advice on whether an Auslan interpreter could be forthcoming not only for this hearing but for all hearings. We thought that was a question worth asking.

Ms DAVIS: I am sorry, Minister. My question was: why is there not an interpreter here today? Are you saying that the Clerk of the Parliament did not want an interpreter here?

Mr PITT: There is a cost factor associated with that and it seems that the cost was going to be insurmountable if it was to be across the entirety of the hearings.

Ms DAVIS: My follow-up question is: given that you are the Minister for Disability Services and an interpreter is to assist people with hearing impairment, why could the funding not come out of your department in order to have an interpreter here today?

Mr PITT: I am very happy to say that this is something that is under consideration for future hearings.

Ms DAVIS: So there was no liaison with Deaf Services Queensland to provide anybody here?

Mr PITT: There were liaisons with Deaf Services Queensland.

Ms DAVIS: And was an interpreter engaged at any time to come here today?

Mr PITT: Those discussions were had. As I have said, this is something that will be under consideration for future hearings.

Ms DAVIS: It is very disappointing that they are not here today. If it is a matter of cost for a three-hour period for this particular session, it would have been highly appropriate and I think very welcomed by the deaf community. You talk about your support of the deaf community. How many initiatives for the deaf community are online or how many online services are available to them? How many of those have been translated into Auslan for the deaf community?

Mr PITT: There is a whole-of-government practice when it comes to the provision of accessible online content. So we look at accessibility right across the Queensland government web portal. This starts with the Queensland government gateway, which is the www.qld.gov.au website address. It starts at that level. There are accessibility flags as you can see moving through each of those pages. It is not possible for every aspect of all pages to be considered in that regard, but we certainly do our best to ensure that is there as much as possible.

In relation to Auslan translation services, as I said, we are very supportive of the need not only to encourage the use of Auslan translators wherever possible but of course to make sure that we are putting those at the fore and raising awareness of what services they provide. What I am happy to report is that in 2010-11 our program has provided more than 400 episodes of interpreting to people who are deaf or hard of hearing. An additional $1.21 million funding has been allocated to Deaf Services Queensland under its Support with Interpreting, Translating and Communication program. Through all of our service centres where we are perhaps using a linker or an intake officer, we always offer the opportunity for using an Auslan interpreter, as we do in providing interpreter services for people who have come from different communities such as a culturally and linguistically diverse community. So those services are provided. It is part of the day-to-day work we do as a department.

Ms DAVIS: I would like to move now to some Carter recommendations. I appreciated the opportunity to recently go and inspect the new facility at Wacol, and I thank you for arranging that for me. In terms of the operation of the unit, on page 3-6 of the SDS, can you talk about the client base of the unit—whether there will be any age restrictions on any of the clients entering the disability unit there at Wacol?

Mr PITT: I am glad, first of all, that you were able to go and visit the facility and I am sure you would agree with me about this facility. I know when I saw it I was certainly surprised as to the state-of-the-art nature of it. Whilst it is a medium secure facility, it also provides I think a very constructive environment for people who are going to be using the service. It feels an awful lot like a home in that regard. It did not feel like an institution, which is one of the key things we were looking to achieve with the facility.

We have obviously spoken about this in the chamber before when looking at the Forensic Disability Bill. One of the things that we take into consideration when looking at the cohort who are going to be in the service is that it is not restricted on gender so you are able to have a mix of males and females in the service. When it comes to the age of the people in the service, it is only a service at this stage for adults.

Ms DAVIS: Sorry, Minister. Could you repeat that. I missed what you said.

Mr PITT: Sorry, I have a bit of a flu so please if you need to get me to repeat something I am very happy to do so. The service is for adults only and it is of course for those people who we think will most benefit from this service.

Ms DAVIS: So it is adults only, yes?

Mr PITT: That is correct.

Ms DAVIS: Are there guidelines separate to the legislation that dictate who would be eligible to enter the forensic disability facility?

Mr PITT: We are aiming to support with this service people who have an intellectual disability or a cognitive disability. One of the clear guidelines of who can qualify for the service is that it is for those people who will most benefit from the service. We do know there are a number of people who are possible candidates. It is up to the Chief Practitioner Disability, who also has a statutory role as Director of Forensic Disability, in partnership and in collaboration with the Director of Mental Health to determine who are the most eligible and suitable clients for the service. One of the key elements here is that they must be someone who will benefit from the service.

Ms DAVIS: Do you think ADHD will be prominently represented in this cohort?

Mr PITT: I think you have to take a range of things into consideration as to who will qualify for the service, but I would have suspected that someone who has an ADHD diagnosis would not be someone who would benefit from the service, no.

Ms DAVIS: That is not the feedback I received when I went on my tour; it was in fact that ADHD would probably feature reasonably well because of the capacity to rehabilitate. So my question further to that then is do you think that clients with ADHD would be the most pressing intellectual or cognitive disability clients to go through this facility?

Mr PITT: Sorry, I get what you are referring to now. That would not be the driver; it would not be the No. 1 driving cohort that we would expect would be in the service. It is not to say that it would be excluded, but the important thing is that this is somebody who would be under a forensic disability order. That is the first thing—that they need to be in the service. There may be a range of other elements to that but they must of course, as we know, have a sole diagnosis, not be a dual diagnosis. There could be a range of things that will be happening here, but ADHD alone will not be one of the significant drivers.

Will they benefit? That is a clinical decision that needs to be made as to who will benefit from the service. But you cannot suggest that just because somebody has ADHD they will benefit more than somebody else from the service. That is my understanding.

Ms DAVIS: Well, given that an ADHD client may very well be able to be rehabilitated more readily than other clients who fulfil the criteria, my question then is for those harder cases will that preclude them from having the opportunity to be rehabilitated through this facility at Wacol? Is it simply for the easier cases?

Mr PITT: It is not about the easier cases; it is a determination as to who will benefit most from the service. That is not a simple decision to make. If it were, we would not need somebody with the expertise of Dr Jeffrey Chan as our chief practitioner to be making those decisions. The clients are going to be based on their unsoundness of mind to be fit for trial to qualify for the service and of course then whether they are going to benefit from it. I am sensing the line of questioning you are going down here. It sounds as though you are heading into more of a clinical answer that you are requiring. I am happy to—

Ms DAVIS: Minister, I just would have assumed that you would have had these discussions with the appropriate people as to what sort of client base would go through the facility and what level of intellectual or cognitive disability they might have in order for this new facility to rehabilitate them in the manner in which you continue to describe and get them back into the community. Apart from who can go in, let us talk about the people who cannot go in and who are not deemed able to be rehabilitated to go back into the community as well as others. Can you tell us what will happen with those people who are not going to be eligible or will not have the opportunity to go through the facility at Wacol?

Mr PITT: Sure. Just before we move on to that, it is important to note that the people who will qualify and the types of intellectual and cognitive disabilities that qualify somebody for the service are spelt out in the act. That is what we have debated in the chamber. But each case is an individual case, so it is important to note that you cannot make a broad statement about if a certain cohort would go through because it depends on other behaviours that are exhibited and a range of circumstances—

Ms DAVIS: That is fine, Minister.

Mr PITT: I just wanted to—

Ms DAVIS: You have answered that question for me.

Mr PITT: I just wanted to make sure I have answered that because I am just not sure that you have acknowledged that in the answer.

Ms DAVIS: No, I got your answer. My question now is what happens to those individuals who will not have the opportunity to go through? Where will they now be rehabilitated? Will they stay in acute mental facilities where they are now? Will you have other options open to them to get them back into the community? If they are not qualifying to go through the facility at Wacol, have you given up on them?

Mr PITT: I thank you for the question and, no, we have not given up on people. I know you are aware of this: the fact is that not everyone is going to be able to go through this service. They either may not be deemed to benefit from it or they may not be able to go through it for reasons of capacity at that time. Those people will remain in an authorised mental health service.

It is important to note that one of the key elements we brought through in this legislation was ensuring that the model of care within an authorised mental health service would be as close to what would be provided at the Forensic Disability Service itself. So Dr Jeffrey Chan, as Chief Practitioner Disability, will be working with Aaron Groves as Director of Mental Health to ensure that the programs and policies within Queensland Health facilities and authorised mental health services will be the appropriate model of care—and that is pushing it towards a therapeutic model of support as opposed to what has been previously experienced in a facility.

Ms DAVIS: But they will still remain in acute mental health care?

Mr PITT: That is correct.

Ms DAVIS: Apart from the 10 clients who will eventually be at the Wacol facility, at this time how many people who are currently on forensic orders are sitting within the acute care system within Health or in any other facility?

Mr PITT: At the moment, we have deemed that there are 45 people who have an intellectual or cognitive disability but no mental illness who are requiring involuntary treatment who are subject to forensic orders in Queensland. So the number is 45 across the state presently. Of those 45, a total of 16 were identified as being detained in an authorised mental health service. The remaining 29 are residing in the community with authorised mental health services monitoring and coordinating their care in partnership with the Department of Communities. So it is 45 people across the state, with 16 of them actually in authorised mental health services at the moment. The majority of people are in the community on limited community treatment orders and are having that work given to them in the community sector.

Ms DAVIS: How many have a dual diagnosis and are currently excluded from that cohort but may benefit from going through the facility? How many people with a dual diagnosis on forensic orders are sitting under Health in mental health facilities?

Mr PITT: Those with a dual diagnosis are not subject to this service.

Ms DAVIS: I understand that. I am simply asking the question. I assume Dr Jeffrey Chan will also be liaising; if the primary issue is a cognitive disability or other, then they will still require similar therapeutic treatments. What I am asking is this: how many people on forensic disorders might actually benefit from going through the facility at Wacol, although they do not fulfil the criteria of a single diagnosis?

Mr PITT: The question you are asking is a question that is probably more appropriately answered by the Minister for Health because the area you are talking about here is the Forensic Disability Service. People who qualify for that service are people of sole diagnosis not dual diagnosis. If you are asking for the broad number of people who are on forensic orders, I am unable to provide you with that information.

Ms DAVIS: In a similar vein but turning to the broader Positive Futures program, again on page 3-6 of the SDS, when the Carter report was released a recommendation within the report was that all aspects of reform be undertaken within two years. Why has it taken so long to implement?

Mr PITT: The Carter report was something that the Queensland government took very seriously and we have responded through Positive Futures. We are investing $228 million over six years, from 2007-08 to 2012-13, to develop a positive behaviour support approach. I can say that all of the Carter report recommendations have been, will be or are currently being implemented. So we are not in any way not fulfilling what we said we would do with the regard to the Carter report.

Ms DAVIS: So how close are you to fulfilling the final recommendations? How soon do you think you will reach the final stages of that?

Mr PITT: It is over a six-year period. It is like anything. We have committed to doing it over a certain period and we said we are going to do it by that time, and we are on track to still do it by that time. We are seeking to have those recommendations implemented in full over that six-year period. I guess in short the answer is that we are on track to fulfil those.

Ms DAVIS: Minister, how many clients in total are currently in facilities as a result of the Carter reforms? We know there are 10 going into Wacol, there will be one next week. How many are currently in facilities as a result? You talked about a program and six years. How many clients are already in facilities?

Mr PITT: Not everybody who will benefit from what we are doing in Positive Futures are actually in facilities.

Ms DAVIS: I understand that but my question was specifically to that.

Mr PITT: Your question is specifically how many people subject to Positive Futures are in facilities? Is that right?

Ms DAVIS: Yes.

Mr PITT: I will have to take that question on notice. It is a specific figure. I will have to have a look at that figure for you.

Ms DAVIS: That is fine. A central part of the Carter reforms is the provisions for the use of restrictive practices. The changes to the restrictive practices legislation are now a couple of years old. Has the implementation now been completed across the sector?

Mr PITT: I am very happy to talk about what we have done in the area of restrictive practices. Of course we have been reviewing our legislation to make sure that it strikes the right balance between protecting rights, supporting positive lives and improving the capacity of those people who care for and support people. We have been working very closely with the non-government sector to ensure that with regard to restrictive practices we have a very firm view of how this should be working and how it will roll out. I am very pleased to report that there is a compliance rate of some 99 per cent with regard to restrictive practices by our non-government service providers.

Ms DAVIS: I am sorry, Minister; I was distracted for a moment. So did you in your answer say that the implementation is now complete?

Mr PITT: What we are saying is that there is a compliance rate of 99 per cent by our non-government service providers with regard to restrictive practices in ensuring that they are complying with what we have set out to do under those reforms. The reforms have regulated and greatly reduced the use of restrictive practices, and I know that the work that is happening through the centre of excellence is providing training, is providing leadership and is providing a better understanding of what is best practice in order to ensure that this is actually applied to the sector. This is certainly about providing support for our non-government providers through capacity grants, access to expert staff and contracted clinicians, as well as ensuring that they have the support they need by way of operational grants to fulfil—

Ms DAVIS: That is wonderful, but at 99.9 per cent would you say that you have reached completion across the sector?

Mr PITT: Yes, there is a compliance rate of 99 per cent.

Ms DAVIS: So, yes, you would say 99.9 per cent? The answer is yes, you think that the—

Mr PITT: Yes. I make the point that for those who have not complied we make no apologies for having some very strong legislative guidelines around this to make sure that the processes that are happening and the work that is being undertaken by the sector is appropriate. This is a very important thing because if someone is not complying it says that the legislation is working.

Ms DAVIS: Thank you. In adopting those provisions for restrictive practices, though, the non-government sector has had to bear a lot of cost with regard to implementing the legislation on restrictive practices. Are you aware of what sort of burden has actually been imposed on the sector? What have you done to relieve the NGOs of such a burden?

Mr PITT: As I just indicated, we have been ensuring that the capacity of our non-government providers has been boosted through training, through the work of the centre of excellence, and we have increased our indexation of our operational grants from 3.25 per cent to 3.75 per cent, which is above inflation and which is certainly recognition of the increased workload that is going to be there.

Ms DAVIS: So you think that is enough to—

Mr PITT: We have also provided $1.2 million—

Ms DAVIS: You think that increase is enough to offset those very heavy burdens imposed upon the sector?

Mr PITT: If you will just let me continue to answer the question, we have also provided $1.2 million to NGOs as part of this transition to ensure that processes around restrictive practices are adhered to. So there has been an additional figure put across the sector in addition to, as we have said, our indexation of grants, and this figure is going to be increased to $2 million in 2011-12.

Ms DAVIS: So what you are saying, Minister, is that the amounts that you have just shared are enough to offset the burden placed upon NGOs for the implementation for the provision of restrictive practices?

Mr PITT: We have dealt—

Ms DAVIS: Just a 'yes' or 'no' will be—

Mr PITT: No, I will not give you just a yes-or-no answer because there is nothing 'yes' or 'no' or simple about some of these things. This is—

Ms DAVIS: It is either enough or it is not.

CHAIR: Member for Aspley, I think we will let the minister answer the question, please.

Mr PITT: What we are dealing with here is that we have provided additional support. We have worked very closely with our non-government providers and we have had feedback to say that this has been a strain in some cases and in others it has not been as difficult a procedure and has been absorbed well and truly into their operating costs. Again, this is different sized providers that have different processes and a different focus as to how they provide their service. So it is not as simple as saying yes or no; it depends on the individual service provider. But what I am pleased to say is that my department has worked with the sector and given them an extension of time, I might add, to ensure we are able to get the compliance to where we needed it to be. We have continued to adjust the level of support based on the need, so I am not going to give a yes-or-no answer to a question which I do not think has a yes-or-no answer. It is different for different service providers.

Ms DAVIS: Perhaps, then, you might give an example of how the cost impacts on a large service provider as opposed to a small service provider, given that you are unable to assist me with a yes-or-no answer.

Mr PITT: This is something that we are doing in response to a very important recommendation of the Carter report. This is not something that we take lightly, and I know it is something that our service providers do not take lightly. This has, as we have said, not been uniform, but the end result and what we are all trying to achieve is something that people acknowledge is important work. If there are difficulties in doing that, that is part of that transition. But I do not see that there is any argument that this is an important step forward to—

Ms DAVIS: I am not arguing that the recommendations of Carter are not worthy of implementation; I was simply asking you to provide me with an example of what the cost is to implement or adopt the provision of restrictive practices for a larger organisation and for a small one, because you in your previous answer said that you could not give me a yes-or-no answer because they are different. So if you could just give me an example—that is all I am asking—we can move on.

Mr PITT: Sure. We are funding, as I said, for operational grants, capacity building and training and leadership within organisations. As I say, this is one of those areas you have to continue to work on. That is why we are providing recurrent funding, to ensure these measures are able to be put out there and absorbed.

Ms DAVIS: So you are not sure, really?

Mr PITT: I am sorry; I am not sure what the question is here.

Ms DAVIS: For the larger organisations we are talking considerable amounts of money—in some cases hundreds of thousands of dollars—to implement these. For the smaller organisations it is less, except that some may have to look at employing people in order to do the right thing and fall within the provisions of the legislation. All I am asking you is: have you any idea how much impost is actually being placed in a financial sense, quite apart from the rebates, on a large and small organisation? I am just asking if you are aware.

Mr PITT: Are you looking for a specific figure? I am not going to go through organisation by organisation.

Ms DAVIS: No, I am not asking you to be specific. I am asking you: are you aware of the size of the figures that it is costing the NGOs to implement the recommendations? That is all I am asking.

Mr PITT: I think I have answered this, and that is that the resources that we have provided are by way of indexation and by ensuring that we are providing more money for operational grants. Also, the recurrent funding that we are providing is there. I can say, though, as I said from the outset, that if we have a compliance rate of 99 per cent and we have worked through with our non-government partners to achieve that, then obviously it was possible. The fact that the compliance rate is as high as it is says that the work that has been done has been able to be completed.

Ms DAVIS: Fair enough, except that they have to comply so they will comply. That is not an option.

Mr PITT: I go back to the point that NGOs report great satisfaction with their ability to now change people's lives, and that goes back to the heart of why we were actually implementing the Carter recommendations. You said that they had to comply. That is because most people agree with the need to comply.

Ms DAVIS: Okay. Thank you, Minister. I am happy to continue, Madam Chair, on another topic.

CHAIR: We might just have a change of pace. I call the member for Burleigh.

Mrs SMITH: Thank you, Madam Chair. Minister, for young people with mental health and disability issues, transitioning from school to further learning or employment is often very difficult. In your opening statement you referred to the My Future, My Life initiative. Can you advise what other initiatives and funding are in place to help these school leavers make the transition?

Mr PITT: I thank the honourable member for the question. Almost $50 million has been set aside to deliver more options to help school leavers make the transition from school to further learning and training and employment, and there are funds of $6.66 million to help an additional 420 young people with a disability who are leaving school. This is about, as I said, building pathways for young people with a disability to support their transition into adult life.

In my early days as the new minister in this portfolio I was fortunate to have the opportunity to attend the annual post school services expo at the Brisbane Convention Centre. I was pleasantly surprised at the number of stallholders who were there and the broad range of information that was being provided. This is an expo that has been successfully running for 10 years, and each year it showcases a range of options, information and advice for young people with a disability who are leaving school.

I was also very lucky to have met at that particular forum not only many young people but also parents, teachers and service providers. What I took away from this is that leaving school and transitioning to another chapter in your life is a big milestone for anybody, but of course for a family of a young person with a disability that can be even more so. This is an area we have paid very close attention to and we have listened to what we have heard in the broader public on this. This has obviously been an area where people have shown some particular concern.

With all of that in mind, I guess that is where our post school support options funding can help make a real difference by offering young people the opportunity to move into a job or into further study. This is not only about building their capabilities and their capacity into the future; it is also about building relationships and building their social networks. This is sometimes something that can be forgotten if you have a program that is just focused on getting an on-paper outcome, but I think all of those other peripheral things that come—those benefits—are great. This is about building their communication skills, their community awareness, enhancing their daily lives and their living skills.

I take a moment to talk about a couple of people that I met there. Jessica and Mark are the two young people who first come to mind that I met at the post school expo. Jessica wants to undertake a course in animal studies, has always loved animals and is going to be pursuing that as a result of some of that work. Mark, who was playing things pretty cool weighing up his options, was quite enjoying the social aspect of the whole thing. He wants to get into a trade. He had not decided which one, but he is going to look at that. These options were not available to him until he had actually seen what was on offer at this particular expo.

The My Future, My Life strategy means that another $1 million will be made available to help around 600 young people with disability in years 11 and 12 to plan for their futures. I wish all of them the greatest of successes and it is a particular project that I have enjoyed working on because I have seen firsthand what those benefits are.

Ms JOHNSTONE: Minister, I am interested in some non-clinical mental health support services. Could you outline for the committee any alternatives that exist to inpatient care for people who are experiencing mental illness and what we are doing to intervene sufficiently early to support people with mental illness so they do not get into the system—that is, patient services in the community? Could you elaborate on that?

Mr PITT: I think it is important in the answer to talk about what we are trying to achieve in the space of mental health here in Queensland, and it is something that is happening across the country. It is certainly a trend that is happening everywhere. In terms of what we are doing for people to keep them out of acute care, straightaway initiatives like our Time Out House come to mind. This is a service aimed at people aged 18 to 25. It is about getting people before they come into the acute system. Again, it is about providing those supports and linkages to services. It is about saying, 'Here are some options with regard to employment.' Those measures work very nicely in working towards partnering with the federal government on initiatives like headspace, which is also aimed at young people. It is very important that we target our initiatives at younger people, because it is a very important aspect at that early part in life where the onset of mental illness can be more prevalent. Those are the sorts of things that we are doing. It is very important to keep people out of hospital wherever possible, and that is what we are aiming to do.

Mrs CUNNINGHAM: I wanted some clarification if I could on two answers to questions that were asked on notice. One answer to a question on notice talked about capital works in the Gladstone electorate. The answer to question on notice No. 9 talked about two three-bedroom facilities that were being constructed as supported accommodation—and this is in the disability assistance package. There is $461,000 that had been deferred and is now, in your answer to the question, finalised for construction in the 2011-12 year. So that is a capital expenditure. Yet the answer to the member for Aspley's question on notice No.6 talks about the capital works but there is no recognition of that work to be done in Gladstone in the list of capital works unless it comes under facilities upgrades, which is not specified. Can you give me an assurance that those two three-bedroom houses will be completed in this financial year?

Mr PITT: Thank you for the question. With regard to the specific notes regarding Gladstone, I will get some information on that. Just broadly, when we talk about our capital program it is a rolling multiyear program. It may be that if something is announced in 2008-09 works commence in 2009-10 and the completion for those facilities is in 2010-11. So looking at each of those years, sometimes what we see in our budget papers does not always reflect on each of those individual capital projects—where it is going to be at—because it is important that we actually have those milestones delivered and sometimes the payment for those milestones does not happen during that financial year. There is nothing to suggest that those are not on track and that they will not be delivered.

Mrs CUNNINGHAM: One of the things that has been really absent in the electorate has been an ability for people with disabilities to remain in their own communities but still live independently. This is not being disrespectful to you. I have had conversations with the previous minister for disabilities in relation to acquiring a motel that was up for sale that would give independent living but still have a common area for meals and other services. Is it envisaged in the rural and regional parts of Queensland—and obviously my interest is Gladstone—that those sorts of facilities will be invested in in the coming year or two years?

Mr PITT: I think when you look broadly at trying to assist people to have independent living you will not find a better example of the work that we are doing there than in the Home and Community Care program that we deliver in partnership with the federal government. Again, it comes down to the individual needs of the person as to what service they provide. It could be that they are having meals delivered as part of a Meals on Wheels program. It could be that, through our mobile care service, we are actually going out and doing a single turnover that might be required. So we are certainly wanting to get the broad range of programs that we are delivering out there but we need to be clever about how we do it because, of course, there is only a certain amount of money to go around when it comes to delivering our services.

We are very clearly aiming to have as much independent living as possible. Each case is different and each client is different in terms of their needs. Some people will require more services than others, but broadly we are trying to have as much independent living as possible because we think that that is where somebody is going to be best placed in their community. They are going to be able to contribute potentially in the workforce if they are living in their own home but having services provided to them. Some people might have more complex needs and may need those services in a group home environment or perhaps in a facility. It is probably not an easy one to answer in that regard. Is that going some way to answering what you are asking?

Mrs CUNNINGHAM: No. I think HACC is a different cohort of people. The people who I wanted to discuss, if you like, or to question were the group of people who definitely needed support services. These are people with both physical and intellectual disabilities. There are no services to speak of in Gladstone except for what was referred to in that question that the department was building two three-bedroom houses under the supported accommodation disability assistance package. That construction had been funded to the tune of $50,000. Your answer says a further $461,000 was deferred into the 2011-12 year for the finalisation of construction, with the project totalling $511,000. I do not know for how long it has been deferred but will it be completed in this financial year?

I wondered whether there was any consideration given to independent living for people with disabilities in rural and regional Queensland? What is happening in Gladstone is that mums and dads with high-needs children are having to send those adult children into other towns. It is absolutely debilitating for both the client who needs support and the parents to have to have that separation. I wondered what investment there is in this budget for those sorts of facilities in, say, Gladstone so that parents and children do not have to be separated. They may be geographically apart—have their own accommodation—but they can still keep that family interaction. That is quite separate from HACC. That is a different service.

Mr PITT: Thank you for the clarification. As I said, we have a general trend towards supporting people in their community and we have to prioritise each case on an individual level of need. The $50,000 that you referred to relates to capital works by the department in a sense. That has actually gone to a non-government organisation. That will not be the total of that particular construction; it will be a contribution towards that. So that is where that money is. Does that clarify it for you?

Mrs CUNNINGHAM: Thanks. Can I also go back to question on notice No. 8. I ask for a breakdown in relation to non-clinical community health services and disability services. In 2009-10 there was $111,000—these numbers are all in that answer that you gave—for community mental health support activities, $175,745 in 2010-11 and in this forthcoming financial year $223,316. The electorate of Gladstone does not have a chronic mental health treatment facility. They rely on Rockhampton. The mental health support services out of the hospital—the outreach services—are stretched. I am wondering what your thoughts are in relation to $223,316 being the allocation for a population of 65,000 people or the adequacy of that amount.

Mr PITT: That figure is for the aspects related to the delivery of community mental health services not for mental health services full stop. Of course, there is an element of mental health funding which is under Queensland Health by way of some of those clinical community mental health services and inpatient services. So that figure is not representative of all of that amount. So I do not think that it is accurate to talk about that being simply all of the funding that we are providing for mental health in Gladstone.

Mrs CUNNINGHAM: But my question was what funding was allocated and spent on disability services and mental health services reported separately. If the mental health service is in receipt of more than that money, it should have been in the answer. The point I am making is that we are reliant for critical mental health—that is the in-hospital care—on Rockhampton. We have nothing. But if there is more allocated to in-community mental health services it should be in that answer because that answer says, 'Community mental health support services get $223,000 full stop for a population of 65,000 people.'

Mr PITT: Again, I am only able to provide an answer based on my portfolio and departmental expenditure. That is the departmental expenditure from the Department of Communities. As I said before, there is a Queensland Health component that is provided and I think that question may be best directed to Minister Wilson.

Mrs CUNNINGHAM: So under your portfolio there is $223,316. That is the end of the entitlement or the allocation?

Mr PITT: That is for the community mental health sector. Correct.

Mrs CUNNINGHAM: Thank you. Can I go to the HACC allocation. You touched on that in your earlier answers. I asked you again in question on notice No. 8 about the breakdown of funding for Gladstone and you said in relation to the Home and Community Care program that there is an increase from $2.7 million to $3 million. I would appreciate a comment in relation to the overreliance now on HACC services with the early release of patients from the Gladstone Hospital and, indeed, from other hospitals. What consideration or what audit was done to fully understand the demand on HACC services? We have a reduction in the amount of health services available at the Gladstone Base Hospital. Bed numbers have almost halved over time. That places a significant increase in demand on HACC services. I would ask whether an audit has been done in the past 12 months to determine the increase in demand on HACC services for the early release of patients.

Mr PITT: Thank you for the question. With regard to the needs assessments around the Home and Community Care program, the Commonwealth government undertakes need assessments with regard to that program, but I think you touch on an important point and that is that Home and Community Care is very well utilised as a program. It is one that performs an extraordinarily important role and we are very fortunate that it is a fairly flexible program and one that we can work very closely with the federal government with because, in delivering the services it seems to fill—you could almost argue that it is the jelly in an ice-cream dish in that it goes into all of those little gaps. It is a flexible program that can deliver services and be responsive in that regard. So we are very pleased about that.

In the Gladstone area we fund 11 service providers under the Home and Community Care program. So these service providers are Meals on Wheels Gladstone, Meals on Wheels Boyne-Tannum, senior citizen and welfare services, the Gladstone Aquatic Therapy Service, the Port Curtis Day Respite Centre, the Flexi Respite service, the Gladstone regional HACC taxi service, the Gladstone

HACC service, the Gladstone Continence Advisory Service, the Nhulundu Wooribah Indigenous Health Organisation and Blue Care Gladstone. Those are the organisations that we are funding. In terms of what outputs they have, they are providing 13,800 meals, almost 40,000 hours of home support services, more than 14,000 transport services and more than 5,000 hours of clinical and specialist care. So you are right in the sense that that service is really working hard and it is something that is invaluable. That is why we put so much value in that program and that is why we continue to work with the Commonwealth on making sure that the needs are being met. Their work is ongoing with regard to the assessment of need and we work closely with them on that.

Mrs CUNNINGHAM: Can I ask just one more question about an anomalous situation that I would be interested in your comment on. I think HACC do a brilliant job. They allow older people particularly, but also people who have mobility issues, people who have access problems, to meet many of those problems. What is the policy behind the HACC taxi service not being able to transport a person to a doctor's appointment?

Mr PITT: This issue was raised with me on a regional visit to Mackay, so I am aware of that issue. That is one of the guidelines that is set down by the Commonwealth government with the program. I am aware, and I am certainly not going to put any particular service providers in it by naming those people, that on occasion they have had to provide that service because it was the most appropriate thing to do. They have done that in consultation with other providers but, of course, it is not something that they would like to do. It is an issue that I am aware of.

Essentially, the people who would be using the service to go to a specialist and the people who would be using the service to go to a GP may well be some of the same people. I am certainly working closely with the Minister for Health on that to see if we cannot get some common sense around the provision of those services and to whom those services are actually let to. I think there is a lot to be said about that sort of approach because you would hate to see somebody who is in breach of their obligations or their contract by doing something which is supporting somebody under the service by going to a specialist appointment. The point you are raising is a very important one.

Mrs CUNNINGHAM: Can I interpret that as you saying that you and the Minister for Health are looking at avenues to allow HACC providers, in concert with the Commonwealth but recognising the Commonwealth's self-imposed constraints on the funding, to provide that very necessary service? Is that what you are saying you and the Minister for Health are having a look at?

Mr PITT: Yes, and I think in some cases some of those contracts may well have been let and it may not be possible at all, but I have certainly raised that as an issue. I think it is the commonsense way to do it. They are two different schemes and they are under different funding areas, but where you are going to have some synergies there I think what we all want is for the end user of the service to be someone who will benefit from that and that you see a service that is streamlined. I am trying to do some work in that area.

Mrs CUNNINGHAM: I certainly think there is a lack of logic, and this has happened in my electorate. Mrs Blogs can get a HACC service to get her shopping but she cannot get a HACC service to get to the doctor to have her prolapsed uterus returned which is critical to her health and comfort. She can get a cab under the HACC program to get her groceries.

Mr PITT: Just going back, the Department of Transport and Main Roads administers the taxi scheme and the Home and Community Care program does contribute funding to it. I am all about being pragmatic and all about trying to get commonsense solutions to that, so I certainly take the issues that you are raising. I think it is a point well made. We have to find a commonsense way of delivering these. I do not think anyone sets out with any program to make some of these lines of division the way they are. I think we all seek to do it the most appropriate way but sometimes there are unintended consequences, and I think this is one that has been identified certainly by yourself but, as I said, it was raised with me on a trip through to Mackay as well that this is something that is happening and we would like to see if we cannot find a way to make that more streamlined.

Ms JOHNSTONE: I want to follow on from the member for Gladstone with questions about HACC. I am also interested in the transport funding elements of the HACC services that are provided. I can take it from your answer to previous members' questions that you are looking at ways to get better outcomes from the transport components of HACC. I am particularly interested in the community transport service systems and any other information you may have about how HACC funding will directly help people with disabilities to remain in their homes rather than prematurely move into residential care.

Mr PITT: I thank the honourable member for the question. You have certainly had conversations with me in the past about this issue so I know that you are someone who is a strong advocate for people in the Townsville electorate. This year's state budget has delivered more than half a billion dollars—$523 million—to ensure the continued home and community care needs of Queenslanders in need are met. As we know, people are doing it tough on a range of fronts at the moment, so I know that these funds could not have come at a better time. It is about reaching out to people, giving them a helping hand when they need it most.

As you have identified, these things are helping people stay out of aged care facilities and allowing them to live independently in their homes. I think when asked about the Home and Community Care program people try to, I guess, encapsulate it, and we hate using the acronym HACC because I think it actually conjures up negative connotations in just the way that the word is used. Meals on Wheels is probably one of the best examples of something that is funded under Home and Community Care, but there are plenty of other activities that are undertaken in the community. These are everyday tasks that people need assistance with. Sometimes it may be, as the member for Gladstone indicated, when they are transitioning out of hospital. Somebody who may have had a fall still requires some support to do personal things such as showering or to have things happen in terms of turning down beds et cetera. Then there are the gradual steps towards their own rehabilitation for things like cleaning the house or having the lawn mowed. These are things that we all take for granted when we are mobile and able to do these things ourselves on a day-to-day basis, but where you have mobility issues or you have got to the stage where you have brittle bones or you are frail, receiving these services is an absolute godsend.

I just have to make sure that I put on the record the admiration I have for people who do work in the home and community care area. They are absolutely the salt of the earth. They are great people doing terrific work. The social element of this is also important. Some of the bonds that are formed between a client of a Home and Community Care service and their provider can be enormously strong. This is important because that person may have no other contact with the outside world. I hear stories all the time about somebody who has basically struck up a new friendship with a person simply because they have had this service provided. They would not have met them in a hundred years, but now they have met them through this program and they provide a lifeline to the rest of the world. They provide social interaction.

The other side of it is the mechanical side of it and the service provision. Those are the benefits that come from this program that you just cannot put a dollar figure on, I think. We think Home and Community Care workers are wonderful people. We think the service being provided is great and, as I said before, it is a program that we very much value and we work closely with the Commonwealth on because it is a program that actually does work. You cannot always say that about programs between different levels of government.

What we are doing is across Queensland. There are 170,000 people who are benefiting from this service. We, of course, are doing work with the Commonwealth as to where to in the future with this service for people of the age of 65 and over who eventually will transition into being under the Commonwealth's responsibility and people under that age who will be under the state's responsibility. That work continues and we are keeping a close eye on that as well.

Ms JOHNSTONE: I have a supplementary question on HACC while we are talking about it. I am also interested to know about different uses of technology. Given that we have had advances in technology, can you outline what plans there are to provide assistive technology to support Queenslanders with a disability, their families and also their carers?

Mr PITT: There are things by way of assistive technology such as personal alarm systems that are available. For example, for a person who may suffer from dementia it may actually be a system where if they wander too far from home the alarm will be triggered so that a response is sent back and somebody will know that they have wandered. It is a sad reality that that can happen. That, to me, is a good example of some of the technology that is there. There are also things that relate to personal distress and having an ability to raise that alarm themselves. A call goes directly to a call centre that can actually sometimes just reassure somebody at the other end of the phone, or if there is emergency treatment needed they can actually go forth and use that.

As a younger minister, I am constantly looking at new ways that we can try to embrace technology. The use of technology and where we see we are going to go in the future will play a very key part of our 10-year plan. That plan has been widely consulted on. We are fortunate to be able to work with other cabinet colleagues such as Minister Finn and Government Services to look at what government technologies are available that can support people more broadly, not only the end user in the community but, of course, our service providers to help streamline what they are doing.

There are other things on the horizon, of course. You have seen the exploration of new consumer based technology such as tablets. I hesitate to refer specifically to iPads but they certainly are the most common one that is out there. Those initiatives with iPads are helping people communicate far better. I digress for a second whilst I am speaking about that. If we are talking about the use of technologies to assist young people particularly, whereas in a school environment an iPad is probably a no-no, sometimes somebody who has one of these in a school environment because of a need which relates to their disability suddenly feels much more included in the school environment: they are the cool kid; they have got an iPad. Then a whole range of things come from that by way of the social interaction. So it is not just a communication device; it becomes a device that is helping bring them closer together with some of their school colleagues as well.

Mrs SMITH: Minister, while we all acknowledge that mental health is an important issue, men's mental health in particular is an area that needs attention. Men's Sheds are offering support for many who may not voluntarily access other services. With that in mind, can you outline what is in the pipeline for Men's Sheds and advise of the benefits of this initiative for Queensland men?

Mr PITT: I thank the member for the question. As we know, more than half a million Queenslanders will experience mental illness in any given year and many are from rural and remote parts of the state, places like where I am from in Gordonvale in Far North Queensland and further afield out west. We are expecting more people to be affected in the next few years because the rates of mental illness tend to rise considerably after natural disasters. Sometimes that does not happen right away; sometimes it can be a late onset and people do not always join the dots on those things and know that those things are happening as a result.

A couple of weeks ago I was a guest of a Twitter chat forum which was with Rural Mental Health. I had seen that they do the forum every couple of weeks and had made contact with the organisation. It was an absolutely eye-opening experience for us. I will get to the Men's Shed component, I promise, in a moment, but this was about linking people who are in rural and remote parts of Australia with people to have those discussions around mental health. That is one of the key elements of the current climate. It is actually being put on the broader public agenda far more than it ever has before, and one of the biggest challenges has been to have people talking about it. So to be able to use those new technologies to do that was great. There were more than 68,000 people who came through that Twitter process who were engaging over the time in the lead-up to and during the chat itself and who were retweeting those things. It was a very useful tool for us to see just how active and engaged people were wanting to be around this area. It raised concerns about isolation in rural areas, but one of the key things that came through was regarding the reluctance of men to come forward and talk about things. I know that I have been guilty of having a bit of a 'she'll be right, mate' type of an approach, and I am sure the member for Caloundra would agree, too. We sometimes think you've got to be tough in this regard as blokes, but ultimately it is about going forward and identifying that you have got some concerns and actually speaking about those and getting them out into the open.

That is what this is about; that is what men's sheds do. Men's sheds are a great way of getting into the spirit of mateship. It gets people together in an environment where they can work on meaningful activities and projects, such as repairing furniture, making cubby houses and cooking. They do a range of things that you probably would not expect, but in the comfort of an environment where men can do that together. Sometimes we all surprise ourselves as to the sort of activities that can come out.

In Queensland there are around 50 men's shed organisations that are a part of the Australian Men's Shed Association. The Australian Men's Shed Association was set up in April 2007. We are continuing to work with the organisation to ensure that we can start growing the prevalence of men's sheds in Queensland. It should be noted that this is not just a government initiative or a government responsibility. These sheds are happening organically in the community. They are growing and coming out of the woodwork because people see the need for them and people see that there are benefits in having these sorts of things in the community. We know that there are plenty of reasons men, not only for their broader health concerns but also for their mental health concerns, need to make sure that they tell people when something is wrong and talk about their issues and concerns. I think men's sheds are a great way of doing that. I am a big supporter of men's sheds and I look forward to watching them grow and, wherever possible, assisting that process along the way.

CHAIR: Thank you. It is good to see that the weaker sex has banded together and been able to produce something as wonderful as this. I think it is a fantastic initiative. I would like to ask a more global question, if possible. Now that we have our first stand-alone mental health portfolio, which is a great initiative particularly given the growing numbers of people who suffer from a mental health problem, could you provide an outline to the committee of some of the achievements that your portfolio has made, given that this is a real advancement?

Mr PITT: Thank you, Madam Chair, for the question. Firstly, I have to say that I am honoured to be Queensland's first Minister for Mental Health. This is an important step forward. If you look at what happened when Professor Patrick McGorry was Australian of the Year, that in itself was a great recognition of the importance of bringing mental health and discussions around mental health to the fore. To have this portfolio here in Queensland is important. I refer back to my answer previously regarding the Twitter discussion. We embraced that and people embraced the fact that I was there as the minister so they had direct access to me, could ask questions of me, could ask about what our future plans were. We were able to bring it into a focal point rather than having mental health as a part of a range of areas. It still is a part in terms of service delivery.

There are shared responsibilities with Queensland Health and, obviously, the community sector that I am particularly responsible for. That is important, but I see the role as much more than that. I see it as the ability to be an advocate; to be somebody who talks about the issue and tries to work with service providers to break down those barriers, to reduce the stigma that is attached to mental illness and to say that it is okay, that this happens, because it does happen a lot more than people probably are aware.

I can give you a very good example, and maybe this is a location based thing as well. Before I was elevated to cabinet, as a local member in Far North Queensland I pushed very strongly to get some support from the government for a carers' support hub in Far North Queensland, which was the Mental Illness Fellowship. They have been doing great work. That program was started under the federal government. It continued to go and go and go, but the funding was running out. I lobbied my predecessor who was responsible for community mental health at the time. With all of the other events that have happened with the natural disasters—seeing the floods happen and then Cyclone Yasi coming through Far North Queensland—the need for this hub was absolutely apparent. I was able to act very quickly to fund that organisation with a figure of $213,000 to ensure that it went forward. I was able to fund it for an additional year as well, not only a one-off payment but for a two-year period. That gave some certainty to the organisation to help ensure that it was able to grow the work it did, to grow the people supporting that work and to get that out to the fore. It is very pleasing to have been able to have done that.

We responded more broadly as a government with very clear linkages to our non-government partners such as the Queensland Alliance for Mental Health on the natural disasters. I think that is probably the key thing here. It should be noted that supporting the carers hub in Far North Queensland was not the only response; it was one of them. Based on that model, we set up a similar circumstance and a project in South-West Queensland, around the Darling Downs area. Early learning has led to that. We needed to be able to act quickly knowing that this is something that is important to the general community and also knowing that the after effects of a natural disaster were really going to hit home, so I think this portfolio could not have come at a better time.

CHAIR: Member for Aspley?

Ms DAVIS: Turning now to the non-government sector, I reference grants and subsidies that appear on page 3-21 of the SDS. Minister, NGOs are barely referred to in the Disability Services SDS yet they play such a major role in delivering community care. What reporting mechanisms are in place for the sector to have their concerns addressed?

Mr PITT: Thank you very much for the question. Obviously, the peak organisations include organisations such as National Disability Services, under the stewardship of Valmae Rose. Certainly Valmae is not backwards in coming forward, which is something that I admire strongly about her. The peak bodies are groups that we provide some funding to. On every occasion, we try to listen to them to see what is needed in the sector. Broadly, the Disability Council of Queensland, which has membership from service providers as well as people with a disability, is the lead advisory group for myself as minister and for the department to ensure that we have a fairly good handle on what the sector is asking for. That is something that we have to make sure that we do. We did that when we were developing our 10-year plan for disability. We will continue to talk to the non-government sector because, as you have quite rightly said, they are an extraordinarily integral part of what we do in terms of delivering our services. We think they deliver services very, very well. The trend across Australia is for government not to be delivering services, if possible, within non-government organisations that are on the ground and that are closer to the coalface. I think they can do some terrific work.

I want to run you through what we are doing. I know you said there was not a strong emphasis on that, but can I say that this year the department has a record grants allocation of $1.318 billion to human service non-government service providers. This includes $781.3 million to disability and community care service providers. I think that funding level is significant and I think that is recognition, certainly in terms of the work that they do.

Ms DAVIS: Earlier you referred to the council that peak stakeholders are members of. How often does that body meet and what reporting mechanism is there for their concerns to come back to you?

Mr PITT: The Disability Council of Queensland has a membership of 12. It is a group that meets four times a year. The membership is based on having the chairs of our regional disability councils in regions across Queensland. The chairs of those regional councils form part of the state-wide council. There is also an independent chair of the council. Also, some other independent appointees can come forward to make up the balance. That could be because the chairs of the regional councils may have a certain focus. They might be people with a disability or a lived experience; they could be carers. We want to make sure that we are not forgetting about the people who you quite rightly pointed out are doing great work, that is, the service providers in the non-government sector. Some of those people might be able to provide the balance to the overall council to ensure we have the right mix of people.

Ms DAVIS: They report back to you quarterly?

Mr PITT: They meet four times a year—

Ms DAVIS: But they report back to you quarterly?

Mr PITT: They report back to us—

Ms DAVIS: Thank you, Minister. That is terrific. Why has there been no real attempt to lessen the impost of bureaucracy, such as compliance costs, blue and yellow card costs and the waits that are associated with that, and the number of forms that the NGOs have to complete to get funding?

Mr PITT: I think that we actually have done some good work in this area. The non-government sector has welcomed the opportunity, particularly with our outputs based funding, to know the real cost of providing services. It was something that was difficult for them to ascertain previously. Whilst it could be argued that there is more of a requirement regarding reporting, which of course is important because we are talking about public money and it is important that we have those things accounted for, through this process they have learned and they have welcomed the fact that they know what the real cost of providing their services is as a result of that. On one hand there may be some more rigorous reporting that has been required, which we have done a lot to try to reduce, but on the other hand they are learning about what they are actually doing in their role.

When we look at red tape reduction, I can find no better example than our Growing Stronger reforms from an end-user point of view. Once upon a time, people would have had to complete about 27 pages of forms at the intake stage to let people know what they were looking for and what services they were trying to apply for; now they have to provide only three pages of forms. I am sure you would agree that that is a fairly substantial reduction in the amount of red tape that they need to go through.

Ms DAVIS: I do not need to fill out the forms, but what I am hearing from the sector is that there is still a lot of paperwork to get funding, that a lot of these NGOs are having to employ individuals in order to fulfil the paperwork and bureaucracy requirements and that that is money being invested in administrative staff that otherwise could be put into staff on the ground to deliver outcomes for people with disabilities. My question is: irrespective of the number of pages you mentioned there, are you aware that there are NGOs that are still struggling under the weight of paperwork and that it is costing them in order to comply? I agree that the sector, in the main, is not unhappy with compliance. What they are concerned about is the cost of compliance. Could you respond to that?

Mr PITT: I will give you another example. It is estimated that our 269 providers have been required, under the terms of their former agreements, to submit approximately 2,600 financial acquittals each quarter. That has been reduced to 262 single certifications each quarter. If we want to talk about whether we have been reducing red tape and reducing reporting requirements, that is an enormous difference: 2,600 acquittals down to 262. I think we are making headway in that regard.

I do not argue that we want to see as many people doing service delivery as possible and not administrative arrangements. That is why not only are we continuing to work with our partners to provide them with the capacity and the training to allow them to do things better and understand their financials betters—not every organisation is as well positioned as some of the major players, so we are doing capacity building within the sector and we are very happy to keep funding that—but also we are looking into the future at different technologies that are available to allow those processes to happen in an online environment and potentially further simplify that reporting. We are very cognisant of that fact. I have met with a number of organisations such as the Cerebral Palsy League and Endeavour, to speak about these matters. No-one is going to suggest that it is perfect, but it is a work in progress that is ongoing. We should all be striving to continue to make these processes simpler and that is what we are seeking to achieve.

CHAIR: We might take a break at this juncture. It is 11 o'clock. The committee will break. The hearing will resume at 11.30 am.

Proceedings suspended from 11.00 am to 11.30 am

CHAIR: Ladies and gentlemen, the committee will now continue its examination of the portfolios of disabilities and mental health. I call the member for Aspley.

Ms DAVIS: Can the minister detail all community mental health expenditure for 2011-12 that is not related to the floods or the cyclone? Whilst there is definitely a need to address the mental health issues resulting from the natural disasters, it is not the only area in mental health that needs attention. Why is there so little emphasis on mental health in the community, both in terms of prevention and support, outside of the natural disaster funding?

Mr PITT: Thank you for the question. I would argue that there is not little emphasis on that. Comparing how much is spent in the clinical sense versus how much is spent in the community sector is a different scenario. The money that is spent in the community sector is largely about early intervention, about reducing people's hospitalisation through other programs that we do like our housing and support program. Whilst you have a service like a time-out house, which you could argue is a step-up type of service, you have step-down services and transitional services like our housing and support program. Those services are important because, again, they take somebody out of a hospital or an acute environment and bring them back into a community setting with the care that they need. It also frees up space for people who do need care in an acute environment. It actually allows that process to happen and takes more people out of that environment. There also is a very strong saving for the community of just over $50,000 per person which is, again, a great thing because that money can be spent on other services.

In terms of having a specific amount for the non-disaster recovery components, if you have a look at the overall spend you will see that we have an $11.2 million package under the disaster recovery area. We have an ongoing budget of around $70 million in the community mental health sector. That is a figure that has been forthcoming for several years. That is about the extent of that funding. I would probably need to have an idea of what specifically you were chasing in terms of various programs in your line of questioning.

Ms DAVIS: I guess what I am really attempting to establish is that, whilst there is certainly a need for assistance to those people affected by the natural disasters, the funding for those in other areas or regions unaffected by disasters or in the south-east corner is still there or is increasing. There is an increasing cohort of people developing or still dealing with a mental illness. So I am asking you whether the money that you are expending in those existing programs is, in fact, being delivered, or is the main focus for your department to deliver to those affected by the recent natural disasters?

Mr PITT: If you want the figure excluding that, I might have to get advice on that. I can run through the range of things that we are doing in the community sector which will tell you—

Ms DAVIS: All I am asking is that the amount of money that is allocated to non-disaster mental health programs is retained at the same level or is increasing. That is all I want to know.

Mr PITT: The answer to that is yes.

Ms DAVIS: Substantially?

Mr PITT: Going back to your earlier question, yes or no, the answer is yes.

CHAIR: Just before we move on, have you finished with natural disasters?

Ms DAVIS: Yes, but not mental health.

CHAIR: Could we just take a quick question from the member for Townsville?

Ms JOHNSTONE: Minister, while we are talking about natural disasters, I am very interested in what the government is doing in terms of supporting people suffering from both the floods and Cyclone Yasi in coming to terms with the trauma that they have experienced. Just last week I was at Mission Beach for a few days and in the Cardwell area. The emotions are still extremely raw for people up there. You do not have to scratch the surface too much to know how tough they are doing it. Our hearts go out to them all. Minister, could you advise the committee what initiatives are in place or are planned to help restore the mental health of Queenslanders who have directly been affected by the natural disasters? How is that progressing?

Mr PITT: Thanks for the question. I am sure that, like many people in Cairns, many people in Townsville would be very happy that Cyclone Yasi did not hit a major population centre. That is certainly worth putting out there straightaway.

You do not need to have been in an impact zone of the cyclone nor to have had your home flooded to have been impacted by the natural disasters. It is an important point to make that, whilst we have services that are targeted on the ground for those particular areas, there were people who were already suffering from a mental illness before the cyclone came to Far North Queensland. Their day-to-day living and their concerns were exacerbated because they could see what was happening through the filter of the media in earlier parts in Central Queensland and then in South-West Queensland later on. It goes back to the question of the member for Aspley about the ongoing services. We were very happy that we continued to fund Lifeline to provide those services and support. Of course, once we were in a situation where almost the entire state of Queensland was affected by natural disaster in some almost direct way, it was very clear that we needed to have those responses on the ground.

It is very similar to post-traumatic stress disorder. Once all the media attention goes away from a natural disaster the reality starts setting in. We certainly conducted a very good campaign around the Easter break to ensure that people were aware of the services that were available. People who had perhaps lost their home or had significant damage to their home were staying with friends and relatives. From that point of view they needed somewhere to be. Of course, though, staying with friends and relatives can be difficult at the best of times, let alone if you have to go through an extraordinary amount of mental anguish at the same time. There is a very fine line between people feeling anxious and concerned after a natural disaster and then slipping into a state where they are suffering from a mental illness. We were aware of that and that is why we rolled out services.

The carers hub that I mentioned earlier was one such example in Far North Queensland. It has outreach services to areas on the Cassowary Coast. Most certainly that is something that we have seen on the ground. There has been a recruitment process in place for other services. Some of those are being auspiced through the Queensland Alliance for Mental Health. Those services are on the ground now.

Again, if you look at the work that the Department of Communities did in terms of providing an outreach service, I can certainly say that plenty of people, either in recovery centres or actually going out and doorknocking, were doing that work. They went door to door to check on how people were going. That was in combination, of course, with the work we were doing with public information campaigns to say, 'If you are hurting or if you need someone to talk to, there is assistance available.

Here is where you go.' It instructed people to use 13HEALTH as the first port of call. We were very pleased then to see the AMAQ come out with their See the Signs campaign, which dovetailed very nicely with what we were doing already, and that was to raise awareness of the signs to look for—that there will be people needing these services and they may not readily recognise it themselves. It is up to friends and neighbours to do that. We were asking people to look out for their friends and neighbours like they did before the event. It is just as important to do that after the event.

Ms DAVIS: Minister, as the member for Gladstone outlined, many regional centres across Queensland rely on hospitals and emergency units to deal with mental health issues because there is inadequate funding for community services to cater for their needs locally. This situation does not help the individuals and it places hospitals under further stress. Is there any plan to fix this and, if so, what is it? Is the department going to keep passing its responsibility for community mental health on to Queensland Health?

Mr PITT: I have to say that that is actually not a reflection of the reality. Growing the community mental health sector is all about keeping people from being hospitalised. All of those programs that we are currently running and have run in the past are doing that work. It is not possible to say that, even with those early intervention services and working to prevent people slipping further along the continuum with regard to their own mental health, somebody will not actually regress to a point where they need to be in a clinical environment. Those decisions need to be made, but, ultimately, that is not something that we can control. We will do our very best to ensure that people are not doing that. There is a range of factors that can cause somebody to go into that environment and most of them are not related to service delivery.

Just briefly, I want to come back to you on your earlier question, if that is okay, regarding the number of clients currently in facilities as a result of the Carter reforms. You asked that question and I gave a commitment to come back to you on it. I want to let you know that there are currently 10 people living in Positive Futures villas at Wacol, two in duplexes at Wacol. The other people with positive behaviour support plans live in supported accommodation. Essentially, that is elsewhere in the community. I wanted to make sure that we did the right thing and came back to you on that.

Ms DAVIS: Thank you for that. With respect to the answer prior to giving me that information, my concern is that there are no services available in some places—none at all. It is emergency wards or it is nothing. What is the department doing to get into those communities to assist people?

Mr PITT: There obviously is a very big discussion happening with regard to national health reforms as to where community mental health sits in that space as well. I have said to people quite often—and I say it as often as possible—that just as you present to your local GP if you have an ailment or other physical health issue, you need to know that you can go to your GP to seek advice about your emotional wellbeing as well. There is no shortage—I should not say there is no shortage: I can think of a couple of areas where there is a shortage of GPs, but that is another story altogether. Ultimately, that is a very legitimate avenue for people.

I do not think we have a shortage of services, by and large. Some of those can be accessed online; some can be accessed by telephone. It is more difficult to get some services to rural and remote parts of the state, as I indicated earlier. Often it is actually people's awareness of services that is an issue. When we have announced a coordinator role in the past, I have heard people ask, 'Why do we need a coordinator role? Just get the services out there.' The services are there; it is about making people aware of those services. That is a very important role to undertake. We think we have a good suite of services available and we rely on our departmental officers and of course our non-government partners to make people aware of those. That is the example of the carers hub that we gave earlier. That is what they do: they bring those services together and link people with the most appropriate services.

Ms DAVIS: So you are happy with the manner in which those linkages are provided to people in rural and remote communities? I am not talking about large regional centres here. One would expect that there would be opportunity for people to get to those services. So you are happy that those linkages are being created and that people are getting the information they need in order to seek assistance?

Mr PITT: Do I think it is a perfect scenario? Absolutely not. But am I satisfied that the services are by and large available? Yes. One thing that came up when we had the Twitter forum was specifically about those small towns. I gave the example of visiting a GP earlier. Sometimes that GP is the only GP in town. One of the other elements that relates to stigma is that people worry that if they present with a problem and talk about their emotional—

Ms DAVIS: So the department is linking with local GPs and the like to provide that?

Mr PITT: Absolutely.

Ms DAVIS: If I could just move along, last year there was much excitement with respect to the Community Mental Health Summit that was held. What has the government done to follow through with any ideas or recommendations from that summit? It has been some time now. I have not seen anything come out from government with regard to those matters raised at the summit.

Mr PITT: The Community Mental Health Summit, as you said, did create an enormous amount of excitement. I think the Premier would probably argue that it was because she was one of the speakers, but it was very much because Patrick McGorry gave the keynote address at that forum. That was a great summit. It was a chance for people to come together and contribute ideas—not only service providers but also consumers, carers and a range of people across the community. Certainly that is what is going to be informing our Queensland community sector plan under the Queensland Plan for Mental Health.

Later this year both I and the Minister for Health will be delivering a combined mental health plan which will incorporate all of the aspects of mental health across Queensland. It will most certainly be very strongly informed by what happened at that summit. As I said, over 150 people contributed at that forum. I also gave the commitment recently—again I refer to the Twitter forum that I hosted a few weeks ago—that all of those ideas that came forward at that point will be taken into consideration. That forum was a new way of accessing people. Even though we had a technical close-off for submissions, we continue to ask questions, we continue to engage with people in the broader public and we continue to learn about what we can do and what sort of vision we want for our community based sector here in Queensland. Those views will also be taken into consideration. As I say, that will be forthcoming later this year.

Ms DAVIS: I am sorry. In the event that I missed it, you have a core group of individuals who you are still liaising with in order to come up with this policy from the stakeholder groups and from those who were attendees at the summit?

Mr PITT: What I am saying is that the summit will inform the plan. We have to obviously look at all of the information that was brought up at that summit and formulate that into something that is workable. We could just put raw data out there but that does not—

Ms DAVIS: Is there a working group from the sector and with individuals that attended in order to develop this policy?

Mr PITT: The summit was done in partnership with the Queensland Alliance for Mental Health. The Queensland Alliance for Mental Health is the group that is working in partnership with us to do that.

Ms DAVIS: So they are working with you on that?

Mr PITT: I think that is a very safe set of hands to have that work done by.

Ms DAVIS: I would like to move to another topic, Madam Chair.

CHAIR: Sure.

Ms DAVIS: I have some general matters. Can the minister advise what happens to funds remaining in funding pools for non-government sectors? I understand that there are nearly 30 funding pools for which the non-government sector can apply. Can you tell me whether in that 12-month period, or whatever period it is that these funding pools are open to access money, the funding is always used? Is it always distributed or is there money that is left over at the end of the funding period?

Mr PITT: Sometimes due to efficiency there are funds left over. At other times there is actually a reprioritisation with agreement—that we will not undertake something we were going to do with a non-government partner. An example of where we reprioritise funds relates to the carers hubs that I referred to earlier. There was a $1.2 million reprioritisation of funds that went towards doing that. I think that is the benefit of not only reprioritising for a very important need but also being able to find funds based on efficiency that we can put to very, very good use. Yes, all funds that we have are committed for a purpose but some funds are returned. It is not always an easy area to talk about and it is one of the hardest letters that I sign in my job but, when a family has suffered the death of their son or their daughter who was on the receiving end of funds, those funds are then reallocated. So there are circumstances like that where funds are actually reallocated across my portfolio as well.

Ms DAVIS: So does this reallocation happen often?

Mr PITT: In that particular circumstance, we hope not.

Ms DAVIS: I understand your hub scenario. There was a disaster; you have a hub. I can accept that. But, generally speaking, funding allocated to a particular funding pool for a specific funding purpose is used for that purpose.

Mr PITT: An example, too, would be that we might be funding a particular individual's support needs through a non-government provider and those funds may then be reallocated because the purpose of those funds was to help the person transition or to help them get the skills and the capability to join the workforce. So sometimes what may have been necessary for that person to be funded for is no longer necessary, and that is one of the great things that I get to do sometimes—to say that somebody does not require a service anymore and we can reprioritise those funds.

Ms DAVIS: So the funding is for the person, not for the provision of the service. Is that what you are saying?

Mr PITT: All funds are allocated to an individual at the end of the day, whether it be directly or through a provider. That is what comes back to our outputs based funding and why I was saying that our non-government partners appreciate this whole process. They know where their money is going. They know specifically where it is being spent. That is very much a part of importantly using public funds the right way but also, if there is a reprioritisation, we can actually focus those funds on getting the best outcome for the individual. It could be that there has been a change of circumstance for the carer as well. A person who may need additional supports because—

Ms DAVIS: I think you have answered my question. You have said that it is for the person, not for the service.

Mr PITT: Can I add something to that? On average, we would plan to have about $6 million reprioritised because we have to be responsive to the needs of our clients and of our non-government partners in changing circumstances. Circumstances, as I said, do change.

Ms DAVIS: So why have 27 different funding pools, which I assume cover different provisions of service, only to then reprioritise? Why would you not just have one big funding pool and reprioritise as you go?

Mr PITT: Because you need to have a plan.

Ms DAVIS: It just does not seem to be much of a plan if you are reprioritising in each of those funding pools.

Mr PITT: If we are talking about reprioritising only about $6 million, if you look at that in the scheme of the amount that we fund across the sector, that is an absolute drop in the ocean. It is not a significant amount in the scheme of our service provision and our budget. We have a plan and we by and large stick to that plan. That is what good strategic planning is about. Ultimately you do have to be responsive to the changing needs and circumstances of carers, of people receiving our services and of course of our non-government partners providing those services. We have a disability services plan that publicly shows our priorities. But I state that we do have to change some of those priorities every now and then.

Ms DAVIS: Within each funding pool, is there an amount allocated for administration—that is, to process the applications—or does that money sit outside of the funding pool? Does all of the money in the funding pool go directly to services or to the reprioritisation of services or, within that, is there an amount to administer the funding pool?

Mr PITT: It does depend on what pool you are talking about. When we look at our intake services and look at assessing the needs and goals of our clients, that work is done by departmental officers.

Ms DAVIS: Yes, but is the budget for that sitting in the pool?

Mr PITT: The budget is all part of a big budget, as you know. It is part of one big bucket and then you drill down into various other smaller buckets. That comes back to the planning for our services.

Ms DAVIS: So, in the main, yes. Within the bundle of money for a particular funding pool, you have an amount allocated for the administration of that funding. Correct?

Mr PITT: Yes and—

Ms DAVIS: If I could just follow on—

Mr PITT: You ask me a question and I need to give you a fulsome response.

CHAIR: Order! Member for Aspley, I think in fairness you need to let the minister complete answering the question. Otherwise we are allowing a degree of confusion to occur here. I call the minister.

Mr PITT: Thank you, Madam Chair. What I was going to say was that, with regard to Growing Stronger, that is one of the key reforms that we have made—that is, that we will have one funding pool and that funds will be allocated on need from that pool. We talked before about having 27 forms to complete but now having only three forms to complete. Again, that was to streamline the process to ensure that we can get the most individualised supports as possible. So that is what we have been trying to achieve with that. There is an administrative component to everything. Otherwise you would never be able to achieve what we are seeking. Somebody has to administer funds. That is the reality of funding distribution.

Ms DAVIS: Minister, I understand that there is a cost for administration. But it was where that cost sat and you have answered that. It is taken out of the bundle of money that is allocated for services. But my question was, as a percentage—

Mr PITT: It is built into that amount. It is not taken out of it. That is what we do when we are planning for our budget. When we look at what services we are looking to provide, we build in an administrative component. We have an indexation component, as I said previously, regarding our operational grant provided to our non-government partners. That is now at a figure of 3.75 per cent. So I think it is a reasonable proportion of those funds going towards administration.

Ms DAVIS: Did you say 3.75 per cent as an average?

Mr PITT: I think it is actually 3.76 per cent.

Ms DAVIS: One of the impositions placed on non-government organisations is the yellow card, which is now coming and there is going to be a fee attached to it. Following changes to the criminal history screening in the Disability Services Act, the disability sector has experienced increased costs and delays with the yellow card. What is the minister doing in order to ensure staff working with people with a disability can have their checks done on time and with the least possible disruption to services? Minister, I am aware that the yellow card is not directly within your portfolio. But, given that it impacts directly on the delivery of disability services, I would appreciate a response.

Mr PITT: Sure. I will answer this in two parts. The first part is related to the time taken for criminal history checks—and you talked about that happening quickly. I think the answer to that is that criminal history checks take as long as they take. That is why we set up the process to ensure that there is rigour there to safeguard people who are going to be issued with a yellow card. Of course we want that to happen as quickly as is practicable, but I make no apologies for the fact that this process can sometimes take some time because we want to be certain that we are giving the tick to the person who is going to be delivering services and that that is a person who is trustworthy and a person who does not have a criminal history which would disqualify them from having a yellow card. The other part of it is that we do provide supplementary funding to people with regard to yellow cards. So from 1 July 2011 the fee increased to $72.50 in accordance with our policy for indexing fees, and this relates to the CPI.

The cost is related to the conduct of checks by police and the price of the card. The Queensland government approved the provision of supplementary funding to support the disability sector in consideration of the introduction of the new yellow card application fee based on yellow card use only. So we are providing supplementary funding to offset the costs of that card to assist the sector.

CHAIR: Member for Aspley, do you have a follow-up question for that one?

Ms DAVIS: I could move on to another section. In terms of funding and processes for organisations, could the minister explain the transition of the funding system from inputs to outputs? How much weighting is still given to inputs? How is funding calculated for an NGO?

Mr PITT: In terms of the reason why we have moved to outputs funding, I think it is important to state that we are trying to achieve our best value for money and we think that is achieved by having output based funding. The transition to output based funding is for a number of reasons—principally to reduce the administration and regulatory burden for service providers, to provide an opportunity to flexibly utilise funding and to implement a common service agreement with providers in receipt of the funding from different service streams within the department.

This exercise, as I said, has been welcomed not only because it allows people to know the real cost of providing a service but because we think there are savings there. We are really committed to ensuring that we get good value for money. One of the ways we are doing this is through the Queensland Compact. This is about improving the sector's capacity and sustainability in reducing that burden, as I said before. It is about enabling providers to focus their effort on delivering services to people with a disability and to not be focused so much on the other side. Those savings that we saw in that streamlining of reporting and acquittals is one of those areas. That is to me a very, very good outcome.

Ms DAVIS: What is the guideline equation used to determine the amount of funding that an NGO receives per service delivered?

Mr PITT: The outputs have been costed. It depends on which organisation you are talking about. For an organisation the scale of Endeavour, for example, it comes down to that organisation's ability to deliver a service. We need to make sure that they will be able to deliver the service and have the capacity to do so. That is important to determine how much funding is distributed to an organisation. That is probably the—

Ms DAVIS: So there is no standard equation per service?

Mr PITT: I might hand over to my director-general to go through that detail with you but, yes, there is.

Ms DAVIS: There is a standard equation. So it does not matter whether it is a large organisation or a small organisation; there is just an equation.

Mr PITT: There is flexibility to allow for circumstances. I think we would not be a responsive government if we did not allow some degree of flexibility. I will hand over to my director-general to speak to you on that.

Ms Apelt: As the minister has indicated, a movement to output funding has allowed us to more accurately cost the nature of the services. For example, there are certain costing formulas for respite services, supported accommodation and a range of other services that are provided through the disability services budget. Latterly, we are also moving to output based funding for community based

mental health services and also for the HACC services. There is a general formulaic approach. The size of the organisation does make a difference. We take into account economies of scale, rural and regional areas; there are certain factors there that will influence the cost of delivering services. It also helps to determine the method of service delivery. You may be aware that in recent years the government has supported an expansion of the local area coordination service. That is a very good example of where the service is being able to be provided on the ground in the community in a much more responsive and cost-effective way than some of the more traditional institutional ranges of providing services to people.

So output based funding has been a tremendous win for non-government organisations. There is more transparency around the relationship between government as the funding agency and non-government organisations as a service delivery arrangement. So we have got a much more mature point of negotiation about what is a reasonable amount of funding for the outputs that government is asking to be delivered. This has been a tremendous advancement.

In relation to the administration component, that is built into the output based funding so output is the cost of the service—for example, cost of the respite service. In addition to that, the government does provide reasonable costs for administration. As the minister mentioned earlier, there is an indexation that is built into the funding to take account of natural rises in the cost of living. We also build in an eight per cent administration component for disability grants. The HACC services, which are a different nature of delivery, has a 1.1 per cent administration component. For NGOs generally, it is between 18 to 20 per cent of the overall grant that is built in to make sure they have sufficient funds to administer the outputs on behalf of government as a funder.

Ms DAVIS: To the director-general: eight per cent seems quite high for the disability grants, given the 3.75 per cent figure for others. Why is it eight per cent?

Ms Apelt: Eight per cent is comparable with other jurisdictions nationally and also internationally. I think we need to recognise the complexity of the services that we are asking non-government organisations to deliver. Over time, community expectations around the quality of service delivery have continued to increase, so there is an expectation now that we have a certain level of training and competence of workers in the non-government sector and that all costs money. In order to be able to purchase the quality that the community expects, there is an expectation that that actually costs.

Ms DAVIS: So in those funding pools where you are looking at an eight per cent component, ordinarily would that funding then get to the non-government sector expediently, or is there money still sitting in the funding pool at the end?

Ms Apelt: No money sits in a funding pool. It does not sit unallocated. As the minister indicated earlier, all money is allocated against a stated priority as outlined in the disability services plan, the HACC plan and also the community mental health plan. There are often unforeseen circumstances, as the minister outlined, and we budget on average about $6 million a year where we could pretty well count on having the opportunity to reprioritise those funds to other areas of stated need. Sometimes that means topping up a service—

Ms DAVIS: But that money reallocated would go to the non-government sector?

Ms Apelt: If it is funding within our overall plan that has been identified for the non-government sector, it goes directly to the non-government sector.

Ms DAVIS: Thank you. How much of the funding remains inputs based? Any?

Ms Apelt: All of the funding within the disability and community services budget is either in the process of being transitioned to output funding, because you will appreciate that there are some funding agreements that have been in place for a number of years. As funding agreements come up for renewal, they are renegotiated along output lines.

Ms DAVIS: Has there been an increase in paperwork for NGOs as a result of the change in the system?

Mr PITT: Is that question directed to me?

Ms DAVIS: I will ask you, Minister. That is fine.

Mr PITT: As I said before, if you look at the example of what we have been able to do by a reduction with the financial acquittals, I think that in itself answers that question. If you have gone from 2,600 financial acquittal breakdowns each quarter down to 262 single certifications each quarter, that says there has been a reduction in paperwork.

What I wanted to add while I am speaking on this is that, when we are moving to our Growing Stronger model in phase 2, an element of Growing Stronger will be that we will have a better idea of where the needs are and where we need to direct and reprioritise our funds and for future planning. That is one of the things that Growing Stronger will build. We are doing this in partnership with the non-government sector.

I want to take the opportunity to acknowledge the significant contribution that our non-government partners have made to informing that system. It is an off-the-shelf system in large part, but a lot of the elements in terms of delivering that and understanding the data that is going to come together to inform

our future priorities are based on experiences by our non-government partners. We work very closely with the sector. I am very confident that we will see an even stronger relationship with the sector in the years ahead based on some of those things we have been able to do in partnership with them.

Ms DAVIS: What reporting is being undertaken to date to identify any problems and benefits from the transitions?

Mr PITT: I meet regularly with the CEOs of some of our larger organisations, and we have peak bodies, such as NDS, who are constantly speaking to us as well and providing feedback as to how successful or otherwise implementation is. I do not pretend to live in a bubble. I certainly do not pretend that everything we do as a government is perfect. We are constantly striving to improve our processes. If there is something that is not working well—and I have made this very clear to my department—I want to know about it so we can try to find ways to mitigate that.

CHAIR: I now call the member for Gladstone.

Mrs CUNNINGHAM: Minister, could I clarify something in an answer you gave in relation to the reallocation of funds. It is a question in my mind and it could be a question in other people's minds. You said that, in the instance where a disability recipient passes away, those funds that are remaining in their funding allocation are reallocated to another person or to another use. That is entirely appropriate, but I agree with you that, given the circumstances of that reallocation, one hopes it is not too common.

This question arises because of circumstances that are not in your portfolio but are related to your portfolio. Where the recipient of a funding allocation is deceased, is an audit done of the residual amount of money allocated to that person? If that residual amount is perhaps less than a pro rata expectation, do you pursue and how hard do you pursue the parents or the administrators of that fund to recoup that money?

Mr PITT: Thank you for the question. I appreciate the sensitive nature of the question and the way you have approached it. This is always done on a case-by-case basis, in short. You certainly do not wish to be scurrying after a family at a time when they are suffering a loss. It could be that they have one or two children, for example, who actually may be in receipt of support from the department, and we need to look at this as a family unit, we need to look at this in its entirety and understand what those supports are doing. Sometimes, indirectly, someone can benefit from a support that was provided to a sibling who may have passed away. We take it on a case-by-case basis.

I would be concerned if there was any overzealousness by anybody in trying to, as you say, pursue people to transfer funds. We know that we have finite funding and resources and we have to make that go as far as possible, but under no circumstances do I think it is appropriate that we have people chasing people down to sign over or remit funds back to the department. I do not think that is appropriate and we try to do that as sensitively as possible.

Mrs CUNNINGHAM: I have got no example of overzealousness. It is a question that arose in my mind when you were answering the member for Aspley's question.

Mr PITT: I think it was a fair question to ask.

Mrs CUNNINGHAM: I thought I would clear it up because we have got other portfolios to interrogate in relation to the recouping of overpayments, so I thought I would ask the question.

CHAIR: We look forward to it.

Mrs CUNNINGHAM: I want to go back to mental health just for a moment. I am interested in pursuing a clarification in my own mind in relation to your expenditure, and again I have to base it on Gladstone because that is what I am most familiar with. I acknowledge that in-hospital mental health care is not your portfolio; that is the Minister for Health's. I acknowledge that at the start. However, in a rural or regional setting the services are not as accessible as perhaps they are in the south-east corner given the trains and buses. Our residential mental health facility is in Rockhampton and it has a limit to the number of people it can accept. Mental health services at the Gladstone Hospital are minimal, if in existence at all, so we are reliant on the mental health care provided externally through workers at the department of mental health stand-alone facility. They are in-community care providers. Often mental health patients are taken by family members or indeed by the police to the base hospital because they have had an episode. They have been referred to the Rockhampton mental health facility, transported to Mental Health in Rockhampton by either police or ambulance staff and the person is seen by a doctor and then discharged because there is insufficient room in the facility. My question is: given that we have no secure facilities at Gladstone Hospital—and that would be the same in many hospitals up the coast—is it your department that bears the cost of administering care to those patients externally or is it the department of health? I will ask that question first.

Mr PITT: Just so I get the tail end of your question, you are asking who is responsible and who funds people who are not in a clinical environment?

Mrs CUNNINGHAM: Yes.

Mr PITT: The answer is if there are clinical services—and, again, trying to speak more broadly—that are provided at a community health centre, it is still Queensland Health because there are still clinical services. If it is community based mental health services, it is provided by the Department of Communities. You raise a very important point in the preamble to your question, and that is related to a capacity issue. I just need to go back to that point about our Housing and Support Program which is aimed at ensuring that people can actually be taken out of an acute environment—out of a hospital environment—and into the broader community. This is very important to transition people from acute care facilities into community living. It is reducing mental health care costs, as I said, by around $53,000 per client each year, but it does free up capacity. That is why our Housing and Support Program is so important.

So whilst the dollars are held dollars for the people in the acute environment, we play a very important role in the Department of Communities trying to actually transition people out to free up that capacity. We work very closely with Health to have those transitional services there. That is very important. That is a program I have a lot of focus on. It is probably a bit different to the health system generally where we talk about trying to have preventative health for somebody—that is, you can talk about living a healthy and active lifestyle, but you are still going to probably have to treat somebody with a heart attack or with clogged arteries or something along those lines down the track. With mental health you can make a real difference by doing things upfront, which is why the department's work is so important. Equally as important is at the fist opportunity to have those services available to actually transition somebody out of that environment and into the community. That can be purpose-built facilities, but it is also important to remember that we have a very large portion of our people in public housing in Queensland who are either suffering from a mental illness or a disability as part of that cohort, and that comes back to our department's whole approach of having no wrong door. We are able to service all of those clients under the umbrella of the Department of Communities and bring that transitioning back.

Mrs CUNNINGHAM: You were talking previously about your allocation of funds and that you have got—I think these were the member for Aspley's words—buckets of money for allocated purposes. Can you clarify for me whether you have available to you financial resources to invest in the opportunity to create facilities that arise over time? They may not be planned but are opportune, efficient and would address a need. I will give you the example so that I am clearer. Sorry; I apologise.

Mr PITT: No, that is okay.

Mrs CUNNINGHAM: We had an opportunity 12 or 18 months ago when Annastacia was the minister to purchase a motel that was no longer needed for its purpose or was going to be sold. It was perfect for an adapted independent living area and we missed the opportunity for a number of reasons, and that is not a criticism of Annastacia. But is there an ability for you to be flexible enough in your budget to be able to grasp those opportunities when they arise, because they are opportunistic, and I mean that in the most positive way? When a facility becomes available—certainly Gladstone has one small respite centre and that is about it—and if the opportunity arose for such a positive step in the right direction for families, for clients and for the community generally, have you got the flexibility to be able to take that opportunity?

Mr PITT: Thank you for the question and for the example because it helps to put it into context. Really what we are talking about here is our strategic asset management, and that is across the entire Department of Communities obviously, not just within my area of disability services and mental health. So certainly we in this budget have set aside funds for the strategic purchasing of land, and in this budget that was in the areas of Brisbane, North Queensland and Far North Queensland. I guess for want of a better phrase, this is about land banking and setting that land aside and making sure that we have land available so that when and if we know that there is a spike in demand or that the culmination of that demand requires a new service we do not then have to search around looking for land. The same can be applied to facilities as well. We do not always get it right and sometimes opportunities come up at short notice and it is not possible to leap in, as you correctly identified. This is about planning for future opportunities. It is something that is very much on our radar and it is something that we do.

It is the same way that the Minister for Housing would be looking at increasing the public housing stock—that is, not necessarily by having to do new builds but sometimes buy existing homes that have come on to the market and are good value for money and would suit the purpose for the client base as well. So to answer your question, yes, we do this. It is particularly important I think to have that land because the further out we go the harder it is going to be to get greenfield sites that are suitable, so I think land banking is certainly a priority. But from the other side, when facilities come up we need to be ready to pounce and be, as you said, opportunistic for all of the right reasons.

Mrs CUNNINGHAM: Just to clarify something, you talk about land banking and it is something that governments in perpetuity have done very well. But there has been a restructure of the way the land is managed in Queensland and DERM has the responsibility to administer that. Can I say that you would have to watch that DERM did not have their hand in your land banking pocket, because they will flog it off at the first opportunity. The other thing—and I continue with my parochial theme—is that you

mentioned Brisbane, you mentioned North Queensland and Far North Queensland. There is an area missing in that map, and that is the one I live in. We really do have some desperate needs in relation to care, so is there any plan to land bank in the central region?

Mr PITT: I thank you for that. I guess what I would say in response is that we look at demographics. We look at where the emerging trends are. Going back to my points before about our Growing Stronger reforms, the data we are going to get from that process will also help dictate where we are putting future services. That comes back to our planning and strategic asset management. That is what we are about. But I certainly recognise that you are a strong advocate for your area. I rely on all members of parliament—and I say that unequivocally—of both sides of politics. I am written to all of the time by local members who provide us with local information, and that is something that we take into consideration. At the end of the day this is about providing the right service in the right locations and, hopefully, at the right time.

Mrs CUNNINGHAM: Thank you.

CHAIR: Thank you, Minister. I call the member for Burleigh.

Mrs SMITH: Minister, admission to hospital provides acute care for people with mental health issues, but support after discharge is critical. Can you advise us of what community mental health programs are available for people with a mental illness, particularly people who are making transition to recovery?

Mr PITT: I thank you for the question and I may well have covered this in some part when talking about our Housing and Support Program earlier. Again, we are in the final phase of implementing the program in 2010-11. It brings the total program budget to $12.14 million. These funds are supporting 242 people, and I am pretty proud to say that we have actually exceeded the estimated target of 240 people over five years of the rollout of this initiative. So that is certainly one such thing that we can mention. When it comes to infrastructure and helping Queenslanders with a mental illness, that is something that we can talk about. We have a rolling four-year capital works program which provides facilities for non-clinical community based mental health services.

Almost $1.9 million has been set aside this budget on capital works. The member for Caloundra will be pleased with an allocation of $1.722 million to purchase properties on the Sunshine Coast and Hervey Bay as part of this allocation. One property will help with the transition of people leaving acute mental health facilities and two properties will be purchased for a planned early intervention service to reduce the need to readmit clients to acute mental health care. There is $168,000 earmarked to continue modifications to properties at Mount Gravatt to deliver a more useable and safe outdoor recreation space for clients.

I am pleased to advise that in the last financial year more than $1.5 million was spent on some other important health facilities. We have had $480,000 for the purchase of land at Kingston for the future construction of accommodation to support people in our transitional recovery program and more than $1 million was spent on two properties to help people with a mental illness—one in Nambour and the other in Maroochydore. It is also worth noting that an important benefit of being part of the Department of Communities is that it actually includes obviously disability services as well as housing services. We have a target for providing new homes for people with a disability under the Nation Building Program, and that target is 22 per cent. Queensland has outperformed in this area. We have provided suitable new homes for more than 1,300 people with a disability. Disability and community care services and housing and homelessness services work closely together on a range of housing and support home modification initiatives for people with a disability, for the frail aged and for people with a mental illness. This financial year we will continue to rollout our initiatives in rolling out infrastructure and better housing for Queenslanders with a mental illness.

CHAIR: I call the member for Townsville.

Ms JOHNSTONE: Minister, I want to ask you a question in relation to autism. Last year at estimates your predecessor announced that an autism plan would be developed for Queensland. Could you please provide a progress report to us on the development of this plan?

Mr PITT: Certainly; thank you. Just as we are seeing the prevalence of mental health in public discussion, I think autism is one area on the spectrum that more people are aware of now than ever before. So it is certainly something that is very much at the forefront of my thinking as well. I am very lucky to have been able to work with two very strong groups that look after autism services and forward thinking in Queensland in AEIOU and Autism Queensland. A few months ago I joined members of the AEIOU Foundation and also parents to mark the start of National Autism Awareness Month, and that was a twilight climb of the Story Bridge. This was an important climb because it helped raise awareness about autism and I am very happy to do whatever I can to help get those messages out. I have subsequently visited one of AEIOU's early childhood centres at Nathan which is offering specialist intervention with funds contributed by both the state and the Commonwealth.

The member for Gladstone would be pleased to note that we recently announced funds for a new early invention outreach service for children with autism in the Gladstone region. I know that that is something that has been welcomed. Autism Queensland will receive more than $325,000 a year to

create a Gladstone based outreach service for children in that area. This is going to be supporting more than 30 children in the Gladstone region. I think this relates back to a point that you talked about earlier. One of the things about living in regional Queensland is that you sometimes have to travel to access services. This will mean they will not have to travel too far from home to receive those early intervention services, so we are very happy about that. They are going to have access to psychologists, speech pathologists, occupational and musical therapists and social workers who will be specialising in caring for children with autism. In that regard I know that announcement has been very welcomed locally.

We are continuing to do work on the autism plan. It is a plan that we are looking at into the future. It is establishing needs for our planning framework. It will guide our future investment in early intervention services for children with autism. It will also focus on future services by outlining key elements of service delivery which reflect contemporary best practice in early intervention services for children with autism.

I can inform the committee that the department is finalising the plan. This plan is for children aged from birth to six years and it is a key action in *Building bright futures: an action plan for children with a disability—birth to eight years*. We are very close to finalising that plan. In this area we are working with over 140 non-government organisations delivering services right across Queensland. The services include early intervention, behavioural intervention therapy, family support and assistance, specialist and therapy services, respite and accommodation support. I think our own autism early intervention program has a budget of around $4 million and that supports around 340 children with autism across Queensland. So we will be consulting with interest groups on the draft autism plan, finalising that plan, and we look forward to considering the results of this feedback and having that plan delivered.

Ms JOHNSTONE: You say that it is almost finalised. Do we have a time line?

Mr PITT: We are hoping to be able to do that later this year.

Ms JOHNSTONE: Great. Thank you.

Ms DAVIS: This is just a follow-up question regarding your comments on autism. I have also had an opportunity to visit AEIOU, and I agree with you that it is a great—

Mr PITT: Was that at the Nathan facility?

Ms DAVIS: It is at Nathan, yes. What is your department doing to make the transition from providing services within Disability Services to Education? AEIOU offers a very substantial program. So when children move from that into the state education system there cannot but be a huge difference between the services provided. What is your department doing to liaise with Education in order to provide a smooth transition for children receiving intensive therapy to one where they are mixing with the general education group?

Mr PITT: The disability plan for children does cover that transitional arrangement but, more importantly, I am working very closely with the Minister for Education, Cameron Dick. This is something that I know he is extremely passionate about and I can certainly say that it goes beyond the area particularly regarding autism. It certainly goes to the interface between our department and what happens in special education units. We are working very closely together on that.

I think it is important, though, that autism early intervention is absolutely the critical element here. What that can mean in many instances is that a child may go through a service such as AEIOU and where they might have been non-verbal they suddenly develop the communication skills and the social skills. This is ongoing work. There is no doubt about that. You are quite correct that there has to be a transition to go into a school environment. But the aim is to have those tools and those skills developed at that early age which will allow those children to participate fully in a regular school environment. That is the aim. So the more work we do in regard to early intervention the better we are.

Autism Queensland and AEIOU work with schools directly also. Sometimes those services are provided in parallel. So it is not necessarily the case that somebody will be in a service with Autism Queensland and it just absolutely stops when they go to a school environment. That transition is managed. So there are roles to be played by me as the Minister for Disability Services, by the Minister for Education and, of course, by our very important service providers.

CHAIR: Thank you. I would like to ask a question about advocacy, given that so many advocacy organisations run on the smell of an oily rag and they are very important to that to huge cohort of people who require support. I am wondering what funding has been earmarked in the 2011-12 state budget for advocacy organisations.

Mr PITT: Thank you for the question. You are quite right: advocacy groups are very important in order to safeguard and protect the rights of people with a disability, for people with a mental illness and also for providing support to families and carers. We as a government are determined to protect the rights of people with a disability and we will continue to support strong and sustained advocacy services right across the state. That is why this year we have set aside more than $11.2 million in recurrent funding to more than 80 organisations so that they can continue to champion the rights and needs of people with a disability. The Commonwealth government, it should be noted, also helps support

advocacy services. The types of advocacy services are also part of this equation. Some may be providing advocacy in the area of legal. So not only is it my department that should be funding those services but sometimes that funding can come from the Commonwealth, as I said, or from the Department of Justice and Attorney-General. So there are a range of different types of advocacy services in the community.

A number of organisations are based in regional and rural parts of the state, including Toowoomba, Rockhampton, Mackay, Townsville and I always love talking about Cairns. But we want people's voices to be heard regardless of where they live in Queensland. At a national level we are working with the federal government and other state jurisdictions to develop a national disability advocacy framework. Its aim is to achieve consistency in the delivery of advocacy services. That is about commonality by way of definitions, objectives, outcomes and principles and probably also agreed definitions around what would be considered to be regional, because that can vary from state to state as well. What is considered regional in Victoria is certainly not, I would suggest, what is considered regional in somewhere like Western Australia or Queensland, which are very decentralised states.

People with a disability need to have confidence in the knowledge that the organisation that they have chosen to advocate on their behalf is the right one to meet their needs. Disability and Community Care Services meets regularly with advocates on individual matters as well as advocacy groups and networks such as the Community Safeguards Coalition. This is more in the area of systemic and policy issues. But I can certainly say that we value advocates. We, as always, would love to fund more and more, because I think ensuring that somebody has the right advice and that their rights are protected and safeguarded is one of the most fundamental things that we aim to provide for people with a disability here in Queensland.

CHAIR: Thank you.

Ms DAVIS: Thank you. Minister, can you outline the processes that will be undertaken with regard to the Voluntary Separation Program in the Public Service as it will affect Disability Services? How many people are expected to be involved in the separation program? Who would be ruled eligible and ineligible to participate? Is it true that people in the strategy, policy and program performance sections will be eligible but no-one in the regional service delivery program will be eligible? Given that a number of people in the regional service delivery program work in policy roles that involve no direct service delivery, why are these people being excluded from the scheme?

Mr PITT: I thank you for the question and I will refer this question to my director-general as the nature of the question is regarding staffing and operational matters. So I will pass you over to Linda Apelt.

Ms Apelt: The Department of Communities is participating in the whole-of-government Voluntary Separation Program. In June 2011, 26 formal letters of offer for a voluntary separation package had been sent to eligible employees. On 1 July 2011, a further 1,232 officers from the department's policy and program areas were invited to express an interest in receiving an offer of a voluntary separation package. An expression of interest to receive an offer will not necessarily result in an offer being made. That is the way the program has been structured.

The guidelines for the Voluntary Separation Program, which are available on the government's website under the Public Service Commission, outline the rules that support the Voluntary Separation Program. But essentially, this is a fairly common way of adjusting staffing levels across the public sector which happens from time to time as part of the overall state budget process. The department will continue to participate in the scheme in 2011 and, as has already been announced by the Treasurer, this is the government's commitment to certainly support and strengthen front-line service delivery throughout the Public Service. So from time to time we need to make sure that we get the balance right, and our emphasis on having well over 83 per cent of our staff within the Department of Communities dedicated to front-line service delivery will remain. For that reason the offers were made to people who work in the policy and program areas. The member for Aspley is quite right: there are a number of people who work on policy and programs but who happen to sit within the service delivery section of the organisational chart. There will be cases where those people will also be eligible to receive an offer.

Ms DAVIS: The Minister for Community Services has talked about the need for efficiencies in the non-government sector, particularly in terms of smaller organisations. Do you also support the move towards corporatisation or amalgamations within the sector? You spoke at a meeting with larger organisations. What support is available for the smaller groups?

Mr PITT: At the end of the day, the way the non-government sector and organisations operate by and large is a matter for those organisations. I think they would be the first to suggest that they would like to run as efficiently as possible. It goes back to some of the points that you have raised today—and they are valid points—and that is about ensuring that at the end of the day the client is receiving the most benefit from funding, whether that be funding that is provided by government or whether it is funding that is raised by other means by a non-government provider.

I do not think this is a matter of having an ideology around having organisations streamlined and running efficiently. I think it makes perfect practical sense to try to do that. What we are trying to do, as I have said previously, is strengthen non-government organisations in terms of building up their capacity and allowing them to find ways of being more efficient, because that will benefit the end user. It will benefit the person who has a disability, or it will benefit a carer who is on the receiving end of some respite. All of these things are important. I do not think it is a matter of dictating terms or having a broadbrush ideology. I think at all times we have to make sure that we are having an emphasis on quality of service, on sustainability and, importantly, on value for money. That will depend on each organisation as to how they are structured, what their governance arrangements are and how they deliver their services.

There will also be an impact as to whether they are a service provider that is by and large in a regional area of the state which sometimes can make the price tag a bit more for services. That is also about trying to get them to invest in new technologies; utilising technology to help deliver their services which may be able to be done via a video conference as opposed to an in-person visit. Those are the sorts of things that I am very supportive of. I am very happy to in some respects concur with the Minister for Community Services in that regard. I certainly do not think it is a matter of dictating that these things happen, but I think NGOs are the best placed to determine how they operate. Going back to the other part of your question, if there are synergies between organisations, if there are amalgamations that can take place, if that is going to suit both organisations and at the end of the day the end user is going to benefit from more efficient and more effective and streamlined service delivery, then I certainly would be in favour of that. But it is not something that I would be suggesting that you dictate terms on.

Ms DAVIS: I would like to look at program delivery. I refer to the number of user services that are in the SDS. The number of users of accommodation support services was cut by 110 in 2010-11. What was the reason for this cut?

Mr PITT: Which page of the SDS are you referring to?

Ms DAVIS: 3-14.

Mr PITT: I want to make sure that we are talking about exactly the same area. Can you point me to that area again?

Ms DAVIS: Compared to last year's budget, support services have been cut by 110 places. I am just asking the reason for this cut?

Mr PITT: Which support services in particular?

Ms DAVIS: The users of accommodation support services.

Mr PITT: I am just going to seek some advice on that so that I can give a proper response. What we are talking about here is where, for example, an individual's needs have become more complex and therefore they actually need to stay longer in the service. That has impacts obviously on other services. That will be where you are seeing that difference in the figure. It does not actually mean that there has been a cut in services, it means the services are being provided to the same people perhaps for longer in a different area. You have to look at this holistically. Accommodation support is only one aspect of a support that somebody might be receiving. You need to look at that in the context of all of those services, whether it be respite support or whether it be some other supports by way of their complex needs, turnover services, a range of different areas. So, you have to look at those things in their entirety.

CHAIR: I will get a follow-up question from the member for Gladstone.

Mrs CUNNINGHAM: It could be the same answer, but I am interested in the reduction in the disability service payments to my electorate. In 2009-10 it was $4.4 million, in 2010-11 it was $4.7 million, but for the forthcoming year it has dropped to $4.1 million. Is that because the funding of other services has been reallocated to a different area or is it a drop in funding?

Mr PITT: I think the answer here is that when we have our budget process we have an estimated budget for what we think the need is going to be. Sometimes the actual does not reflect that so there needs to be an adjustment to that. Basically, it may well not have been as many people as we thought who were going to take those services up. Sometimes that can actually be the difference between what we thought was going to be happening and what was the end result. The change in client needs can have an effect on individuals as well. So it does depend on what the actual was compared to the previous year. Does that make sense?

Mrs CUNNINGHAM: Yes.

CHAIR: Member for Aspley, are you continuing?

Ms DAVIS: Similarly then your response with regard to community access services, which were cut by 455 users, would be the same as you gave for the number of users of services?

Mr PITT: What we are talking about are unique service users. It does not necessarily mean that there is a budget cut. The number of service users may have declined and that could again be because they are using a service for longer as opposed to being a reduction in the amount that we are funding for those.

Ms DAVIS: So for the number of services then, the actual services provided, which also shows cuts, like accommodation support services fell by 140 and community access by 1,746, why would that be?

Mr PITT: What I can say is that in 2010-11 through community access services an additional 420 people with a disability have been supported. So there is actually an additional number of people who have been supported through community access services not a reduction.

Ms DAVIS: Are you telling me that that did not reduce by 1,746, but in fact it increased by that amount you just gave?

Mr PITT: This is a budgetary question that you are probably going to need a different answer to that I am not going to provide to you so I will pass that to Linda Apelt to answer.

Ms Apelt: What we note in the service standard tables that the member is referring to is a general trend that we have observed in Disability Services over a number of years where people who have particularly complex and therefore quite expensive needs are tending to stay in the services longer. So the budget has not been cut. In some instances we have got three per cent of the clients that actually receive 10 per cent of the accommodation support dollars. So what we are seeing is that increasingly the services provided, particularly accommodation support services, are provided to people who have very, very complex needs. We have an ageing cohort that is coming through the system where people are staying with us longer. But also as people are ageing it is a combination of looking after their health needs that go with ageing as well as their disability needs. That is a general trend that we see in Queensland but which is comparable nationally and internationally.

Ms DAVIS: If I can refer to DISQIS, which is a major project for the department, can you explain what exactly has been achieved in this program, what flaws or bugs might still be in the system and do you perceive the $38 million capital investment to be the best use of Disability Services funds?

Mr PITT: With regard to DISQIS, where you see that in the budget papers, DISQIS has actually been renamed Business Information Solution. So there is a new name for that.

Ms DAVIS: Did that cost any money?

Mr PITT: What DISQIS is contributing to is what I was talking to you about earlier and that is the Growing Stronger reforms. I see that as extraordinarily well spent money given that that is going to be one of the key tools we are going to be using for our planning into the future. As I said, DISQIS was renamed BIS in September 2010, the first release of functionality to support the Growing Stronger reforms. From time to time the department enters into strategic partnering arrangements for significant ICT projects in order to mitigate risks of implementation through partnering with expert organisations. We engaged Curam to partner with other contractor and internal staff to analyse, develop and implement BIS. These specialist IT skills have been necessary for the successful implementation of BIS.

I make the point that this is important given that we have seen in recent times concerns with the rollout of information technology. We have been very, very clear to make sure that we have taken a very firm and close view of how these systems are being rolled out to make sure that the safeguards are there to make sure that the process worked well. What I can say is that BIS has undergone extensive system and user acceptance testing. Following approval of the final deployment gate, BIS has commenced deployment into production mode. This has been completed and it is available to commence data migration from here on in. Importantly, regarding the data migration, the results have been worked through.

I think you mentioned have there been any bugs or other concerns. As well as this process of not only doing this testing off line and doing the user testing appropriately, it is also important to make sure that if we have that data migration that we have a backup version of that completed at that time. This is just one of a number of safeguards that we are using. Very importantly, we have relied on expert advice and, going back a couple of steps, phase 1 of Growing Stronger was trialled in the south-west region and at that time and throughout the trial it has gone extraordinarily well. There have not been any issues that have been raised. The fortunate thing for us is that we will be drawing from the same data pool for this system and going into the new system. We will not be just flicking a switch. We will not be turning something over and running it. We will be able to rely on the baseline data to ensure that that is getting fed into the system. If we have any concerns with that new system we will be able to default back to the previous system. These are the safeguards that we have put in place to ensure that we have integrity in our system.

We have had phase 2 rollout testing and that in itself has gone extraordinarily well. We are being cautious. We are requiring sign off from a range of different departmental officers and, of course, as I said, we are relying on expert advice from the ICT area. It is not something we take lightly. I may be in a more fortunate position than some in that I have had some experience in this area so I do know a little bit about some of the things coming across my desk, but most certainly I will be relying on that expert advice we have been given. To date all of the safeguards we have had in place, all of the different stages we have gone through, by way of system development, data migration, the reconciliation of that data and then moving forward to a go-live, all have gone extremely well and at this stage we are not aware of any concerns that will come up by way of the rollout of this new process.

Ms DAVIS: I do not think the former minister for health thought there were any problems with the health payroll system either. If I could just ask one final question, just generally speaking, are there any plans to move to outcomes based funding? I know you are running outputs, but outcomes.

Mr PITT: I will take this opportunity to talk about where we are headed into the future and what space we are playing with in relation to Disability Services. As you are aware, at the moment we are on the brink of potentially a significant reform here in Australia working with the Commonwealth on the long-term support needs of people with a disability. That is through a potential national disability insurance scheme. What we are doing between now and the potential rollout of a national disability insurance scheme, if we are able to reach agreement through our various jurisdictions and with the Commonwealth, is looking at how we prepare ourselves for a new system. I think the idea of outcomes based funding is important.

We expect that our non-government providers and our partners are providing what they say they are providing. We have legislation in place that ensures that if they are not providing those services that we are able to put a hold on those arrangements and ensure that we have continuity of service with another provider ultimately so that the end user still receives that service. This goes hand in hand with our 10-year plan. We have to start thinking about where we want to be in the future and how we are going to fit potentially into a national system. That is where a lot of thinking is heading towards. That is why I have been talking at length about those national arrangements and where we want to be.

We are all keen to achieve positive outcomes for our clients. It is probably a matter of one step at a time. We have moved to outputs funding and I guess we will have to bring NGOs along with us for that second part of that. But all of that has to be in the frame of where we want to go into the future.

CHAIR: The time for questions has expired and I believe you need to make a quick closing statement.

Mr PITT: I do appreciate that. I want to acknowledge the hard work of my department. I want to thank in particular Director-General Linda Apelt, Associate Director-General Tony Hayes, Deputy Director-General Michael Hogan and chief financial officers Michael Kelly and John Marsh. I also want to thank the parliamentary staff here today, particularly the hardworking Hansard staff. That leads me to the member for Aspley's question, the first of the day, which related to Auslan interpreters. I want to reiterate my support and the respect I have for Auslan interpreters, particularly the role they played during our summer of disasters. I think they were a real lifeline for the deaf community. I just want to put on record that it was my suggestion that the services of Auslan interpreters be made available for the estimates hearing. This is something that was very clearly at the forefront of my mind, as I said.

We put this proposition to the Speaker's office and advice from the Speaker's office at the time was that there were technical issues with a dual broadcast. I also inquired about the possibility of close captioning and was subsequently advised of the issues associated with real time captioning. This is not something that we have forgotten about or had not been thinking about. We had a tentative booking with an Auslan interpreter to be part of the proceedings, but there are other reasons these things do not happen. As I said, to have that cost across the entire proceedings of estimates over the two weeks is something that I was referring to with my costs as extraordinarily expensive. The technical issues, as I said, are an issue. We are hoping to work through those. I would be very keen to see that resolved in time for next year's hearing.

Finally I want to acknowledge the work of staff of my ministerial office in helping me prepare for estimates. I also want to thank, Madam Chair, yourself and all of the members of the committee today. I appreciate the spirit in which the estimates process has been undertaken today and I thank you very much for your participation.

CHAIR: Thank you, Minister, and to your staff and your departmental officers we also say thank you. For those of you who are interested, and I am sure most of you will be, the transcript of the hearing will be available on the Hansard page of the parliament website within approximately two hours. We will now break for lunch and the hearing will resume at 2.30 with the examination of the budget estimates within the portfolio of Health.

Proceedings suspended from 1.03 pm to 2.30 pm

ESTIMATES—HEALTH AND DISABILITIES COMMITTEE—HEALTH

In Attendance

Hon. GJ Wilson, Minister for Health

Mr C Crowther, Principal Adviser

Queensland Health

Dr T O'Connell, Director-General (Acting)

Ms J Giles, Director, State Funding Unit

Dr J Young, Chief Health Officer

Ms K Byrne, Chief Executive, Clinical and Statewide Services

Dr A Groves, Executive Director, Mental Health Directorate

Health Quality and Complaints Commission

Adjunct Prof. C Herbert, Chief Executive Officer

CHAIR: Ladies and gentlemen, could I have your attention. The hearing of estimates by the Health and Disabilities Committee has now resumed. I would like to introduce myself. I am Lindy-Nelson Carr, the member for Mundingburra and chair of the committee. Mr Mark McArdle, the member for Caloundra, is the deputy chair. The other committee members are Mrs Liz Cunningham MP, the member for Gladstone; Mrs Tracy Davis MP, the member for Aspley; Mrs Mandy Johnstone MP, the member for Townsville; and Mrs Christine Smith MP, the member for Burleigh. We have a visiting member present here today, Mr Peter Dowling, the member for Redlands; welcome. I ask that mobile phones or pagers be either switched off or switched to silent. I remind you that food and drink is not permitted in the chamber.

The next item for consideration is the proposed expenditure for the organisational units within the portfolio of the Minister for Health. The committee has resolved that the chief executive officers of the Health Quality and Complaints Commission and the Queensland Institute of Medical Research will be examined later this afternoon, between 4.30 and 6.30 pm. I now declare the proposed expenditure for the organisational units within the portfolio of the Minister for Health be opened for examination. The time allocated is five and a half hours. The question before the committee is—

That the proposed expenditure be agreed to.

Minister, would you care to make an opening statement? I remind you that there is a time limit of three minutes for such a statement.

Mr WILSON: Thank you very much, Madam Chair, and good afternoon members of the committee. Thank you for the opportunity to address you here today. We meet to debate the Health budget, which stands at a record $11 billion. No government in Queensland's history has committed more funding to health services. The budget also provides for our record hospital building program. This government will build more new hospitals, new wards, upgraded health facilities and new services than any government in our state's history and more than any other government in the rest of Australia. That is our commitment to health and Queenslanders can see it for themselves when they drive past the building site for the Queensland Children's Hospital, when they see the cranes on the Gold Coast University site, or when they use the newly opened Cairns Hospital Emergency Department or the new Bundaberg Hospital emergency department and maternity wards. Starting this week, Queenslanders can see the progress of our hospital building program on the precinct of the Sunshine Coast University Hospital and private hospital sites.

We promised the nation's largest hospital building program and, all across the state, there are building sites that show we are delivering what we promised. We are committed to delivering more services sooner and closer to home—not only services for patients now, but also world-class, first-class innovative services for the future—and we are providing the additional staff needed to support those services. Those services include additional support for mental health with the highest level of funding for mental health services in the state's history. This comes at a time when Queenslanders need it more than ever following the recent natural disasters. It is about delivering world-first health services for the future and delivering new research, technology and greater innovation, as well as identifying how Queensland can continue to deliver health services in new and flexible ways. Of course, behind every health system are highly dedicated health professionals. Every day across the state our staff look after thousands of patients. We are continuing to boost those staff to deliver more health services sooner and closer to home for Queenslanders.

The budget estimates process is important as an examination of the spending priorities of the government of the day. Any reasonable examination of the budget will find this government has prioritised health services through a record Health budget; we have prioritised mental health services through a record mental health budget; we have prioritised the health workforce with record numbers of clinical and frontline staff; and we have prioritised the delivery of new health services across Queensland with a record hospital building program. As the committee considers this government's record on spending on health, in the background is the alternative vision provided by the opposition: a promise to cut the Health budget by around $400 million and a threat to tear up the health reform agreement that is changing the face of health services in the state. State budgets are about choices and estimates hearings are about examining priorities. The choices this government has made and the priorities that we have focused on are in clear contrast to the service cuts and project cancellations that are promised by the opposition. That is the contrast that is clear for Queenslanders to see.

Finally, I am proud to announce the next step forward in this government's comprehensive health reform plan. We are changing the face of health service delivery in Queensland. Last month I introduced to the House a bill to enable the biggest shake-up of health services in a generation. We are breaking up Queensland Health and delivering more control back to local communities by establishing local hospital networks. Today I announce the opening of expressions of interest for dedicated Queenslanders who want to serve on the local health network governing councils. The government is serious about changing the face of health in Queensland. As I conclude I say that we have introduced a bill in the parliament and we are delivering the management of health back to local communities. Today I invite dedicated Queenslanders to step forward and express interest in leading their local health services toward a brighter future.

This government is delivering more services sooner and closer to home for Queenslanders. Our record Health budget is delivering just that and record numbers of frontline clinical staff are delivering that. I thank you for the opportunity to showcase our public health services today.

CHAIR: I call on the member for Caloundra.

Mr McARDLE: Minister, good afternoon to yourself and to your staff. In March 2010 the pay rollout was an unmitigated disaster, causing incredible pain and suffering for many Queensland Health employees and it is now being followed by the equally disastrous multi-million overpayment claim against many nurses, doctors and other Queensland Health staff. Minister, when the House resumes on 2 August 2011, will you move a motion referring the health payroll overpayments issue to the Health and Disabilities Committee for a thorough public investigation and inquiry, to provide a public forum for those affected by the payroll system to come forward and speak about their experiences?

Mr WILSON: I thank the honourable member for the question. The issue of the health payroll has been examined extensively by a whole range of agencies and entities. The health payroll has been examined by the Auditor-General, who published several reports. It has been examined by PricewaterhouseCoopers. It has been examined by KPMG. It has been examined by Ernst & Young. All of those organisations have identified the blueprint, taken together, for establishing the new payroll situation for Queensland Health. Nothing can be clearer than that this government is absolutely dedicated to implementing the Ernst & Young recommendations and the recommendations of the Auditor-General. The Auditor-General's reports are public, as have been all of the comments that we have been making about the blueprint for reform of the payroll system.

Mr McARDLE: Thank you, Minister. I understand that.

Mr WILSON: There is no doubt that the introduction of the—

Mr McARDLE: The other point, though, is that the overpayment issue is the subject of the question. Will you refer the overpayment issue—

CHAIR: Order!

Mr McARDLE:—to this committee on passing a motion in the House?

CHAIR: Order, member for Caloundra! If we are going to ask questions this afternoon and hear the minister's answers, I request that we listen to the minister's answer and then ask the ensuing question. Minister?

Mr WILSON: As I was about to say, it is clear that the payroll system as introduced is unacceptable. That has been acknowledged by the government on quite a number of occasions. In addition to that, the reform strategy and the new system to be introduced has been publicly discussed and made known. As I have indicated, the government is absolutely committed to implementing the recommendations of the Ernst & Young report and we will continue to do that. Why? Because we are interested in making sure that the interests of staff are put first. One of the key ways in which we achieve that, of course, is to ensure that the recommendations to government of the independent agencies on the way in which the payroll should be implemented are implemented, as required by them. We are absolutely focused on ensuring that that takes place. Indeed, all of the evidence from the independent

commentators on the new payroll is that it is operating at industry standards. The amount of backlog has been dramatically reduced. The number of nil pays are very, very small. All of the independent commentators say that it is operating according to industry standards. We have always said—

Mr McARDLE: Madam Chair, I think the minister has had more than enough time to answer the question.

Mr WILSON:—that the priority is actually making a difference for staff.

Mr McARDLE: Thank you very much. Minister, I table a letter forwarded to Dr Dominique Hannah, showing a claim of $25,822.75, which it is alleged is owed by her to Queensland Health. That one payment was supposed to have been made on 8 March 2010.

Minister, you indicated that the Auditor-General had looked at the issue of the payroll system. We all agree with that. He looked at how you were going to fix it. My question is very clear here. There is a second debacle by Queensland Health while you are at the helm where nurses, doctors and allied health professionals have been sent letters claiming, in total, millions of dollars are owed to the point where the Premier has now had to step in and place a moratorium on any action. The question is simple: on 2 August, given this body has the authority, if the House passes a motion, to look into the overpayment issue, will you put a motion to the House giving this body, the Health and Disabilities Committee, full authority to thoroughly investigate the second debacle, to understand why it happened and to give the public who are impacted by the decision by your department the opportunity to come forward and outline their concerns?

CHAIR: Before you answer, Minister, I would say this: member for Caloundra, you have already asked this question. It is your time, you are questioning.

Mr McARDLE: Correct.

CHAIR: Minister?

Mr WILSON: I thank the honourable member for the question. The step taken by Queensland Health shortly before the end of the last financial year was a step that had been foreshadowed for some time regarding the necessity for issuing or commencing a process for the purpose of recovery of overpayment. It is understood, and I said clearly at the time when Queensland Health initiated this project and when the announcement was made, that the recovery exercise was an exercise that they were required, as an employer, by law to undertake, but they had been instructed by me to do that in a sensible, sensitive and responsible fashion. Consequently, the recovery process commenced and it commenced in the last financial year.

It is clear that from the experience of some staff and, indeed, quite a number of staff, that there are a number of issues that they want additionally addressed, in particular in relation to underpayments. In the context of considerable discussions that I held and the department held with unions and a range of others, a new package of measures has been put in place directed towards staff and supporting staff who are experiencing difficulties with their pay. That is the action plan that we have put together and that action plan has the support of all of the relevant unions. That is the action plan that is being rolled out as we speak. Why? Because the department is focused on addressing the concerns that its staff have with the payroll situation they face. They are focused on making sure that we restore the confidence of staff in the payroll system.

I indicated before that the independent commentators recognise that the payroll system has been stabilised and is operating within industry standards. However, from the point of view of individual workers, they are entitled to have confidence in the information provided to them about their payroll. The first obligation of an employer is to ensure that workers are paid accurately and in a timely fashion and are provided with accurate information. That is why this new raft of initiatives has been undertaken with the support of unions—to restore the confidence of staff in the information that they have been provided by the department of health.

One, there is a moratorium on the recovery of those overpayments. Two, there are stronger processes to reimburse underpaid staff. Three, there is an independent Workplace Ombudsman to examine individual claims of workers regarding their pay and their pay information. There is more support and training for line managers and recognition of payroll hub staff and the trial of a new pay cycle arrangement. They are the actions and they are the initiatives of a government that is preoccupied with ensuring that the concerns of staff are held foremost by Queensland Health and that all of the appropriate actions are taken to address their concerns.

Mr McARDLE: Acting Director-General, in his recent report the Auditor-General said that two recommendations of 11 had been resolved. Can you outline what the nine outstanding recommendations are? That is in relation to the payroll system.

Dr O'Connell: The Auditor-General has conducted a couple of major audits in 2010-11 that contain information about Queensland Health's payroll implementation. They were, as you say, the report to parliament No. 7 for 2010 about information systems governance and control including the

Queensland Health implementation of continuity project and the Auditor-General's report to parliament No. 13 released on 31 October. This was a general financial statements audit which highlighted a number of findings for Queensland Health.

The Queensland government accepted all of the Auditor-General's recommendations and developed a comprehensive plan that included the implementation of a new payroll operating model and a personalised service model to deal with anyone experiencing payroll issues. There was a review of the one-size-fits-all shared services model which was undertaken by PricewaterhouseCoopers, and there was a review of the payroll and rostering system that was carried out by Ernst & Young. Queensland Health has taken action in response to the recommendations from this plan resulting in significant improvements to the payroll system.

Last month the Auditor-General tabled a follow-up audit report No. 4 in parliament. In this report it was acknowledged that Queensland Health has progressed the improvement of the payroll and rostering system. The Auditor-General also reflected on the successful implementation of the localised payroll operating model with the expectation that it will deliver improved client satisfaction. The new operating model provides a direct 'hire to retire' service between payroll hubs and facility unit managers within local health service districts and divisions. This implementation included the establishment of two new payroll hubs at Mackay and Gold Coast.

Since June 2010 Queensland Health has also implemented more than 250 system fixes, with the most recent releases—for December 2010, February 2011, April 2011 and June 2011—being implemented successfully. These have included a range of critical system fixes and enhancements which have decreased the number of payroll inquiries and staff seeking financial assistance. More fixes and enhancements are planned over the coming months.

Significant progress has also been made on recommendations regarding issues management. Over 6,000 issues have been consolidated into one issues management register. As at last month there were approximately 790 system issues remaining open on the issues register. The main outstanding areas involve leave, terminations, pay slips, pay rules, rostering, employee movements and the management of employee details. This is largely because Queensland Health has a massive payroll. For example, the pay that is being paid today, for this most recent payroll, involves $233 million going into our staff accounts. That is paying 82,989 staff.

The system has stabilised as a result of the measure that I have talked about. For example, in the pay period that is going into our staff's bank accounts today there are no 'no pays' that are due to system issues. There were 18 staff who had 'no pays' but these were due to clerical issues such as new starters who had forgotten to complete their paperwork or whose line managers had not yet had a chance to complete the paperwork when they started, casuals or contractors who were extending their employment and the paperwork for that extension just has not gone through yet. Similarly, there are no staff who have accessed emergency payments this pay today or last pay.

Mr McARDLE: Acting Director-General—

Mr WILSON: I would like to add to that if I may, Madam Chair.

CHAIR: Minister, just a moment. Do you wish to have further comment on that question?

Mr McARDLE: Not on that question. I have asked the question on that point. I want to ask one other question as well.

CHAIR: So you are happy if the minister—

Mr WILSON: I can provide further information to the committee.

CHAIR: Thank you, Minister.

Mr McARDLE: Madam Chair, I asked the acting director-general. If I asked the acting director-general, that is fine. However, I do not want time consumed by the minister now chiming in and eating up more time, repeating the same exercise.

Mr WILSON: I am happy to help the committee.

CHAIR: Minister, you will get an opportunity to further elaborate on that.

Mr WILSON: I am always happy to assist the committee.

CHAIR: Thank you. Member for Caloundra.

Mr McARDLE: Minister, did you personally approve the process of collecting the overpayments and issuing the letters regarding the overpayments?

Mr WILSON: I thank the honourable member for the question. To complete the answer I wanted to give before, I can let the committee know that, in relation to the question just asked of the acting director-general, the Auditor-General said that two of the nine recommendations had been completely done and the balance were ongoing. He was not in any way critical. In fact, the point was that Queensland Health has acted on all of them, and I think it is important to make that clear.

CHAIR: Thank you.

Mr WILSON: Further—

Mr McARDLE: Did you approve the process to collect the moneys from employees of Queensland Health? I ask just to assist you and remind you of the question.

Mr WILSON: Thank you for the question. Can we just be clear here about the interest and concerns of the shadow minister for health, the member for Caloundra. If the member for Caloundra were sincerely interested in the issues and concerns of staff, why has he not raised any issue with me previously, in the 4½ months that I have been in this position, regarding individual staff issues? I have had a check done and I have here the file that is kept for the member for Caloundra on issues arising from individual members of staff of Queensland Health.

Mr McARDLE: Minister, if we are going to play the game of slinging mud back and forth, let us do that. Let us answer the question.

CHAIR: No, excuse me, member for Caloundra, let us not.

Mr McARDLE: If you want to play the game back and forth, we will do that.

CHAIR: Member for Caloundra, it is a mouthful even getting those words out. Let us not sling mud; let us do this like adults.

Mr McARDLE: Correct. I agree, Madam Chair.

CHAIR: Minister.

Mr WILSON: Thank you, Madam Chair. The concern I have is to ensure that all staff are treated properly and that at all times the proper steps are taken to restore the confidence of staff in the payroll system. In the last financial year, on advice given to me, it was important that the legal obligations of Queensland Health as an employer be fulfilled, namely, the commencement of a process for the recovery of overpayments to their staff. That was the advice provided by Queensland Health. Queensland Health then undertook that exercise because, as a matter of law, they are required to do so. In doing so, they were acting in line with the earlier indications that had been given months before—indeed last year, as I am advised—that at some point appropriate steps would need to be taken to advise staff of the amounts that the system concluded had been overpaid to them. Indeed, as I was advised, the department could not take the step they ultimately took until such time as there was evidence that the payroll system had stabilised and for a length of time that showed a level of confidence in the system at a system level.

Accordingly, to ensure that workers had the greatest certainty regarding their income for the financial year 2010-11 for the purposes of tax, it was important for the recovery exercise, one, to commence after the advice had been received by Queensland Health that the system had stabilised and, secondly, before the end of the financial year to ensure that workers were not adversely affected by something which was not of their doing—that is, the difficulties experienced with the payroll system during that financial year. That is what took place.

I instructed the department that when they commenced that exercise they needed to undertake the exercise responsibly and sensitively. That is why they had also established a system for individual contact with members of staff, for potential case management of the circumstances facing individual staff if they wished it and a raft of other initiatives. It was important to ensure that staff had the maximum opportunity to inform themselves of the circumstances that Queensland Health were advising them of. Then it became apparent that there were issues of a lack of confidence held by staff around the reliability of the information that they had been given. Accordingly, further steps were taken—the raft of new measures that I spoke of earlier were undertaken—to ensure that the concerns of staff were being further addressed.

What this package of new measures achieves is a breathing space for staff because there was a moratorium on the collection or recovery of the overpayments as claimed by Queensland Health, the employer. That gives time for staff and workers to get on with the important job that they are doing for Queenslanders and also gives them a breathing space to make appropriate inquiries of Queensland Health and indeed of the Workplace Ombudsman, who has been appointed as part of the new measures. That is a key element of the package I put together.

CHAIR: Thank you, Minister. With your indulgence, just before you speak, member for Caloundra, I would like to mention that Dr Alex Douglas has arrived. He is the member for Gaven. I would like to welcome him to this afternoon's proceedings.

Mr McARDLE: Acting Director-General, the minister referred to the reliability of the information contained in the letters forwarded to a number of people. Can you advise what the department did—

Mr WILSON: I take a point of order.

CHAIR: Excuse me, Minister, the question is directed to the director-general.

Mr WILSON: I have a point of order about the accuracy. It is not an accurate portrayal of what I said. It is the level of confidence of the staff in the reliability of the information.

CHAIR: Thank you, Minister.

Mr McARDLE: Acting Director-General, in relation to the confidence in the information contained within the letters, can you advise whether the department undertook any investigation, before these letters were forwarded, to confirm that the contents of those letters were correct? If so, was the briefing forwarded to either the minister or the Premier along those lines?

Dr O'Connell: The information which was contained in the letters to the 38,000 staff who received the letters before the end of the last financial year was accurate according to the systems that we had in place. The minister, as always, was briefed about such an important issue.

One of the things that gave a sense of urgency to this that I think is important is that the overpayments could potentially have implications for employees' tax and Commonwealth benefits entitlements. There is a risk that employees who have been overpaid may have an increased reportable fringe benefits amount listed on their payment. Interim cash payments and salary overpayments may also attract an additional fringe benefits tax liability because they are classified as loan fringe benefits for tax purposes. We did not want our staff to unnecessarily go through the angst of having the ATO deal in that way. So it was important that we issued these letters before 30 June.

As I said, the information in those letters was as accurate as we believed our system could generate and we thought that staff would appreciate receiving this information before the end of the tax year so that they were not exposed—certainly Queensland Health is committed to paying eligible employees for financial costs or penalties that are directly attributable to a payroll system error as a result of the Queensland Health payroll implementation. We do not want our staff to be out of pocket as a result of the unfortunate episode that has occurred over the last 18 months.

Mr McARDLE: Acting Director-General, thank you very much. I have a follow-up question to you. In an interview with Madonna King on 1 July, Mr Fraser, the Treasurer, was asked whether or not that data in essence can be relied upon. He said, 'Well they can't. They can't and that's why the letter says, "That is what our system shows."' Obviously it is from a broken system. That statement flies in the face of what you have just said. It flies in the face of what was common knowledge to the people within Queensland Health and to the people of Queensland that this system had failed utterly. Are you saying that, with all the background knowledge of the payroll system and the issues that arose, no checking was done before those letters were forwarded out? You simply accepted what was on the system and did nothing to ensure it was right?

Dr O'Connell: The system is checked by the people who are the custodians of the system. The data which is generated of course is data which we send to our staff every week. We are sending out 82,989 pieces of information from the system to our staff. There is a quality assurance process which goes on in the management of the payroll system. We issued information in the letters to 38,000 staff which was we believe accurate, otherwise we would not have sent it out.

Mr McARDLE: Thank you very much. Acting Director-General, my question before last posed two points. Was the briefing forwarded to the minister? And you said he was briefed. I also asked the question: before this process was undertaken, was the briefing forwarded to the Premier? Was the Premier briefed upon the overpayment situation? Before the letters were forwarded out, was she informed of what Queensland Health intended to do and did she sanction that process?

Dr O'Connell: Unfortunately my reports do not directly go to the Premier. My reports go to the minister, and I am not sure whether the minister forwarded that briefing to the Premier.

Mr McARDLE: Did the department forward a briefing to the Premier?

Dr O'Connell: We would not normally directly brief the Premier. We would normally—

Mr McARDLE: Did you advise the Premier of what you were doing?

Dr O'Connell: The Premier has been involved all along, as I think she said in yesterday's estimates briefing, in all of these matters quite intensely over the last 18 months.

Mr McARDLE: Would I be right to assume, Acting Director-General, that she would have known before the letters were forwarded out what Queensland Health intended to do and that she sanctioned that action if, as you said and as she said yesterday in this chamber, she was fully briefed of what was going on?

Mr WILSON: Point of order—

Mr McARDLE: That is my wording, not hers.

Dr O'Connell: As I have said, Mr McArdle, I did not personally brief the Premier. My briefings all go to the minister, so I am not sure what the minister did with that.

CHAIR: Minister, would you like to—

Mr McARDLE: I think the minister is keen to answer the question.

Mr WILSON: Further to what I was saying before—and then I will come to this—section 73 of the Financial Accountability Act 2009 requires a recovery process. This is going to the question of the commencement of the recovery before the end of last financial year. Also, the Queensland Audit Office had indicated that it was appropriate for recovery action to take place. We had received further advice also from the Australian Taxation Office that if the recovery process commenced before the end of the financial year then staff would not be taxed in respect of the sums that had been said had been overpaid to them. So the law required that the recovery action commence. It was important before the end of the financial year that that recovery action commenced so that the Australian Taxation Office could have the confidence that the funds claimed to be overpaid by Queensland Health would not need to, and would not properly, be taxed in the hands of the worker. They are the factors that were bearing upon the timing of the recovery process.

As the Premier said yesterday, she has remained abreast in a broad sense of the developments and the initiatives in relation to the payroll. But the requirement to commence the recovery action before the end of the financial year was advised to me by Queensland Health for the reasons that I have just outlined, and on the basis of that advice that recovery process commenced. It was explained to all of the relevant unions at the time, and I made a public apology at the time that the recovery process commenced that, firstly, this process was one required by law to commence before the end of the financial year and that, secondly, it was no fault of any of the workers who were receiving the letters that they were in this situation. It was entirely a problem created by Queensland Health as an employer.

Accordingly, I had instructed Queensland Health to make sure that they took all of the appropriate steps to address the concerns of individual staff with sensitivity and responsibility. Accordingly, they undertook a number of initiatives such as setting up the call centre, providing case manager support if that was requested, indicating to staff that there were a range of different ways in which recovery or repayment could be made, and a few other things as well. They are the things that bore upon the timing. On the basis of that advice, the recovery action did proceed.

It became apparent that for many staff they did not have confidence in the information that had been sent to them. Accordingly, there needed to be steps taken by Queensland Health to rebuild the confidence of staff in the payroll system and the information coming from the payroll system. So, on the one hand, whilst all of the advice coming to the department and coming to me clearly said that the system had stabilised and that it was important to commence the recovery process in the time frame in which it was commenced, the challenge that Queensland Health has is actually restoring the confidence of the staff of Queensland Health that the information provided in those recovery letters and provided in supplementary information provided to staff is in fact information that they can have confidence in such that they could take appropriate steps regarding the recovery.

CHAIR: Thank you, Minister.

Mr WILSON: That is why the moratorium has been introduced to create breathing space.

Mr McARDLE: Acting Director-General, prior to the department starting a recovery procedure, I understand there was a random audit undertaken of employees who had been overpaid for the purpose of identifying any evidence of excessive or unjustifiable payments that led to the police being involved in what were in fact allegations of fraud. Can you advise how people were selected for that audit and who undertook the audit?

Dr O'Connell: Queensland Health does have a statutory obligation to report suspected official misconduct to the Crime and Misconduct Commission and any suspected criminal matters to the Queensland Police Service. In October 2010 the CMC approved processes implemented by Queensland Health to examine claims by staff for interim cash hardship payments. The CMC authorised Queensland Health to use such processes to examine payments to an initial cohort of approximately 600 employees. The rigorous assessment process was designed to ensure that individual employees were treated fairly and equitably while protecting the public interest.

Where there appeared to be a suspicion of criminal conduct—that is, no reasonable explanation for claim for hardship payment—Queensland Health referred employees to the Police Service. This process accords with Queensland Health's statutory obligation under the Financial and Performance Management Standard 2009 and of course accords with standard notification of suspected criminal conduct to the appropriate law enforcement agency. This process did not include Queensland Health first seeking an explanation directly from the staff member. We felt that to do so would expose the staff member to potential self-incrimination and potentially impact on the police investigations. In the event that a relevant staff member is able to provide a reasonable explanation to the investigating police for the basis of the claim, the matter is returned to Queensland Health to manage internally.

Mr McARDLE: Thank you, Acting Director-General. Can I ask how many people were referred to the police?

Dr O'Connell: Yes. To date, 88 Queensland Health employees have been referred to the police in accordance with that process that I just explained to you before. As at 5 May, of those 88 people referred to the police, 18 people have actually been charged or convicted; three have not been able to

be located by the police; two matters have been returned by the police for insufficient evidence; 40 have not yet been contacted by the police at that date, 5 May; and 15 contacted by the police have an interview pending; 10 staff were interviewed and files referred back to Queensland Health to verify the versions supplied, and these are potentially still subject to being charged.

Mr McARDLE: Thank you for that. Acting Director-General, you said there were 600 files audited. Are we relying upon the same data that we referred to earlier in relation to the overpayments to determine who those 600 are or were there 600 people picked at random across the Queensland Health payroll system?

Dr O'Connell: Thank you for that question. I may need to ask how that 600 were selected from the deputy director-general for HR.

CHAIR: Minister, you may want to take this on notice if the information is not forthcoming.

Mr WILSON: If you are happy with that, Madam Chair, we could take that matter on notice.

Dr O'Connell: I am happy to research that for you and answer that later today, if you would like, Mr McArdle.

Mr McARDLE: Thank you for that. You said to me that it was a CMC approved process. Can you explain that process to me?

Dr O'Connell: I cannot explain the internal processes within the CMC.

Mr McARDLE: No. How does the face-to-face interaction between Queensland Health and CMC come about?

Dr O'Connell: Queensland Health notified the CMC of suspected fraudulent claims by staff and representatives of the CMC attended two meetings with Queensland Health on 6 and 14 October to assist in determining an appropriate action plan by the department. On 21 October last year the chairman of the CMC wrote to the director-general at the time noting, with appreciation, the cooperative approach taken by Queensland Health to deal with this issue. Our own internal assurance and risk advisory services provided general advice to the Queensland Audit Office and Queensland Health's internal audit committee. So this would be a standard interaction between those two agencies about suspicious behaviour.

Mr McARDLE: Thank you very much.

CHAIR: I now call the member for Gladstone.

Mrs CUNNINGHAM: I would like to continue on with a couple of questions in relation to the payroll, if I might. Queensland Health has issued letters to employees of Queensland Health requiring repayment of certain amounts. I have seen the pay slips of a number of nursing staff in particular during the maladjustment of the payroll system, the introduction of that payroll system. Some of those pay slips were unintelligible. This may be similar to a question the member for Caloundra asked. The pay slips themselves were appalling in terms of the way they presented to the payee. How can Queensland Health be confident of the records they have got and they are operating on?

Mr WILSON: I take it that question is directed to me?

Mrs CUNNINGHAM: Yes.

Mr WILSON: The advice to me from Queensland Health is that they have undertaken the most rigorous assessment they could of the reliability of the information in the payroll system. I understand that there were essentially three components to that exercise. Data was checked by payroll staff, the data was checked also at a local level, and of course in the letters that were sent out there was a recognition that this information may be queried by staff. Indeed, publicly I called upon staff to dispute the information should they wish to and to ask questions and to follow up with Queensland Health if they were not satisfied with the information that was provided to them.

The advice was that Queensland Health had the best available information to them to send out and they were providing the best information they had to individual workers. They were putting an individual worker in a position of having an opportunity to challenge that, to ask questions about it, to dispute it, to agree with it—as quite a number have. In their own individual circumstances, they found they were comfortable with that information.

What was commencing was a process that was designed to ultimately benefit staff in giving them the opportunity to notify Queensland Health if they believed the information that Queensland Health held in their payroll about their entitlements or otherwise was accurate or not. That is a process that has been continuing, such that staff have been making inquiries of Queensland Health and giving the feedback as to whether or not they were in agreement with the information that Queensland Health had.

Mrs CUNNINGHAM: Can I say something? Minister, one of the things in parliament that we often deal with—not regularly but often—is reverse onus of proof, and some find it objectionable when that is included in legislation. It appears to me that a lot of the nursing staff and allied staff at a hospital are being required to meet a reverse onus of proof. They have got appalling pay slips, they are often tired

because of their shiftwork and they have been living under incredible stress for all the months that this rollout occurred, yet Queensland Health are sending them an account that says, 'You owe certain amounts of money. By the way, if you can prove that you don't owe it back to us, just let us know.' But the detail upon which they must base that proof is flawed pay slips that Queensland Health themselves provided. I have to say that I agree with the Queensland Nurses Union, which said, 'Queensland Health has to prove that you've been overpaid; it's not up to you to prove to Queensland Health that you've not been overpaid.' Wouldn't that be a reasonable position for the nurses to be in, to say, 'You haven't provided enough proof that I have been overpaid. Prove it'?

Mr WILSON: It is a very reasonable position. To assist nurses and other staff to have a clear picture of the position ultimately, Queensland Health have provided them with the information that the system holds that says what the potential sum of money that has been overpaid to them amounts to. It is ultimately in the hands of Queensland Health. As any employer would do, Queensland Health as an employer has to establish what the facts are. It is not for any worker to be required to disprove what the employer says; it is the obligation of the employer to pay the right amount at the right time and provide the right information about it. If Queensland Health cannot establish that with any one or more members of staff then that is Queensland Health's problem; it is not the member of staff's problem.

Informing staff in June of what is recorded on the pay system in relation to them was a step that enabled them to say, 'I don't agree. I dispute it. Even if I don't have any information to dispute it with, I don't accept it.' Any of those options were at that time, and remain so, available to staff to take. The obligation is on Queensland Health as an employer to establish what the position is. The moratorium on the actual recovery process itself, as distinct from informing all staff of what the system records in relation to them, creates a big breathing space for staff to, as I said earlier, get on with their normal life and also follow up with Queensland Health and take the time they need to be satisfied or not satisfied about the information that Queensland Health has regarding their pay situation on the pay system.

Additionally, as has been announced by the Premier and me, a number of other new measures were in the package that were directed towards staff on the front line—nurse unit managers, directors of nursing and other line managers—to support them in the administrative burden that they have acquired as a result of what has taken place, and there is recognition of other staff. There is no doubt about it: Queensland Health staff have had a very difficult time in this whole process. I apologised to them at the time that this process commenced. It is one not of their making. No-one wants to be in this situation; no employer wants to be in this situation, particularly Queensland Health. I recognise the patience and forbearance of staff regarding this very difficult situation. That is why I am particularly pleased that further measures have been introduced to create that breathing space so that staff can make up their own minds whether or not Queensland Health as the employer has made out its case that a particular employee might owe them a certain sum of money.

Mrs CUNNINGHAM: I have to say, Minister, that employees of Queensland Health, particularly the people at the coalface, the ones who are working on the wards, are crushed by what has occurred and do not feel confident that they can defend the demand by Queensland Health on them financially with the paperwork they have got available, yet that is the only tool they have. All they have are these terrible—I am not allowed to say that other word—pay slips that have the hours worked, a deduction of $2,300 and pay for the week of $1.36. Yet they have to defend themselves based on that document. I hear what you are saying.

I have a question to the acting director-general. Is the $62 million in alleged overpayments intrinsic to the forthcoming budget that we are reviewing today? What I am asking is whether the $62 million that is now claimed to have been overpaid to workers part of this budget cycle. If it is not repaid, will the Queensland Health budget have a $62 million deficit?

Dr O'Connell: Clearly, if the $62 million is not repaid then, yes, it is money which is not available to us to spend. However, it is our intention to recover as much of that as possible. We are trying to do that in a way which is as friendly to staff as possible. Certainly, I believe that front-line staff who, as you say, have disquiet about the whole process have information to help them with that repayment process. That is why we would not want them to depend on just the pay slip. We have given them case managers if they require it to talk them through the various pay slips, statements of pay and hours worked which we have started to generate as a new process.

We have been listening to Queensland Health staff and their concern about the pay slips. I think they were much less legible in the past than they are now. We have been listening to those concerns and we have been changing the information that is on the pay slip so it is easier to understand. The changes occurred in April and they now include more information about not only how much they earn but also the taxation and deductions they have paid, their annual leave entitlements and any overpayments received. We are making it much easier to get access by making the process of distributing the pay slips much slicker so it goes to people's private postal addresses much more easily.

We have also introduced a range of measures which provide information to help them understand the pay slip. For example, we have done a 'your pay slip explained' satellite broadcast and a 'your pay slip explained' brochure, and we have frequently asked questions, glossaries of terms et cetera. I think some staff are challenged by the pay slip. We want to make it as user friendly as possible.

Mrs CUNNINGHAM: Can I just go back to the critical part of the question. The $62 million that at the end of last financial year was deemed to be overpaid to Queensland Health staff has been transferred across to this current financial year as recoverable funds in the budget. If it is not recovered, will the budget suffer for that amount?

Dr O'Connell: It is treated as a loan to the staff. Clearly, as I said before, if we do not recover it then it is moneys that we have lost but it is our intention to recover it. I think the vast, vast majority of our staff are really well meaning and intend to pay it back. We have already recovered millions of dollars that has been paid back because our staff have embarked on voluntary repayment schedules. We are not asking them to pay the whole amount back in a lump sum. Many of them have embarked upon schedules where they are paying back quite small amounts every pay. That is okay. Many of them are on quite low pays and we do not want them to feel burdened by a large lump sum. We want them to pay it back in a way which is comfortable for them.

Mrs CUNNINGHAM: Thank you.

CHAIR: We will have one government question.

Ms JOHNSTONE: Minister, I refer to SDS page 1-154 and the government's $1.8 billion investment in health infrastructure in the coming year. Could you outline to the committee how that investment will help people in the electorate of Townsville and the city of Townsville?

Mr WILSON: I thank the honourable member for the question. The budget this year is a record $11 billion budget. The budget includes funding of about $1.6 billion for the building program—at a total of $7 billion over the years. It is the biggest hospital building program in Australia. A key part of that building program is the services at the Townsville Hospital, and $437 million is the funding to the Townsville Hospital. It is a four-stage expansion of the services at that hospital. Stage 1 is the $94 million of state and Commonwealth funding to provide 100 additional beds and extend the emergency department and the medical imaging department. The new four-storey North Block will be completed in July 2011. Stage 1 commenced in 2007 and the refurbishment of the old emergency department to expand short-stay beds will be completed by the end of 2011. Stage 2 is the $25 million state government Mums and Bubs funding for expansion of the neonatal intensive care unit, which will provide 18 additional neonatal cots and be delivered in 2012. Stage 3, $250 million from the Commonwealth Health and Hospitals Fund, will provide an additional central energy facility, a new clinical support services building, two additional operating theatres and expanded pathology services, and an additional 66-bed ward block will be completed by 2014. Stage 4—I indicated earlier there were four stages—is $67 million from the Commonwealth Health and Hospitals Fund Regional Cancer Centres program for significant expansion of oncology services at the hospital by 2014.

In total, the $437 million redevelopment of the Townsville Hospital which commenced in 2007 and will be completed by 2014 will deliver 214 more beds to the hospital. This is an important part of the government's building program. It is directed at providing more beds, more staff and more services sooner and closer to home for Queenslanders. Townsville is a very important Northern Queensland centre and is growing every day. We want to make sure that there are more and more services available at the hospital for that expanding population. That is one of the major hospitals, all of which throughout the state are being dramatically built anew, redeveloped or expanded as part of the $1.8 billion capital works program in this year or part of the longer term building program that we have for hospitals in Queensland. As I say, it is a record budget this year—$11 billion or a 10.6 per cent increase in the budget this year. Since 2005 the Health budget has doubled. It is not only an investment in buildings; it is investing in the services that are provided in these expanded hospitals and in, for example, the hospital expansion program at Townsville.

In 2009 we made an election commitment to employ an additional 3,700 clinicians—doctors, nurses and other allied health professionals—in this term of government. We have more than exceeded that promise. Indeed, the Prime Minister made a commitment last year to employ on top of that 3,700 an additional 1,200 clinicians. As of February this year, we had met that new additional target of 4,900. I understand that that number at present is approximately 5,200. So it is not just an expansion of our hospitals in Townsville and in other major centres; it is the employing of the vital health professional workforce that is necessary to ensure there are more and more services provided in regional Queensland, where the majority of Queenslanders live and where Queensland is growing as rapidly as possible.

CHAIR: Thank you, Minister. I call the member for Caloundra.

Mr McARDLE: Thank you, Madam Chair. Acting Director-General, there are a number of components within Queensland Health dealing with this payroll issue across various sectors. I understand there is an overpayment team, there is a payroll team itself, there is a state-wide operations team, there is a payroll systems support team and a number of case managers. You may need to take this on notice, but can you tell me how many employees fit within each of those teams and whether those employees are new full-time equivalents since the rollout in March 2010?

Dr O'Connell: What I can tell you is that there has been an increased number of payroll staff, as you highlight. We are currently employing approximately 300 additional payroll staff. That is because the new payroll system implementation clearly has been a very complicated process which requires much more intense handling of individual staff members—that is, in the early days there was correction of errors in the system but with the stabilisation of the system there has been a change in focus in the kind of work that is being done. We are trying to ensure access to emergency financial assistance for all of our employees but, as you have heard, there have been no people accessing that in the last few pay periods. We are developing and rolling out localised payroll operating models to re-establish working relationships between employees and payroll hubs. We are resolving many of the critical issues and implementing arrangements to fix the remaining problems, and of course we have engaged Ernst & Young to independently review Queensland Health's current payroll and rostering systems.

As I said before, it is a very complicated system. There are over 80,000 staff. Not only that, there are 13 awards with multiple industrial agreements and they provide for over 200 different allowances and in excess of 24,000 different combinations of calculation groups and rules. It is a very complicated system and we have needed to bring on these staff to assist with that.

I will provide a breakdown for you later in the day of those individual teams that you have mentioned. But, as I said, in total there are approximately 300 additional staff. We are clearly working closely with the ASU about the roles those staff have. We believe that we need to elevate some of those staff to a slightly higher level to provide more of a supportive role for the payroll staff within their individual teams. We have a plan to convert some of the temporary staff to permanent staff—approximately 140 of them who have already been with us for one year, so I think that is appropriate. But clearly—and this is in consultation with the ASU—over time, as the payroll system improves, it would not be our intention to continue employing those numbers indefinitely.

Mr McARDLE: Thank you. Acting Director-General, you are aware, of course, that this year I think we are spending over $90 million to correct the problems in the payroll structure. The overall figure for correction was $209 million. Has the department received any advice that it may cost more than that to correct the problems within the payroll system, either written or oral?

Dr O'Connell: The amount of $209 million that you referred to is an amount which CBRC approved in November 2010—$208.6 million to be exact. That was for additional payroll staff and to reimplement the solution over the following 18 months. That funding paid for $15.8 million to the Payroll Improvement Program to implement a new payroll operating model and to improve the performance of the current payroll solution; $30.8 million was allocated to improve the payroll system through a service agreement with CorpTech, which are the custodians of this system; $55 million was paid for a Payroll Foundation Program to implement the recommendations from the Ernst & Young review; and $107 million was paid to the Queensland Health Shared Service Partner for additional payroll staff. We will need to make a small increase in investment as a result of the various elements that the minister referred to earlier in one of the previous answers to your questions. We are currently discussing with Treasury exactly how much that is, but it is of the order of $10 million.

Mr McARDLE: Minister, in the letters that were forwarded to the various employees it refers to a person titled 'case manager'. A person could telephone or arrange an appointment with a case manager to discuss the concerns that they had. Would that case manager have the authority to extinguish a debt if that person believed that the employee did not owe them money? If that person did not have the authority, who does have the authority in Queensland Health to extinguish the debt referred to in one of those letters?

Mr WILSON: I thank the honourable member for the question. The case manager is an important element of the initiative that was taken at the time that the recovery process commenced, in June of this year. In terms of the outcome of any work that the case manager does with an individual employee, that would need to be addressed and considered by the appropriate authorised officer at a senior level within Queensland Health. I am not in a position to provide the committee with legal advice, nor would it be proper to do so, as to who would at a senior level under the relevant legislation be authorised. Ultimately, it would be a matter for the director-general.

But the real issue here is that the case manager approach being made available for individual workers means that they can receive information that the payroll system records against their name. They have been informed of this information and been invited to challenge it and provide any information they have and to dispute that information if they so wish and to place the burden where it ought to be—with Queensland Health as the employer, acting through the particular case manager—to establish whether or not the sum that is recorded in the correspondence is indeed a sum that can be relied upon. That iterative process is available to all workers, and in the breathing space that we have created through the moratorium and the other initiatives in the package that was announced just recently workers now have the opportunity to undertake that inquiry with some confidence that ultimately they may arrive at a position that they can be satisfied with, whatever that might be.

CHAIR: Thank you, Minister.

Mr McARDLE: Acting Director-General, the minister indicated that it may be the position that you hold at the moment, or perhaps the person who assumes that position is the one who has the authority to eradicate this alleged debt. Can you confirm that it is only you within Queensland Health who has the legal authority to erase the debt or are there other officers within the department, because I can envisage that the person who fills your shoes in due course will have significant numbers of files in front of them to try to work through the process?

Dr O'Connell: I personally have not delegated the authority to waive debts to anybody in the organisation. There was a clear decision made which is widely known that amounts less than $200 would be waived. That applies to the period from the commencement of the system to 30 June, and then a subsequent decision was also made for the subsequent financial year. That was a clear business decision based on the fact that the cost of recovery of amounts less than $200 was approximately the same as the amount that was being recovered and so was not a smart business decision on behalf of the taxpayers of Queensland.

That is a decision that was announced by the Deputy Premier at the time when he was Minister for Health. At the moment there is no intention to waive any other payments. The whole process that we are going through at the moment is not a waiving of the debts; it is merely a moratorium to give breathing space, as the minister said, because we certainly are not in the business of pursuing our staff in a harassing way to get this money. We want them to feel comfortable about paying that back. As I said, millions of dollars—I think the total now is up to $11.7 million—has already been paid back in these voluntary arrangements.

It is not the authority of the case managers to either waive or pursue this. The sole purpose of the case managers is to assist staff in understanding their pay slips, in understanding what their actual situation is and engaging in a conversation about what way works best for you in paying back this money.

Mr McARDLE: If I can ask this one question: 32,000 employees have received letters.

Dr O'Connell: Thirty-eight, yes.

Mr McARDLE: My apologies, 38,000. There could be several thousand who approach Queensland Health via the case manager. That will then land on your table for determination. That will take an incredibly lengthy period of time, will it not?

Dr O'Connell: It certainly will.

Mr McARDLE: And more importantly, it leaves the nurses and the doctors and all of those strung out for a very long period of time with a debt hanging over their head. How long do you think it will take before that is going to be resolved?

Dr O'Connell: It is our intention to deal with this matter as quickly as possible. If people are comfortable with a moratorium and not wishing to voluntarily pay the money back, then clearly they have made a decision that they are comfortable and they are effectively saying that to us. If they are uncomfortable about that and they would like to pay it back then the case managers are there to have a conversation with them about the best way to do that.

One of the reasons we brought on these additional payroll staff is so that we can be as efficient as we possibly can in dealing with this so that any disquiet which our staff has is minimised. We would not want this to go on forever. Certainly, the Premier in her conversations with me and the minister in his conversations with me have emphasised that we do not want a situation where people have a big debt at the end of the financial year. We want to resolve these issues as quickly as we possibly can. Of course, ultimately the way that we have to do this is to make the system intrinsically much smarter and reliable. We have already reached a point where it is significantly stabilised and, as I have said to you, this pay has no 'no pays' due to system error and no staff accessing emergency payments.

But we do need to change the way the system works. I think one of the problems with the system is that the time of closure of the roster is the same time as the time of closure of the pay cycle. That is a problem for us. Unfortunately, the worst day of the week is the one which historically has been used for that, namely a Sunday. So on the day of the week when we have the lowest number of staff because it is our least busy day any changes to the roster are much more likely to slip through. So that will represent, if there has been a shift change, an overpayment for one staff member and an underpayment for another.

I think we have to ultimately change that process. That is why one of the elements that the minister referred to before is an exploration of the way that we can change the pay cycle so that those adjustments are much less likely. We have certainly got a lot of cooperation from the unions in that concept. We are going to be having a trial in a small number of places. The unions are keen to get over that issue of what are the systemic issues which make our system inefficient. So we are really keen to work with them. We want that process to be overseen by the Queensland Industrial Relations Commission, because we want an independent umpire so that staff can feel completely reassured that this process of fixing the system is not just a bandaid solution but is actually going to deliver them increasingly reliable pay. As I said, I am comfortable at the moment that we have reached quite a significant level of stabilisation already.

Mr McARDLE: Thank you. At some point in time, of course, the moratorium will end. That is a statement by the Premier, I think.

Dr O'Connell: Yes.

Mr McARDLE: So I think we are in agreement that it will take a very long period of time for these repayment issues to clear the desk of the director-general and it will still leave this hanging over several thousand Queensland Health employees as to what is going to happen with that debt. Either it will be wiped or they will have to repay it. I think we agree on that.

Dr O'Connell: I am sorry, I did not hear a question there.

Mr McARDLE: I think it was a statement that we both agree that the issue is going to take a long time to resolve and in that period of time there are going to be a lot of people within Queensland Health who have a debt hanging over their head. I think we both agree that there are several thousand files that could cross your desk and that will take you some lengthy period of time to work through.

Mr WILSON: Point of order. Perhaps the question could be asked.

CHAIR: Before I answer the point of order, can I just say that we are dealing with hypotheticals here, member for Caloundra. I think you have been told that it is going to take some time but that it will be done as soon as possible. We were dealing in hypotheticals. You have a point of order?

Mr WILSON: My point of order was could the member ask a specific question rather than make a comment.

CHAIR: Yes. I think the member is getting around to that.

Mr McARDLE: Yes, I think I was, too. Thank you, Minister, for that. Acting Director-General, I am going to move on to the issue of the maintenance of Queensland Health facilities in hospitals. Can you advise how much is allocated in the budget specifically towards the maintenance of Queensland Health facilities in hospitals?

Dr O'Connell: We have massive infrastructure, of course, in Queensland Health with 182 hospitals. We maintain a broad range of building infrastructure to support the delivery of services and, of course, it has a gross book value of over $8½ billion. There is a significant maintenance bill associated with that. The actuals for 2010-11 for operational resourcing was $140 million. Queensland set a target funding level for building infrastructure maintenance at 2.15 per cent of the undepreciated asset replacement value and this target exceeds the one per cent minimum set by the whole-of-government policy for the maintenance of Queensland government buildings. The higher level is due to the critical and complex nature of hospital facilities. The maintenance of building infrastructure is managed by Queensland Health staff and work is undertaken by internal trade staff complemented by contractors and the Department of Public Works and Q-Build. Clearly, the kinds of buildings that we are talking about here are not just hospitals; they are also primary health clinics, nursing homes, ancillary buildings and even staff accommodation.

Mr McARDLE: Acting Director-General, is there a system for tracking which facilities and hospitals require maintenance within Queensland Health?

Dr O'Connell: There are risk registers, yes, and there are audits. Each of the districts report on the maintenance requirements for their district on an annual basis.

Mr McARDLE: Is this in the computerised materials management system?

Dr O'Connell: I believe that is the system which manages it. Yes, it is.

Mr McARDLE: Is there a list of backlog maintenance items in that system at the moment?

Dr O'Connell: There will always be a list of items which are in the queue to be dealt with, because clearly we cannot do every single item of maintenance simultaneously. So there is a prioritisation, yes.

Mr McARDLE: So there is a backlog in that system. Do you know how much that backlog is at the moment in dollar value?

Dr O'Connell: No, I do not have that in front of me. We could find that out for you.

CHAIR: So we will take that on notice?

Mr McARDLE: Perhaps I can assist the acting director-general. I table a document that says that the backlog maintenance—and I think this is actually for the last financial year—is $361.839 million. Can you comment upon that figure? I should point out that that is a copy of slides presented at a forum. Can you comment upon that figure?

Dr O'Connell: I think probably it is best if I comment on that figure once I have checked the data that I was going to check to answer your first question, which is what is the current level. I am not sure which forum and who presented the data that you have just mentioned there—the figure that you have just mentioned there.

Mr McARDLE: The slides will indicate, I think, some detail that can be checked by the department. The slides indicate $361 million. Is that the current figure or is the current figure in excess of $400 million? Perhaps you can take that on notice as well.

Dr O'Connell: Yes, I will.

Mr McARDLE: The other point is that, with the computerised materials management system, which I understand is where detail of the backlog maintenance is maintained, will you—or perhaps I should ask the minister this. My apologies to you, Minister.

Mr WILSON: Could you start the question again?

Mr McARDLE: My apologies, yes. The computerised materials management system, I understand, is a system where the backlog maintenance details are kept within Queensland Health. I understand that it is a central system. I think the acting director-general indicated that the districts refer to a central system. Minister, will you undertake to table a copy of the backlog maintenance details contained in that system either in hard copy or on disk for this committee?

Mr WILSON: I thank the honourable member for the question. I cannot accept the description that you put forward, not having the material in front of me, that it is an apt description that the register constitutes backlog maintenance. I would take advice from the acting director-general. He is getting some further information in relation to this matter whilst this committee is sitting. I would think that the register is a register of maintenance that has been identified to be undertaken and then prioritised, but I would need to take advice from the deputy director-general of infrastructure regarding that.

I would think that, in any large system organisation like Queensland Health with over $8 billion worth of assets and spending nearly $2 billion certainly this year, it is a very large asset base. You heard from the acting director-general earlier of the approach to asset maintenance and to costs. I would expect Queensland Health to have a well arranged process for identifying the timely undertaking of maintenance required across its facilities, especially with such a large asset base, and especially also given that the facilities of Queensland Health not only are quite variable in their nature—from hospitals to community health centres and to nursing homes—but also we find that those facilities are in remote and rural places, including in the Far North. So those facilities will have different requirements regarding their maintenance because of seasonal factors and suchlike. But I would expect Queensland Health to have a well organised arrangement for identifying maintenance such that it can then be addressed as required in a timely way. The deputy director-general in charge of facilities will hopefully be able to give us some further information before the committee finishes tonight.

CHAIR: It is afternoon tea time. The committee hearing will resume at 4.30.

Proceedings suspended from 3.59 pm to 4.29 pm

CHAIR: Ladies and gentlemen, we will now continue the examination of the portfolio of the Minister for Health. I would like to call on the member for Caloundra.

Mr McARDLE: Acting Director-General, prior to the break we were talking about the issue of the maintenance backlog or backlog maintenance and you have taken some questions on notice for which I thank you. I wonder if you could also take on notice and advise the committee for 2008, 2009, 2010 and then to date what was the backlog maintenance figure at that point in time?

Dr O'Connell: Yes, I will do that.

Mr McARDLE: Perhaps I will ask the minister this question: in regard to the backlog maintenance, and I know the data is not here and I accept that, maybe you can take on notice as well what action the department will take to deal with that backlog maintenance, how long it will take to deal with it and, perhaps more importantly, outline the facilities that are impacted by that maintenance backlog?

Mr WILSON: I thank the honourable member for the question. I note that you have asked for additional information through the Acting Director-General and his undertaking to provide that for those several other years. Can I just make clear that the description that you are using repeatedly in relation to maintenance is a description describing it as backlog. I did make it clear in my earlier response to a question regarding maintenance that I would expect that there would be a system run by Queensland Health that identifies in a proper way, by auditing and regular review, maintenance identified that needs to take place. The appropriate description of that maintenance, as to whether it is backlog or otherwise, depends upon independent experts who are building experts making assessments about the timeframes over which maintenance might need to be undertaken. I respectfully caution the honourable member that one may be misdescribing the maintenance by using the name 'backlog'. I would expect the department, as I said earlier, to have a register and a method of identifying on a routine basis maintenance that needs to be done, and then I would expect that they would have an assessment process in place that identifies what maintenance needs to be done over what timeframe with graded levels of urgency or importance from high to low. There will be some system like that, I guess. And as I indicated earlier, I was happy for the Deputy Director-General for Facilities to make that information available to the Director-General and I later so that we could provide it to the committee.

Mr McARDLE: I do appreciate that. I table a document which is a copy of a series of slides, the first one titled 'Master data standardisation project supporting local health and hospital networks.' I will fold the document to a particular page which has on it this particular slide—'CMMS update current situation'. The third dot point reads, 'The AMSU'—and I am not quite certain what that stands for—'currently have three system developments on hold awaiting funding'. The first one, they say, is asbestos management. I wonder if the Acting Director-General will take on notice to provide to the committee details of what those system developments are and what the asbestos management relates to for the benefit of this committee.

Dr O'Connell: Madam Chair, can I ask Mr McArdle where this has come from just so that we understand the source of the information.

Mr McARDLE: It is a document that came into my possession and I am simply asking you to look at it and make a comment upon the content of the document and, if you can find details out about the document, present that to the committee.

CHAIR: Before we go on to the next line of questioning, the chief executive officers of the Health Quality and Complaints Commission and the Queensland Institute of Medical Research will be questioned by the committee during parts of this hearing and that may go on until 6.30 tonight. Members may ask questions about other relevant issues during this time as well. I would ask the public officials and the CEOs of statutory bodies to identify themselves when they first answer a question, if the minister, Director-General or CEO refers a question to them, so that Hansard can then record their name. I first of all call the member for Caloundra.

Mr McARDLE: If I could just talk to the CEO of the Health Quality and Complaints Commission. Professor Herbert, good to see you again. Professor, back in November 2010 you appeared before what was then the Social Development Committee. Professor Ward, who I think is in the chamber today, was commenting upon the role of the HQCC in the new federal health reform process. There was some doubt as to what role the HQCC would play, in particular with reference to the 10 national standards regarding hospitals. Could you elaborate as to where you now see the HQCC standing in the new rollout of the new national health reforms and, in particular, the 10 national standards?

Prof. Herbert: We have worked with both the national body, the Australian Commission on Safety and Quality in Health Care, and with Queensland Health and have spoken with the minister about our ongoing role. At the moment we are putting together a transition plan which we hope to share with the minister when he attends our commission in August. That transition plan supports our view that we should not have duplication, that we should support the national standards and, indeed, still be the statutory authority that is independent and can overview compliance with those standards along with the national body. Our sense is that there is going to be a whole framework set up under the National Health Reform. We will not duplicate. We have been very fortunate in Queensland to have been established since 2006 and to have had nine standards out from July 2007 onwards. We have measured 226 hospitals eight times and September will be a ninth time. It is fantastic data and shows increased compliance of Queensland hospitals, both public and private. We certainly do not want to go backwards. We think we have information now that is unique, that will assist the national agenda and we would like to see Queensland at least retain the clinical standards which are not yet with the Australian commission. These two are an AMI, a myocardial infarct—so a heart attack—at hospital and afterwards the care that we think is appropriate and follow that through to 90 days. The second one is VTE or thrombosis. So, it is preventative action, and just following that through. We would also like to look at whether regulated standards make a difference. We have got the hospitals saying they have complied. We would like to test that. When we do not find that the information given to us has complete integrity, and that happens sometimes when you have complaints or investigations going on at the same time, we just work with the hospitals to see which information is correct and then we work with them on an improvement plan and then we monitor the improvement plan. So, the good thing with this is that we are doing what we were set out to do from 2006 onwards: to monitor the improvement and to ensure that improvement is happening.

Mr McARDLE: In November of 2009 I asked Professor Ward in relation to the paper check—I use that term but not in a derogatory sense—undertaken by HQCC to check hospitals complying with the standards that they have set. Professor Ward made the comment that you were developing a project that looks at how we could audit or investigate or look at particular hospitals, implying that you would move from a paper check to a physical visit and then ascertain how hospitals were complying. Has that progressed at all and, if it has progressed, at what stage are we at?

Prof. Herbert: It is progressing. We were able to share with the minister at a recent visit when he comes to see us in August that we have been developing a business intelligence tool and that tool will look at standards compliance, complaints—just a profile—and also RCA reports that under legislation we receive. We are pulling those together under the future LHHN so we will give him a bit of a showcase of what a profile looks like. We will go out and test these. Now, it is early days. We are putting together a response framework. Under that response framework we are using the sense of the Australian Tax Office and in that we are presuming most people do the right thing and do good, but because we are

only 70 people strong what we are going to do is put effort into where we are finding anomalies and go out and test that. The other thing we want to do is that, if we find trending either in single facilities or across multiple, we could pull those together and work on improvement plans there. So, we are getting very close. We are testing it at the moment.

Mr McARDLE: When you say testing it, can you name hospitals that you are testing the process on and can you give any indication of the outcome of those tests?

Prof. Herbert: I am not able to do that. This is only a pilot and it is for all the facilities. So we are pulling the information historically from 2006 forward under new arrangements and just aggregating. So pilots only at the moment.

Mr McARDLE: Could you indicate as to when testing in the field will commence?

Prof. Herbert: I cannot say exactly when. Definitely by the time the LHHN is operational we will be able to work with the leaders of those groups to show them the information we have at hand. So it is just showing what we have got and what we want to do with that information with them and what we expect them to do and give back to us.

Mr McARDLE: Do you have an expectation that you will actually start testing by visiting hospitals in, say, two or three years time? I am just trying to get a timeline as to where you are at and when you will start knocking on hospital doors, shall we say, to assess how they are progressing?

Prof. Herbert: As I said before we are taking a responsive regulation approach to this so not all hospitals will have us knocking on their doors and, indeed, some of the ones who are playing well in the field and improving well we would be asking them to work with other hospitals that might be struggling so that we get the best outcome across the system. It is both public and private, but this one with LHHNs will be with the public facilities.

Mr McARDLE: Of course. In May of 2010, again before the same committee, this question was raised—

The Commission has serious concerns about the theoretical risk inherent in Queensland's independent healthcare watchdog reporting to Parliament through the Minister for Health, the Minister responsible for Queensland's largest healthcare provider.

Do you still have a concern that the HQCC, given the new national reforms that are coming through, given that there will now be 17 statutory bodies—perhaps 18 with Queensland Health per se in Brisbane—should be totally independent of Queensland Health to remove that perceived or theoretical risk?

Prof. Herbert: Certainly I think post-Bundaberg the Queensland public expect that the health watchdog is independent. We have been working very closely with both the minister and the department to make sure some of those processes are clearer and end up with a sense of the public gaining confidence in that independence. I think the national reform actually may assist in that sense. Our sense is that we are working together to achieve that. It is important that we do not stop moving towards a sense of independence. If we are ever perceived as part of the department, I think the public confidence is robbed. We have had that sense in the past of the public perceiving that, so we try to make sure that we promote that independence. Our sense at the moment is that we are being supported to achieve that.

Mr McARDLE: Professor, would you, in fact, like to be independent? As the CEO of the HQCC, would you like to be a completely separate body and not have to report, as indicated you did back in 2010 and 2009, but report straight to the parliament?

Prof. Herbert: I think as much independence as we can have is an absolute bonus. I will say that, operationally, if we do need to report through a minister, having the minister understanding the portfolio is extremely important and it is just being able to separate out—and we are trying to work on some really good administrative processes to separate out—when the minister seeks advice from his department and when that might not be appropriate because of the information that we are trying to glean. We are trying to work together on that.

Mr McARDLE: Professor, with regards the 10 national standards and the role the HQCC will have in that process, do you see yourself reporting both to the minister and also to the Commonwealth authorities?

Prof. Herbert: I think it is more that our role will be a role of being able to glean information that either the facilities or the LHHNs can have and can send to us when we want to verify compliance. The national health reform is setting out some performance authorities going forward. We will not want to duplicate effort and we certainly will not want facilities duplicating their reporting or certainly different reporting. It would be more when we have concerns, because of the risk we will call for that information and work with them on improvement.

Mr McARDLE: Thank you.

CHAIR: Thank you, member for Caloundra. I would ask the member for Gladstone.

Mrs CUNNINGHAM: Thank you, Madam Chair. To continue on with that, other than the legislative obligation to report to the Minister for Health, are there any other ties that keep you from being a completely separate entity?

Prof. Herbert: No, I think it is the administrative process. It is the way it is set up and interpreted, but certainly we have been pushing and we are being heard, I believe.

Mrs CUNNINGHAM: Because I think you are right: if there is a perception that there is interdependence between yourself and the minister, irrespective of who that minister is—

Mr WILSON: Thank you.

Mrs CUNNINGHAM:—public perception is public reality. It is critically important that the HQCC is seen to be and is independent and acting independently for your role to have credibility and applicability as well. I have been sitting here thinking how to word this question without casting aspersions on anybody. I preface it by saying I am not casting aspersions on anyone. In the past few months and the beginning of our estimates hearings, obviously there was a concentration on the pay difficulties that staff in Queensland Health have experienced. Their individual experiences, in some measure, have been not only totally unacceptable but completely unnerving for some members of the Health staff. I have heard comments such as 'We used to like working here, but now we come because we have to' and 'I had to move away from a patient because I knew if I did not I would say something that would reflect so poorly on Queensland Health that I could not remain in that patient contact'. In your observation or in your experience with the HQCC, has there been a spike in complaints about health care at public hospitals in the past four to six months?

Prof. Herbert: We have not seen that spike, or seen a spike. We measure all of the complaints coming through and they remain consistent. It is consistent across Australia, because we work with the other health complaints entities. About one-third come from public hospitals, one-third from medical practitioners and the other third is made up from anyone else. At this stage, and I cannot answer directly on two to three months but with the figures we collect, and we measure them every month, they remain consistent. We are having an upsurge in complaints, but that is across-the-board; that is not just with the public health system.

Mrs CUNNINGHAM: I guess that reflects positively on the Health workers, that they have been able to maintain that dedication to the community in the face of their own individual difficult circumstances. In the past three to six months, you said that there was an increase in complaints to the Health Quality and Complaints Commission. Has that increase been in any particular area?

Prof. Herbert: There does not appear to be any specific area, except for one relating to dental. That is private dental and it relates to an item out of Medicare where general practices work together and it was an interpretation on fees. That does not really support what you are saying. Certainly we are working with the other health complaints entities across Australia, because it is a national problem and not just within Queensland.

Mrs CUNNINGHAM: Finally, there is always not enough money to go around. Given the pivotal role that the HQCC is fulfilling, is the budget for the HQCC adequate for the forthcoming year in light of your current and increased responsibility with the national interest in health and the role that you have to fulfil?

Prof. Herbert: We believe our current budget is. We are not sure of what is going to happen related to the standards, but we are certainly rolling out the profiles. We have held off on recruiting people to permanent roles and we are doing an internal review at the moment, as is good practice, to really look at our future and where we can value add to the public of Queensland in healthcare improvement. I think this focus on risk profiling, sharing of information, responding and working with facilities and providers to improve will see us putting more people on analysis and being able to go out and audit. We will recruit to those positions. At the moment, because we have retained some and rolled it over to be able to achieve this, going forward we will have to review that.

Mrs CUNNINGHAM: So are you saying that some positions have not been filled as a budgetary measure or because the job that is to be filled is unclear?

Prof. Herbert: It is a little of both. That lack of clarity is only because we are working with the Australian commission to work out where standards go in the future and how our role and the Australian commission's role are best served for the facilities, particularly in Queensland. We do not want to duplicate. We do not believe we should lose money, because we will then channel that money to positions where we do more work on analysis and auditing, which is, as Mr McArdle said, to get out there and actually work with the facilities that are not achieving.

CHAIR: Thank you Professor Herbert, for now anyway. I would ask the member to Burleigh to take the microphone.

Mrs SMITH: Minister, we have recently seen the expansion of the Robina Hospital to 364 beds, with additional services. Can you outline what new services will be available on the Gold Coast when the Gold Coast University Hospital is completed in 2012?

Mr WILSON: I thank the honourable member for the question. The new university hospital is the biggest single hospital building project, I believe, in Australia at the moment. I have visited it on a number of occasions and have talked with workers, as well as project managers. Are you talking about the Gold Coast University Hospital or the Robina Hospital?

Mrs SMITH: The Gold Coast University Hospital.

Mr WILSON: I thought you were, because I am impressed by what is happening there. The fact that a private hospital is co-locating on that site to get the best synergies out of a public hospital and a private hospital is a particularly attractive way of proceeding. All the seven major buildings for the Gold Coast University Hospital are under construction. Construction to floor six and the final occupied floor in the clinical services building, which is the ninth level, is the point they have reached on the main building. Internal fitout of the pathology and education building, which is located on the corner of Parklands Drive and Olsen Avenue, has commenced. The internal site infrastructure, including road and inground services, are substantially complete. Site accommodation for structures is complete. It is all located on a 19 hectare site at Parklands.

As I was saying a moment ago, the master plan includes provision for a 400 bed co-located private hospital, plus a 2,230 space carpark, to be delivered by November 2012. There is a transition strategy in place for 2012-13 through to 2015-16, with capacity expansion of up to 40 per cent and redevelopment strategies have been built into the master plan. The new services that will be offered at the Gold Coast University Hospital include radiotherapy cancer services, neonatal intensive care, trauma services including a helicopter retrieval service, neurosciences and cardiac surgery. Areas that will offer expanded services from their current scope include 300 additional beds, a new emergency department, a special care nursery, seven additional operating theatres with capacity for more, a four level pathology and education department, delivery suites and a birthing centre, an intensive care unit, a medical assessment unit, expanded mental health services, radiology and pharmacy.

The range of healthcare services to be provided and the way they are delivered in modern hospitals is undergoing a major transformation. This facility, as a tertiary level health facility, will mean that the hospital will offer the local community probably one of the widest ranges—Dr Douglas and other doctors will probably tell me that I am missing something out of this scope—of public health services that you can get anywhere in Australia and certainly far more than is presently available. The hospital will be equipped to offer new and extended specialised services obviously to treat more patients on the Gold Coast, minimising the need to travel to Brisbane to receive certain types of treatment. I do not actually have the figures with me, but there will be significant employment at the hospital, which is good for the local economy. That will come not only from the construction impact that is happening at the moment. I think at peak there are about 1,500 construction workers on the site.

I have just been told that there are up to 2,000 construction workers on the site. That is obviously also good for those workers, their families, the local community and the local economy. It is one of the three major hospital projects that are underway—the Queensland Children's Hospital and the Sunshine Coast University Hospital are the other two—and part of the hospital expansion program that has budgeted $1.8 billion this financial year. All of that falls inside the $7 billion hospital expansion plan.

On the Gold Coast we will be in a position in which fewer people will be needing to travel to Brisbane for treatment. There will be modern facilities augmenting what has happened at Robina Hospital and also at the Robina Health Precinct just across the road from the hospital. It is such a significant advance on the Gold Coast Hospital which, if my memory serves me right, was built in the late 1960s, early 1970s or something like that. The Gold Coast is probably one of the biggest growing areas of Queensland. We believe it is absolutely well timed that the university hospital is being constructed in the time frame in which I am indicating. In talking to the contractors, the managing contractors and others associated with the hospital and also with those associated with the private hospital to be built on site, a far more imaginative approach is being taken to the delivery of health care now with the co-location of public and private hospitals and oftentimes with a research facility. My acting director-general will correct me if I have this wrong, but my memory is that there are also research and training facilities as part of the co-located hospitals on the site. So everyone has a win. I understand that it is also highly valuable for the purpose of attracting specialists to a region if they have the opportunity to work in both systems—the public hospital and the private hospital system. You actually get the critical mass that helps attract specialists to the region that might not otherwise come. That is good for training and it is also good for the provision of services to the local community.

CHAIR: Thank you, Minister. I would like to ask a couple of questions related to Townsville. One, of course, relates to the hospital redevelopment in Townsville. As with anything on such a massive scale, there are going to be complications with parking, as we have experienced. My first question relates to the staff car parking site. I am wondering whether many of the problems associated with parking have been alleviated, and these problems occur whenever a new building of this magnitude is being constructed.

Mr WILSON: Thank you very much for the question. I do recognise that it is always a challenge providing adequate car parking, particularly for staff but also for the public at any of our hospitals. An added difficulty is when you are expanding a hospital and also wanting to expand a car park at the same time as wanting to continue its use as a working car park and a working hospital.

CHAIR: Then we have the added complication sometimes of dreadful weather patterns.

Mr WILSON: Correct. If we can find a contractual remedy to variable weather patterns we will make a big advance for the construction industry—

CHAIR: A lot of money too.

Mr WILSON:—in Queensland. The expansion of the services at the hospital in Townsville is a four-stage build of $437 million. I referred to this earlier. In short, stage 1 is $94 million for an extra 100 beds and the expansion of the emergency department. Stage 2 is $25 million for the neonatal intensive care unit—another 18 beds there—and stage 3 is $250 million for the energy facility, clinical support services, pathology and other things. Stage 4 includes $67 million that is going into the regional cancer centre.

In relation particularly to the car park, there is a 600-space staff car park currently being constructed on the eastern campus of the hospital to provide additional staff car parking and to alleviate the disruption on site during the construction period. This car park is on track to be available to staff at the end of July 2011. I stand to be corrected—and someone will tell me if my memory is serving me well or not—but my memory is that there is already a substantial car park; the 600 is in addition to the substantial car park. I think it is about 2,000. Someone will double-check that figure for me. I do not want to mislead the committee.

CHAIR: That would be great. That is in addition?

Dr O'Connell: I can inform you that since November 2010, 100 informal staff car parks have been provided on the site.

Mr WILSON: The objective here is actually adding to an existing, already large car park but it has been impacted because of the construction of the facility. I thank staff and the public for their forbearance. It is challenging, particularly for staff who are working night shifts, in terms of their sense of comfort as well as security associated with accessing the car park. I would expect and I would be confident that the district CEO has made the appropriate arrangements to ensure that the use of the interim car park is available with adequate security for staff using that car park, particularly on night shift.

CHAIR: Is that interim car park not going to be used forever; it is just an interim car park?

Mr WILSON: My understanding is that the objective is to add another 600, a car park of 600, to the already number of car parks that are there.

CHAIR: And include those ones?

Mr WILSON: We will get it directly. We will get the information accurate for you and provide it to you before the committee finishes. My understanding is that we are adding 600 to about 2,000 already and the 100 is an interim arrangement. I will double-check that so that the committee has got accurate information.

CHAIR: Thanks. My next question is sort of related to that in that we have the official opening of this stage of north block of the Townsville Hospital next weekend. I know that you are officiating and I am looking forward to being there with you. This state-of-the-art facility is absolutely magnificent. It is very welcome and it will be the biggest emergency department in the state, which is fabulous. My next question is a typical Townsville question in that many in Townsville never think they get enough. In order to run this facility well into the future and to make sure that the facility receives the full benefit, have the costings been taken into consideration to make sure that this will run adequately well into the future?

Mr WILSON: Absolutely! The facilities planning is done in conjunction with health service planning. The objective is actually to provide the health service with the facilities, the vehicle, for doing so. I will ask my acting director-general if he could obtain any further information on this. The objective is to open the emergency department and get it functioning.

CHAIR: So it is fully budgeted and ready to go and it will continue into the future?

Dr O'Connell: Certainly the emergency department is. The beds in the hospital are being built so that there is capacity to grow with the known increases in demand over the next few years. We would not necessarily want to open every single bed the day that it opens because that would assume that there was a step-wise rise in demand on the day that it opened. Of course, that is not the case. So the funding arrangements for districts, so many of which have capital programs underway at the moment, will be on an activity based funding arrangement. That is the new way of funding districts from 1 July. That is very much in accord with the national reform. The Commonwealth insisted that activity based funding be the way that the states and the Commonwealth together contribute to the funding of hospitals. We will be buying increased services at Townsville. Every year that will go up. The Commonwealth will eventually be contributing 50 per cent to the growth in expenditure on activity based funding. Our plan would be to continue to spend on staff to staff the beds as the activity ramps up.

CHAIR: So that is all part of the More Beds for Hospitals?

Dr O'Connell: More Beds for Hospitals is a language which was used to describe all of the increased beds which came about as a result of the largest health infrastructure program in Australia, which is what the Queensland Health infrastructure program is. By the way, that is equivalent to the health infrastructure programs of all of the other states combined. It is massive. The intention was always to have these beds available for growth. We do not want to have to rebuild the hospital two years after we have just finished it. The physical capacity is, therefore, expecting increased activity over the next five to 10 years and the funding will go up year by year so that we fill progressively each of those beds.

CHAIR: That is great.

Mr WILSON: If I can just add to illustrate what the acting director-general is saying there, the $7 billion building program—not just this year—is delivering approximately 1,700 extra beds and 250 treatment spaces over a five-year period. So the objective is to build for growth so that capacity is there to then service demand which the acting director-general has spoken of.

CHAIR: I understand.

Mrs CUNNINGHAM: I have some questions in relation to some of the stuff that you have just talked about. You talked about activity funding hospitals. That raises with me a huge concern in relation to the Gladstone Hospital. I know the minister is expecting these questions, so full steam ahead. It concerns me that in your answer to my question on notice No. 8 you said that the Gladstone Base Hospital's funding in 2008-09 was $34 million, in 2009-10 it was $37 million and in 2010-11 it was 39 million. When we think about $2 million, it seems like a lot of money but it is not in terms of health provision. As you know, we have a significant industry increase in my electorate with something like 15,000 workers just in the LNG industry alone and there are other industries that are announcing at present. I have already spoken to the minister and to his predecessor in relation to the fact that, whilst we are funded under Rockhampton, we do not get a very good showing in terms of services and many—and I mean that—of the patients who present at the Gladstone Hospital are transferred to Rockhampton and are treated there. Under an activity based model how will Gladstone services ever improve if they cannot provide the activity?

Mr WILSON: I thank the honourable member for the question. I will address a number of aspects and then ask my acting director-general to address the second part of your question. I want to put on the record that the government is committed to ensuring that the objective of the health service planning process for the Bowen Basin and the Galilee Basin, which is the overarching project that is underway at the moment, inside of which there is planning being undertaken for the Gladstone Hospital, is to have the most reliable and accurate forecasting of population growth, the distribution of the population, the industry composition and other important factors of community development over the next five to 10 years so that health service planning for Gladstone Hospital in particular—and likewise for the broader region—can be as sound and as rigorous as possible. On the back of that, judgements can then be made about what services are needed, where they are needed, which cohort of patients of the community are needing them and the timing of their introduction.

You are right and quite fair in saying that we have had a number of conversations about Gladstone Hospital. I can say to you here, member for Gladstone, that I want the Queensland Health exercise in health service planning for the Gladstone region to be as thorough and rigorous as possible and to take into account the impacts of the LNG industry—not just in terms of the temporary workforce but also for the longer term, more permanent population that will be attracted to the region and indeed from which the region will grow—so that some very sound decisions can be made about what new or different service provision could be made at the Gladstone Hospital. We have discussed in the past the situation at Gladstone. The advice to me is that presently there is approximately 61 per cent bed occupancy; elective surgery is able to be undertaken within seven days; the emergency department sees category 1s immediately, as you would expect; and the average waiting time is approximately 25 minutes. I understand that the workforce there has increased approximately 20 per cent since 2005, I think from memory.

Just last year Queensland Health finished construction of a five-chair dental clinic that was opened in 2010, and modern telehealth facilities have been recently added. Of course, as you would be aware as the local member, a $3.5 million partnership has been created with Queensland Health and the Queensland Gas Co. for the development of a renal satellite unit which would provide a service to 60 locals, and there is an upgrade being assisted by QGC in relation to an operating suite. So that is where we are now, and I say that in no way to discourage the member for Gladstone from a quite legitimate expectation that the Gladstone Hospital service planning exercise will be as thorough and as rigorous as possible to identify what change in service provision and what additional service provision is needed over the next five to 10 years or longer. Can I ask my acting director-general to address the specific aspect at the end of your question around activity based funding and its effect on the health services delivered at the hospital.

Dr O'Connell: It is an exciting time for Gladstone at the moment, with all of the industrial development which we are expecting over the next few years. You rightly imply that there will be a population rise as a result of that activity, of course assuming that each of those developments gets government approval and that the global economy continues to support it. We expect to see a 20 per cent increase in population, in fact, over the next five years in Gladstone. The approach to that does need a plan. So the Central Queensland health services plan for the period from now until 2026 is currently being developed and it is estimated to be completed by the end of this calendar year.

That plan will inform the health service requirements of all the communities including Gladstone. That is important because Gladstone is within a hub-and-spoke kind of model in that district, with Rockhampton as the main hospital in the district. It is important that there be a clear delineation of roles between the various hospitals and that it is clear in everyone's mind what the rules are about the ability to move patients, if that is required, in either direction and what services are provided. The services, as the minister said, have been growing in Gladstone in the form of the investment in the Gladstone community oral health clinic and in the renal services that were recently announced.

I can reassure you that the activity based funding model will not be a threat to Gladstone. The principle of activity based funding is that when an activity is performed a reward, so to speak—a payment—is given for that activity. Really, the only issue then is whether the hospital can be efficient enough to make sure that it is not spending more than it is rewarded in dollars for the delivery of that particular service. I am comfortable that Gladstone will be able to do that. So whatever activity is engaged in is rewarded. Of course, the district will take into account all of the relative expenditures between the various hospitals.

The minister referred earlier to the issue of the current level of pressure on the hospital. With an occupancy of only 61 per cent in a hospital the size of Gladstone's—I think it is only about 68 beds—clearly the resources are not currently being stretched. I think we can be reassured by that—that a low occupancy represents the fact that the capacity is well able to cope with the demand. The fact is that the activity levels in a number of areas of Gladstone are actually decreasing. Paediatric admissions, for example, have gone down 1.4 per cent. Obstetrics have gone down 13 per cent. Surgical admissions have gone down 5.6 per cent. As the minister said, elective surgery capacity is adequately meeting the demand, with no-one waiting over the expected—

Mrs CUNNINGHAM: With respect, Dr O'Connell, the activity is decreasing because fewer services are being offered and more patients are being sent to Rockhampton. It is because we do not have the services, not because they are underutilised. People are sent through to Rockhampton for relatively simple fractures. Women are sent to Rockhampton if their BMI is one or two over the accepted norm. A woman with a premmie baby was referred from Gladstone to Rockhampton, which had no beds, and she ended up in Nambour. I do not want neonatal critical services in Gladstone. I want the mums to be able to have their babies. I want the broken arms to be able to be fixed. I want the people who need elective surgery to be able to have the elective surgery in Gladstone.

The activity is down because the services are not there, because there is no investment in doctors and there is no investment in the nursing staff and the allied health staff to keep those specialty services there. All that you have said reiterates the fact that the services in Gladstone are being deteriorated, not increased. Rockhampton does not share well. They keep the resources up there. They keep the specialties up there. We have a young population. Our obstetrics should be growing. The reason they are not is that either the parents are made to go to Rockhampton or they go private because they can stay. We are really at risk of losing obstetrics gynaecology that we share with the private providers. If that is your answer to the problem in Gladstone—a 61 per cent bed occupancy so it is not stressed—you are being fed false information, inaccurate information.

CHAIR: Would you care to make a comment on that?

Dr O'Connell: I just reply that there are specialist services provided in a range of areas—general medicine, surgery, paediatrics and O&G.

Mrs CUNNINGHAM: There are.

Dr O'Connell: So it is not as if there are not those services there.

Mrs CUNNINGHAM: The paediatrician who has been there for a number of years had a heart attack and is working part time. The second paediatrics position I think is still unfilled. I have a follow-up question in relation to our staffing. In September last year we relied 50 per cent on locums, and at that time a locum was paid around $2,500 a day. Is it true that locum services for the budget for this coming year for Gladstone have been reduced to $1,800 a day, whereas for places like Biloela it is $2,500? If that is the case, will you comment on the probability of doctors happily putting their hands up to come to Gladstone as a locum when they can earn $700 extra an hour's travel away?

Dr O'Connell: There clearly have been recruitment challenges in getting senior medical officers to come to Gladstone Hospital since early 2010. We have used a locum medical staff, which has increased, to maintain clinical services to ease the pressure on the hospital. We have four of the eight SMO positions permanently filled. Clearly the locum senior medical officers are contracted by Gladstone

Hospital to cover the vacant positions. In an ideal world, we would not be using locum officers. Locum officers, as you have told us, are more expensive. They have the problem that they do not provide necessarily the continuity of care or the commitment to the hospital that a permanent employee does. We would like to move away from being dependent on locum officers.

There are a range of fees which are paid to locums across Queensland. I think that is another area which is a challenge for us—that there is a relative attractiveness, as you say, to go to various places if you are receiving a higher wage. I think we need to look at that. Can we standardise locum rates so that that incentive to prefer a particular place is removed? I think that certainly needs to be looked into.

Mrs CUNNINGHAM: Has the locum rate in Gladstone been reduced?

Dr O'Connell: It is our intention to minimise the use of locums in hospitals across Queensland. The dependence on locums in Central Queensland is quite high. We would like to be able to reduce that. We would like to be spending more money on permanent staff than on locum staff. I have not given any direction to any of the district CEOs about what their particular locum budget should be.

Mrs CUNNINGHAM: So you do not know whether it was $2,500 or thereabouts a day for a locum. I am with you: I would love our hospital to have permanent staff. They are committed to the region. There is continuity of service. There is a genuine sense of appreciation for the permanent staff who commit to the region. At the moment we have permanent staff who work their butts off and then you have the locum that is paid a squillion to work beside them and do whatever they want to do. So these permanent staff are undervalued. Is it the intention of Queensland Health to place constraints on the price that will be paid to locums in order to endeavour to manage the locum numbers in Central Queensland? If so, if no locums will take up the reduced paid positions, how will you manage medical services in a place like Gladstone, where the population, even on your figures, is going to increase by 20 per cent?

Dr O'Connell: As the population increases, clearly ABF funding will actually provide the opportunity to increase the number of staff across the whole range—nurses, doctors and allied health. So the growth in population and the ABF model is not going to be a problem in that regard. The issue of locums is a different issue. It is the issue that they cost more compared to permanent employees. We have to try to reduce that budget. It is money which just goes into the pockets of those locum doctors rather than us being able to spend the money on the services which we would like to deliver. So, yes, we do have to decrease the total locum budget in Queensland. Yes, I would like to pay them as little as I can above the standard rate, and there is always going to be a tension in doing that from district to district and town to town. I have given no directives about any particular price to pay for locums, but certainly it is my intention to pay as little as I possibly can.

CHAIR: The member for Gaven wants to ask a follow-up question on that topic.

Dr DOUGLAS: It is not specific to Gladstone, but what I would like to know is whether you have any other models—

CHAIR: Is this to the minister or to the acting director-general?

Dr DOUGLAS: This is to the acting director-general—other than activity based funding for regional hospitals that are being used to allow for a reasonable case load to justify that specialist position or to maintain accreditation of those positions within the hospital. I would like to know: where are they? Of course there are other models, aren't there? There is block funding and there is diagnostic related groups and that sort of stuff. There are a variety of others as well. Is there any other model that is being used and where is it?

Dr O'Connell: In the current arrangements and the arrangements which pertain now in all of the states from 1 July 2012, ABF funding will be applied to the larger centres. In Queensland the model this year and for the foreseeable future will only apply to the largest 30 or so hospitals. All of the other facilities will be block funded. Your question was about promoting research, did you say?

Dr DOUGLAS: No. This relates to the issue which was raised by the member for Gladstone where she highlighted the fact that by using ABF type data you can diminish the number of services, because in fact the services are being provided elsewhere, and that leads to a further reduction of services progressively over time. I was saying that to allow for the growth in places like Gladstone or anywhere that is growing—I am on the Gold Coast, for example—you have to have an element of other than activity based funding. This is because it will not allow for the expansion of services because inherently the system attempts to diminish the services. What are you doing to get around that area with growth?

Dr O'Connell: Even in the 30 hospitals that do have ABF as their model of funding, only half of the funding actually is applied in that way. There are still fixed services which are independent of the particular case load that is going through the hospitals, so only about half of the funding that even the big 30 hospitals get will be according to this casemix model.

I have not seen over the last few years a situation where big hospitals have decreased their activity; it is going up across the board. The population in Queensland is going up at 1.7 per cent, but the increased rate of activity in both medical admissions and ED attendances is going up at a rate far greater than that. ABF attracts that because it rewards for each of those individual episodes of care with a price. There is an issue of course that may eventually lead to the opposite of what you are describing—namely, unfettered demand and paying for every single service regardless of its true worth. There needs to be some kind of capping in that process, and that is something which is pertained in Victoria, for example, where they have had the ABF model of funding for 17 years. There are expected levels of activity, and activity above that is rewarded but at a slightly reduced rate.

In fact, the baseline of what we expect in terms of activity is going up in all of these 30 hospitals, as I said, faster than the Queensland population rise and that will be funded. That is one of the main reasons why the Queensland Health budget this year has gone up by 10 per cent to $11 billion. We are increasing spending. In fact, it is really challenging for state budgets across the country—the rate at which health expenditure is going up.

CHAIR: Thank you. I call the member for Gladstone.

Mrs CUNNINGHAM: You listed the statistics for the Gladstone Hospital: 61 per cent bed occupancy; elective surgery within seven days—although my information is elective surgery will not be performed this month because there is not enough doctor coverage; emergency department category 1 within minutes and average wait time 25 minutes. I would like to see the basis of that average wait time because I get a lot of people in my office who say they waited a jolly lot longer than that.

You talked about our hospital being a senior medical officer model. The people I have spoken to say that they see the only way forward for the hospital in a sustainable way to retain doctors and specialists—that is, to retain them as full-time staff and being able to use and improve their skills—is to move to a consultancy model. Please do not go back to the strategic planning; it is emblazoned in my head that you are doing a strategic plan. Any other organisation would have had one 10 years ago. There was one being done last year, due in October—

CHAIR: What is your question.

Mrs CUNNINGHAM: Is there any consideration in the budget to move the Gladstone Base Hospital to a consultancy model of care rather than a senior medical officer model of care?

Dr O'Connell: Can I start by giving you the latest information about the surgical situation, since you started with that in your question. The surgeon position at Gladstone Hospital did become vacant in December 2009 and three recruitment rounds have been conducted with no successful appointment. The position has been filled by locum surgeons over that period. However, I am pleased to say that a senior staff surgeon at Rockhampton Hospital has requested deployment to the surgeon position at Gladstone from 1 August 2011. This will re-establish the public surgical service on a permanent basis in Gladstone. What we are seeing there is that Queensland Health is giving its hardest efforts, its strongest efforts, to keep those specialist positions going. Ultimately, it is up to the individual specialist to decide whether they want to apply for these positions. I am really pleased that this surgeon from Rockhampton has agreed.

With regard to the body of your question about the nature of the doctors, there are 22.5 medical officers at Gladstone. One of them is a director of medical services; four of them are FTE medical specialists—one each in surgery, general medicine, paediatrics and obstetrics/gynaecology; there are 8.25 FTE senior medical officers—these have traditionally supported a generalist model of service delivery, crossing the emergency department and inpatient areas, including the four-bed high dependency, and I think that is an appropriate model, a generalist model, for that size hospital; and nine junior medical officers, with at least two positions at the principal house officer level to support the overnight medical coverage of the hospital. There are 0.26 FTE visiting medical officers for the areas of surgery, that is a local private surgeon, as well as endocrinology and dermatology, with visiting outreach services from Brisbane.

At the moment, given the level of activity that we are seeing, that is an appropriate mix of people at those various levels. Certainly, if we move to a purely VMO model, if that is what you are suggesting—and I am not sure if that is exactly what you are suggesting—that would be incredibly expensive and would not be appropriate for the level of activity in the hospital. We are using a Clinical Services Capability Framework version 3.0. I recently mentioned to all of the other state directors-general at the Australian Health Ministers Advisory Council meeting that this is the pre-eminent service planning framework. It tells us what level of services are safe for the various levels of activity, and at the moment Gladstone Hospital is functioning with the right spectrum of staff for the kinds of levels of activity that it has got in each of the domains that I mentioned previously.

Mrs CUNNINGHAM: On the current process—that is, that Gladstone's activity is qualified and constrained and the policy seems to be to send patients through to Rockhampton or elsewhere—our activity will be artificially held back so that we cannot build to justify a greater level of service.

Dr O'Connell: It is certainly not my intention to put a brake on the growth in services at Gladstone. Any transfers of patients to Rockhampton are made on a clinical needs basis by the doctors in Gladstone Hospital, and that is appropriate. In any hospital network within a district, it is appropriate to have a range of services with hospital role delineation appropriate for the level of backup at each of the facilities.

I would expect to see an ongoing arrangement like that even in metropolitan Brisbane. A network of hospitals like the very impressive hospitals in metro south have patient movements between QEII and PA depending on what services are available at each of the hospitals. That is appropriate. The range of specialists who work in each of those hospitals is tailor-made for that level of activity and service profile according to the Clinical Services Capability Framework.

Mrs CUNNINGHAM: Except when transferring between the Royal Brisbane Hospital and the PA you do not need a cut lunch and a car.

Dr O'Connell: Indeed, that is true. An hour and a half is very different to 20 minutes, that is right, but as I said I expect that clinical need would be used to decide which patients were appropriate to move between centres.

Mrs CUNNINGHAM: In Gladstone in the emergency department, I am told that we have fewer full-time equivalent nurse positions for the number of patients on a daily average compared to Rockhampton. I am told that we have five staff on the floor on a day shift, we have four or five for evenings and we have three for nights, and that one of those staff escorts a patient to Rockhampton two out of three shifts each day. Approximately 20 patients a day cannot see a GP in Gladstone because the GPs have closed their books; the only option they have is to come to the emergency department and wait. Is there any intention—quite apart from your staffing model which will not be due until December—to have a look at that clinical staff to patient ratio in Gladstone compared to Rockhampton?

Dr O'Connell: With regard to the point about the GPs, Gladstone has been approved to host a GP super clinic which will increase the workforce of GPs and ancillary healthcare providers required to deliver the wider range of services.

Mr WILSON: That is federal government.

Dr O'Connell: The GP super clinics are a federal government initiative, yes.

Mrs CUNNINGHAM: But that GP super clinic has got five houses on it at the moment. They are just going through the DA; it received its DA approval last Tuesday I think. That is a long time coming. Do not rely on that to address the patient increase that is coming to Gladstone.

Dr O'Connell: Fair enough. All I am saying is that when it does come it will help to decongest the emergency department. There is a formula for what is an appropriate nursing to patient ratio in various wards which is agreed with the Queensland Nurses Union; it is called the BPF. I will need to look into the issue of what the current nurse to attendance ratios are for those two hospitals and get back to you about how they look vis-a-vis the BPF.

Mrs CUNNINGHAM: I have one more question. In relation to administering the oral health budget, can you clarify whether the number of patients who will be treated each financial year is determined at the beginning of a budget cycle? When that amount of money is expended, do the patients have to be held over to the following financial year, or is it as Queensland Health's mantra states—'The patient good overrides all other considerations'?

CHAIR: Who is that question directed to?

Mrs CUNNINGHAM: To the acting director-general.

Dr O'Connell: Certainly that is not the way I expect services to be delivered—that if the money runs out 10 months into a 12-month period the services stop. That is certainly not my expectation. The way that we fund oral health services is that we expect the services to be delivered evenly across the entire year, and that is my expectation in Gladstone as anywhere else.

I am really pleased we were able to increase the oral health services in Gladstone recently with the new five-chair Gladstone community oral health clinic that was opened in December 2010 to replace the former three-chair facility. This completed the staged development of facilities to accommodate community health services, community mental health services and oral health services which commenced in 2007.

Mrs CUNNINGHAM: So there are more dentists at the hospital now?

Dr O'Connell: I am not sure—well, dentists do not normally work at hospitals.

Mrs CUNNINGHAM: Thank you.

CHAIR: I call the member for Caloundra.

Mr McARDLE: Acting director-general, yesterday the Minister for Public Works and ICT said—

The IT Consolidation program requires each agency to determine the amount of backup that they need, the kind of space that they need and their procedures for storing their data.

Can you explain Queensland Health policy in relation to 'determine the amount of backup that they need, the kind of space that they need and their procedures for storing their data'?

Dr O'Connell: I presume that related to hardware issues. I was not here during that questioning but I presume that related to servers, the location of servers, et cetera.

Mr McARDLE: The area of backup.

Dr O'Connell: Yes. There is a standard procedure with any of the IT programs which we rollout in Queensland in which the server capacity is determined for the level of activity and the number of transactions which are expected with each of the individual programs. Clearly we always have to build server capacity in such a way that it is able to cope with an expected ongoing growth in the level of transactions which would occur within that system. Things like the physical location of the servers will depend very much on whether we can achieve economies of scale by placing them next to servers which run other systems and there are a number of hubs for those servers in Queensland where we can get some economies of scale and where we can have mirror backup kinds of arrangements.

Mr McARDLE: You would anticipate that Queensland Health would have backup for their systems as a norm? It would not be unusual; every system would be backed up or something?

Dr O'Connell: Increasingly there are RAID arrangements, if you will excuse the technical term, to back up and support systems. These are often clinically critical systems that we do not want to go down, so we have to have maximum up-time for those clinical systems which impact on day-to-day front-line clinical service delivery. Clearly for other systems which are more accounting systems that are not critical, we would still have backup but we would just accept the occasional midnight turning of the system the way that banks do for example.

Mr McARDLE: Thank you very much. Acting Director-General, are you aware of a system failure that occurred within your department on Monday, 11 July this year?

Dr O'Connell: I am not sure which one you are referring to, Mr McArdle.

Mr McARDLE: What I will do is this: the Minister for Public Works and ICT said again—

If an agency had an issue with their storage then they would advise their minister.

You would agree with that?

Mr WILSON: I am sorry?

Dr O'Connell: If an agency had an issue with their storage—

Mr McARDLE: If an agency had an issue with their storage then they would advise their minister—their computer storage, their backup storage. That would be brought to the attention, I would have thought, of the department fairly quickly.

Mr WILSON: Is that what the minister said?

Mr McARDLE: I understand it is. I understand it is a quote from the minister—

If an agency had an issue with their storage then they would advise their minister.

I will table an email from the RTI unit within Queensland Health dated 12 July 2011 in relation to an RTI application for eHealth documents that states—

Yesterday, work continued on the documents subject to your application (approx. 4000 pages). Early yesterday afternoon, an IT systems failure occurred for this team—we lost everything we had done to that point and also could not access the documents from the system.

The system failure was not rectified yesterday and in fact, it continues today.

Given the above, we cannot meet the timeframe to provide you with the decision and documents today.

In terms of your options from here as your application is now a deemed decision in that we did not meet the deadline to issue you a decision, you have the right to seek review by the Information Commissioner. Your other option is to relaunch the application.

The important point I am trying to get to is this: clearly the work referred to here had been ongoing well before 12 July because they refer to 'yesterday work continued on the documents'. It appears, however, that there was no backup because the text then goes on to say 'we lost everything we had done to that point and also could not access the documents from the system'. It just concerns me that with an RTI application no backup was put in place and therefore it poses the question as to what is the backup capacity of Queensland Health not just in relation to this matter, which is an important matter touching upon eHealth, but on other matters—for example, blood tests, scans and X-rays. Can you just elaborate as to how it would appear from the text of that document backup did not occur and how that relates to your comment in relation to Queensland Health having a system in place?

Dr O'Connell: I think I understand where you are coming from with that question. I mentioned before that front-line systems which involve clinical interactions, results of blood tests et cetera are important systems in which the backup has to be not only made but be available in a rapid period of time so that the down time is minimised. The kinds of systems which merely retrieve documents—for example, the thousands of pages of documents for an RTI application—which are not critically important to individual patient care can afford to have a different level of support. That does not necessarily mean

that there is no backup at all for this information. The point may be—and I will check this with the deputy DG IT—that the backup information might have to have been retrieved from a server and it takes 24 to 48 hours to upload those files again because they are non-critical files. So I will confirm with him that that is the case. It clearly occurred at a time when they were just about to release all of this information—and that is unfortunate—but it does not necessarily mean that we have lost all of those files.

Mr McARDLE: Could I pose this question then, Acting Director-General: RTI applications, or the old FOI applications, are accessed not just by the opposition but they are accessed by the public as well. So from the public's perspective they are very important applications. They are very important documents because they are seeking very important pieces of information and data. I understand of course in relation to blood tests et cetera the relevance of them with regard to clinical outcomes. But are you saying to me that an RTI application filed by 'Mrs Smith' is not an important document or not an important application, therefore a backup system should not be used?

Dr O'Connell: Absolutely not. What I am saying is that the backup systems which allow us to deliver that information can be structured in a way where you are allowed to take 24 to 48 hours to retrieve the files from the backup server. It is a different arrangement to the kinds of systems where you need to have instantaneous mirrored servers where the information is live in backup form. So I am certainly not saying that that information for RTIs is not important. It is important, and of course it is generated. All of that information is generated from files which are important for our business. So not only during that brief period of time is there an embarrassment to our ability to deliver the RTI data, but for a short period of hours we have lost the information which was relevant to our business, for example, last year if the RTI relates to last year. It does not mean we have lost it forever; it just means it is on a server where the backup process may take a little bit of time.

The minister has just given me information about that particular RTI request which you asked for, Mr McArdle. While there has been three months between the date of receipt of the application—the original RTI request—and now, I understand that the opposition as the applicant, because in this case it was the opposition, agreed to a revised scope on 18 May. Further, I am advised that the cost estimate notice, which the opposition is required to respond to, was issued on 25 May and they did not respond until 23 June. So some of the delay there is about that business of handling the cost estimate notice paperwork. I understand that in addition to the above, Queensland Health has also been required to consult with a number of third parties including non-government organisations and private companies in relation to that particular application you are talking about. I am informed that on 8 July the RTI decision maker made contact with the applicant to advise of the need to seek an extension for the processing period. But your point is more about the issue of backup and I hope I have reassured you that the backup is just at a different level of criticality. It does not mean that we do not have a backup; it just means that those files cannot necessarily be reloaded—uploaded again—into the system within a matter of seconds which we require when we have clinical systems. It can afford to wait a day or two for data which is from files which pertain to issues a year or two or three old.

Mr McARDLE: You mentioned to me in response then that the data, I think you said, could be loaded in a matter of a couple of seconds back into the system.

Dr O'Connell: For clinical systems, yes, we like to have mirrored systems where the data is relatively immediately available. We do not want clinical systems to go down for more than an hour.

Mr McARDLE: I accept that; of course we do not. No-one wants that. But of course the wording here says—

... we lost everything we had done to that point and also could not access the documents from the system.

Dr O'Connell: I presume you are reading—

Mr McARDLE: This is the text.

Dr O'Connell: I presume you are reading a note, though, from a fairly low-level officer who was retrieving those documents. That officer does not necessarily understand the backup processes for the system.

Mr McARDLE: A low-level officer?

Dr O'Connell: I am not sure. If you could tell me who that is; I have not seen this letter.

Mr McARDLE: Manager for the Administrative Law Team of Queensland Health. I will not give the person's name.

Dr O'Connell: Right.

Mr McARDLE: So that is not a low admin officer; it is somebody who is quite senior, I would have thought.

Dr O'Connell: Thank you.

Mr McARDLE: That would then mean that this particular person knows exactly how the system works, knows exactly how documents can be retrieved and knows exactly what can be done to get those documents back. So I am quite concerned. I would call that particular person very high level within

the RTI in Queensland Health and yet that particular person from the text of their letter said that they had lost everything to that point. With all due respect, my question is this: I would have thought that if it could have been retrieved that would also have been expressed by somebody of this person's stature given the title they hold.

Dr O'Connell: Thank you for giving me the title of this person's role; this is a person who manages the generation of data and the collation of data from a number of sources, and they do this not only from their own files but from files across the system. Certainly their understanding at the time was that they had lost the information, but in fact I have just been informed that there was no loss of any information at all and that in fact the access was merely lost for 48 hours, which is of course completely consistent with what I said to you before.

Mr McARDLE: It might be consistent with what you say; it really worries me now that they say 'we have lost everything we have done to that point and could not access the documents'. You are now saying that that is wrong?

Dr O'Connell: That is right; the files were not lost.

Mr McARDLE: So has the rejection of the RTI been wrong? The RTI officer states—

Given the above, we cannot meet the timeframe to provide you with the decision and documents today.

That was on the basis that they could not access the documents and could not comply with the time line we requested. Is that now an incorrect determination?

Dr O'Connell: At the time of course it was correct, because the 48-hour window when they did not have access to the files—these archived files—occurred at the time when they were obliged to release the documents under the RTI request. But now that the files are all recovered, they can now be released and we will be releasing them to you.

Mr McARDLE: You will release those documents?

Dr O'Connell: If there is an RTI request and you have paid the amount that is required—

Mr McARDLE: We certainly have. I understand we have; we paid the amount.

Dr O'Connell:—our intention would be to release the files.

Mr McARDLE: Can I just make this point very clear, Acting Director-General—

CHAIR: Does your question come to the point?

Mr McARDLE: Yes, there is. Will you now confirm that, provided the money has been paid—and it has been paid to the best of my knowledge—you have just said that you will release the RTI documents?

Dr O'Connell: That would be my intention, yes.

Mr McARDLE: Thank you. Acting Director-General, can you give a broad overview of the eHealth program?

Dr O'Connell: The eHealth program is quite a massive program. The eHealth program is Queensland's contribution to a range of activities which are occurring across the whole country. The intention of the eHealth program is to improve access to and increase the quality of healthcare services. For example, it includes things like timely discharge and information being sent to general practitioners electronically. It includes Queensland women getting access to BreastScreen services using digital facilities so that we avoid recalls due to technical faults with film, improving diagnostic outcomes. It means that diagnostic images from smaller rural and remote healthcare facilities reported on by radiologists in major hospitals reduces the need for sick patients to travel. It involves electronic record keeping which is now automated for patients who are undergoing anaesthesia.

It involves things like patients' endoscopy records being able to be retrieved regardless of their location, making access to information available at points of care. It is part of a whole Commonwealth program. So we have been tapping into Commonwealth funds to deliver this program. COAG has committed to invest in national health infrastructure to accelerate the development of a national eHealth record system for Australia, including the personally controlled electronic health record system. COAG agreed to fund $218 million from July 2009 to June next year for the National E-Health Transition Authority to deliver the technical specifications in infrastructure required to enable an electronic health records system for Australia. Queensland has met its COAG commitment to the funding of that authority with a contribution of $21.8 million from July 2009 to June next year.

NEHTA—this authority—has been delivering infrastructure such as the Healthcare Identifiers Service last year to enable patients to be accurately identified in the personally controlled eHealth records system and also the development of national eHealth specifications, such as e-referrals and then discharge summaries to ensure the seamless exchange of priority clinical information. The personally controlled eHealth record system announced by the Commonwealth last May aims to improve information flow between the different health sectors by allowing the consumer to make key health information available to their chosen healthcare providers. The Commonwealth has only

committed to $466 million over two years to June next year for release 1 of that system and has not made commitments for the next phases of that release. Nevertheless, release 1 of the system will go live on 1 July 2012.

There are dozens of elements to the eHealth program in Queensland. I am really happy to give you details of each of them. For me, being an anaesthetist myself, the ones that are particularly important are the AARK system, which is Automated Anaesthetic Record Keeping. It enables us to have standard information collection during a period of criticality for the patient, while they are unconscious under anaesthesia. It enables us to identify deterioration. It even enables us to have other anaesthetists at a remote site viewing that information as it is occurring live. It enables us to retrieve records which are vital clinical records of vital signs, temperature, blood pressure, pulse rate et cetera, which can then inform information sent to the Coroner, for example, if death occurs under anaesthesia. What I can say is that the clinicians in Queensland are hungry for more of this program to improve the electronic IT support for their various clinical activities and we are doing that on dozens of different fronts with different programs of the range that I have mentioned to you there.

I think the other thing which you may be interested in is that this is not just limited to Queensland Health's activities. I think one of our more successful programs has been the dissemination of electronic discharge summaries to general practitioners. We are now able to send discharge summaries in an extremely timely way—in a matter of only hours to days of the discharge of a patient—whereas previously patients would carry the second or third copy of a letter to a doctor written by hand and take it to their GP the next time they visited their GP and, hopefully, not lose it in between. Now this information is transmitted—of course with the patient's consent—automatically to the GP so that when the GP sees the patient at the next visit all of that information about the patient's care provided during the acute admission at the acute hospital is available to the doctor.

Another system which I am excited to say has started going live in a pilot site only in the last two weeks is the electronic viewer system, which enables us to view records from a range of different databases and information systems anywhere. Theoretically—and this is how it will work when it is rolled out; at the moment it is in just one hospital—information is able to be viewed throughout the state in those locations which will have access. The pilot—I expect to be successful—enables us to roll out that program in dozens of hospitals in a matter of only a year.

CHAIR: Thank you for that very in-depth answer. Member for Caloundra, do you have further questions?

Mr McARDLE: Yes, I do. Thank you very much. Acting Director-General, in 2007-08 there was a budget component of $243 million to establish a state-wide eHealth program. I take it that that funding has now ended—in fact, it ended the last financial year—and there is more funding now in the budget to develop, as you indicated further, an eHealth project across the state. Can you outline for me what were the major achievements of that initial $243 million outlay?

Dr O'Connell: I have mentioned some of them. We have validated electronic discharge summaries. They have been rising from 42,000 in 2009 to 222,000 in 2010, up to 518,000 in 2011. So that is really quite an exponential growth in that activity. We have women's breast screening using digital mammography—280,000 as at June 2010, already up to 469,000 as at 30 June a week or two ago. We have the number of technical patient recalls avoided by using digital mammography rising from 2,200 in 2009 to 5,800 in 2010 to already 7,000 on 30 June. We have the number of episodes of care captured by that anaesthesia record information system that I referred to earlier going up from 60,000 in 2009 to 173,000 in 2010 and already at 213,000 on 1 May. The number of procedures captured by the endoscopy services information system, for example, has gone from 2,000 in 2009 to almost 15,000 in 2010 and already it is over double that, at 33,372 as at 30 June. So they are just a small set of the various ways in which we are seeing really an exponential growth in the use of electronic data transfer and information transfer to benefit patients in quite practical ways.

Mr McARDLE: So if I can just summarise that, some of them will therefore include the EDIS.

Dr O'Connell: The endoscopy procedure—

Mr McARDLE: The Emergency Department Information Systems.

Dr O'Connell: EDIS, yes.

Mr McARDLE: That is part of the system. You mentioned the discharge summary, the BreastScreen Queensland Screening and Assessment Service and the Queensland Radiology Information System. The system for oral health was part of the process, the mental health application was part of the process—

Dr O'Connell: Yes.

Mr McARDLE: And also the Automated Anaesthetic Record Keeping, as you said, was also part of that process. Do you know how much was spent on each of those particular projects I referred to during that period of four years?

Mr WILSON: Thank you for the question. That information in that detail for each of those eight or 10 categories that you have identified across four financial years is not at my fingertips. So I am not able to provide that detail to you and I do not think you would expect me to have that detail at my fingertips. I have no personal knowledge of those four years of expenditure across those eight or 10 different items.

Mr McARDLE: Thank you, Minister. Acting Director-General, of the items that I read out, I think you would agree that every one of them had been in place during that four-year period from 2007-08 to the end of the last financial year. Just to make it clear, each of those programs, I think you are saying, was initiated in the 2007-08 financial year and they have been rolled out as far as they have to date from that until the conclusion of the 2010-11 financial year; is that right?

Dr O'Connell: As I said before, there are dozens of individual elements to the whole IT program set and each of them has different starting points—periods in which we go through the development of the product, the piloting, the dissemination, the embedding of the new ways of working using that information system. The juggernaut of IT rollouts across Queensland has been forecast four years ahead. We have to do that. These are big programs. There is expensive both hardware and implementation costs. So it would be unfair to the work of the IT division to say that they all started at one point and they all ended at another, because that is not the case. There is a range of time lines for each of these projects, as you would expect, and they overlap and they are all slightly out of phase because resources have to move between each of them to maximise the opportunity with each of the phases of the projects.

Mr McARDLE: Thank you. Will you take on notice to advise when each of those projects that we agreed were part of the eHealth rollout commenced?

Dr O'Connell: Yes, of course.

Mr McARDLE: The financial year and the amount of money in each year expended on each of those projects.

Dr O'Connell: Yes, I can do that, yes. Can I just be clear about the ones that you quoted? I think you quoted four of those programs in your question.

Mr McARDLE: EDIS.

Dr O'Connell: EDIS, yes.

Mr McARDLE: The Enterprise Discharge Summary, BreastScreen Queensland Screening and Assessment Service.

Dr O'Connell: Yes.

Mr McARDLE: Queensland Radiology Information System.

Dr O'Connell: Yes.

Mr McARDLE: The system for oral health.

Dr O'Connell: Yes.

Mr McARDLE: And the mental health application.

Dr O'Connell: Yes. Okay. Will do.

Mr McARDLE: And also the automated—

Dr O'Connell: The anaesthesia record—AARK.

Mr McARDLE: Yes, recording keeping.

Dr O'Connell: Okay.

Mr McARDLE: For those systems, if you could just indicate when they commenced and each year along the way what money was placed into them at that point in time.

Dr O'Connell: Sure.

Mr McARDLE: Could you also confirm and take on notice that none of those programs commenced before 2007-08?

Dr O'Connell: I would need to check the rollout schedule.

Mr McARDLE: On notice. That is fine.

Dr O'Connell: Madam Chair, I do have some answers for previous questions that we were not able to answer at the time, if you would like me to provide those?

CHAIR: For the member for Caloundra?

Dr O'Connell: This was the question that the member for Caloundra asked about how many staff were employed in the following areas of payroll: overpayments team, pay systems support, case managers and state-wide operations.

CHAIR: Sure.

Dr O'Connell: As at 31 May this year, there were 71 full-time equivalent staff working in the overpayments team. This number includes case managers dealing directly with employees who wish to have their overpayment case managed. A further seven full-time equivalent staff were employed in the system support team and another 27 full-time equivalent staff were in the state-wide operations team. Of course, as I said earlier in the answer to the question, there are approximately 300 extra staff in payroll. So that means that the additional 200 that I have not specifically allocated to those projects—those elements—are payroll officers who have been employed in various payroll offices across the state working on day-to-day payroll processing, and numbers vary depending on their workload and normal turnover.

CHAIR: Thank you. The member for Gaven has a related IT question.

Dr DOUGLAS: Thanks. This is to the acting director-general. I think those statistics on the improvement in the timeliness and the amount of reports of the results are very good. In tandem with the rollout of that proposal, what has the department done, and in each region, with regard to automated recalls and red-flagging systems? A high percentage of these endoscopy results are primarily related to a national bowel-screening program as well. So what is being done with regard to that and what mechanisms are in place to avoid system gaps?

Dr O'Connell: The Commonwealth's bowel-screening program is a huge program. It involves offering faecal occult blood testing to people of various landmark ages in their lives when their potential risk of developing colonic cancer is increasing. That system is handled by the Commonwealth so that patients who have their samples sent back to the central location in which the collation of that occurs—and this is, by the way, an estimated 805,000 Queenslanders at those age milestones: as I said, 50, 55 and 65.

This is a lot of information. That information is collated and when a patient has a positive result then information is fed back to the patient or the GP to advise that they need to then be inserted into the next phase of program, which is assessment to determine whether they require endoscopy. This is a system which is kind of at the interface of primary care with GPs, the Commonwealth funding that program and then, of course, Queensland Health provides the endoscopies themselves. The endoscopy information system that I referred to before is information about the results of the actual endoscopy. So it is not about that issue that we talked about before. Queensland Health would manage the risk of patients within the normal clinical pathways that occur within Queensland Health for the management of someone who, at endoscopy, for example, was found to have a polyp. Follow up systems would then be triggered to tell them to come back at a particular period of time. That can vary with the individual clinician's preference as to when they like to review patients who have things like polyps which at the moment are not cancerous or the patient might then, of course, be inserted into a surgery program if they need to have a colonic cancer identified at endoscopy removed. Have I reassured you?

Dr DOUGLAS: Not really. As you know, there are plenty of patients who do not necessarily have a nominated GP. I was interested in, with the rollout of these programs, what have you put in place, because these are very large numbers of people, for automated systems and red flagging systems so patients are not lost? What is in place? Irrespective of what the Commonwealth is doing, I want to know what is in place on the ground level. We have gone to 30,000. That is large numbers and it is being done electronically.

Dr O'Connell: I will ask the chief health officer to give us more information about that. Dr Jeannette Young, Chief Health Officer, will assist us with that answer.

Dr Young: We have processes in place for these large numbers, as has been mentioned, that are automated. An invitation is sent out by the Commonwealth to individuals to return a sample that is tested for blood, so a faecal sample that is tested for blood. If that is positive then that comes into the Queensland Health system and we have an IT system that then tracks it. That person then is offered a colonoscopy and that can either be done in the public system or the private system. Where we do not have public capacity to provide the colonoscopies in a timely manner we have purchased capacity from the private sector so that will occur. But, of course, some people will choose to have the whole process done in the private sector. That then just becomes part of our normal process for any patient who has a colonoscopy done which has a result. So if there is an abnormality found during that colonoscopy process then the patient will just go through the usual process for that. They will go on to a surgical waiting list. It is cancer, of course, so they are regarded as a category 1 patient and treated within those appropriate timeframes.

CHAIR: Member for Caloundra, had you completed your numbers of questions before the dinner break, because there are others who would like to ask a couple of questions?

Mr McARDLE: Yes.

Ms JOHNSTONE: As you are probably aware, the state seat of Townsville has an Aboriginal and Torres Strait Islander population of over nine per cent, including the discrete Indigenous community of Palm Island. I am very concerned about acquired hearing loss in that population, particularly on Palm

Island, and I am wondering if you could please update the committee on a whole-of-community response on Palm Island for the early diagnosis and treatment of hearing problems in young children basically with the aim of preventing acquired hearing loss.

Mr WILSON: I thank the honourable member for the question. The Healthy Hearing program is facilitated by the primary health team, Joyce Palmer Health Service, in collaboration with primary schools and we will be screening approximately 150 students in a 12-month period. The Healthy Hearing program is conducted through the schools for years prep, 1, 2, 3 and 7 and then there is follow-up screening which is managed by the community health team and links with outpatient services, Australian Hearing Services and ENT services at the Townsville Health Service District. All Indigenous health workers in the community health team have completed training in health hearing assessment, along with the school based youth health nurse, clinical nurse consultant and enrolled nurse. Australian Hearing Services provides audiometric assessments on Palm Island every second month. The Deadly Ears program risk assessment was completed in June 2011 and a clinic service is scheduled to commence in November 2011.

The member for Townsville probably is aware, but I will mention it in case she is not, that the Deadly Ears program, which is a Queensland Health program, and a second program run by Education Queensland in the 35 Indigenous communities in the equivalent of kindergarten for four-year olds, both those projects were identified in a Productivity Commission report last year that focused on initiatives taken by different jurisdictions across Australia directed at improving the health and education of Indigenous people and particularly students. Those two programs, the Deadly Ears program and the four-year old kindergarten program in the 35 indigenous communities were identified as leading Australia in the level of innovation, impact and effectiveness within the community. It is something to the great credit of all of the folk involved in the Deadly Ears program as well as the kindergarten program which is an item I became aware of in a previous life. It is such an area of important need in Indigenous communities and is probably not as widely recognised for the great successes that they have been having.

Ms JOHNSTONE: If I could just ask a follow up question, with those programs, specifically for Palm Island, are we able to track a cohort of children to measure the success of them? What I am worried about is I believe that probably close to 90 per cent of the kids in primary school on Palm Island—it may even be higher—have acquired hearing loss. We need to get them before they get to school. This kindergarten program may address some of that, but really what I would love to see for Palm Island is a specific whole-of-government coordinated approach that targets a specific cohort of kids that says let us focus on these little ones and see if we can get them to prep with as minimal acquired hearing loss as possible. My question is are these programs, the Deadly Ears program and the other program you mentioned, able to track that and get that to happen at a very young age before the hearing loss occurs?

Mr WILSON: I would like to think so but personally I am not in a position to say so, so I am going to seek some advice from someone in the department through the Acting Director-General so that we can actually have some information on what is happening presently. I could not support more fulsomely your area of interest because if you make a big difference there you make a difference for a lifetime.

Dr O'Connell: What I can say is that these programs are designed to detect children who have hearing problems at an early enough point in their illness—whatever that is, whether it is chronic otitis or whatever the aetiology of that deafness problem or hearing impairment problem is—where it has minimal impact on their subsequent learning. So clearly the earlier they are identified the better that is. I can take as a question on notice the exact age range, for example, of the typical groups of patients which are seen in the two programs if that will help.

Ms JOHNSTONE: That would be good, and if you could also maybe take on notice and provide information to me about how specialist services are provided to Palm Island given that it is isolated and difficult for the children to get across to Townsville all the time that would be great.

Mr WILSON: I am reminded that the four-year old kindergarten program in the 35 Indigenous communities—I am disappointed I did not recall its name—is the Bound for Success program in the Department of Education and Training and it is a wonderful program.

Dr O'Connell: I can tell you that the Deadly Ears program is progressing on Palm Island.

Ms JOHNSTONE: Yes, but I am specifically interested in getting to a very young age group of children so that there is not a lag in diagnosis once they get into the education system. I am actually trying to avoid the kids getting to grade 1 or 2 before anyone realises there is a problem and they are labelled as naughty children when they actually just cannot hear.

CHAIR: We might have time for one more question before the dinner break. Member for Burleigh?

Mrs SMITH: Minister, can you outline the government's progress in reducing the number of long wait elective surgery patients in Queensland's public system?

Mr WILSON: I thank the honourable member for the question. This is an important area in which we have been wanting to make good progress for a long time. In Queensland those waiting longer than the recommended time is the fewest in Queensland's history and it is also the shortest list in Australia. This is not Queensland Health saying so, it is the COAG Reform Council which has rated Queensland No. 1 in the nation and, additionally, the Australian Institute of Health and Welfare Report did likewise. My recollection is that as of this year the list of those waiting for elective surgery was halved for category 1, halved for category 2 and virtually eliminated for category 3. The average waiting time for categories 1 and 2 is better than the national average, from my recollection.

Dr O'Connell: Yes, it is.

Mr WILSON: But particularly I am delighted that the long waits for category 3 have been virtually eliminated. I should say that this good outcome is the result of a lot of sharp focus that a particular person applied to it in an earlier job and that is the current Acting Director-General when he was the head of the Centre for Healthcare Improvement. It just shows that innovative programs looking for different ways of running the hospital and elective surgery, as well as, of course, the funding for Surgery Connect, accessing the private system for surgery, can really pay great rewards. I must say that by contrast, and I know the shadow spokesperson for health for the LNP talks about elective surgery from time to time, but if you want to measure the value and the effectiveness of what has been achieved by Queensland Health in the last 12 months under the stewardship of the Acting Director-General in his former role, compare the long waits that have been achieved in Queensland in this period, and indeed I am told it is about 169 for category 3, to when the LNP were in government when it was 8,500.

CHAIR: The committee will continue its examination at 7.30.

Proceedings suspended from 6.30 pm to 7.30 pm

CHAIR: Ladies and gentlemen, the committee will now continue its examination of the portfolio of the Minister for Health. I have great pleasure in calling the member for Caloundra.

Mr McARDLE: Acting Director-General, I table a copy of the ED multiperformance reports from February 2010 to February 2011 that are no longer available on the Queensland Health website. In fact, in days gone by you would publish the most recent month that was available. You would then have an archive section that you could access on the website and those had been collated over that time. Is it the intention of Queensland Health not to publish in this format? I should ask the minister; it is a policy question, really.

Mr WILSON: I am sorry, I thought you were asking the acting director-general.

Mr McARDLE: It might well be a policy question. Therefore, I cannot ask the acting DG. These documents were published on the website on an ongoing basis. I have tabled February 2010 to February 2011. They were archived and, therefore, you could access back a period. Those documents are no longer available on the website, either in that format or archival. Is it the intention of Queensland Health not to publish these documents in this format again on the website—that is, the 'Our Performance' website of Queensland Health?

Mr WILSON: I did not hear the last sentence.

Mr McARDLE: Is it the intention of Queensland Health not to publish these documents in this format again on Queensland Health's 'Our Performance' website?

Mr WILSON: Thank you very much for the question. I am advised that the information that was customarily provided in that quarterly report in a different format is now published in real time on the website and, it is proposed, in another tranche of materials that will be published to actually go to archival material. In the first rollout of the website, which is a new way in which we are presenting the information, as you correctly say the archival material is not accessible on the website, but I am told that it will be at a later time. It has been the intention of the department to make it available as part of the web based information. The information that is on the web now, I am advised, is the most extensive information about elective surgery, EDs, radiation treatment, specialist outpatient waiting lists and dental treatment. It is across those five areas. The advice to me is that information is—

Mr McARDLE: Minister, I am talking about the emergency department documents, not the quarterly report. They are quite distinct documents. I am talking about the emergency department documents that were on the website on a monthly basis and which I tabled. I think you are referring to the quarterly report.

Mr WILSON: I am told it is a combination. Maybe the acting director-general can explain how the information is presented.

Dr O'Connell: The information that we wanted to publish in a much more dynamic, lively way for the use of the people of Queensland has been put up so that it is a combination of information from the quarterly report and from ED information which has been published in other forums on the website. As the minister says, the website provides the most extensive performance information of any of the states. With the first version of the website we decided to emphasise what we believed people wanted most, which was information that was the most recent. For example, I have here in front of me something that

I printed off the website today—the website that you are referring to—which tells me the information for emergency departments for the month of May. It is the most recent information that we have collated. It is our intention, as the minister said, to eventually have the archived information from previous years. We do that in PDF format. They would just be PDF versions of the kind of information that you have tabled this evening. As I said, the main emphasis was that we thought people wanted to know, 'How are the EDs in my district performing today and in the last few weeks?' So the information is up to date. In fact, the information on things like bypass is from the day before. It is really quite current.

Mr McARDLE: I am not asking you to table the document, but may I look at the document?

Dr O'Connell: Yes, you may.

Mr WILSON: I have Gladstone on the screen of my iPad.

Mrs CUNNINGHAM: I have Gladstone in the papers.

Mr WILSON: It is really the way to go. It is real-time information, month by month. It is simply presented in a different format. We are absolutely committed to transparency. Likewise, we are promoting and pushing ahead with the transparency that is part of the national health reforms. That is the way in which we will gradually, faster rather than slower, be able to improve ED performance. We were happy to embrace transparency. It might sound provocative to the shadow minister for health, but unfortunately the shadow Treasurer declined to guarantee that an LNP government would have the same level of transparency in relation to our hospital system that we presently have, when he was on radio only a couple of weeks ago.

Mr McARDLE: Acting Director-General, from looking at this very quickly, I understand that the emergency department data is not collated in relation to children under the age of 14 years—that is, the tranche of data that would be available under the old system in the ED—category wait times et cetera, et cetera. That is the case, isn't it? Children under the age of 14 years are not captured within that data?

Dr O'Connell: You can drill down in each of those boxes to more information. I would need to check exactly about that.

Mr McARDLE: Certainly. I table the May 2011 emergency department monthly performance report for patients 14 years and under, which actually provides the data from the EDs across attendances, admissions and percentages, did-not-waits, percentage seen within time and median wait times for the reporting hospitals. I will table a copy of that for the benefit of the committee and also for the acting DG and the minister. It bears the Queensland government insignia. As I understand it, this is new data that I have not heard of before, in a format that mirrors what was placed on the 'Our Performance' website but centralised clearly to children under the age of 14 years. If you want to look at the document, please do so.

Dr O'Connell: I would appreciate having a look at what the member is referring to.

Mr McARDLE: I will let you do that before I ask the question. Maybe I will ask the question anyway. Given that the data is now available, is it the intention of Queensland Health to publish that data in a format akin to what you will see in a moment on your website so that people can also see how hospitals are dealing with the concerns of their children, in particular treatment times, waiting times, percentages et cetera.

Mr WILSON: Madam Chair, that is a policy question.

Mr McARDLE: Yes, it is a policy question. I apologise.

Mr WILSON: I have said that we are committed to transparency. The material that is on the web now, in this new month-by-month format, is information, I am advised, that was previously available. What has been done is to make it available in real time, month by month, but it is simply collated differently. As a policy question, I can reiterate and reinforce that the government is committed to transparency. This is the way in which we get a better understanding of how emergency departments work, hospital by hospital; how the elective surgery lists are working, hospital by hospital; and likewise across the outpatient clinics and across all the major areas of service delivery.

There is no doubt that the information the Queensland government provides on its website leads Australia for the level of transparency. Indeed, that is recognised nationally. I have participated in the ministerial council of health ministers and argued in support of the transparency model that the federal government is promoting from the performance improvement authority. We have strongly supported the establishment of the national performance improvement authority so that we can continue to drive reform and improvement of service delivery in Queensland hospitals, not confined and not limited to emergency departments.

Will we stop where we are? We will not stop where we are. Do we want to do better on transparency? Yes, we do. We will continue to improve the level of transparency, because that is what Queenslanders would expect. It is what they look to for assurance. Folk can go onto the net right now, as I just did for Gladstone, and look at the details for Gladstone Hospital. It is in real time, month by month. What we are doing with this level of transparency is actually empowering consumers of health services. That is a good thing to do.

In conjunction with this initiative, we have asked the health consumers of Queensland to do some very good work around how we can engage consumers more effectively in the delivery of health care within their local communities and in their regions. One key vehicle for empowering consumers in the local communities where their hospitals are is to provide them with information. The member for Gladstone, may I say respectfully, provides a fantastic illustration of the level of community interest there is in one's hospital. Like a school, a hospital has a high level of social and community ownership. They are probably the two institutions that communities would say they revolve around and are focused on in the way in which the communities are looked after and grow. Therefore, transparency is where we are at. Will we stop where we are? No, we will not. We will keep progressing and adding to transparency, because it is a good thing to do. I reiterate that the opportunity was there for the shadow Treasurer the other day on public radio and he declined to guarantee that an LNP government would provide the same level of transparency as this government when it comes to the management of our public hospitals.

Mr McARDLE: Acting Director-General, have you now had a chance to look at that particular document?

Dr O'Connell: Yes, I have.

Mr McARDLE: Do you recognise the document at all?

Dr O'Connell: Yes, I have seen documents of this nature. There are a number of them which are produced.

Mr McARDLE: So it is correct to say that on a regular basis a document of that nature, based upon your comments, is generated within Queensland Health to indicate the details with regard to children under the age of 14 years?

Dr O'Connell: Yes.

Mr McARDLE: It is not a policy question. Is there any impediment to this document being published on your 'Our Performance' website?

Dr O'Connell: I think it would be a great idea to add this data to the 'Our Performance' website. The most useful way for it to be presented would not be in this format but, rather, for individual hospitals to have their information for this particular subset of patients displayed so that the audience for that website—namely, the people of Queensland who want to know how their local hospital is performing—can see that information. It would be my intention to publish data in a way which was both timely and useful for the people of Queensland. Ultimately, as the minister said, we intend to continue to increase the amount of data that is available. It has to be in a user-friendly format, otherwise it ends up being web page after web page of endless tables of figures.

I would also say that we are not just publishing data about how our emergency departments are servicing children; we are actually growing the services for children themselves. We have paediatric ED expansion programs going on at Prince Charles, Redcliffe, Caboolture, Redlands, Logan and Ipswich. There will be an extra 45 emergency treatment spaces for children, 59 beds and 26 specialist outpatient consulting rooms as part of our overall South-East Queensland paediatric planning report. This is not just about recording our performance at one point in time and doing nothing about it; it is actually about trying to grow the ability to service sick children at the same time.

Mr McARDLE: Thank you. In addition, the data in relation to the May ED report—

Dr O'Connell: For children again?

Mr McARDLE: No, generally. The data in relation to the May ED report is still available in the old text, is it not, or the old format? It is still published within Queensland Health?

Dr O'Connell: Yes, I believe it is.

Mr McARDLE: In fact, I am holding up the data for May 2011 for the ED.

Dr O'Connell: Right.

Mr McARDLE: And this here is the data that we obtained from the website today for the various hospitals across the tranche of information. There are two pages here and you have 56 pages there.

Dr O'Connell: Of course, it is not meant to be read in paper format.

Mr McARDLE: Hold on. You made the comment that it was good for the individual to look up how their hospital is going. That is a much more complicated system when you are trying to compare a series of hospitals than looking at that and then going down the list. Would you agree with that? Do you think it is more complicated?

Dr O'Connell: No, I would not.

Mr McARDLE: It is not?

Dr O'Connell: No. I am actually quite proud of the user-friendliness of the new website. On the opening page that the layperson comes across is a map of Queensland. They just click on the area they live in and it takes them straight to their hospital. Through a colour coding system they are able to compare the performance of their local hospital with national performance; there is a series of green and red colour codings for the figures. They instantly get an impression of how good their hospital going compared to national data.

Mr McARDLE: I think that is a wonderful thing, but it is also much more complicated than trying to compare hospitals looking at two pages as opposed to having to go to screen after screen and getting the detail in that manner. You and I may disagree on that I suspect.

Dr O'Connell: I think people will not be deciding whether they are going to go to QEII or Cairns Hospital. They are really only going to decide, 'Am I going to go to QEII, Redlands or PA', their three local hospitals. So those three spots are easily clickable on the website. I think if you were choosing between the 30 biggest hospitals in Queensland and that was practically what you were doing, then you are right, the first format would be more user friendly. However, the reality is that people are really only going to go to one of two or three of their nearest hospitals.

Mr McARDLE: A cynic may argue that it was a very well orchestrated arrangement to ensure that comparison between hospitals on relevant data over which the government had suffered significantly during the past two years is the real cause for this blurring of the data.

Dr O'Connell: That would be very cynical.

Mr McARDLE: It would be very cynical; I accept that. We will leave it at that.

Dr O'Connell: I think the important thing is to give people timely information. There is much more information than is on the federal 'MyHospitals' website—much more detail and, importantly, it is much more up to date.

CHAIR: Maybe it is the changing way that we view these things.

Mr McARDLE: It may well be a changing way that things are done. I agree entirely, Madam Chair. Acting Director-General, in November 2010 a meeting took place on the Access Improvement Service's Southern Emergency Department Network, which I understand encompasses the Metro South Health Service District. I understand that this is a regular meeting of various people to discuss concerns in relation to matters. I understand that part of that process at the Logan ED involved an order for eight chairs to be placed within the ED to increase patient capacity. However, there was no increase in staffing to warrant this extra capacity. Is it a matter that there is a process of expanding capacity by ordering chairs into an ED as opposed to beds?

Dr O'Connell: The time that you are speaking about I think I did visit Logan Hospital, either before or after that meeting—I do not remember which. One of the things I do say to all of the emergency department physicians whom I meet when I tour the state visiting the emergency departments is that they must look for opportunities to use models of care such as fast-track zones to accelerate the management of patients who are in the lower acuity triage categories such as triage categories 4 and 5, especially ambulatory patients. The successful approach to those kinds of patients in hospitals across Australia and in the UK has been to manage them in an ambulatory setting—in other words, the patients walk in to the ED because they can. Instead of lying them down in a bed and treating them as if they are critically ill, you would sit them in a chair. That is a great way, for example, to receive some nebulised Ventolin while you are having an asthma attack or to have a small cut on your finger sutured. It allows us to manage more patients more rapidly, keep them away in a different stream from the main body of the emergency department, which is rightfully the place where we would deal with patients who require a bed.

Using that way of treating patients, hospitals that have introduced fast-track zones in a separate physical stream of the ED have seen real improvements in the time to treat category 4 and 5 patients. I do promote chairs for patients who are fast-track zone appropriate patients and the patients leave the ED as soon as they have had their treatment and it is appropriate to go.

Mr WILSON: Madam Chair, I have some information that I can provide to the committee about the steps that have been taken with the emergency department at Logan. I think you would be interested in them because they illustrate the actions that Queensland Health is undertaking to improve access in one of the busiest emergency departments. It is the third busiest emergency department in the state. It is the largest emergency department and the busiest. There is, indeed, no secret that Logan Hospital faces particular challenges. That is why two rounds of funding, federal and state, are being dedicated to an expansion of the emergency department and doing other things at Logan Hospital.

Queensland Health, I am advised, has already identified these issues and taken action to redesign what is called the patient flow, which the acting director-general has been instrumental in creating over the last couple of years in Queensland Health. They have been constructively engaging clinical staff in improving the emergency department performance. There is a project that is underway and it is posted on the Queensland Health website telling people what is happening.

The government also announced a massive expansion of the emergency department at the last election and then when the opportunity arose under the health reform partnership to expand the expansion, so to speak, that was done in March this year. That is when the federal funding became available. We have augmented it with state funding so that you get twice the value of the combined funding. The government has prioritised Logan Hospital for expansion. We will more than double the existing ED space. The original ED expansion was to deliver 38 ED bays and short-stay beds in March 2011. The health reform partnership, through our lobbying of the federal government, delivered an extra $175 million for 50 new beds and an even larger expanded emergency department.

Improving the emergency department performance is not just about more ED spaces; it is also about building a better design for the hospital to improve flow through the ED. There is improved site access with the new ED entrance; there are more overnight beds for patients to move into once they are treated; there is more rehabilitation and subacute beds, which frees up acute space in the emergency department itself so patients move on out of the emergency department into what are called step-down facilities; and there is a new 23-hour ward that will take pressure off the emergency department.

Queensland Health has prioritised Logan Hospital emergency department for the access improvement project which is called redesigning patient journeys. The project started four weeks ago. It is being led by Ernst & Young. They are redesigning the processes of the emergency department from beginning to end to better align them and produce better outcomes. Finally, it is a clinician led project specifically designed to engage clinical staff in designing their work environment. Are there challenges at the emergency department at Logan? Yes, there are. Is Queensland Health taking action to address them with combined state and federal funding? Yes, it is.

Mr McARDLE: Acting Director-General, will these plastic chairs be counted as bed alternatives?

Dr O'Connell: No. Emergency department spaces are not counted as bed alternatives. There was a new definition for how to count beds, which is national, agreed to by all the states and that commenced in approximately 2009. We count beds according to that definition and only beds which have admitted patients in them are counted in that way. So certainly a chair in an emergency department would not be counted in that way.

Mr McARDLE: So when the document—and I will table the document shortly—refers to chairs being placed to increase patient capacity, is that a normal position now with regard to Queensland Health?

Dr O'Connell: It is capacity in an ED—

Mr McARDLE: Chairs are used to increase capacity in the ED by placing patients in chairs?

Dr O'Connell: It is capacity in an ED in the sense that it is somewhere that someone can either sit or—just as someone can lie on a bed, someone can sit in a chair. They are both a form of capacity.

Mr McARDLE: Or they could be used to form a bed, as they were in the Gold Coast Hospital not long ago.

Mr WILSON: I object to that comment. That is an unnecessary and highly unfair slur upon the staff and the clinicians in the Gold Coast Hospital. The member knows that there is no foundation to that sort of slur whatsoever. I would ask him to withdraw it.

CHAIR: Member for Caloundra?

Mr McARDLE: Madam Deputy Chair, it was not a personal reflection upon the minister.

Mr WILSON: No, and I am defending the staff at the Gold Coast Hospital who have had to put up with that sort of comment which is so ill-founded. It is not factually based and it is a slur on the good work that those people in the emergency department did over that Easter long weekend. I will stand up for them any time.

CHAIR: Thank you, Minister. Perhaps the member for Caloundra could reword that question.

Mr McARDLE: Madam Chair**—**

Mr WILSON: It is a smart alec comment and he ought to do better than that.

CHAIR: Excuse me, Minister. Member for Caloundra.

Mr McARDLE: Dear, oh, dear. Madam Chair, I will table the photograph that appeared in the *Courier-Mail*.

Mr WILSON: Why don't you go down and talk to the emergency department clinicians face to face and say to them what you are implying here?

Mr McARDLE: What we will do, Minister, with all due respect, is get back to the topic. What I made quite clear was that chairs of this nature have been used in this manner in the past. Is it now the practice to supply these chairs to increase capacity in the ED and is it a practice that is now entrenched across Queensland Health? Let me make the statement quite clearly. The LNP have been saying now for a lengthy period of time that it is about time this government listened to clinicians. Mr Rudd made that point very clear on his listening tour—

CHAIR: Member for Caloundra, do you have a question?

Mr McARDLE:—when he put in place the local hospital health networks proposal. I think you and I share a very similar point of view on that.

CHAIR: Member for Caloundra, do you have a question?

Mr McARDLE: I did pose a question. Is it now the practice in relation to Queensland Health to place these chairs to increase the capacity in the manner indicated?

Dr O'Connell: We certainly are not placing chairs in waiting rooms for patients to be cared for. Clearly we need chairs in waiting rooms for people who are waiting to come into the ED.

Mr WILSON: Pretty simple, really.

Dr O'Connell: The picture that you have tabled there is one of a patient who happened to be lying in the waiting room because at that particular time on that particular day there was an extraordinary circumstance where there was a surge in demand in that ED, which is a smallish ED, which is why we are rebuilding the entire hospital. He sat out there. He decided to lie down of his own accord. He could have just sat in the chair if he wanted to. He decided to lie down himself and the picture was taken as he happened to be lying down. I sometimes lounge across lounge chairs myself.

CHAIR: Member for Caloundra, do you have a further question?

Mr McARDLE: Minister, the photo indicates to me a person who has some form of drip placed in his arm.

Dr O'Connell: He does, yes.

Mr McARDLE: He is covered by a blanket. He also has his arm placed on a fourth chair, as I count the chair numbers. It seems unlikely that he moved from a sitting position into that position of his own volition. It is more likely, I would have thought—you are a doctor; of course I accept that—that he was placed in that position by someone clinically qualified to—

Mr WILSON: That is calling upon a speculation from the acting director-general, and he is not in a position to speculate.

CHAIR: Minister, I will make that determination, thank you. I think the point has been made.

Mr McARDLE: Yes, thank you.

CHAIR: I think the question has been answered. I think we will move on. I am going to start the ball rolling with a question to the minister. This one is completely different. We have a large increase in renal dialysis patients in North Queensland. I would be very grateful if you could provide information on the state-wide funding plans to manage the increased number of people throughout the state who are seeking renal dialysis.

Mr WILSON: I thank the honourable member for the question. It is a challenge in the renal dialysis arena, partly attributable to the ageing population and the growing complexity of different health conditions that our ageing population has. It is also associated with the incredible increase in diabetes that is taking place in Australia, particularly with our older population. Diabetes is, I am told, being recorded at a rate of 60 diagnoses a day. That is about 300,000 Queenslanders. I am speaking about type 2 diabetes. The scary thing is that it is estimated that there is another 60 a day who have type 2 diabetes but who do not know it, and it is expected that over the next 20 years the 300,000 will increase to 600,000. One of the conditions is kidney failure, along with nerve problems and also eyes, and there is one other that I cannot recall.

In terms of then addressing the demand and the need for Queenslanders to have renal dialysis, I understand that there has been 10 per cent in real growth in patients requiring dialysis across Queensland and that is continuing to grow. It is expected that that will increase by approximately 70 per cent over the next decade. As the honourable chair may be aware, it is a particularly challenging issue with Indigenous Australians, who are hospitalised at 11 times the rate of other Australians for regular dialysis.

In 2007 Queensland Health developed the Queensland Statewide Renal Health Services Plan. This strategy identified five improvement initiatives including chronic kidney disease detection and management, home based treatment options, multidisciplinary workforce expansion, development of a governance framework and development of service standards. So, whilst the initiatives are now underway, we want to continue the work that is being done with clinical stakeholders, including the Statewide Renal Clinical Network, to address these objectives. Prevention and management of chronic kidney disease patients prior to dialysis is essential to developing a sustained, long-term program for the growing cohort of patients. It may be, honourable Chair, that the acting director-general has available to him more particularised information about Townsville which he may be able to provide to the committee either directly or through the agency—

CHAIR: That would be good, but I am interested in the state-wide perspective of what sort of plan you might have in order to address this growing problem.

Dr O'Connell: Renal failure in Townsville?

CHAIR: Not just in Townsville but throughout Queensland and certainly in the north, where we do have a high proportion of a group of people who require the services of dialysis.

Dr O'Connell: We have been growing, as the minister said, the renal services. I am pleased to say that the north of Queensland is really leading the way in terms of the use of things like home dialysis, which is an efficient way of delivering dialysis. As the minister said, clearly our preference is for patients not to get end-stage renal failure, which requires dialysis.

CHAIR: A lot of people are coming in from far-flung communities where they cannot actually do that. That is the problem.

Dr O'Connell: Indeed. So, as much as possible in those situations, especially because the Indigenous rate of renal failure is so much higher than that of the mainstream population, we do have to cater for the needs of Indigenous patients. Clearly the demand is growing at a significant rate—10 per cent annual growth in the patients who are requiring dialysis. That is a real challenge across Australia at the moment. I think it would be fair to say that the threshold for putting people on dialysis has been falling over the last 20 or so years, which is another challenge. We are dialysing people now who are at an advanced age, whereas 20 or 30 years ago that would not have been done.

All of these things represent significant service delivery challenges. But we are adding beds in a number of places—recently in Maryborough, Gladstone, Logan. Across the state we are adding dialysis chairs and we are also making more use of individual chairs. So there are a number of places now which have three dialysis shifts per day instead of just the one or two they may have had a few years ago. So we are making the maximum use of each individual machine, and of course that requires staffing 24/7 instead of just for one shift per day. They are real challenges for us.

The minister referred to the Statewide Renal Clinical Network. They have been incredibly helpful in advising the service plans and in promoting new models of care. We took on their advice, for example, in incorporating in the new activity based funding formula a small incentive for home based dialysis so that districts who deliver more home based dialysis get a marginal increase in funding compared to facility delivered dialysis as a way of promoting what we know is not only cheaper but also more user friendly for the individual patients having that service delivered at home.

CHAIR: I guess it is a challenge well into the future, isn't it? But it leads into the next question, Minister. Both the member for Townsville and I are very interested in the issue of public intoxication. Would you explain, please, how Queensland Health is working with the Department of Communities, the Queensland Police Service and the Attorney-General's department to find a solution to the unlawful activities of publicly intoxicated and homeless people in Townsville?

Mr WILSON: I thank the honourable member for the question. I recognise that both you, the member for Mundingburra, and your colleague the member for Townsville have been real champions around this significant public health issue. I know that the member for Townsville, with your support, has led a community discussion on this subject and has lobbied very hard, particularly my predecessor and more recently me and the Premier, for an action plan to deal with these issues. I want to recognise that and congratulate you both.

As a result, I am advised that back in October 2010 the Premier released the government's Townsville public intoxication and homelessness action plan. The plan has 21 actions which address the issues of public intoxication and homelessness in Townsville, and it provides a model in general terms for other areas of the state. So there is a lot we could learn out of this. There is an $885,000 package which includes boosting the bed numbers in the diversionary centre by 20 beds within two months to a total of 50 beds; a 'break the cycle' program of up to five days of live-in care at the diversionary centre, to be operational by November 2010; extending Townsville's community patrol service—it will now run until midnight seven days a week, an extra two hours a night—to be operational by the end of October 2010; establishing a rapid-response approach, with Queensland police liaison officers working with the community patrol to deal with issues as soon as they arise, to be operational as well by the end of last year.

As a government we are committed to breaking the cycle of homelessness and intoxication in Townsville. It is important that we look after the health and wellbeing of Townsville's most disadvantaged residents through medical and social support. But our public parks also must be safe for all North Queenslanders to enjoy. Service providers have been told to take a firmer and indeed a tougher approach to public nuisance. That includes individual case plans to stop people falling through the cracks, with all agencies and non-government organisations sharing information about an individual's contacts with diversionary and support services. Queensland Health is also investigating specific proposals to provide a stronger focus on detoxification, including an analysis of mandatory detoxification options in limited circumstances where that might be the step of last resort or the only appropriate step to indeed save someone from their addiction. This is a very significant area of analysis of work that is being undertaken by government. Indeed, I believe it may be a first in Australia.

CHAIR: Yes.

Mr WILSON: That means that we need to ensure that all relevant parties are engaged in a very robust discussion and analysis of what are our options and what steps or alternative steps are available to be taken in this situation and also to ensure that there is a good, shall I say, scientific approach to assessing its effectiveness and value over time so that the knowledge gained from that assessment of a trial, or something like that, can be used to better inform the next phase of the trial. But also, if we are potentially leading Australia, I think there will be a lot of people interested in what such an exercise has discovered.

We may draw constructive comment and contribution from other practitioners dealing with this challenge in the rest of Australia. It is not unique of course to Townsville, it is not unique to Queensland, it is not unique to a particular group in the community; I want to heavily stress that. Whilst it might exhibit in a way that suggests that it is unique to a particular group in the community, it is very clear that it is not. One needs to be sensitive about the perceptions that some may have about such a project, but there is no doubt that lots of other things have been tried and they have not worked so well. I well understand the strong interest there is in Townsville from the Townsville community in examining what actions can be taken around mandatory detoxification options in the limited circumstances that have been discussed by you and other people who are interested in this project in Townsville.

CHAIR: Thanks, Minister. You are right: alcoholism does not know any social boundaries at all.

Ms JOHNSTONE: Minister, I want to follow on the same topic. I am interested to know how the mental health system or the health system broadly would diagnose and treat patients who are presenting with symptoms of disturbed mental health or a mental illness but whose primary diagnosis is alcoholism. What I am really asking is this: how do we treat patients with dual diagnosis of substance addiction and mental illness? This relates particularly to people who are chronic alcoholics who end up with mental illness, acquired brain injuries, whatever. How do we treat those people in our health system currently?

Mr WILSON: Thank you very much for the question. By way of preface, can I say that in the record Health budget for this year there is a record amount allocated to mental health—$950 million. That is going to be available in a range of different service areas to support Queenslanders in this very challenging area of mental health. We have come a long way from where Queensland was a decade or more ago in terms of the funding that was then being provided to this important area of mental health. That is just by way of background.

In relation to the particular situations that you raise where there is this duality happening, Queensland Health has a No Wrong Door approach to the treatment of people with dual diagnoses of mental health issues and drug dependence. That means that mental health services ensure patients receive a drug dependency treatment if they need it. ATOD services—which is alcohol, tobacco and other drugs—are available to provide access to mental health services for clients who need that.

Queensland Health services either provide the treatment or refer a client directly to another service provider who can. The Mental Health Alcohol and Other Drugs Directorate provides services to individuals who present with comorbid issues across Queensland through its acute and community based mental health services, including Child and Youth Mental Health Service. These services provide clinical assessments and psychological assessments to individuals, their partners and families on mental illness and substance related matters through a recovery based model of care. They also collaborate with other service providers, including alcohol and other drugs treatment services, community health services and the non-government sector.

In 2010, Queensland Health provided 7,849 episodes of care to assist people to deal with their problematic alcohol use across Queensland and 776 alcohol withdrawal treatments, which was an increase of 107 alcohol withdrawal treatments from the previous year. The government also invests in other programs designed to help people access treatment for mental health and drug and alcohol related issues. I have a bit more information but I can indicate that Dr Aaron Groves is present this evening. Dr Groves is the Executive Director of the Mental Health Alcohol and Other Drugs Directorate and the committee may find it valuable to hear from Dr Groves.

Queensland Health in partnership with the Queensland University of Technology at the Institute of Health and Biomedical Innovation has developed an innovative, world-class, online treatment program for people experiencing difficulties with alcohol misuse and their mental health. OnTrack delivers information and effective psychological treatment online allowing Queenslanders access to free support, 24 hours a day, seven days a week, in the privacy of their homes. I can say that 13,000 Queenslanders have accessed the site since it was launched in 2009 and 470 have registered for treatment programs—this is brilliant; I would like it to be more but it is good that it is happening—and are already benefiting from this exciting service.

OnTrack is an example of the innovative methods the Bligh government is using to improve the lives of all Queenslanders when it comes to alcohol and other drugs and mental health. Through the acting director-general, I will ask Dr Groves to elaborate from his very experienced background and his very significant position as Director of Mental Health on this very special area of work that you are focused on.

Dr Groves: I think there are a couple of things I can add which will expand on what the minister has said. The first aspect is that for a long time there has been a tradition in this country, particularly in this state, where drug and alcohol and mental health services have often been run as separate systems and have not come together particularly well. Three years ago in this state we took an active decision to introduce the No Wrong Door policy that the minister mentioned. A very important part of that was skilling up both sectors so they had a better capacity and understanding of knowing what to do to treat people who came into those sectors and where the problem tended to be a little bit of both.

Just by way of example, about half at the very least of all people who get admitted to a mental health unit have an underlying drug and alcohol problem, and probably three-quarters of those people who go first to an alcohol and drug treatment service in Queensland have some sort of mental health problem as well. So one of the things we have done is we have worked with the clinicians in our state to develop a whole lot of dual diagnosis clinical tools for all people who work, whether it is in the mental health system or the drug and alcohol system, to give them the skills to be able to actually deal with the problems irrespective of which part of the system we are coming towards. Indeed, we are hoping to head towards a policy where it is not a No Wrong Door policy but an Every Door is a Right Door policy, which might be an even better example of where we are going.

The other aspect that I want to focus on briefly is that an important aspect of what we are trying to do is make sure that we take the good learnings that both parts of the sector do—and they are slightly different in approach around how they look at those clinical problems—and bring them together. For example, the alcohol and drug sector has had a very proud tradition of looking at not only how we reduce demand and supply of drugs as an underlying problem of what goes on but also harm minimisation. Sometimes that has not been a strong feature of the mental health system.

By the same token, I think the mental health system, which is much larger in size in this state, has had a very good stock of other services available to them—such as inpatient beds, for example. We have a limited number of inpatient beds so it means that if somebody presents with a psychosis that is drug related they are much more likely to end up in the mental health system even though they do not have a mental illness. One of the things we are encouraging to do is a greater coming together of those particular approaches to what we need to do.

The final thing I would like to mention is that a common problem that people who are acutely psychotic represent in the community is coming into contact with the police. That is a very difficult situation for the police to have to deal with. We have spent a quite significant amount of investment in the last four years with our Mental Health Intervention Project training up about 7,500 police, 2,000 ambulance staff members and Queensland Health staff in a crisis intervention model where the three agencies come together, know how to share information and know how to refer amongst one another. An important aspect of that is making sure the police are well armed in knowing what to do, whether it is a drug related problem or a psychotic condition that they might be seeing in a crisis. We can then make sure that, first of all, the community is safe when they are involved in coming into contact with somebody in a crisis and, secondly, they go to the right part of the service and they get the right care they need. They are the sorts of things I wanted to add to the minister's response.

Ms JOHNSTONE: Through you, Minister: with the integration of mental health services and alcohol and other drug services specifically in Townsville, what tools do the workers have to reach the most chronically alcoholic people in our community, those people who will not voluntarily choose to accept services? What are the tools that funded services, health services, have to work with those people who are so chronically affected by their drug of choice that they cannot understand questions that are being asked of them?

Dr Groves: I think that is perhaps one of the most difficult areas of health service delivery that we have. In a situation where somebody can become so incapable of acting for themselves that they cannot make those sorts of clinical decisions, often we have to get involved in guardianship type decisions and get other people who can be healthcare decision makers for them. There is nothing more frustrating for a health worker, wherever they are, than seeing someone who is unwell and incapable of making decisions. One of the things we have done is made sure that the workers—whether it is a worker in the ATOD sector, a Queensland Health clinical staff member or a worker in one of the services that we fund through the non-government sector—are well aware that when they come to a point where somebody can no longer make a decision for themselves something needs to be done for them. That is a responsibility that Queensland Health has.

Ms JOHNSTONE: Is that happening in Townsville?

Dr Groves: Yes, it should be. Just to follow up on that question in relation to the people where the initial action plan was, you may be aware that there were a number of people—in the order of 40—who were part of that initial collaborative action. As I understand it at the moment, there are only five people left who are actually sleeping rough out of that initial group. That has been through all of those agencies working together and ensuring that, if they come to the attention of one department but they actually need the assistance of services from another department, all of those departments are working together and are able to make those decisions. Previously, people did not know how they could step in and make

health decisions for people who were clearly incapable of making them or make decisions in relation to people's housing if Health had to deal with those particular problems. Those other people either have transient accommodation or short-, medium- or long-term accommodation that has been sorted out through the action plan.

Ms JOHNSTONE: Through you, Minister, I would like to ask a question by way of example. Someone who is a chronic alcoholic tries to commit suicide in the community, they are taken to the Townsville Hospital via ambulance and they are refused assistance through the mental health unit because they are actually determined to be an alcoholic and not have a mental illness. How do we deal with that situation to ensure the safety of those people in our community? That is the dilemma that has come to me through a lot of constituents who know I have an interest in this matter, from all walks of life.

Mr WILSON: There is no doubt that this is a very serious issue and a complex one that does not readily admit of a simple solution every time. I believe that, essentially, any solution has to be driven by a strong reference to clinical advice about what is in the best interests of the person or the patient—however one wants to describe the person—from a clinical point of view. I might ask Dr Groves to maybe tease out, as it were, the challenges of the clinical assessment and recommendation that is faced when someone like that presents.

Ms JOHNSTONE: Particularly in the context of the Mental Health Act, where there are thresholds that can be reached where decisions are taken away from the individual about their wellbeing.

Mr WILSON: Sure.

Dr Groves: Maybe I will deal with that first point in relation to the Mental Health Act. The Mental Health Act does not allow us to involuntarily treat people if they do not have a mental illness, and it is unlikely that somebody with chronic alcoholism as you have described actually fulfils the criteria for the Mental Health Act. They are not likely to have a mental illness of such type that that is really the problem; it is primarily their alcoholism. So if they have secondary mental health problems that might be likely but unlikely to lead to them being able to be locked up under the Mental Health Act. That then brings us to the matter of what you do when somebody is presenting or somebody is bringing a person into care who is a chronic alcoholic and has impaired decision making, and that is a very complex clinical situation that you need to deal with.

One of the fundamental issues is that you tend to be unlikely to get success with rehabilitation of that person unless they have been through a period of detoxification first of all and then they can engage in rehabilitation, and that is often a very difficult first point. Detoxification services for people who present in this way are somewhat difficult to deliver because, again, we tend not to deliver those involuntarily. In fact, there is good reason for that, because the available evidence says that the more times a person is detoxified during their life the more likely that is to be harmful. We in fact know that there is a distinct possibility that people die in detoxification. It is a very important thing for us to actually get right, so you should not take those positions lightly. Therefore, it is pretty important that they are going to have all of the support systems in place once they are detoxified to get into a rehabilitation program and for it to be successful. I think that is the really first important point. I think there is nothing more frustrating than a family coming together supporting somebody through their detoxification in the early days of their rehabilitation and them then relapsing because the underlying issues for why they are an alcoholic are not being addressed.

So it is a very difficult set of circumstances. It is something that we really try to treat on a case-by-case basis. I think the minister has talked about the number of people who have been through both detoxification services and treatment and rehab services during the year. Clearly, for the vast majority of those people they have made an active choice and decision to embark on that. I think there is nothing more frustrating for a family member or a loved one than to see somebody who is in those early stages of thinking about doing something about their alcoholism but not being committed to it. It is one of those difficult situations.

CHAIR: Just on that, Minister—this will be my final question and then we will go to the member for Caloundra—in terms of a person who is mandatorily to go through detox and rehab who is close to going to prison but will be mandated to attend this session of their life otherwise they go straight to prison, could the same thing apply with people who are suffering from chronic alcoholism if they have a criminal reason not to remain where they are and to continue the criminal behaviour that they are engaged in, whatever that might be, or to go to jail? Clearly a lot of alcoholics and drug addicts do not belong in jail because they have all of those other underlying problems. But surely if a magistrate makes that order then Queensland Health will be able to assist in that detoxification process. And indeed, should a diagnosis be made of this person having a mental illness, part of that procedure could take place in a secure mental health unit.

Mr WILSON: Thank you, Madam Chair. All of what you say may be theoretically possible, and I say that respectfully.

CHAIR: I understand that.

Mr WILSON: Queensland Health is, as I indicated earlier, investigating what are the possible options to address the issue of mandatory detoxification, and even the conversation that has happened in the last 10 minutes illustrates the incredible complexity of this situation. Certainly when I first became acquainted with the issue—and I think I was talking to either of you or both of you—my initial reaction was thinking about the drug diversion courts which have been so successful.

CHAIR: Very successful.

Mr WILSON: I think Rod Welford was Attorney-General when it was brought in, in 2006 or something like that, and that has been quite remarkable. As a government we have said that we want to seriously investigate this to work out how we can do this, and I am committed to that.

CHAIR: That is good.

Mr WILSON: I say at the same time that it is a very challenging policy area—the intersection of at least three major policy areas. I am advised that Queensland Health is looking at the options for introducing stronger alcohol rehabilitation services in the Townsville region, including a very careful examination of mandatory detoxification options. Queensland Health has been directed to investigate every option, including the use of space at the acute mental health ward. There is some symmetry between mandatory treatment of acute alcoholism and acute psychiatric care, but there are also some differences. Obviously any mandatory detoxification facility has to be secure. It also has to be proximate to a full range of medical services. Therefore, Queensland Health is investigating whether a purpose-built facility is the best option. Given the significant cost and time it would take to establish a facility and the need for immediate availability of access to health services, it is probably not the best option. But all options should be looked at and it is under consideration. There is the option of using community or private sector facilities, and again it is theoretically an option and therefore under consideration. Queensland Health will continue the work and obviously consult with yourselves and other relevant stakeholders in the Townsville region.

I suppose the other caution I would put on the record—and I do this respectfully; it is just an observation that I think is appropriate in the context of this very difficult policy area—is that it would be highly beneficial if all interested parties bring a very open mind to this area, and I know you as members have to as well, so that we can explore the options in a fairly neutral environment to maximise a good result. So I am being a little cautious even here tonight in what I say because it is an area of some considerable sensitivity but equal need for some really serious outcome to be achieved.

Could I ask for your guidance, Madam Chair: I have responses to previous questions that we were unable to give responses to, including questions from the member for Caloundra, and I think there might be a couple from other members as well.

CHAIR: Before we go on to those—

Mr WILSON: I do not want to cut off your topic; I am just flagging that I need your guidance.

CHAIR: Sure. I just know that the member for Caloundra wants to ask a question related to—

Mr WILSON: This topic?

CHAIR: Yes, this topic. So we might just conclude that and then I will give you that opportunity.

Mr WILSON: Thank you.

Mr McARDLE: Minister—and perhaps Dr Groves can help as well—the doctor discussed the issue of drug induced psychosis and then suicide was mentioned as well. When I talk to paramedics they say that they are continually surprised at the suicides that occur from drug induced psychosis clients or patients. There has been some debate for some time about the issue of talking about suicide—not the 'how', which is a whole different question entirely and fraught with so much danger. I wonder, Minister, if you could comment on the following, or perhaps the doctor could comment as well.

The issue of suicide is of course very much an issue we have to deal with in our society. The media generally, for very good reasons, do not report on individual suicides. Is it time that we started to discuss the fact of suicide, not the how? If we do, do we need to put in place safeguards to ensure that the discussion itself does not lead to copycat? Is there also a need now for strong research to be undertaken into the reasons for suicide so we better understand, because what I am getting back is that it is a malignancy in our society that we need to deal with but we do not quite know how to start the process? So, Minister, I ask you to comment on that if you can comment on that—it is not a policy request under any circumstances—and perhaps Dr Groves, if you permit, could pass a comment as well.

Mr WILSON: I thank the honourable member for the question and I will turn to Dr Groves in a moment. This is a very serious issue that you raise. An average of 500 people die by suicide each year in Queensland. Whilst there is a declining rate of suicide, so we are told, statistically in recent years, the rates remain unacceptably high for Aboriginal and Torres Strait Islander people—that is, up to 70 per cent higher than the general population. In terms of people with a mental illness, the 80 people who die by suicide in Queensland each year are in contact with mental health services and fewer than 10 people

who suicide are receiving inpatient mental health care. Rates for people living in rural and remote locations are 20 per cent to 30 per cent higher than for the general population. Suicide prevention is part of the broader mental health reform agenda and is central to the provision of all mental health services and programs delivered throughout Queensland Health.

In 2011-12, as I indicated earlier, Queensland Health will invest $950 million in mental health in the areas of mental health promotion, mental illness prevention, community based services, acute inpatient services and extended treatment services. In the last financial year there was an additional $3.6 million allocated for targeted cross-government suicide prevention initiatives which included the establishment of five temporary positions across four Queensland government agencies with a key role in suicide prevention and direct contact with groups at heightened risk of suicide—that is, the Department of Communities, the Department of Community Safety, Corrective Services, the Department of Education and Training and the Queensland Police Service—and the establishment of 10 project positions within mental health service acute care teams to enhance the assessment and management of suicide risk, particularly within acute settings.

I will just briefly flag the other ones. There is a pilot project to provide follow-up support to people presenting at EDs at the Royal Brisbane and PA hospitals who are potential suicide risks; work to develop a whole-of-agency suicide risk management framework to guide the approach to mental health folk and follow-up; continuing the Queensland Suicide Register; comprehensive planning for the establishment of an advisory group on suicide to provide state-level mechanisms for key stakeholders engaged in the collection and management of information, and this is an important opportunity to engage stakeholders around this area; and support for research into key factors associated with suicide, particularly young people with an ATSI background.

The other point I will just make and then pass to Dr Groves, if I may, is that there is funding that has been made available to the Queensland Alliance for Mental Health as part of our antistigma campaign over four years to manage community activities linked to this campaign. Those potential community activities include developing community workshops and radio programs, photographic competitions and a speakers' bureau to make a contribution to turning the mind of the public into a far more positive one around mental health generally, which, of course, to the extent that it is not so generous can contribute to our suicide rate. I might ask Dr Groves if he would like to add a response to your question, member for Caloundra.

Dr Groves: I think there were two parts to your question, as I can see it, that have not yet been addressed. The first one is about the dialogue, or the debate, or the community discussion around suicide. You are quite right: there has always been a concern that talking about the facts of suicide does tend to lead to the phenomenon of copycat suicide. That is a well recognised phenomenon. So we have developed guidelines in this country for adequate and appropriate media reporting in relation to suicide. It gives plenty of opportunity for the media to portray it in a very constructive way. My impression is that that is something that does not tend to happen terribly often.

I think one of the things that has not been well understood in this country is that we reached a peak of suicide in 1997 in this country and it has been slowly going down since that point in time. It is exactly the same in Queensland. That was the peak at that period of time. Part of the reason it has been going down is we have had a National Suicide Prevention Strategy in one form or another since the mid 1990s to try to address that and we have mirrored that in Queensland. Initially, in the first five years it was primarily looking at youth suicide. We expanded that in the next five years to having a more broad approach.

We have always believed that we have better figures in Queensland, because some time ago we funded ASRAP, which is an organisation that I know you are aware of, to keep our Queensland suicide register. It keeps more up-to-date figures than the Coroner's report. It reports nationally and then it gets in the ABS's causes of death data. So suicide for a long time looked like it was going down very rapidly but the simple fact of the matter was that the ABS was not going back and historically readjusting the figures. So we have all known in Queensland that they have been a little bit higher and that happened last year when that was announced.

Nevertheless, there has been—and there is—a real trend in suicide slowing down in this country, but I think it has led to a concern of people saying, 'But there are still 2½ thousand suicides in this country. Where do we rank internationally?' We do not rank too badly but there is always more you can do. I think one of the issues has been when is the right time for the community to have more of a discussion about what they need to do. That has been a strong feature of what we are trying to develop in the next aspect of how we are dealing with suicide in this state so that it is not just seen as a health issue or a mental health issue but a whole of the community issue. What is important is to have more people in the community who understand the sorts of risk factors, how to talk safely about the issues if someone they believe might be at risk or thinking of suicide and how to encourage them into pathways of care.

Maybe I can give you an example of one program that we think is fantastic, although it does not belong to Queensland Health. That is the Mates in Construction project, which we have jointly funded with AusCare. Essentially, it was an idea that came to us some years ago when we saw that rates of

suicide in the building industry were higher in comparison with other parts of the building industry. The building industry came to us and said they know there is a problem and they think the best way is not to actually have counsellors or people coming out and helping them but to train people in the building industry to go around and talk to their mates and talk safely about the sorts of problems that they have and then, if they think somebody is travelling pretty badly, having had that initial dialogue, to know how to get them into care—whether it is through their general practitioner, whether it is through any part of the public system. That has worked outstandingly well and we have seen some really good results in that area.

Recently, as part of thinking through how we respond to the increasing degrees of mental anguish following the disasters we have actually got Mates in Construction to talk to other primary industry areas and say, 'Maybe you need to think about developing this within your own industry,' whether it is the cotton farmers of Theodore, or the banana growers, or whoever it might happen to be, so that they start to develop internal community-led mechanisms for making it something that is reasonable and safe to talk about. It is not about how people kill themselves, but what are the signs to look out for and how to help your mate. That has been a very strong feature of what we have tried to develop in this state and it is something that is supported by the literature and it is something that is part of the national suicide prevention framework.

On research, because I think you also asked a little bit about research, research is something that has always been fraught in the suicide area. There are always major methodological problems with most suicide work that has been done, because suicide is, in fact, a very rare event. There are 4½ million Queenslanders and 500 of them suicide. So when you try to do research into rare events it is very hard to find trends. But we do know the things that the minister has just mentioned. Aboriginal and Torres Strait Islander people kill themselves at excessive rates compared with their non-Indigenous counterparts right throughout Australia and through many parts of world where the heritage of Indigenous peoples are shared. That is something that needs to be addressed. We also know, though, that really 40 or 50 years ago suicide in Indigenous people was an unheard of event. So this is a modern phenomena. Suicide has always been around in the world but it has not been in Indigenous communities. So that is something that we need to think about addressing.

The other issue is that youth suicide is, in fact, perhaps a little bit overexaggerated. In fact, it is more likely that people are going to be killing themselves between the ages of about 25 and 44 than they are in that youth group, despite the fact that there has been a fair bit of concern about that. Youth are more likely to talk about it. They are more likely to consider it. They are going through a transition in their life that is very difficult and often presents with them having suicidal ideas, but that is quite different from them going on and suiciding. So there is a difference between getting services for them and actually preventing suicide.

So they are the two issues that we are putting most of our focus on at the moment in how we are going about it. I think there were two other issues you touched on briefly. One of them was about people who are presenting with alcohol and drug problems and frequently talking about suicide or making suicidal gestures. We know that when people are intoxicated their thresholds for acting in stupid ways are much lower and they are more likely to harm themselves, particularly if they have some sort of personal crisis going on. Some of them will die by accident—and that is terribly tragic—but most of the time they will resolve.

So we see people presenting with alcohol intoxication when they present to emergency departments, often then sobering up, the crisis that brought them there settling down and they do not need anything further. But one of the things that we have thought that is really important is that we need to let their general practitioner know that they have been to an emergency department and close the loop so that the GP will follow them up. We have funded a couple of projects north and south of the river. In a true sign of cooperation with the Commonwealth, they have put in half the funding and we put in half the funding. We have looked at making sure that people who present to emergency departments who have self-harmed who we discharged that day get followed up and linked up with their GP.

CHAIR: If they have a GP.

Dr Groves: Their local GP.

CHAIR: A lot of these people do not. Do you have a follow-up question?

Mr McARDLE: Not on that issue, no.

Mr WILSON: Might I have the indulgence of the committee? I just want to place on record something in relation to Mates in Construction and recognise Jorgen Gullestrup and the construction industry employers and unions who put this project together some years ago and which has been funded out of the industry. It is making such great headway. It is worthy of great public knowledge.

CHAIR: Thank you.

Mr WILSON: I just want your guidance about the responses to these earlier questions.

CHAIR: Yes, thank you for reminding me. Go ahead.

Mr WILSON: Thank you. Earlier, the member for Caloundra asked about the process used to arrive at the cohort of 600 cases reviewed in relation to payroll fraud allegations. I should say the responses I am providing now, I am advised by the department, are the responses to provide. The process involved the application of business rules based upon a risk management approach. The CMC has also approved that process and the process involved identifying cases involving larger sums of money and cases of multiple cash advances, particularly if the person's individual pay did not seem to be low. The cash advance data, of course, is entirely separate from the payroll data and kept in an entirely separate system.

This may have been a question from the member for Gladstone—I am not sure—but Queensland Health advises that both the Gladstone emergency department and the Rockhampton emergency department utilise a nurse ratio system supported by the Nurses Union. They both have staff ratios which are consistent with those standards. There was a question asked about how many staff are employed in the following areas of payroll—

Dr O'Connell: I think I have answered that one, Minister.

Mr WILSON: You have answered that one?

Dr O'Connell: Yes.

Mr WILSON: Good. There was an earlier question on infrastructure maintenance work that may be outstanding. I am advised that the current value is $349 million. As at 31 December 2010, the value was $361.8 million. I will recite them chronologically. On 31 December 2010, the value was $361.8 million and the current value—if not today's date a most recent date—is $349 million. In other words it has trended down. At less than five per cent of asset replacement value, these figures are rated as good under the Queensland government guideline.

I am not sure which member of the committee asked any one of those particular questions but I thought it better to have the responses back to the committee before we finished tonight.

CHAIR: Thank you for that clarification.

Mr WILSON: I am sorry, but there is the other matter on notice relating to the breakdown of historical funding for IT projects. I think that was over that four-year period. We will take that matter on notice. There is a fair lot of data and history to go back to.

Mr McARDLE: Yes.

Dr O'Connell: There was another matter which was put on notice and that was the Townsville car parking issue.

CHAIR: Yes.

Dr O'Connell: I can tell you that there are currently 1,920 formal car parks and 130 informal car parks, which are on grassed areas at the Townsville hospital. So that is a total of 2,050 car parks. In February 2011, Queensland Health purchased the former CSIRO site, which is next to the hospital campus. The plan on this site is to use it for future expansion of the hospital but in the short term it will be used for car parking to develop an additional 600 car parks. At the moment they are currently using 100 spots as informal car parks on gravel at that CSIRO site. Those 100 informal spaces are being converted into a new, as I said, 600-space car park.

Construction of the new car park began in April 2011, with completion anticipated by the end of July—so quite soon. The car parking on this site is anticipated to be for five to 10 years until further expansion is required. Queensland Health is undertaking a land use report to determine the future use of the full CSIRO site, which will also look again at car parking needs on this new site. The life of the car park could be extended beyond five to 10 years if required by adding additional layers of asphalt subject to the planning underway for the CSIRO site.

This new car park is intended for the use by daytime Queensland Health staff, that is, staff using the facility during normal office hours. Of course, the intention of the new staff car park is to free up car parking spaces on the hospital campus so that more car parking spaces are available for patients and visitors to the hospital.

CHAIR: Thank you.

Mrs CUNNINGHAM: Minister, thank you for that reply about the nurse ratio. What you are saying then is that the full-time equivalent nurse numbers in Gladstone compare mathematically correctly to the same methodology of getting full-time equivalent nurses in the emergency department in Rockhampton. So if you did a mathematical comparison they would be equitable?

Mr WILSON: I will ask the acting director-general to respond to that.

Dr O'Connell: As I mentioned earlier in my initial response to the question, Queensland Health has used the business planning framework, that BPF methodology that I referred to, for a decade now. It is used in EDs to calculate nursing staffing requirements and the tool provides the ability to increase the nursing FTE number according to the level of acuity of the patients, their triage categories and the

number of presentations et cetera. In 2010 the chief nurse led the enhancement project for emergency departments and the application of the BPF to emergency departments to ensure that ED nursing staff were appropriate in terms of the service profile, taking into account the number of ED presentations and the Australian triage scoring categories of 1 to 5. That model is used to inform budget requirements for future years.

When you examine the situation in those two hospitals that we have been talking about, the ratio of nurses to presentations at Rocky is one to 760 and the ratio at Gladstone is one to 1,000. The reason there is that difference is that there is a significantly different number in presentations in those two hospitals. Rocky has 44,000 per annum compared to Gladstone's 27. The treatment bays in Rocky are different. There are 17 bays including paeds and short-stay units, whereas Gladstone has only six bays and supports the outpatient department. The most important difference, of course, is that the majority of cases at Rocky are the higher triage categories, the more acute patients. So 57 per cent of the patients are category 1 to 3, whereas at Gladstone only 30 per cent of the patients are category 1 to 3. That is why the FTEs for nursing for those two hospitals are 57.8 at Rocky and 25.2 at Gladstone.

Mrs CUNNINGHAM: Acting Director-General, I will have a look at those numbers and when we meet next week, I think it is—

Dr O'Connell: Yes, we are meeting on Wednesday.

Mrs CUNNINGHAM:—and my eyes do not glaze over, I will take you on.

Dr O'Connell: It might be because of the late hour that your eyes are glazing over at the moment.

Mrs CUNNINGHAM: I have one last question, because I know that the member for Caloundra has some questions. The minister raised this in relation to the renal services to be established in Gladstone—and I welcome that, but it was paid for by LNG. When I talked to the current minister and his predecessors—so I acknowledge it is not a problem that has been just during your time, Minister Wilson—I was told that no renal service would be established at Gladstone because there were only five renal patients. I went about and proved that that was inaccurate. At least when you called surgeries and asked for renal patients being treated by having renal dialysis it was more like, I think, about 25 or something. When that funding was announced you said—and you reiterated it tonight—that those renal chairs, three of, would help 60 patients. Can you tell me how that number multiplied, please?

Mr WILSON: I do not have that detail personally with me. That is the advice I have been given. There may be someone through the acting director-general who is in a position to advise how that has been calculated.

Dr O'Connell: No, I cannot tell you that just at the moment, I am afraid.

Mrs CUNNINGHAM: That is okay. I will see you Wednesday.

Mr WILSON: Perhaps, on the acting director-general's behalf, I can undertake for him that he will have the answer for you on Wednesday when he meets with you, if that is satisfactory.

Dr O'Connell: We will submit the response to the committee. There were some other questions which have not been answered that I could continue with if we are going through that process of answering questions on notice.

CHAIR: No, we will go to the member for Caloundra.

Mr McARDLE: Can you advise if the renal services in Metro South Health Service District are at capacity at this point in time?

Dr O'Connell: The renal services at Metro South are under significant pressure. Of course, Princess Alexandra Hospital is in a unique position in that it is probably the leading renal centre in Australia. It is doing cadaveric transplantations, for which it is receiving additional funding. The situation is that the PA is also providing some services for patients from the eastern end of the old Darling Downs-West Moreton district, although we do clearly provide dialysis services there as well. And certainly they are very close to capacity, which is why it is important that we, as much as possible, network the services to make the maximum use of all of the potential spaces that are available. In terms of absolute numbers, I cannot tell you just off the top of my head whether the words 'at capacity' could be used, but certainly they are very challenged at the moment because of the issues that we raised before of the significant rise in chronic renal failure.

Mr McARDLE: I also understand that in that district the growth in demand for services over the next few years is 10 per cent, or 40 patients per annum. Would that be fair?

Dr O'Connell: It is about 10 per cent, yes. Ten per cent is a figure that would probably be applicable to the entire state, actually.

Mr McARDLE: So it is an area that really is, as you said, stretched? You did not use the words 'at capacity'. I will use the vernacular 'to the max'. Is there any way to engage private renal dialysis services in the area to assist patients in Metro South?

Dr O'Connell: We are currently exploring possibilities to access capacity in the private sector. For example, as you undoubtedly know, there are possibilities of new private health services in the Springfield area and it may be that we would tap into that. We are currently having conversations between the districts, Metro South and West Moreton, to explore what arrangements are possible. We have used the private sector in Cairns, which has worked very well.

Mr McARDLE: For Metro South?

Dr O'Connell: No, I am talking about the principle of using private sector capacity to service demand in the public sector for renal dialysis. We have used the private service in Cairns which I believe has been quite a successful model.

Mr McARDLE: Metro South's need for services has been growing for some time, has it not?

Dr O'Connell: It has been a steady growth. As you say, that 10 per cent figure that you are using is a figure across the whole state.

Mr McARDLE: It is a significant figure.

Dr O'Connell: Absolutely.

Mr McARDLE: What is the funding in this year's budget to assist renal services in Metro South?

Dr O'Connell: I will have to take that question on notice for that particular district. I do not have the breakdown of individual services in each district.

Mr WILSON: Whilst that is happening, I can indicate that funding over 2006, 2007 and 2008 was increased for Redland Hospital's dialysis unit.

CHAIR: It might be worth clarifying at this juncture that if you have answers to questions you can, if they are legible, table them should we run out of time or you can get them to us in writing by close of business on Friday.

Dr O'Connell: I think I will choose the latter option, thank you.

Mr McARDLE: Just to recap that last point, you will get back to the committee with what the extra funding is in the budget for those services at Metro South?

Dr O'Connell: Yes, I will. In fact, I can tell you that out of my budget as divisional head for the Centre for Healthcare Improvement we put in an extra $600,000 specifically for the issue of cadaveric transplantation, because we are keen to address the Commonwealth's desire to improve the rate of cadaveric transplantation and we were keen to get as many transplants occurring each year as possible. From that particular source there has also been an increase in funding to that district at PA.

Mr McARDLE: I will table a document. I will not give the names of the people, but it is from the director of nephrology to the CEO of Metro South and is dated May this year. Perhaps that can be shown to the acting director-general. It indicates that patients planning to relocate from around Queensland, interstate or overseas into Metro South have been asked to defer their plans to move to Metro South because they cannot accommodate their need for dialysis. Can you comment upon that? I think it is the second tranche of points down towards the bottom—maybe the second or third last point.

Dr O'Connell: Yes. It says—

A number of haemodialysis patients imminently planning to relocate from Cairns, Metro North, Gold Coast, New South Wales and New Zealand into the Metro South HSD have been asked to defer their plans to move as their haemodialysis requirements cannot currently be accommodated.

Mr McARDLE: That is a worrying comment, is it not? Before I go on, just go to the first point of that second bracket of points. I think you will find it says that Metro South is at full capacity.

Dr O'Connell: It reads—

A 10% annual growth in patients requiring renal replacement therapy has saturated available in-centre haemodialysis facilities in the Metro South District.

What it is referring to there—

Mr McARDLE: No, go down further—not the first three points.

Mr WILSON: I wonder whether the acting director-general could have the opportunity of reading the document fully and then responding to the question. It is a little unfair to have this presented to him without any time for him to read it and then for him to be asked to comment upon particular paragraphs when he has not read the whole document.

Mr McARDLE: I am not asking for a comment on the paragraph.

Mr WILSON: With respect, Madam Chair, could he have the chance to read the document?

CHAIR: Member for Caloundra, what is your question related to?

Mr McARDLE: The question has two points—just to note the phrase in I think it is the fourth dot point down, at the end there: 'at full capacity'. Then you drop down to the point below that you read out in relation to Gold Coast, Cairns et cetera. It is a very worrying situation when you have it at capacity,

based upon the content of that document, and also people being asked not to come because we cannot cater for their needs. That would, I would say, require some urgent attention to deal with a position that is getting well and truly out of hand; would you agree with that?

Mr WILSON: There are about four questions all rolled up as one being asked of the acting director-general. Surely he can have the opportunity to read it and consider it and then answer each one separately.

CHAIR: I do not think that is an unreasonable request, to be frank. If you have a question to ask, please do so.

Mr McARDLE: Is that phrase that you read out about Cairns et cetera reason for real concern in relation to the provision of renal services in Metro South?

Dr O'Connell: I think it is reasonable for people who are incredibly technology dependent—namely, people who are on artificial ventilation at home or who are on dialysis which requires a machine three times a week—to plan their movements interstate and overseas. I think that is a very reasonable thing to do. I think it is unreasonable to expect that we could instantly provide planned dialysis services for people who are moving from across the Tasman. It is not like going around to the corner shop to buy the latest edition of a book. This is a level of intense medical therapy which really has to be taken into account. You cannot expect to move freely around the country and drop into any dialysis centre. The statement there from a clinician who I know is a very passionate and committed clinician is one reflection of the fact that they are challenged in the delivery of services, but I do not think he would say that he would expect to deliver a service where anybody could drop in unannounced and just start dialysis which is going to consume a machine three times a week for eight hours each session, potentially. Even he would not suggest that that is a good marker of the level of capacity of services.

CHAIR: Thank you. But as I said, member for Caloundra, I think it is a difficult scenario that we have here in that—

Mr McARDLE: Perhaps if I could put a question that the D-G could take on notice?

CHAIR: That might be better.

Dr O'Connell: I am happy to do that.

Mr McARDLE: Go down to the fifth dot point on the page.

Dr O'Connell: Haemodialysis in metro south district?

Mr McARDLE: That is right. It says at the end that it is at full capacity. That is quite different to—I will paraphrase the term that you used—under stress or under strain. That implies that it is at full capacity; it cannot take any more.

Dr O'Connell: I would need to talk to that clinician about that. We would need to establish, for example, that each one of these facilities was running the machines, for example at three sessions a day. He may not have taken into account the possibility that funding could be made available to increase the utilisation of each machine.

CHAIR: That is a fair enough comment.

Dr O'Connell: This is a letter in which he is providing a background brief to a district CEO. The CEO's response might have been, for example, 'Well, if you're only using it for two sessions a day, why don't I give you funding to increase it to three?' This is really just the first interaction between this very passionate clinician and the administration.

CHAIR: Thank you. I know the minister made that point as well.

Mr McARDLE: I have one quick question. Would you anticipate the director to be aware of the point you have just raised? A director in that position who is—

Dr O'Connell: He is aware because I have spoken to him about that.

Mr McARDLE: He would take that into account, wouldn't he?

Dr O'Connell: Not necessarily.

Mr WILSON: That is an unfair question. How can the Director-General—

Mr McARDLE: Could you take that on notice as well?

Mr WILSON: How can he—

CHAIR: Excuse me—

Mr WILSON: I raise a point of order.

CHAIR: It is late in the evening, Minister, and I cannot hear what is being asked or said, because three people are speaking at the same time. I think this situation is extremely difficult, member for all Caloundra.

Mr McARDLE: I agree.

CHAIR: We have a document here that nobody else but you has read. I think that the question should be taken on notice.

Mr McARDLE: I accept that.

CHAIR: Member for Gladstone?

Mrs CUNNINGHAM: I would like to speak about the Gladstone Hospital, again. It is just a question. Today, and in parliament as well, you have talked and I have listened with care about the need to finalise the strategic plan. I believe it is well overdue. When I have asked about increased funding, increased staff, a change to the service model from senior medical officer to a consultancy based model, you have also replied that much of it will be contingent on this strategic plan. You have also commented on and I have also raised the fact that LNG has contributed funds to the Gladstone Hospital for renal dialysis, operating theatres and the emergency department. It is clear that, without that strategic plan, it is possible to accept funding and utilise it productively at the hospital. Therefore, on the back of the projected employment increases in the town from LNG, Boulder Steel and others, will you give immediate consideration to an increase in services at the Gladstone Hospital, irrespective that the strategic plan is not completed, on the basis that you have been able to accept this other funding to increase services already?

Mr WILSON: I thank the honourable member for the question. I think there is a long way between, on the one hand, accepting the Queensland Gas Corporation's willingness to make a social contribution to the health of the local community in Gladstone in relation to a specific initiative such as renal support and, on the other hand, the global position of the Gladstone Hospital in respect of all of the health services needed by the people living in the Gladstone area and that are provided either by Gladstone or somewhere else, and what that health service plan should look like for the future. I do not see them as inconsistent.

The fact is, as I said before, the health service plan is being finalised. What I did not get to say earlier or, rather, what I neglected to say was that when it is finalised—and I have asked the department to finalise is as quickly as possible—I understand that the normal process for health service plans is that they go out for community consultation. I understand that that is what would happen with this plan. That is to create an opportunity where people such as yourself, clinicians in the local community, the chamber of commerce, the LNG proponents and any interested party can make their comment and contribution to the draft position that is put in the health service plan. I think that is a good thing. It is important that designing a health service plan does engage very strongly and actively the local community. It is an opportunity not only for their involvement but also to challenge Queensland Health professionals who have been involved in putting the health service plan together. I think it would be particularly important to engage the LNG proponents that are involved in Gladstone and also the major managing contractors and the major construction companies. There may be many others. That is why I am keen for it to be available as soon as possible, for that conversation to happen with the community and for Queensland Health then to be able to finalise the health service plan as quickly as possible after that consultation process.

My understanding is that such a plan creates the opportunity for doing, as it were, an audit of what is presently available as distinct from what is presently needed, according to different points of view, within the Gladstone community and then mapping forward what the population and other trends are for the community over the next five to 10 years. And, thirdly, then looking at the Gladstone Hospital in the context of the region based at Rockhampton. I understand that you have some points of view in relation to that relationship between Rockhampton and Gladstone. As I see it, it presents an opportunity to have a fresh look and potentially a fresh start for identifying what services are needed for what cohorts of the community, where and when.

Member for Gladstone, through your relentless questioning or otherwise, I can say that I am just as keen to see this document as no doubt you are to get things moving. However, I do seriously say that I think it is very important to engage the LNG proponents. They are major multinational companies. They do a lot of long-term planning. We need to make sure that government access to planning information through the various central agencies is as robust as possible. One way of doing that, if ways can be found, is engaging with QGC and other gas proponents, maybe in some confidential briefings or what have you, where they have the opportunity to challenge what they think might be different figures from the research, the business investment and business case development that they do that underpins this unprecedented investment that is going into Gladstone. The short point is that if we see the health service plan sooner rather than later, it will make us all happy, potentially.

CHAIR: Thank you, Minister. The final question of the evening will be from the member for Gaven.

Dr DOUGLAS: Thank you, Madam Chair. It is a change of topic and it is to the Minister: can you indicate how much outside contract pathology service is outsourced from Queensland Health? Rather than item by item or job lot by job lot—and I know it is a difficult question, but there may be people here

who can assist you. I am led to believe that there is an amount routinely sent by aircraft to Singapore every night. I would like to know how much goes out in terms of a percentage and what is the cost to Queensland Health?

Mr WILSON: I am getting some advice on that. You will appreciate, perhaps, that that detail is not readily at my finger tips.

CHAIR: Not at 25 past nine?

Mr WILSON: Apart from other physiological conditions we might be experiencing at the moment.

Dr DOUGLAS: I appreciate that.

Mr WILSON: I will ask Ms Byrne to answer.

Dr DOUGLAS: If she has the detail there, that would be good.

Ms Byrne: I am the chief executive of Clinical and Statewide Services, of which pathology is a part. I am aware of the matter, it having been raised earlier in the week, so I do know the answer. It is not a routine matter. Some items are sent to other laboratories in other parts of the country, indeed in rare circumstances or for rare genetic conditions, for instance, where the testing is not available in this country or where it is of such a highly specialised nature that it would only be perhaps available in a couple of centres in the world.

Dr DOUGLAS: So?

Ms Byrne: So it is not a routine matter for routine pathology.

Dr DOUGLAS: In percentage terms, is it less than one per cent; is that what you are saying?

Ms Byrne: It is less than one per cent, absolutely.

Dr DOUGLAS: Is there more to that answer?

Ms Byrne: No. The question was raised earlier in the week. We were quite perplexed by it, because we could not really see that there was a lot of substance. We were grasping to see what we could answer and there were lots of questions that came. Frankly, I do not think that there is a matter of concern there. It is rare genetic conditions that have no basis for testing in this country. That is about the limit of it.

Dr DOUGLAS: It is not routine tests?

Ms Byrne: Not routine tests.

Dr DOUGLAS: And it is not routine tests that have been incomplete at the end of the working day?

Ms Byrne: No.

CHAIR: Thank you, member for Gaven. Member for Caloundra, you have a very short question?

Mr McARDLE: Thank you. It is a very short question.

CHAIR: With a short response.

Mr McARDLE: It may not need a response at all. Acting Director-General, in considering your response to the renal issue in metro south, would you also take into account this brief to the then Minister for Health, dated 8 December 2010, requesting funding in the 2010-11 budget process for further funding to alleviate the concern within metro south renal services?

Dr O'Connell: Yes, I will.

Mr McARDLE: Thank you.

CHAIR: Do you wish to formally table that document?

Mr McARDLE: I do.

CHAIR: The time allocated for the consideration of the estimates for the organisational units within the portfolio for the Minister for Health has now expired. I thank you, Minister, and your departmental officers for your attendance. The transcript of this part of the hearing will be available on the parliament's website in approximately two hours, for those people who are desperate to read it. That completes the committee's hearings into the matters referred to it by the parliament. Before I conclude, on behalf of the committee I thank Hansard, the secretariat and the attendants for their assistance.

Mr WILSON: Chair, I want to put on record my thanks, firstly to the committee, secondly to Hansard and the other parliamentary staff who support this committee function and thirdly, but certainly not last, to my Acting Director-General and all of the staff of Queensland Health who have been engaged in preparing information to best assist this committee in its deliberations. I also place on record my sincere appreciation to my ministerial staff for their support for this committee process. Thank you very much.

CHAIR: I would like to thank the committee members, including the committee staff. This is a new way of doing business for estimates. I think it has worked very well. This has been a very long, one could say, marathon effort. Thanks is due all round.

Mrs CUNNINGHAM: Because I am sitting in Mark's seat, I can do this. I put on the record my appreciation, the appreciation of the committee and all who attended for the Chair. This is a new format and I thank you, Madam Chair, for the manner in which you have chaired the proceedings.

CHAIR: I declare this public meeting closed, on that very happy note.

Committee adjourned at 9.30 pm