LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2022-2023

(Reference: Inquiry into Appropriation Bill 2022-2023 and Appropriation (Office of the Legislative Assembly) Bill 2022-2023)

Members:

MR J MILLIGAN (Chair)
MR A BRADDOCK (Deputy Chair)
DR M PATERSON

TRANSCRIPT OF EVIDENCE

CANBERRA

TUESDAY, 23 AUGUST 2022

Secretary to the committee:
Dr David Monk (Ph 620 50129)

By authority of the Legislative Assembly for the Australian Capital Territory

APPEARANCES

Privilege statement

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Amended 20 May 2013

The committee met at 9 am.

Appearances:

Berry, Ms Yvette, Deputy Chief Minister, Minister for Early Childhood Development, Minister for Education and Youth Affairs, Minister for Housing and Suburban Development, Minister for the Prevention of Domestic and Family Violence, Minister for Sport and Recreation and Minister for Women

Chief Minister, Treasury and Economic Development Directorate
Kelley, Ms Rebecca, Executive Branch Manager, Sport and Recreation
Tanton, Mr Graham, Executive Group Manager, Property and Shared Services

Transport Canberra and City Services
Iglesias, Mr Daniel, Executive Branch Manager, City Presentation
Corrigan, Mr Jim, Deputy Director-General, City Services

Community Services Directorate
Rule, Ms Catherine, Director-General
Windeyer, Ms Kirsty, Coordinator-General for Family Safety
O'Brien, Ms Freya, Acting Executive Branch Manager, Social and Community Inclusion
Murray, Ms Christine, Executive Group Manager, Inclusion and Participation

THE CHAIR: Good morning and welcome to the public hearing of the Select Committee on Estimates 2022-2023. In the proceedings today we will examine the expenditure proposals and revenue estimates for the Chief Minister, Treasury and Economic Development Directorate, the Community Services Directorate and the Health Directorate.

The committee wishes to acknowledge the traditional custodians of the land that we are meeting on, the Ngunnawal people. The committee wishes to acknowledge and respect their continuing culture and the contribution they make to the life of this city and this region. We would also like to acknowledge and welcome other Aboriginal and Torres Strait Islander people who may be attending today's event.

Please be aware that the proceedings today are being recorded and transcribed by Hansard and will be published. The proceedings are also being broadcast and webstreamed live.

When taking a question on notice, it would be useful if witnesses could use the words, "I will take that as a question taken on notice." This will help the committee and witnesses to confirm questions taken on notice from the transcript.

In the first session today, we will be hearing from Minister Berry, in her capacity as Minister for Sport and Recreation. Welcome, and welcome to the officials that are here today. I remind witnesses of the protections and obligations afforded by parliamentary privilege and draw your attention to the privilege statement. When you speak, can you please confirm for the record that you understand the privilege implications of that

statement.

As we will not be starting off with opening statements, we will go straight to questions. I will ask the first question. In the budget estimates, it appears that there is no additional funding for community facilities or indoor sporting facilities, despite the numerous scoping studies that this government has done over the last three years. Can you please give us an update? If there is any funding to build these new facilities, where is it going? If not, where are the consultation and scoping studies up to?

Ms Berry: Thank you for that question. As members may be aware, there is significant funding in this year's budget and previous budgets for a new facility at Tuggeranong, the new ice sports facility. That will be a significant infrastructure project which will include indoor facilities, as well as an ice rink. With respect to that project, the negotiations on the contract are still being completed, but I am hoping that will be completed very soon and we will have an announcement to make about that project starting and work beginning on the build of that facility in Tuggeranong.

That is a very exciting new facility for the ACT. It will include an Olympic-size twin-sheet ice rink, as well as an indoor rock-climbing gym and other ancillary activities at that facility. With respect to the suggestion that there are no new indoor facilities happening in the ACT, that is one very significant and big commitment that the ACT government made. As I said we will have more to say about that very soon.

We have also committed funding for a new tennis facility in Amaroo. Whilst not an indoor facility, it is a much-needed sports facility in the Gungahlin precinct and has been well received by the Gungahlin community—I think you would agree, Mr Milligan—and we are looking forward to work starting on that project to ensure that there is a tennis facility of that nature within the Gungahlin area.

We have provided $100,000, which is not in the budget but through sport and recreation, to Basketball ACT to refresh the plans that they have developed for their facility in Belconnen. That will give us the chance to consider, given the changes in cost et cetera that we are facing in the infrastructure space as a result of COVID, what that might look like. The government will be able to consider future commitments in that space going forward.

I also acknowledge the contributions of federal Labor, who made a commitment to turn on and refresh the Australian Institute of Sport arena, which will be another significant venue for Canberrans to go back to. It is about making sure that it is actually fit for purpose as a short to medium-term asset while the government gets through this period of difficulty and makes plans for future large indoor spaces, as well as outdoor stadiums or venues.

It is not just the ACT government that provides these kinds of facilities. I know that the University of Canberra are considering work around their master plan and what they can include as part of their master plan in their sports precinct.

This weekend I will be opening the Scorers Academy at the Mpowerdome, at Fadden. That has been a really great project. I have been watching that evolve. I am looking forward to seeing how that is looking, having regard to the use of that facility for

basketball and other sports into the future. Again, it is a private facility. Private providers have noted the space in the market for them to be able to start their business out there. It is a great outcome for that facility that there has been private investment in sport in the ACT.

Those are a couple of things that are occurring right now and in the short term, with respect to providing sports facilities in the ACT, including indoor sports facilities. We are also developing a strategic plan which we are continuing to work on with sports organisations about sport in the ACT. Of course, that was delayed as a result of COVID. People in all directorates across the government were focusing on responding to COVID and keeping everybody safe. A lot of work that would have occurred earlier has been delayed, but that work has been continuing. Sport and rec have been engaging with sport and recreation organisations across the ACT to make sure that we understand very clearly, across sport and within the ACT, how we can have a sport and recreation strategic plan, as well as having a good look at the facilities that the ACT government owns and manages, combined with the government's future plans around bigger, Major Projects Canberra projects in the ACT and how they align with smaller, community-based sporting infrastructure.

That is a bit of an update. I do not know whether anybody else has anything to add to that.

THE CHAIR: My question was specifically in relation to indoor sporting facilities. You mentioned the ice rink facility. Tennis is outdoors; it is not indoors. AIS is funded by the federal government, not the ACT government. You mentioned UC; that is, once again, not funded by the ACT government, and Mpowerdome is private.

Ms Berry: That is right.

THE CHAIR: In effect, you have mentioned no initiatives that this government is doing for indoor sporting facilities, or investment in those facilities. My question is: what money are you investing in indoor facilities that is actually coming from the ACT government?

Ms Berry: Mr Milligan, it might surprise you to know that the ACT government is the only funder of sports facilities in the ACT—indeed, in the country. That is why it is important to understand that there are more facilities that are being invested in by the private sector, which is a good thing. They have seen an opportunity, because of the growth in sport and recreation in the ACT, to provide sporting facilities across those areas.

That is a good thing because we can partner with those organisations, if appropriate. It also takes the pressure off the facilities that the government owns and operates to ensure that we have a good balance across our city, including private facilities. As I said they have taken the opportunity to build a business around sport and recreation. That is great; we encourage that. It also means that the ACT government can focus on other facilities into the future which might be appropriate for the ACT, as we work with our sport and recreation communities around a strategic plan.

I do not know what facility you are referring to, Mr Milligan, but while funding for an

indoor facility of some sort is not in this budget, that is not to say that work is not happening around better understanding the needs of our different sports, and making sure that our new school builds—again, we talked about this yesterday—have facilities that can incorporate sport organisations, as well as other community organisations. That is a significant investment in our schools to ensure that they are not just a school community, although that is the priority, but that we have sports facilities around those schools that can be used by sporting organisations, which includes double gymnasiums in our high schools.

I forgot to mention the Home of Football in Throsby, which will also include indoor facilities. So to suggest that there has been no investment or that there is no investment, is wrong, because there is.

THE CHAIR: You have done copious amounts of studies, including for Gungahlin, Woden and other areas, yet nothing has come from those studies yet. There has not been any soil turned and there is no plan for an indoor specific-purpose facility anywhere in this budget that I can see.

Ms Berry: Just because it is not in this budget does not mean that it is not happening, Mr Milligan.

THE CHAIR: Okay. So there is nothing—

Ms Berry: I have already said that.

THE CHAIR: There is nothing in the budget; okay. You have clarified that the government is not investing in sports facilities.

Ms Berry: No, I have not clarified that, and you are verballing me, Mr Milligan. I would ask you to please not do that. There is significant investment across this city in sports facilities, and I have just outlined a number of them to you.

THE CHAIR: Which are not indoor sporting facilities.

Ms Berry: Yes; actually, they are.

THE CHAIR: Partly, a lot of them are federal.

Ms Berry: They are combinations of indoor facilities, and there is private investment in facilities, as well as federal government investment. You cannot just make things up, like you are doing now.

THE CHAIR: I do not think I am.

Ms Berry: Well, I think you are.

THE CHAIR: No, I am not.

Ms Berry: I have just outlined a whole range of facilities across the ACT. They exist. They are fair dinkum; they are real.

DR PATERSON: Can you inform the committee more about the indoor sports facility? When might the public announcement be made, and when should work start on that?

Ms Berry: For the ice sports facility?

DR PATERSON: Yes.

Ms Berry: This has been quite a journey for the ACT ice sports community, and I have been really appreciative of the fact that they have been working closely with the government on a facility that best suits the needs of ice sports. As everybody will know, the facility at Woden is not appropriate for ice sports and ice-skating in the ACT. It is not the right size. We have been given a special ticket so that teams like the Canberra Brave can play as part of the national league. But it is not the right size; all of the other ice sports facilities are Olympic size, twin-sheet facilities.

Being able to build on something like that and partner up with a non-government organisation—not just ACT government funded, Mr Milligan, for your information—has been a really great way to build a facility that is not just about the ACT government having skin in the game. We are able to work in partnership with an organisation who are specialists in a niche market. Ice sports facilities do not exist everywhere. We have been able to work with them on a site for the facility. We had committed to building a new facility on the south side. Included in that facility, as I said, is an indoor rock-climbing gym.

I note that Rebecca Kelley is here. Rebecca might be able to give more of an update. I have just been talking about how it has been delayed as a result of COVID and things like that, but we are in negotiations and we are very close to being able to make an announcement. With respect to some of the preliminary plans, what else is in the facility? I have said there will be an Olympic twin sheet, as well as an indoor rock-climbing gym.

Ms Kelley: That is right. I acknowledge the privilege statement. As the minister outlined, it is a multipurpose facility in many respects, not just the twin sheet. Rock climbing is part of the plans. There will also be a dedicated curling capacity within the rink, which is a unique facility. We expect that it will be an attractive place to bring fairly unique events to Canberra, when we have interest from the international Curling Federation and the Australian Curling Federation.

As the minister said, we are in the final reams of negotiation. Our partners are global specialists, having regard to the nature of the partnerships they are making. We are bedding that down and hopefully we will be in a position to make that announcement soon.

Ms Berry: I want to add, Dr Paterson, that there is funding for an indoor facility, an indoor pool—not a court facility but an indoor pool—that is additional to the funding, to support the continued operation of the Olympic pool. There is some early feasibility and design costing work for a new dive pool at the Stromlo Leisure Centre. That might not have been seen in the budget but it is an important initiative. We know how much Canberrans have valued the dive pool over a number of decades. It is a rite of passage

for teenagers in the ACT to have that first dive into the dive pool. We know that it is older, and it is not really fit for purpose anymore.

We want to make sure that that sport and the users of that facility can have a much more up-to-date, modern, fit-for-purpose facility and an indoor facility so that it can be used all year round. That is an important commitment in this budget as well. In fact, when Stromlo was being developed, we made sure that there was space there to expand and to have an indoor dive pool. Again, that will provide more opportunities. It makes the use of that pool much more viable because it can be used all year round, unlike the existing pool, which is only a pool for summer, for a couple of months.

MS CASTLEY: Minister, you just mentioned Stromlo. I know that it was opened two years ago. As part of that a creche was promised at Stromlo Leisure Centre. I am wondering when that will open.

Ms Berry: It might be a decision for the operator of that pool. I will ask Mr Tanton to respond.

Mr Tanton: At this point in time there has been no decision made around a creche at that site. We will continue to have discussions with the operator in that regard. At this stage we would need to have consultation more broadly with the operator and with the other elements of government.

MS CASTLEY: Minister, you said when it opened that there would be a creche. I know that people out at Stromlo have lots of comments and questions about when that will happen. People have fully expected a creche; that was part of the package deal.

Ms Berry: Yes, I can understand that. I have not had this raised with me, so thank you for raising it with me today.

MS CASTLEY: It is a lifeline for women, for some mums, to get to the gym, if there is a creche. They were totally expecting it. That is why I am raising it with you.

Ms Berry: One of the challenges for the operator has been that it was right in the middle of COVID. Opening a new facility in the middle of an uncertain period of time was probably not a decision that would have been taken lightly by the operator. As Mr Tanton said, we will continue to work with them. That was one of the commitments that we made, but it has not come to fruition yet. I understand the challenges of getting to the gym with a couple of young kids, and to pools. That was a commitment, so we will keep working with the operator about time frames for that.

THE CHAIR: You mentioned that the government is committing to a dive pool out at Stromlo?

Ms Berry: No. The government is undertaking feasibility and costing.

THE CHAIR: Feasibility and costing. What consultation is happening on that feasibility and when is that due?

Mr Tanton: The consultation, as the budget has announced, will start shortly in regard

to that. We will start to develop a program plan, working with sport and recreation in regard to what may be needed. We are also having discussions with relevant groups who might be utilising the pool. That includes the diving community; there is also water polo and multi-use. It is about understanding what the best design and the needs around that pool may be to get the most out of it.

We are investing substantial money. There is a feasibility study. There will be another approach to government once we have done that. It will then be up to the government to decide on the way forward. But that process is just kicking off at this point in time, and we are hoping to get that momentum going quite quickly.

THE CHAIR: It is just about to start?

Mr Tanton: That is correct.

MR DAVIS: In our parliamentary and governing agreement, at appendix 4, item 6.1, the ACT Greens committed to develop an indoor and outdoor facilities management plan. That was one of the subjects of a motion that I brought to the Assembly in April last year that was unanimously supported. Minister, you provided an update in April this year which does not mention a facilities management plan. It does mention, though, an infrastructure road map. Would someone mind explaining to me the difference between the facilities management plan and an infrastructure road map?

Ms Berry: Just to clarify, Mr Davis, that was a Greens commitment as an annexure to the parliamentary agreement. The government, as I said earlier in response to Mr Milligan's questions, is working right now on a strategic plan with sports in the ACT. That was delayed as a result of COVID and responding to that pandemic. However, those conversations have been continuing, and we will be releasing that draft shortly. I will ask Ms Kelley to respond.

We are also doing work around our existing infrastructure in the community sports space and more broadly. As part of the infrastructure pipeline in the Chief Minister's portfolio responsibility areas, that is also being updated because things have changed a little bit over the last couple of years, as everybody would understand, around what are the short to medium term approaches for the ACT and what is now being pushed out to a longer term aspiration. There has been talk around new stadiums and things like that. I think everybody agrees that we all want a new stadium—of course, we do—but the time frame for that, and how we need to think about that time frame, is an important part of this work that we are doing in the community sports space.

I want to go back to the infrastructure around sports facilities. It needs to be remembered that we are fixing something built 40 years ago, well before self-government, when facilities were built by men for men. Upgrading and refreshing facilities so that they are more inclusive for women takes some time because we have hundreds of those across the facilities.

MR DAVIS: Can I ask a clarifying question, because I am genuinely confused. While you are right to point out that that was a Greens commitment, it is now an Assembly commitment. The Assembly agreed to the resolution; the Assembly agreed to the wording of developing a facilities management plan. There was no mention specifically

of a facilities management plan in your update, but there was mention of a road map. I do not understand the difference between the two.

Ms Berry: We can probably help out there. It is important to understand that what we are talking about here is a holistic approach to facilities in the ACT. It is not as simple as fixing things in various people's electorates. We have the whole of Canberra to consider as part of these facilities, and it is about making sure that they are fit for purpose and upgraded appropriately. Ms Kelley, do you have an update on our strategic plan, and on the work we are doing around infrastructure?

Ms Kelley: Yes, certainly. Our strategic plan is in a near-ready draft format in order to have another show and tell or to discuss that with the sector. Certainly, one of the key priorities that has come out of the planning process is places and spaces. A key outcome is to have a shared understanding with the sector in terms of what our priorities are right across the diverse range of sports that we have.

The release or development of the road plan was probably the immediate step in order to have some transparency around the scope of works over the current term of government. Part of the work on which we are moving forward—we are certainly talking to the sports, and bringing the sports along on a journey—is the expectation that they have their own strategic facility plans. When we sit down and talk with sports, we do not want to end up with a Taj Mahal list, if you like, of what everybody would like and what their wish list is, because we know that in reality that is a very difficult benchmark to achieve.

Probably the next step from here will be looking at what that shared understanding looks like—and, going to your point, what a management plan looks like. In the background we are working quite closely with our colleagues at TCCS on actual management of the current facility base. That could be forward planning for dryland ovals. With respect to what our forward planning is—when I say "our", they are TCCS assets—it is about what that forward planning looks like and the priority around the current pavilions.

If we talk about female-friendly pavilions, at the moment 26 of 65 are female friendly. The management plan will effectively talk to what the rollout is, and what the next ones on the list are. We have a further five coming this year, but what are the next five after that? That is the work that is happening in parallel to the development of the strategic plan. Certainly, we will see more definite documents come out to help with guidance around what you are expecting a facilities management plan to look like.

MR DAVIS: Do we have an expected date as to when, as per the resolution of the Assembly, a facilities management plan will be released and available for comment?

Ms Kelley: As I said it is a work in progress. The strategic plan is the priority at this point in time. There will be further conversations with sports around what their expectations are beyond the current road map. In parallel to that, there is the work with TCCS, with Property Group with the pools, and our colleagues at Stromlo Forest Park. There is a fair bit of cross-directorate work that is going on. I would anticipate that perhaps by the end of the year, in accordance with the release of the strategic plan, we will be in a better position to either have something ready or certainly anticipate a time

frame.

MR DAVIS: Do you have a rough estimate of how many community sports facilities are managed by TCCS as opposed to your directorate? How are you working with TCCS to audit, for lack of a better word, and reflect on the condition of community sports facilities that they manage, as part of the plan that you are developing?

Ms Kelley: To be clear, CMTEDD sport and recreation do not have a direct management responsibility. I will pass to Daniel Iglesias. All operational management of government-owned facilities rests with TCCS.

Mr Iglesias: I acknowledge the privilege statement. Within our sportsground facilities, we have direct responsibility in TCCS for 127 sportsgrounds. It is not only the physical surface that we are talking about; it is also the pavilions that might be attached to those sportsgrounds, as well as temporary stands and permanent stand structures. It is a significant community asset that reflects the fact that we are effectively the most sport-active community in Australia.

MR DAVIS: When you say 127 sportsgrounds, is that ovals or are we talking about assets?

Mr Iglesias: That is ovals.

MR DAVIS: How are we accounting for those other community sport assets that sit beside suburban playgrounds—the old tennis court, the old half-basketball court and other stuff? How are they being accounted for in TCCS's plan and in the inevitable facilities management plan?

Mr Iglesias: As far as we are concerned, we are just the managers of the sportsgrounds and associated structures.

MR DAVIS: Who manages community sport infrastructure like tennis courts that are attached to playgrounds, particularly in older suburbs? The minister mentioned—

Ms Berry: That is TCCS. It is probably not this portfolio. It is probably with Chris Steel. I think that is what you are talking about.

MR DAVIS: It is. I assumed that those pieces of infrastructure would be in some way accounted for in a facilities management plan, as they are facilities that we probably need to manage.

Ms Berry: I cannot recall; you would probably have to refer to Minister Steel, but I know that there has been work in that space.

Mr Corrigan: I have read and acknowledge the privilege statement. Mr Davis, with all of the assets that TCCS manage across the territory, we have asset management plans for them. With those facilities that you mentioned—where we hit tennis balls against the wall, and those sorts of things—obviously, we know about those assets and we manage them as necessary. I can take it on notice if you want some details about how many of those extra facilities we manage besides all of the ovals and sportsgrounds. We

can do that and provide that to you. TCCS manage all of that, unless they are on private land or something like that.

MR DAVIS: I would appreciate it if you could take that on notice. Could you also let me know how regularly they are checked by inspectors for their condition?

Mr Corrigan: Yes, okay.

DR PATERSON: My question is in relation to sporting facilities in Phillip and Woden. The Phillip enclosed oval was a Labor election promise. I think that the planning and design work has happened. I believe that construction was originally planned to begin this year, but there is no funding in the budget for that project. Is that still a priority for the government?

Ms Berry: It was an election commitment, so we will deliver on that. I will ask Ms Kelley to provide an update for the committee.

Ms Kelley: As you mentioned, planning and design are well underway for the work to happen at Phillip enclosed oval. We had some unexpected work on site; in order to fit the facility in, we had to make a technical amendment to allow a corner of the block to be available for the size of the pavilion. We had to work through that process, in which case we were not ready for a business case for the current budget for construction. We anticipate that that will be ready in the forward budgets.

DR PATERSON: In relation to the Phillip swimming pool, there was a petition last year. There was temporary relief provided to the lessee for last summer, for them to get the pool in order. We are fast approaching next summer, and the community is very keen to see the pool reopen or for something to be done about the situation. Will the government be following this up with the Phillip pool owner?

Ms Berry: That is a good question. Because it is a private facility, it is not normally something that the government would engage in, but we can follow it up.

Ms Kelley: We have been working quite closely with EPSDD, given that it is a leasing and regulation matter, and also with Access Canberra. The expectation at this point in time under their lease obligations is that the pool will be open for this summer. That is the current understanding. Certainly, it has been the correspondence that has gone back to the owner.

MR BRADDOCK: At the start of the answer to that question from Dr Paterson, you mentioned that it was an election commitment, which I noted was from Labor, but in response to the question by Mr Davis, you mentioned that it was a Greens election commitment. Do you treat commitments from the two different parties differently when you approach your duties as sports minister?

Ms Berry: No, if that is what you took from my question. The thing that we do prioritise is the parliamentary agreement, and not so much the election commitments that are attached to that. My clarification with Mr Davis was about whether it was in the agreement or an attachment. That was my clarification.

MR DAVIS: Minister, as you are no doubt aware from your other portfolios, I am always interested in what the government is doing particularly for low income Canberrans. Can you speak a little more to point 5 of that same resolution we have referenced before, which was examination of participation barriers for Canberrans from low income households? I understand the government commissioned a report and it was working through some of its recommendations. Do you have an update on that? If I am not mistaken, it was the Orima report.

Ms Berry: Yes, we can provide an update. I would also point out that in the budget there was funding for a number of organisations that provide sport and recreation facilities for low income families, particularly targeted support, or support for families in a range of different ways to participate in sport. One of those organisations is Every Chance to Play.

Every Chance to Play provides targeted support to low income families. As you will recall, there are a number of other areas across government that provide targeted support to low income families to make sure that they can participate in sport and recreation. In my education portfolio, I also announced the Future of Education Equity Fund, which is an improvement on the previous bursary fund to provide people on low incomes or people experiencing financial difficulty with opportunities to access funds so that they can purchase things they need for school, and that can include sports equipment as well. In the sports portfolio space, we can provide a bit of an update on that report.

Ms Kelley: The Orima research has been well received by the sector in terms of providing some practical recommendations for sports to take on board. Initially, we have shared that research at one of our industry networking sessions. That has been uploaded and is available on the sport and recreation website. We anticipate that a number of sports will be taking on board and considering how they might seek some funding through our next grant round to deliver upon some of those recommendations.

Our grants program has undergone a review over the last six months. We currently have that under consideration before that next round is open. Beyond that, again, within our strategic plan, one of the other pillars that will be evident is welcoming and inclusive environments, and the participation performance elements of the plan.

We heard overwhelmingly through the feedback that support for those families, members of our community and individuals that have greater challenges in terms of getting involved and participating came across clearly as part of that. There will be targeted work that we will see, probably in the next 12 to 18 months, in and around that.

The minister mentioned funding to a number of organisations to support those more vulnerable members of our community. We are working with Kulture Break, Abilities Unlimited Australia, Pegasus riding school, Every Chance to Play and the Heart Foundation on some specific work that they will be delivering within this cohort of our community over the next three years. Hopefully, in our next reporting we will have some really productive stories to share in terms of how that is progressing.

MR DAVIS: Can I clarify specifically how people are able to apply for some of those grants, for some of that money? One of my reservations with some of these programs is that you have to self-declare that you need that money. I know as a kid who grew up

broke, if you asked me to self-declare, I would not have played sport. How are we making sure that young people and their families know that this money is available in the first instance, and are able to apply for it in a way that does not further marginalise them?

Ms Kelley: I think that is a really good question. It is certainly an element that Every Chance to Play have looked at. When Every Chance to Play started, there was a referral network from the range of community services that support these families. They had to have a level of engagement or admit that they needed support. The level that we need to dig down to is how we make this more publicly known, so that there is not that factor. It came out in the research that many do not come forward because they do not want to see themselves in that light, because they work really hard to get what they get and sometimes still feel a little bit short, in terms of how they are able to access those funds.

We absolutely have more work to be done, and we will be working with Every Chance to Play as to how that system can best work to make sure this is available. We have had success previously through promotion of sports. I can refer to our previous Indigenous sports grant program, which was federally funded. The sports promoted the opportunity; then there was an application via the sports. We need to explore what those models look like, to best ensure that those in need and those who will benefit from it most have access to it readily, without needing to fill out copious documentation or put their name up in lights, so to speak.

MR DAVIS: I have a quick clarifying question on the Orima report. How many recommendations were there and has the government agreed to all of the recommendations?

Ms Kelley: I will take that on notice. With the type of recommendations in the report, it was more a research report that was for the benefit of sports. It was not necessarily something that we intended putting a government response to, in terms of accepting those recommendations. We are certainly seeing it as research, data and tool-based activity to assist not only sports but also future government decision-making around how we can best target the resources that we have.

MS CASTLEY: Minister, I have some questions about the Gungahlin pool. A freedom of information document that we received in February said that the Gungahlin pool, and also Tuggeranong—Mr Davis will probably be interested—will need to be closed, in order to be changed from gas to electricity. When will that happen and how long will it take?

Mr Tanton: At both Gungahlin and Tuggeranong the plant and equipment are fine. We do not have any plans at this point to look to convert either of those facilities from gas to electric. If they come at end of life or if it is required because of another matter, we will look at that at that point. But at this point there are no plans for converting those facilities from gas to electric in the near term.

MS CASTLEY: This brief says, "A future transition to fully electric heating equipment at the year-round aquatic centres, Lakeside and Gungahlin, will require closure of the facilities for an extended period, likely several months." Is that not happening now? Also, at the top, it says that they will be charged extra: "Swimmers will be charged

extra for using the facility if it remains on gas."

Ms Berry: Ms Castley, you may be aware that the government has committed to a transition to gas across the city.

MS CASTLEY: I understand.

Ms Berry: As part of that, as with the rest of the community, once gas reaches its end of life or replacement parts for the infrastructure become unavailable or more expensive, at some point, for those gas appliances like the boilers in our swimming pools, they will need to be replaced and electrified. As Mr Tanton said, those boilers are fine. There is nothing wrong with them at the moment. We have not identified any issues. But at some point in the future we will replace them with electrification, the same as we would with any facilities across the ACT, including schools that have gas boilers for heating. At some point we will be replacing them with electric boilers. But there is no immediate need for that to occur in our pools. In the future, which could be 10 years away, those appliances might need replacing, but at the moment they do not. When they are replaced in 10 years time, they will need to close.

MS CASTLEY: I was not questioning the need to move from gas to electricity. I totally understand that that will happen. From reading this question time brief, it seems that it is imminent. If work has to happen then people in Gungahlin, or whoever uses the pool, will be charged extra to use the pool.

Ms Berry: Let us be clear: it is not imminent. I was informed that you had a Facebook post that suggested that, and you have removed it, so that is good. It is not imminent. If you can provide that information to people who follow your Facebook page, that would be helpful, because there is no intention to have an imminent closure of those pools to change over from gas to electric.

MS CASTLEY: How much is the final cost for fixing the Gungahlin pool? I know that it is due to be opened this weekend. What has it come to?

Mr Tanton: We are looking at the budgeted appropriations that were provided to us; it is around $2.9 million. We are doing the final reconciliations. As you know, the pool soft-opened on the 22nd, which was Monday. We are finalising the body of works in and around that, but we will do a reconciliation.

The remedial works were in line with the budget. We also did some other maintenance works during that period. We took the opportunity to look at upgrading the balance tanks, and some of the plant as well, in the program pool and the like. We took the opportunity to do that. That will come out of the ongoing business-as-usual maintenance fund, not out of the remedial works budget.

MS CASTLEY: Was there any compensation paid to YMCA and their people who use the pool for the time that it was closed?

Mr Tanton: There was not compensation paid to the users of the pool. There has been funding provided in support of the YMCA, as part of that pool closure, because they get different levels of revenue coming in from those. With respect to the actual funding

amounts, I will seek guidance on that regarding commercial-in-confidence. Different pool operators have different costs, so there are commercial sensitivities in regard to the support that we provided to the YMCA both for the closure of the 50-metre pool and, while we were doing maintenance, for the program pool as well.

MS CASTLEY: If you can, if it is not commercial-in-confidence, could you take that on notice? That would be great. A lot of constituents have talked to us about the fact that they joined the gym for the pool and have been unable to use it, so they have had to double up payments between Gungahlin and going to a pool elsewhere. Has there been no compensation for those people?

Mr Tanton: My understanding is that they manage a number of pools, including Stromlo and Civic pool. Members who were not able to utilise the swimming pool facilities at Gungahlin were able to use the facilities either at the Civic Olympic pool or Stromlo. There has been no direct conversation with potential users.

MS CLAY: Minister, I am interested in cricket facilities in Belconnen. I sponsored a petition last December and the government has responded to the petition. I want to do a bit of a follow-up. Has there been an announcement? Is there any funding to refurbish the cricket nets in Aranda?

Ms Berry: I will check with one of my officials. Of course, I am interested in facilities across the ACT. There have been some upgrades to facilities in Belconnen over the last couple of years—Melba, I think.

Mr Iglesias: A number of upgrades were done to a number of ovals that incorporate cricketing facilities across Belconnen. Was the question about Belconnen, Ms Clay?

MS CLAY: Belconnen and specifically Aranda.

Mr Iglesias: Aranda is not specifically on our schedule for the next 12 months. We have rolled out improvements at Higgins, at Melba, as the minister mentioned—that was specifically to upgrade cricket infrastructure—and at Hawker and Charnwood. At this stage not at Aranda, no.

MS CLAY: Was there a proposal regarding cricket nets at Aranda? If there was, what was the reason why that one got knocked back?

Ms Berry: Before you respond to that one, Mr Iglesias, I might say that, for sports facilities across the ACT, we have a limited budget, of course, and they need to be prioritised, with respect to availability of funding in the budget for that work and on the upgrading or replacing of an ageing facility. While Aranda is on the list, it is not one that has been done yet. There are other projects across the city that are being considered as part of that priority, depending on the age, whether they are fit for purpose and safety aspects.

Mr Iglesias: The minister is absolutely correct. Of those 127 sportsgrounds, there are any number of upgrades in any given year that we look to prioritise. That includes lighting, irrigation and upgrades to facilities such as pavilions. All of that is obviously a competing processing for resources.

Typically speaking, we look at those sites that have the highest use and that have the broadest appeal for a number of different sports. We go for that as a priority. We look at what other facilities are available for a particular code in neighbouring grounds. For example, we are putting a lot of effort into new cricket nets at Taylor, in Gungahlin. It is a balancing act, and it does mean that we do need to prioritise. In some instances, we do not get to the grounds that we would like to get to.

MS CLAY: Thank you, Mr Iglesias; that was really helpful. I know that Weetangera is not on that list of upgrades in the next 12 months, just as Aranda is not. I also know there were some conversations with the community about how to use existing facilities better. There were some good discussions about cricket and rugby sharing those facilities. Has that progressed to the point where we have both sporting groups now able to share the facilities at Weetangera?

Mr Iglesias: I am not sure. I will take that one on notice, Ms Clay. I do know about the discussion you are referring to, but I am unaware of where we have got to with that. We can get that for you quite quickly.

MS CLAY: Yes, on notice would be great.

MR DAVIS: Do you think that Ms Clay and others might have avoided this confusion if we had already developed a facilities management plan and people knew, with a degree of confidence and certainty, when they could expect their facilities to be upgraded over the short, medium and long term?

Ms Berry: Thank you, Mr Davis, for the question. As with anything within a community and within a government, things change. You constantly need to update people about changes or things that affect them in their individual lives. Not everybody will go online and Google a strategic plan on anything, so we need to make sure that, when we prioritise this work, it is prioritised in the way that Mr Iglesias has described.

Before COVID there were different priorities around all kinds of infrastructure, including sporting infrastructure. That has meant those priorities have changed. Indeed, even over a few years, the infrastructure plan that the government had prior to COVID is being updated and will change as a result of that.

Whilst having a plan is good, and we are developing a plan, it will always be the case that members, including backbenchers, will need to continually update community members about things that are affecting them. That is what you are there for, as a backbench—to pass on the message of the government of the day and point people in the right direction.

We are doing that work. As to whether it would make a difference to the question that Ms Clay has asked today, I think that is a maybe. It is not necessarily completely true that a plan on its own is more powerful than individual conversations that members of this place can have with constituents.

MR DAVIS: I think my job description is a little bit more detailed than that. Given that government has failed to recognise a sports and recreation peak body, how does it go

about consulting on these changing priorities with sports? As you rightly pointed out, Minister, most people will not go online and Google a plan, but most people have a relationship with their sports club.

Ms Berry: Yes.

MR DAVIS: Their sports club can understand the competing priorities and be represented by some peak body, as we have discussed in this place before. How do people, other than members such as me explaining the government's competing priorities, know that the government's priorities have changed?

Ms Berry: Sport and rec work very closely with individual sports clubs. All sports clubs, I would say, know very well the priorities for their areas. If they have issues that they want addressed, these are raised with sport and rec. Generally, there is a broad time frame when they will understand that something might occur on their particular sports field.

For example, regarding Ms Clay's reference to Weetangera sports fields—and I have a conflict here, because a member of my family plays at Weetangera sports fields—there are some issues at the sports fields that the club has raised with sport and rec around drainage issues, because of the incredible amount of rain we have had. That has impacted that sports fields. Sport and rec and TCCS are working very closely with that club to say, "Here's what the remediation plan will look like here." And it is significant. The club itself is very aware of it. We try and encourage the clubs to make sure that they put that out to individual teams, parents and others. Generally, everybody on the sports field and on the sidelines knows what is going on.

MR DAVIS: The challenge does not seem to be that the sports club that is facing an immediate challenge, like the one you described, is not being consulted. That is not the feedback that I get. People think they get good consultation at that point, and they understand. It is the flow-on effects of the sports club after that, and the sports club after that, whose investments have been delayed or de-prioritised because we have had to change course. I am interested more in how we are talking to those people so that everyone across community sports understands what is happening, and people do not feel like they are being short-changed.

Ms Berry: Again, having spent some time at a barbecue at a local football club, those clubs, from my perspective and the feedback that I hear, know very well what is happening in their facilities and in their clubs, because they are in regular, direct contact with sport and rec and TCCS. If your feedback is different, that is not the feedback that I get. They might not be happy with the time frames. Certainly, I know that they are in regular contact. They know who they can call. The grounds managers and others are available, and they are a phone call away. I think that is key. A plan would help with that. I am not suggesting that that would not be the case. But I am saying that there is a very close and productive working relationship with sport and rec and with all of those clubs, including the peak bodies.

The other part that I want to clarify is when you said that the ACT government does not recognise a peak body. We do not fund a peak body, but we are working with, or hearing from, the organisation comps that want to set up a peak body. It has been some time

since I have met with them, unless they have been in contact with sport and rec. My understanding was that they were still working through what they were going to do.

With respect to the history in the ACT on that particular role, when Shane Rattenbury was the minister for sport, there was a peak body. It was at a time when sports had not evolved and did not have the skills or the size to be able to lobby for themselves or manage their business. A peak organisation at that time was in place and did support those clubs. That organisation folded.

Clubs since then have evolved and do have the administrative clout to manage their businesses and to lobby government. We have seen that with the Amaroo tennis facility. That is one way that sports organisations lobby the government, including Basketball ACT, with their facility in Belconnen—roller derby as well. We have seen that evolution of sport in the ACT: as our city has grown, so too have our sports and peak organisations. I am not sure whether there is an update that can be provided on comms, perhaps.

Ms Kelley: I am meeting with them next week. But we understand that they have moved to a point of nearly finalising their constitution, with a name now to be known as the Alliance for Community Sport ACT. We have regular conversations with them.

To your point, Mr Davis, about where projects might get bumped for other priorities that are coming in, we do work really closely with the sports. I can give you an example of tennis and AFL, just within the last week. We do rely on the peak bodies. They have a raft of clubs, and we need to understand from the peak body what is the priority from the sport's perspective so that we can then build that into programming. The intel that we have then informs the forward plan. But certainly I take your point that that is not as transparent as it could be and that is where we need to improve.

With AFL there is an example. We know that there are priority needs across possibly four or five clubs. Whether it is the Jets or Eastlake, they all have grand plans. But it is really for the sport to say, "We need your input," to say which one is coming first so that we can then work through it. We seek the peak body's support in communicating to the clubs as well, because the peak bodies understand that government has a limited resource bucket to deliver all of these things. So it is an ongoing conversation. As the minister said, sometimes they do not like it; it is not welcomed if they get bumped. But we hope that there is a level of rapport such that they have an understanding.

THE CHAIR: Just in relation to the Amaroo tennis facility, it appears that there has been a delay in the commencement and then, obviously, the completion of it. I am just interested to find out: what is the reason behind that delay?

Ms Berry: I can start with that response and then I might ask Ms Kelley to provide a little more detail. As with any development in the ACT, there is due diligence which needs to occur to understand the site better and to ensure that the site is feasible, to understand the site's geology, any environmental issues, and any other issues that could impact on the development.

That can include things like whether there are golden sun moths on the site or pink-tailed worm-lizards; if the site has any stormwater issues that we should be aware

of; and also working with other parts of government around roads, infrastructure and things like that. That work needs to happen in any development and that has been the case here. I understand that some of that work did delay the start of this project.

Ms Kelley: Yes. I can add to that, Minister. There have not been significant delays. We were always on track for a business case to be presented through the 2023 budget for construction, and that has now been realised. The process of community consultation was obviously very important around this. There was a great deal of interest, as we know, in this facility. We have had some great feedback come through the recent opening of YourSay consultation, and that feedback that we have received now comes in to inform the final design process, moving forward.

So, from our perspective, it is on track now, and whilst it all seems to be behind a planning curtain at this stage, things will move pretty quickly next year. We also had some delays from the tennis parties themselves, in that they wanted to explore some of the court deliverers and elected to go down a more complicated design process. Obviously a tennis facility needs to be operated by the organisations that are happy with it. It was really important that we took on board that tennis feedback, so that was the only other minor delay that we had.

THE CHAIR: Obviously, the environmental aspect, as you mentioned, is a component of it. It is suggested that the tennis facility in Amaroo may see the same fate as the Throsby home of football, in terms of the water course, potentially, and the swamp area. Is that being addressed? Is that going to be looked at?

Ms Kelley: It has been addressed, certainly. I recall that we spoke about this previously. Because of the Throsby experience, that work was done up-front on the known water course issues around that site. The design is taking into account where those 10 courts will fit without great impact, and we are looking at the road access into the site necessarily needing to bridge over some of the water course there.

THE CHAIR: Has consultation started or is it about to start? How are you going to consult with the community? How can they provide feedback?

Ms Kelley: We have had that open on YourSay for well over the last month, so that is—

THE CHAIR: YourSay?

Ms Kelley: Yes. I am pretty sure it is just about closed, if it has not already. I need to check that date. But we have had a raft of feedback to talk to some of that. It was everything from the access, what the access will look like, what the wayfinding will be for existing path infrastructure through there, noise concerns, and what the landscaping will look like in terms of tree barriers and the like between the facility and the adjacent residents in Moncrieff there.

There were some concerns from older members of our community around the court surface and the fact that it is all hard court planned and there are not any synthetic courts. It is a preference of Tennis ACT that it is a 10 hard court facility because they would like to use it as an event base. That is the requirement. So there is a whole raft of

feedback that is now coming in to inform that design. I have just checked my date here, and that consultation has now closed.

THE CHAIR: It has closed; okay. Obviously, you will take into account the parking, potential parking issues. With that becoming a much larger sporting facility, of course it will attract more traffic. That will be a key component of the design and costing, I guess.

Ms Kelley: Yes; absolutely. As you say, it will become a bit more of a precinct than it is now, more so than just the district playing fields. The existing parking for the district playing fields was certainly all taken into account. We are still on a journey there in terms of final design, but we can certainly share that with you once it gets to that point.

THE CHAIR: And just to clarify: in the previous question about compensation and the Gungahlin pool, the leisure centre, were you taking that question on notice?

Mr Tanton: Yes,; happy to take that on notice. We just need to get some advice regarding the commercial sensitivities around it.

MS CASTLEY: Just a supplementary on that one. I understand that people were charged at Stromlo as well as Gungahlin, so could you look into that? It was not free, so Gungahlin residents had paid at Gungahlin and when they used the other facilities they were also charged at those facilities. That was the compensation that I was asking about. Can you look into that?

Mr Tanton: Yes, happy to look—

MS CASTLEY: See how much that was. Will there be compensation for that, of double—

Mr Tanton: We will speak to the operators in regard to that. Again, they may not have been made aware of individuals who may or may not have been charged. I am not aware of any individuals that have raised concerns with me or with ACT Property Group but—

MS CASTLEY: I have got a few people who have definitely confirmed that that is the case.

Mr Tanton: We will speak with the vendors and the operators and see if we can work through that.

MS CASTLEY: Thank you.

Ms Berry: Perhaps if you could direct them my way, I would be able to assist them. Thank you.

MS CASTLEY: Certainly. Will do. Thank you.

THE CHAIR: Excellent. Thank you very much.

MR DAVIS: Minister, I just want to pick you up on a point that you made before, and

it goes to a point Ms Kelley made as well about sports groups lobbying the government for funding, particularly the peaks—AFL, tennis, et cetera. I wonder, at a macro level, are we happy with that arrangement? Do we think it is sustainable in the long term that community sport must lobby against each other for, as Ms Kelley describes it, a finite amount of resourcing? If we are, that is one question, and if we are not, what would an alternative model look like where these sports collaborated with government and with each other to allocate some of this money?

Ms Berry: Thank you, Mr Davis. I wonder what that would look like as well. I think that the nature of sport is that they are competitive and that they are competing against each other for participation in their own individual sports. I think the strategic plan that we have been working on across sports goes to understanding a little bit better the priorities for the ACT community. That is how we work closely with sports. There are regular meetings with sports CEOs to understand participation rates, facility needs, where there is pressure. We have talked about that with, for example, the AFL organisations, where they are experiencing pressure and growth and how the government can meet those needs. I don't think you will ever stop individual sports from lobbying government for their own individual facilities, even with a peak organisation. That was certainly not my experience, even with the previous one, whatever they were called—

Ms Kelley: ACTSPORT.

Ms Berry: ACTSPORT. Whilst they were a peak organisation, individual sports are still going to lobby for their own facilities.

MR DAVIS: Certainly, but as you have pointed out, that organisation does not exist anymore. That might speak to their efficacy. Community sports, while they are competitive, as you say, are rallying around this new alliance. They do seem to acknowledge among themselves that the current arrangement is not sustainable, which is why they seem to be agitating for the development of a peak body. So I just wonder: are they putting in all this work to set up a peak body, with the government still wanting to maintain its current model of lobbying for the finite amount?

Ms Berry: First of all, just to be clear, the organisation that you are referring to are still sorting out their constitution. Then we will understand what their actual role will be. Even in the meetings that I have had with them—and it might be the same for Ms Kelley—they have never said to me that that will not be the case, that individual sports will not be lobbying for their own facilities or needs. That has never been my understanding of their organisation and how they will operate. However, it has been some time since this organisation first was thought about. They have been working on what it is that they will actually be doing. It is still not clear to me exactly what they will be doing. Ms Kelley is meeting with them next week. But they have never suggested to me that they will be lobbying on behalf of individual clubs. That will still always be the case.

Ms Kelley: To add to that, my understanding—and I have sat at many of their alliance meetings—is that the things that they are looking to collaborate on, because they are their common denominators, are things like workforce capability, education and training, and how the CEOs, responsible to their individual boards, are maintaining the

integrity of what their board is asking of them. To be fair, they might sit around a table and look at what their common denominators are around facility needs and how can they have a coordinated approach to government. Outside of that, they will always still come and have an individual meeting with us about all of their sports because, ultimately, they are responsible to their boards to deliver those facilities. I take your point: it would be great if they could come to a—

MR DAVIS: Forgive me for aspiring to utopia.

Ms Kelley: Yes: football year first and then softball will be in three years time. Those conversations can be had. I think our role is to build up their understanding about the priorities and where they are up to. I think the key piece that we will drive forward through our new strategic plan is: what are our capabilities around data and insights? That is informing the decision-making, moving forward, in terms of participation: where are the areas of Canberra that we have under-demand in facilities? That consultative piece, supported by the data, I think, will complement the discussions the alliance is having on the way that they want to approach government, both as a collective but also individually to achieve their facility aspirations.

MR DAVIS: This will be quick. How, then, is sport expected to lobby? There is always demand for more resourcing than what we have. As Ms Kelley said, it is finite. How do we make sure that the smaller clubs, not your AFL, basketball and tennis but your badminton and your roller derby, are still being equally heard by government when their lobbying power is much, much less?

Ms Berry: I think roller derby is a very good example of that. Roller derby and badminton are also part of the CEO conversations.

Ms Kelley: Croquet, Minister, is probably a good example.

Ms Berry: Croquet, yes. Croquet is another niche sport—even water polo, and we have been working with them on the additional upgrades at Gungahlin pool. All of those sports are represented generally at those CEO meetings and catch-ups that they have with sport and rec quarterly. They are always provided with opportunities in those forums to identify the people they need to speak with in either sport and rec or TCCS, and also, of course, members of the government.

THE CHAIR: You certainly used that two minutes efficiently. That brings us to the end of this session. I want to thank Ms Berry and the directorate staff for attending today. If witnesses have taken any questions on notice, could you please provide answers to the committee secretary within five working days. Good morning and thank you.

Short suspension.

THE CHAIR: Welcome back to the public hearings of estimates 2022-23. In this session we will hear from the Minister for Women and Minister for the Prevention of Domestic and Family Violence. Welcome back, Ms Berry and directorate staff. Please be aware that the proceedings today are being recorded and transcribed by Hansard and will be published. The proceedings are also being broadcast and webstreamed live.

When taking a question on notice, it would be useful if witnesses could use the words: "I will take that as a question taken on notice." This will help the committee and witnesses to confirm questions taken on notice from the transcript. I remind witnesses of the protections and obligations afforded by parliamentary privilege and draw your attention to the privilege statement. When you first speak, please acknowledge the privilege statement.

We are not starting with opening statements; we are going straight to questions. I will start the first question. My question relates to family safety. Accordingly, the minister has previously stated that the recent increase of $5 per household per year for this term of the family safety levy will fund frontline services. What proportion of the Safer Families levy will be funding frontline community services, as opposed to frontline government services?

Ms Berry: Thanks for that question. I note that you referred to government frontline services, because it is true that government does provide frontlines services, as well as the community. We can provide a breakdown of the different funding that comes out of the levy. It is in the budget papers. It is laid out very clearly, the funding that comes out for the different organisations, services, projects and programs, I can direct you to page 366 of the budget outlook paper, which is very detailed on the funding that is provided to various organisations. I might ask Ms Windeyer, Coordinator-General for Family Safety, to provide some more information.

Ms Windeyer: Thank you. I acknowledge that I have read the privilege statement. In relation to the funding for frontline services, I would first like to acknowledge the excellent work that our frontline services do, particularly in the last couple of years, over the COVID-19 period.

In the 2022-23 budget there is an additional $620,000 over two years for the Domestic Violence Crisis Service and the Canberra Rape Crisis Centre, to meet growing demand. There is $5.9 million over three years to continue the successful Family Violence Safety Action Pilot, which has now become a program. That includes funding for both government and community sector frontline workers.

$4.36 million has been provided to establish and pilot a multidisciplinary centre for victim-survivors of sexual violence. This includes funding for both government and the community sector frontline workers. There is $1.8 million over two years to directly invest in the training and capability of community workers responding to and supporting victim-survivors. There is $1.48 million over four years to establish a team of independent sexual violence advisers for victim-survivor advocacy and expert case coordination and system navigation.

DVCS will continue to run the important Room4Change program, with $1.251 million in 2022-23. DVCS will continue to deliver their Safer Families collaboration program, with $1.396 million over four years committed through previous budgets, and the Women's Legal Centre and Legal Aid will continue to run the successful health justice partnerships, with $4 million over four years committed through previous budgets.

In relation to the breakdown between government and community positions across the

frontline domestic family and sexual violence sector, it is not possible to give a meaningful breakdown of the difference between the two, firstly because some of the initiatives involve partnerships between government and community and involve workers located in both government and the sector organisations. An example of that is the Family Violence Safety Action Pilot.

Secondly, for some of the initiatives, the secretariat and scoping work may be initially done in government and then either put out to tender or operated from within an existing community provider. Lastly, some of the initiatives need to be scoped in partnership between the government and the community sector and that will include determining where the services, either new or existing, are best placed to operate from.

We do know that both the government and the community sector have a vital role in delivering and developing responses to domestic, family and sexual violence. It is only through those partnerships between government and the community sector that the integrated responses that victims and perpetrators require can be developed and delivered.

THE CHAIR: Thank you. Is there any funding that has been provided for this training by the commonwealth government?

Ms Berry: With the new Minister for Women and the ministers for social services and family safety within the federal government, we had a meeting about a month ago to talk about the national plan. That meeting was very collaborative and we are looking forward to future meetings with new federal government ministers around funding to respond to domestic and family violence.

I think one of the really important initiatives that the federal government has introduced is the 10 days domestic and family violence leave that will be available for all workers to access. I think that is a significant step that the federal government has made to ensure that domestic and family violence is an issue that the community is responsible for, not just individual organisations.

That sends a very clear message to everybody that not just the ACT government but the federal government takes domestic and family violence seriously, and how we respond to that. Leave for people who are experiencing domestic and family violence can be accessed in a friendly way, and safely, as part of their work environment. I guess that is one example of opportunities provided by the federal government. As I said, we had our first meeting just a month ago and we are hoping to have more discussions with the federal government about funding for frontline services.

One of the other funding commitments that the federal government made was around support for frontline workers in domestic and family violence in the ACT, as well as funding for refuges. I am not sure of the breakdown of that for ACT refuges, but what has been a very clear difference in the approach is a willingness to understand and fund actual services, rather than just having an advertising campaign which has meant more pressure on services. The inability of services to respond to those kinds of advertising and awareness campaigns without the funding is very difficult and something all women's ministers across the country have raised.

So there is funding across a range of different areas from the federal government, but I would have to take some of that on notice because there is probably a bunch that I have missed that have not immediately been applied. As I said, there will be future conversations with federal ministers around funding in those spaces as well.

Ms Rule: I have read and acknowledge the privilege statement. We have got some detail we can share on the national partnership agreement payments: what has been agreed and what funding has already been allocated. I do not know if you want to go into that now.

Ms Windeyer: I am happy to provide that information about the national partnership agreement, which was endorsed between the ACT and commonwealth governments in December 2021. It aims to support service providers to deliver critical domestic, family and sexual violence services and to enhance capacity to meet demand, particularly as a result of the ongoing impacts of COVID-19.

The ACT will receive up to $4.2 million over the two years of the new agreement, through four payments, which will boost the ACT government's investment in domestic, family and sexual domestic violence prevention and response. The first payment of just over $1 million is being used to support services to respond to COVID-19 and new initiatives commenced under a previous national partnership.

Later payments will focus on responses to systemic gaps and sector capability. We are working closely with the domestic, family and sexual violence sectors to prioritise and allocate this additional investment. Negotiations with the commonwealth on this money are, as the minister said, being undertaken at the moment. It is intended that the remaining approximately $2 million in funding will be made available to the sector from the open grants process.

We had many consultations with the sector and they agreed that the following funding categories should be prioritised. The first is sector sustainability and capability building, focusing on, firstly, Aboriginal and Torres Strait Islander services, workforce development, community engagement, and, secondly, mainstream and specialist services capability and building partnerships. The second category is Aboriginal and Torres Strait Islander family, domestic and sexual violence responses. The third category is innovative service responses, including for children and young people.

Those funding streams reflect the priorities that were shared by the sector through a variety of ways, including through the national women's safety summit delegates' statement, a dedicated sector roundtable to discuss this additional funding, in partnership with the commonwealth, and additional meetings that I held with family safety and Aboriginal and Torres Strait Islander community members.

THE CHAIR: Thank you.

MS CLAY: I will try and be brief. Minister, on domestic violence, you mentioned in the JACS inquiry into the family violence bill earlier this year that there was a joint discussion paper with the Domestic Violence Prevention Council that looked at criminalising coercive control. Is that paper out yet?

Ms Windeyer: Minister Berry asked the Domestic Violence Prevention Council to give some information and recommendations in relation to criminalising coercive control. In January this year those recommendations were provided to the minister. They emphasised that coercive control is inextricably linked with domestic and family violence but that criminalisation may create unintended harms, particularly for Aboriginal and Torres Strait Islander people and culturally and linguistically diverse communities. It was advice to the minister; it was not a report or a paper.

The ACT is now working with the commonwealth, states and territories to progress the national principles to address coercive control. These will support the development of a nationally consistent understanding of coercive control. Those principles align with advice from the Domestic Violence Prevention Council that, prior to committing to a position on criminalisation of coercive control as a standalone offence, the ACT government should monitor how the other jurisdictions are implementing the criminalisation of the offence, continue to engage in community-led consultation and conduct more research, and take other non-legislative measures to address coercive control.

MS CLAY: I might jump in. We have a *Hansard* transcript from March. I will read out the minister's comment:

> That is provided to me by the Domestic Violence Prevention Council, as part of their work and the advice that they provide to me as minister.

The chair, not me, said:

> Are you planning to release that report?

And we heard:

> It is advice to me by the DVPC. I do not know that there is any issue with releasing it …

I am just trying to find out. I do not have a problem with the information, but are we going to get a public statement or a public report, given that in March we seemed to think that we might?

THE CHAIR: Can we be direct to that question, due to the fact that it is a short session?

MS CLAY: Is there going to be a statement in relation to that?

Ms Berry: I think I was going to check with the DVPC about whether that advice could be released. I think I called it a report, but it is not a report; it is advice. I might take that question on notice and check on the release of that advice. You basically got, in a nutshell, what the advice was, so we have kind of answered that question.

MRS KIKKERT: Minister, some of the community services have raised concern about the money that is funded to DVCS and CRCC that is not new money but money from previous funding reallocated to them. Their overall concern is that the increase in the levy is not going to frontline services but is actually going to government training, government reviews and roles and strategies. Could you please confirm that the increase

in the $5 levy is actually going towards community service frontliners, as opposed to government frontline services creating strategies and reviews?

Ms Berry: Thank you for that question. As we talked about earlier, in response to Mr Milligan's question, all of the funding that has been provided through the levy is detailed and reported in the budget papers. You can see that there is funding going to frontline services and government frontline services, in partnership with community organisations, specialist services and government. That has been an important approach in the implementation of the levy, because we need to work together to be able to have an impact on this issue and respond to domestic and family violence effectively.

The funding that was provided to organisations during the last couple of years for COVID was in response to increases in domestic and family violence and the complexity of domestic and family violence as a result of COVID. It was made clear at the time that it was specifically in response to COVID. However, from conversations with the organisations and the Domestic Violence Crisis Service, unfortunately they are still experiencing challenges in supporting people who have experienced domestic and family violence, so we are working with the Domestic Violence Crisis Service around their work to ensure that they are getting the funding that they need to meet the needs of community members.

The funding that has been provided in the levy is now separate to the COVID funding, which was not out of the levy; it was federal government funding. We are now funding those organisations, out of the family safety levy, the same amount of money that was funded previously by the federal government. So in one way we have filled the gap that was left once the federal government finished funding for the COVID response and have taken on that responsibility through the family safety levy.

As I said, we are continuing to work closely with those organisations around their responses and the experiences they are having, to make sure that we meet the needs of people who are experiencing domestic and family violence. I can assure you, and members of the committee and others, that funding from the levy is going to both community organisations and frontline services. That is important.

The government is also a frontline service and does provide services to individuals across a range of different areas and has the capacity to develop strategies and implement programs—for example, the risk assessment framework, which was supported very well by community service organisations and specialist services. That will work across government and community organisations to really understand the risks to individuals. Some of that work is funded by the family safety levy, but that work needs to be done together, in a partnership.

As Ms Windeyer said, we can't split the amount that is going to which individual organisation as we develop those frameworks. However, those organisations are providing important expertise to help the government to develop that framework so that it meets the needs of the community and so that we understand where the pressures are and whether this kind of framework will actually work.

MS CLAY: Minister, KPMG has been calling on the federal government to do gender-responsive budgeting. I have just seen Victoria announce that they have done

gender-responsive budgeting. They have a long list of budget decisions that they are attributing to the use of that tool, such as nursing positions; more funding into the community sector to address job insecurity; funding for LGBTQIA+ health and wellbeing; along with funding for migrant and refugee women. I know we have the wellbeing indicators and I know that we have the women's budget statement. I am just wondering if either of those tools is getting to that level of gender-lens budgeting where it is actually changing government decisions. Can you give me examples of some of the government decisions made as a result of that?

Ms Berry: Yes. As you said, Ms Clay, gender is considered in the budget process through the wellbeing impact statements. Those impact assessments are compulsory for all business cases that are presented to budget and to the government to consider. The gender impact assessment tool is available, and it assists in considering gender as part of a budget process, with additional support available if it is requested. The tool was developed to support ACT public service employees and, more broadly, ACT businesses and community sectors to make sure that they undertook a better analysis of the impact of their programs and services and how that impact would occur for men, women and gender-diverse individuals in the ACT. As you know, we are continuing to explore the gender focus and how that can be delivered practically and meaningfully across the ACT government, particularly in procurement processes. That work is directly out of the women's third action plan, which is currently in development.

As far as a gender lens or a gendered budget process goes, as you know, we are still working with and receiving advice from some academics in this space. I might be able to get an update from Ms O'Brien about where that work is up to and when we can expect to be able to provide an update more fully on that work. I will just say that it is exciting to see gender-responsive budgeting in the federal sphere, brought back into the federal government budget. We work closely with the federal government on that work so that we are not doubling up. It has been a positive outcome for women across the country but also for the budget federally. Ms O'Brien?

Ms O'Brien: Thank you for the question. I have read and acknowledge the privilege statement. As the minister said, we are taking an iterative approach to gender-responsive budgeting. We have engaged academics to help us to develop some educational materials so that we have a mature understanding about how to most effectively develop gender-responsive budgeting within our existing processes. All of the research says that that is really the critical element to embed gender-responsive budgeting within our Treasury and budget and cabinet processes. We are working really closely with Treasury and the wellbeing team within CMTEDD to ensure that that is embedded into the process.

We also have, as the minister mentioned, the gender impact assessment tool. It is a separate tool that can be used across government, industry and the community to get a more in-depth understanding of how to consider gender, as well as intersectionality. That is looking at women from culturally and linguistically diverse backgrounds and really looking at diversity, using that broader wellbeing lens. We are hoping that we will be able to build on this as we go through. We are also engaging quite regularly now across jurisdictions, learning from those who are a little bit further along than us, and also with the commonwealth.

MS CLAY: On the gendered impact assessment tool, the minister mentioned that the directorate staff can ask for help with that. How many times have people asked for help when using that tool? If that is something to take on notice, that is not a problem.

Ms Berry: If that information is available, we will provide it. I will take that question on notice.

MS CLAY: I am also wondering: are we measuring the outcomes of these tools and what impact they are having? For example, one outcome might be decreasing the pay gap or decreasing the employment gap between men and women. Have we got any tangible measures?

Ms O'Brien: I can take that question. We are looking at each business case and we are assessing the wellbeing impact assessments that go up as part of that budget process. It is really on a case-by-case basis, based on each business case. As you would know, changes to gender equality take time and we have not established any particular measures and do not expect to see changes in the pay gap immediately. We are building on our understanding of how to measure those as we go forward.

Ms Murray: I have read and acknowledge the privilege statement. The purpose of evaluation is very well understood in this space. I think we need to consider that, when you talk about the outcomes, one outcome which we measure and see in the statements that we put out in relation to the budget talks about the financial outcomes, but we certainly, in our process and our practice, have spent a lot of time looking at the evaluation and the success of individual programs and what they have meant.

Again, we know that generational societal change takes a long period of time. That evaluation and conversation is something that we do ongoing. It is not necessarily able to be centrally reported, as some might take 10 years, for example, to see an increase in changes, but we will monitor. Our women in construction initiatives are an excellent example of a program that we identified that we would fund, we would support and we would promote to achieve a particular aim.

Minister Stephen-Smith spoke yesterday about the additional support for the community sector and the work that we are doing in that space. So there are individual things that actually go together. You would not necessarily evaluate them in a siloed or linear approach, but we do individually evaluate those programs.

MS LAWDER: If I could repeat, I think, one of Ms Clay's questions: can you give an example of where a budget item or a policy decision may have been changed because of the use of gender-appropriate budgeting? How long will it take to implement a gender-responsive budget, do you think? You did indicate earlier this year that work was underway towards that. What is the time line that you currently have for that?

Ms Murray: Thank you for the question. We have spent a lot of time working with the academics, as Ms O'Brien has indicated, around what is the better practice model that we should put in place. That model, as the minister and Ms O'Brien have indicated, is looking at the current processes that are in place and building it into business as usual. At the moment, what work we have is integrated but also a little bit to the side. So the work we are doing collaboratively with Treasury and also the wellbeing team is to fully

implement gender budgeting into the current processes; it is taking a step.

I think the education that Ms O'Brien spoke about is a really critical part as well. What we need to do is make sure that we are building this in as business as usual and that it is what people turn their mind to. I think the committee heard yesterday from our colleagues at Major Projects about CIT and some of the work that they were doing on the build, which included surveying women on women's safety. That work has been done as a business as usual type of approach. I think it is a really good example of how, if we integrate it, it becomes just part of how we do business. That is the approach that all of the academics and the good examples across the country have indicated is really strong, rather than something that is tacked onto the side. I hope that answers your question.

MS LAWDER: Apart from the time line—

Ms Murray: The time line? Again, I think that each step we take—will we ever be fully there? The UNHCR say by 2050 we might achieve pay parity. We are trying to do everything we can to reduce that in terms of each step we take. I think each budget will be improved, so year on year we will look to enhance it. I am reticent to say, "Well we will achieve it by a particular date," because I think it is a continual improvement process. I am not trying to be cute in my answer. I think it is an ongoing and continuing process.

DR PATERSON: Minister, in the last 18 months there has been a lot of momentum around sexual assault prevention and response. There was the steering group committee's final report last year, and then the government's response to that report. I am really glad to see that there is significant funding in the budget to address some of the recommendations of that report. I am wondering if you can outline what the priorities are in funding, in responding to that report?

Ms Berry: Thank you for that question. I know this has been an issue that has been well supported and collaborated on across government. I want to thank everybody who contributed to the Sexual Assault Prevention and Response Program and the steering committee's work and all of the different work groups all across government, including your own contributions, Dr Paterson, with the consent bill. It has been a remarkable period of time. I particularly want to acknowledge victim-survivors for their contribution to this and their ongoing contributions as we set up a program for victim-survivors.

This budget allocates $10 million over four years to reform activities. That is responding to a few of the recommendations in the report that was provided to the government, in a whole range of different areas. The foundational work that this $10 million in funding provides includes $585,000 over two years for a specialist service review to ensure that our services are meeting the needs of our community or, if they are not meeting the needs, to look at what we need to do to support them better.

$2.8 million has already been committed for the multidisciplinary review of sexual assault matters that have not progressed to charge. That is work that we are doing with the ACT police and the DPP to understand those cases and really dig in deeply to find out why cases were notified and then did not go to court. What happened in those

circumstances? We will take a deep dive in understanding what happened in that space. That is a significant piece of work.

The other funding that we have provided is around the immediate and much-needed support for victim-survivors. This includes $1.5 million for a new independent sexual violence adviser, who will help victim-survivors to navigate the system. That was something we heard very clearly from victim survivors: "Where do I go first? Which door do I knock on? And what other services are available to me?" That independent sexual violence adviser will be, I think, a significant game changer in that space for victim-survivors to understand how to navigate their way to different supports or court proceedings, if that is where they decide to go.

There is $515,000 to reinstate the wraparound service model to provide holistic supports and $4.4 million to pilot a multidisciplinary centre to co-locate specialist services. Again, the advice that we got from victim survivors, but also support services, was that there is this kind of siloing of supports and an inability to understand the supports that are available or that different kinds of supports might be required for different circumstances. So that funding will make a real difference to people who have experienced sexual assaults in the ACT.

There is funding for more long-term initiatives, which is around preventing violence and continuing to hear from victim-survivors and community members. There is $1 million in funding for the design and implementation of a prevention strategy, as well as research and analysis. $1.4 million will establish a victim-survivor consultation program, and $935,000 will support further consultation with Aboriginal and Torres Strait Islander communities on the implementation of the report. There has been quite a bit of funding in this budget for consultation activities as well, relating to domestic, family and sexual violence, and why that funding is important.

DR PATERSON: Thank you. On the recommendation in the report about ACT Policing cases that did not progress to charge, that was funded in last year's budget. I am just wondering what the progress of that is and when a report might be released on that?

Ms Berry: Yes. We can provide an update on that work. Ms Windeyer.

Ms Windeyer: Thank you. That review of cases has commenced. It is overseen by a committee which consists of independent co-chairs, the Director of Public Prosecutions, the Chief Police Officer, the Victims of Crime Commissioner. I, in my position, am also on that oversight committee. The review of cases reported to ACT Policing is crucial to inform system developments in sexual assault matters.

There have been a couple of meetings of the oversight committee, and the committee has looked at the process that will happen in order to undertake the review. The process is, firstly, that the Director of Public Prosecutions will look at the cases that are sent by ACT Policing, with a view to deciding whether or not those cases should progress to charge. The second phase of the process will be for a process review team, which will consist of a broader cohort of people looking at those cases in order to address and identify any systemic issues in the undertaking of those cases by ACT Policing and whether or not there need to be changes.

DR PATERSON: In terms of the legislative change to the affirmative consent model in the Crimes Act, is there any thought being given to an education campaign on the changes?

Ms Windeyer: Yes. When you have new legislation, particularly something as significant as the changes to the consent law, it is imperative that there is education in relation to the impact and the meaning of that. So, along with the prevention strategy, there will be developed an education campaign to ensure that what it means gets out into the community.

Ms Berry: I should just add to that the work of Chanel Contos in presenting to education ministers about consent, specifically as part of the curriculum. That was very well received and is now specifically in the curriculum and will be delivered in a different kind of way in our schools to ensure that, as part of that education program, we are educating our young people so that we can minimise the impacts of sexual assault and violence across our community. It is a really important part of that program.

MS LAWDER: My question is about the gender impact assessment tool or analysis tool. We have already briefly mentioned it today. We also spoke about it during the hearings back in February. At that point, Minister, you stated that it is not tracked because it is a support tool. In the YWCA's budget submission they have recommended that it should be tracked. Do you have any plans to start tracking the effectiveness and efficiency of the gender impact analysis tool? Otherwise, how can you say that it is well used or well regarded, if you have no measures?

Ms Berry: Thank you for that question. I think it is a good question. We partially responded to that in previous answers. With the gender-responsive budgeting and how we track whether it is having an impact, I think Ms Murray talked about different parts of our response, as a government and as a community, to ensure that more gender equality across our community can be easily seen on its own.

You can see the impact. You can see it is making a difference, but how do you then gather up how responsive budgeting is working across the government and assess what is its impact to women and girls across our community? I think some of it we will be able to track in a way that makes sense, but some of it will be change that we will see over the decades.

It is more challenging to gather as information. For example, in the sport and recreation space we made it compulsory that all sports organisations that receive the triennial funding from the ACT government are required to have 40 per cent female representations on their boards. That happened. So you can see that. That is a positive response and it is happening now as a matter of business. As to how we make sure that we measure the impact of gender-responsive budgeting, we are probably, as a world, still learning about how that works on the ground. Freya O'Brien may have some more information.

Ms O'Brien: The wellbeing impact assessments were actually informed by the gender impact analysis tool. We use that tool and share that and engage with CMTEDD to make sure that the information and the approaches that were captured in that are

reflected within the wellbeing tool. Our tool is used for every budget initiative and, hopefully, moving forward will be incorporated into some policy development as well.

I think that will mean that every single budget measure will consider a whole range of different types of wellbeing, including gender equality. That then leads to our wellbeing framework and those indicators as well. That is a way of tracking the impacts of these initiatives on wellbeing over time, including on gender equality.

MS LAWDER: I am still unsure of exactly how it might be tracked or be presumed to be being used. You are saying it is provided to CMTEDD to include in their analysis. But how do you track what they may have decided before they looked at it and what they may decide after they have looked at the gender impact analysis? How do you know that it is making a difference?

Ms O'Brien: The wellbeing impact analysis was informed by the gender impact assessment tool. That is not provided to treasury. They have looked at the rationale and the way that we have put some instructions there to consider the impacts on gender equality within their existing tool. Then, within the wellbeing impact assessment you are asked to consider the eight different diversity areas, one of which is gender. There is, for the first time in this budget, a note that went to ERC that reflected where they believed the particular measure impacted gender equality.

So, it is really through the wellbeing impact assessments that we will be taking this forward. The gender impact analysis tool was something that we developed several years ago, before we had matured to the point with the wellbeing impact assessments that we have now. We are just making sure that we are building on that sort of work and that understanding. So, going forward we hope to continue to build on the incorporation agenda and the understanding of how to do an analysis on gender impact through the wellbeing impact assessment tool.

Ms Murray: If I could very quickly add, I think that it is really important that we spend time educating at the point of the policy development, and that by the time we get to a budget analysis anything that is added on is either a tack-on or a change. So, the work that we are really investing in is that policy development work and working early to educate different directorates who might not necessarily think that there is a gender impact immediately on the body of work that they are doing, to consider that there is a gendered impact at that policy development phase.

We work with almost every directorate, having conversations. At the policy concept stage we are working as part of the second action plan. One of the bodies of work that we are doing is educating directorates to be thinking, when we are putting pen to paper, to start the conversation about a policy: how is it going to impact? Then, as Ms O'Brien indicated, at the time that it comes to a decision for ERC there is material that has been developed. The Office of Women do support some directorates at that point in pulling that together, but every single submission has an analysis that sits over the top of it.

As I said, if we get to that point of analysis without that early investment in terms of education and also support for the development of policy, I think it is too late. So, our hope is that when the Office of Women sit with treasury officials and review each and every one of those, there is the assessment that is undertaken in terms whether this

meets the criteria.

MS CLAY: Have you looked at the measures that Victoria is using in their gender budget lensing and use those measures?

Ms Murray: I am happy to take that. We absolutely have. We are looking at Victoria and we are looking at other states that are in this space. The minister has been having a lot of conversations with the commonwealth in particular. This is a topic of conversation that is really open. As we have said before, we have brought in academics to continue to keep us abreast of the whole-of-world considerations in this space as well. So, we are trying to create the best practice model rather than something that is pulled off the shelf and, "Here you go." So, actually we have been looking at Victoria, the other states and jurisdictions, and also internationally.

MRS KIKKERT: Minister, how much funding is provided for children, specifically children and victims/survivors of domestic violence, to receive trauma counselling in refuges?

Ms Windeyer: There are a variety of responses that the ACT government has in relation to supports for children and young people who experience domestic and family violence. Obviously, there are children who live in or touch refuges. That is one place where those children who live with domestic and family violence touch services.

At the moment we are developing a new service for children who are aged between five and 12. That is in partnership with the community sector. We are hoping that that program will commence in the fourth term of this year. The service is for supporting children to recover from domestic and family violence by providing a safe space for them to talk and connect with others. It is for children, with a mothers' group designed to provide them with tools to support their children. The refuges will be part of that design process, and those children will be able to access that service.

The new service will be evaluated while it is in its pilot phase to consider whether it could be expanded. That is where we are at in relation to that particular thing. The other thing is that in the national partnership funding money, which we talked about earlier, there are, as I mentioned, categories that are allocated. Children and young people are specifically set out as one of the priority categories for innovative and new responses.

That was indicated by the sector, and there will be a grants process for sector providers to come within that. We have had some conversations with some of the refuges in relation to applying for funding in relation to needs of the children and young people who live with domestic and family violence, so I would expect that that will come through in that particular program as well.

MRS KIKKERT: Thank you. Will this program include specialised trauma counselling sessions for children?

Ms Windeyer: It is not trauma counselling, as such. It depends on what you mean by that. It is designed to look at best practice systems which have been developed both in Victoria and overseas in relation to what supports those children and young people who live with and experience domestic and family violence. It is a parallel group work model,

where children attend a group with their peers, and mothers attend a separate group.

MRS KIKKERT: Okay. And why is it just between five and 12 years old? If you are 13 or 14, and you find yourself in this situation—traumatised—then you are excluded from this program.

Ms Windeyer: It is just a different program. For children who are between 12 and 25, then the government is supporting Relationships Australia to deliver a program called Got Your Back. That is a support group for young people who are in that category of over 12 years. Those groups operate in Belconnen and in Woden youth centres during the term time. They are led by young people who decide the topics to be covered and they invite guest speakers to attend, if they want to.

They are led by a skilled facilitator in partnership with a youth worker from a youth centre. What we have heard is that there are different needs for young people as compared to children, so our responses need to be specifically tailored for the age of either the children or the young people. There are currently 19 young people attending Got Your Back, and new groups are being established in other ACT locations in 2022.

MRS KIKKERT: Thank you. We have heard from staff who work at these refuges that they are also overwhelmed with the trauma that they are continuously hearing every single day. What sort of support are they receiving? Is there any funding from this budget that is going towards supporting the staff in these refuges?

Ms Windeyer: The funding for staff from refuges comes from different money than from the family safety bucket. That is under housing and homelessness.

Ms Rule: With that type of grant funding, we would expect to give the funding to the organisations and that they would use that bucket of funding to manage all of their obligations, like paying their staff and managing the work health and safety obligations they have for their staff, including the work that they need to do to protect their staff from vicarious trauma. So it is not something we fund directly, but we would expect services to use the grant funding that we give them in managing all of the aspects of their relationships with their employees, including that one.

DR PATERSON: Just going back to the children's service, is there any detail on where that might be located and also the sort of numbers of children—a projection of the numbers of children that may be attending that service?

Ms Windeyer: At the beginning it will be a pilot. The government just did an open tender process to select the delivery partner. The successful respondent was the Australian Childhood Foundation. At the moment, they are preparing the design of it and working in partnership with the community and sector organisations who work with children and young people, or where they touch these services.

The initial number of children will be small groups of approximately eight children in the one group, with the parallel group for mothers. In the fourth term of this year, what we are aiming for is that there is one group to pilot and then, having a look at that, and adjusting it, then expanding that in 2023.

DR PATERSON: The pilot will go for what length of time?

Ms Windeyer: It will go for the term time.

DR PATERSON: Okay. Thank you.

THE CHAIR: We have 60 seconds, if anyone has a supplementary question.

Ms Berry: Just on that last question, Dr Paterson, this pilot came out of an extraordinary meeting that was held with the community services and specialist support services, including refuges and one of the priority areas that they wanted the government to do work on, was around how we support young people who are impacted by, or live in homes where they experience, domestic and family violence. So this has been well informed by specialists, and this is where we are as part of that journey together.

THE CHAIR: We now draw this session to a close. I would like to thank Ms Berry and all directorate staff on behalf of the committee. If any questions have been taken on notice, can you please provide answers to the committee secretary within five working days.

Hearing suspended from 11.15 to 11.30 am.

Appearances:

Stephen-Smith, Ms Rachel, Minister for Aboriginal and Torres Strait Islander Affairs, Minister for Families and Community Services and Minister for Health

Community Services Directorate
Rule, Ms Catherine, Director-General
Wood, Ms Jo, Deputy Director-General, Programs and Operations
Graham, Ms Tamara, Acting Executive Branch Manager, Office for Aboriginal and Torres Strait Islander Affairs

ACT Health Directorate
Cross, Ms Rebecca, Director-General
Anton, Ms Deborah, Acting Deputy Director-General
Coleman, Dr Kerryn, Chief Health Officer
George, Ms Jacinta, Executive Group Manager, Health System Planning and Evaluation
Lopa, Ms Liz, Executive Group Manager, Strategic Infrastructure
O'Halloran, Mr Peter, Chief Information Officer, Digital Solutions Division
Culhane, Mr Michael, Executive Group Manager, Policy, Partnerships and Programs
Barbaro, Ms Fiona, Executive Group Manager, Population Health Division

Canberra Health Services
Peffer, Mr Dave, Chief Executive Officer
Zagari, Ms Janet, Deputy Chief Executive Officer
O'Neill, Ms Cathie, Chief Operating Officer
Howard, Dr Grant, Executive Director, Medical Services
Freiberg, Ms Susan, Executive Director, Women, Youth and Children
Smitham, Ms Kalena, Executive Group Manager, People and Culture

THE CHAIR: We will kick off the hearings again for the 2022-23 estimates. In this session we will hear from Minister Rachel Stephen-Smith, Minister for Aboriginal and Torres Strait Islander Affairs, and officials. Thank you for coming along. Before we start, we need to go through some housekeeping matters that I wish to draw your attention to.

Please respect the stated room limits and physical distancing requirements that are in place in this building as part of the Legislative Assembly's COVID-safe measures. Please allow the cleaner to clean the desks and seats between witnesses. Please practise good hand and respiratory hygiene. Witnesses are to speak directly into the microphone for Hansard to be able to transcribe them accurately. The first time witnesses speak, they will need to state their name and capacity in which they appear. Those witnesses on Webex, if you could mention your name each time you speak, that will help Hansard. Please be aware that the proceedings today are being recorded and transcribed by Hansard and will be published. The proceedings are also being broadcast and webstreamed live.

When taking a question on notice, it would be useful if witnesses could use the words, "I will take that as a question taken on notice." This will help the committee and

witnesses to confirm questions taken on notice from the transcript. I also remind witnesses of the protections and obligations afforded by parliamentary privilege, and draw your attention to the privilege statement. I ask that when you speak, you confirm that you understand the privilege implications of that statement.

We are not taking any opening statements, so we might just go straight to questioning. Given that this is a short session—I think it is only about 30 minutes—I suggest that we do one substantive and two supplementary questions. Obviously, if the response can be as direct as possible to the question, that will allow more questions to be asked. I will pass my substantive over to Mrs Kikkert to start off.

MRS KIKKERT: Thank you very much, Chair. Minister, I refer to the treaty process, which is listed as a priority of this budget. In answers to questions on notice from me dated 18 March this year, you assured me that "Professor Arabena, in the role of facilitator, will be having discussions with all Aboriginal and Torres Strait Islander people who claim a traditional connection to the ACT," including the Ngambri and the Ngarigu people. I received a similar promise in a letter from you dated 15 December last year. In a 7 July media release in relation to Professor Arabena's completed report, you acknowledged that, "for various reasons, this process did not engage as broadly as we had intended," and you apologised to those traditional owner individuals and families who were not consulted or engaged. Minister, can you detail the various reasons that this consultation process did not engage all the traditional owners, despite your earlier assurances to me?

Ms Stephen-Smith: Thank you, Mrs Kikkert. I acknowledge the privilege statement. I will hand over to officials in a minute. There are a couple of reasons that I will touch on. One was around time frames. We certainly heard from Professor Arabena and those involved that the time frame in her consultations was quite short. My understanding is that that was, in part, around her availability to undertake the work. It was also a result, in my understanding—and obviously I was not party to the actual conversations—of the way that her initial conversations with the United Ngunnawal Elders Council played out and actually resulted in her going in a particular direction in her process. That was deeper in terms of the types of things that were discussed around treaty, but also significantly narrower, in terms of the breadth of consultation than we had expected. I do not know if Ms Wood wants to add something.

Ms Wood: Yes; I think the minister highlighting the time frames for the project obviously meant that there needed to be certain kinds of ways that communication and engagement happened. Some of it was necessarily through emails, through phone calls, and through that kind of outreach. That did not necessarily get broader engagement. So Ms Arabena has advised us that she made some attempts to reach families beyond those directly involved in UNEC, but she did not necessarily get responses from those people. That is, in some ways, not surprising, because we know that we need to work on engagement over a period of time.

Where we have some divisions in community, I think we have learned some things from this project about how we might take the next steps in this conversation. It has always been the intention, and continues to be the intention, to take this conversation really broadly. That will work on how we build that engagement at the front end and think through the time that it will take to do that as well.

MRS KIKKERT: When Professor Arabena was contracted to complete a treaty consultation and report, what steps did you take to make sure that she understood the necessity to consult with all people who claim a traditional connection to the ACT, and will you be looking at redoing the consultation process?

Ms Stephen-Smith: Professor Arabena's contract—Karabena Consulting's contract—is available online through the Tenders ACT open access arrangement, so you can have a look at her tender. In my statement on 7 July, I indicated that the contract was to facilitate a range of engagement activities to re-establish relationships between the United Ngunnawal Elders Council, government and other families; bring people with strong connection to this land together in a way that supports healing and deep listening; and advise on what is required to commence a process about treaty in the ACT. From the conversations that were had in relation to establishing that contract and the wording of the contract itself, it was clear that there was an expectation that it would go beyond United Ngunnawal Elders Council and the families that are involved in that.

At the time that we announced this process, the Chief Minister and I were also very clear that discussions would take place over coming weeks and months, and that this was one step at the beginning of a process. So we never expected that this was going to be a single process that was going to land us at a conclusion about what a treaty would look like or how to get there. This was the start of a conversation, and officials worked quite closely to try to establish what that was going to look like. I think it is important to recognise that it took quite a long time to get to the point where the United Ngunnawal Elders Council could agree on someone that they were willing to start that conversation with. So it was their advice that this would be a good starting point for the process.

I have, as you indicated, made a public statement that this was the very first step in a process. There are some valuable recommendations in the Karabena Consulting report about some next steps that could be taken, but there are a range of other things that we will need to do. We recognised from the start that this process was not going to be definitive and that it was an early series of conversations. Do you want to say anything about the process?

Ms Rule: Yes. I would just add that there were really fulsome conversations with the consultants at the beginning of that project to establish our expectations. As the minister has indicated, our expectations were not fully met by this project, but I would also say that, as the minister has explained, we intended this to be one step in a bigger conversation. We are actively talking to other jurisdictions about their different pathways through the conversations for treaty.

It is a very complex process, and we know that we need to get a range of different people engaged and provide different ways for that conversation to happen. This was one way that that conversation could happen in an in-depth way with the United Ngunnawal Elders Council, but we are working on what the other conversations are that we need to have with other traditional owners in the ACT and the Aboriginal and Torres Strait Islander community more broadly.

MRS KIKKERT: Thank you. Minister, I was first contacted on 20 May by local

Aboriginal families. They were concerned that they were not being engaged in Professor Arabena's treaty consultation. Minister, when did you first hear concerns about the lack of breadth in her consultation? What did you do to address these concerns with Professor Arabena before she completed her report?

Ms Stephen-Smith: Thank you, Mrs Kikkert. I will have to take the question on notice in relation to when I first became aware. I recall some phone calls, but I cannot tell you exactly when they occurred. I had a meeting with Professor Arabena when she had developed her draft report.

Again, I am happy to take on notice the date of that meeting; my office can probably get me some advice around that pretty quickly. I expressed some concerns in my meeting with her about the lack of breadth of consultation. She explained the constraints that she was operating under, in terms of time frame and her capacity to get in contact with all of those people. She said that she had also received some very strong advice from the United Ngunnawal Elders Council that they represent the Ngunnawal community. Now, we all recognise that there are Ngunnawal families and individuals who are not represented on the United Ngunnawal Elders Council.

So, there was that opportunity to have a conversation with Professor Arabena before she finalised her report, but it was pretty close to being finalised at that time. I think she did take into account some of the feedback from me and from the directorate when finalising her report. You will see in her report that she had also received direct feedback from members of the community about the process, and she acknowledges in her report that some people were not comfortable with the process and did not think it was representative.

DR PATERSON: Minister, as you said, treaty is a process. I was wondering about the lessons learned, and what will be the next steps, going forward.

Ms Stephen-Smith: There were a number of lessons learned thank you, Dr Paterson. I might hand to Ms Wood to talk about some of the conversations with other jurisdictions, but one of the things that came up recently at a meeting of ministers for Aboriginal and Torres Strait Islander affairs from across the country around everybody's progress on these issues is something we already knew: that these things take time, that there are a range of conversations that need to be had, and that people will want to engage in different ways.

One of the key things that came up was the need for truth-telling to precede the finalisation of a treaty process. That has arisen in both Victoria and Queensland. Someone has described it in these conversations as, "The treaty is the what; the truth-telling is the why." The *Uluru Statement from the Heart* really talks about the establishment of a Makarrata commission to undertake that process of truth-telling, leading to treaty. That is part of our considerations in the next stage of this process: how do we facilitate some healing in the community, and how do we facilitate the truth-telling that is going to be required to get us to the point where the community is ready for treaty?

The other lesson from other jurisdictions has been around the readiness of government for treaty, as well. There is the readiness of the community, but there is also the

readiness of government. The indication from Victoria is that that takes time.

Ms Wood: I think they are the really key lessons from other jurisdictions. The other thing that has been emphasised with us is the need for community leadership. The minister talked about community readiness but, ultimately, it is the need for community leadership. You see in other jurisdictions that, as they progress through their treaty conversations, they build different structures to do that. They have had different models around commissioners and panels and advancement committees, and generally there has been a move to more independence as they have gone through that process. It is not government led. In fact, some of the lessons from some jurisdictions go to when they started off with a process that was too heavily government led. It did not work in engaging the Aboriginal and Torres Strait Islander community. It also did not work in engaging the broader community. There are some important lessons that we are thinking through about how we could apply that and what structures we need in the ACT to progress the conversation.

Part of the time needed is in actually allowing the time for community to work through how they are going to engage with government on treaty. That means firstly bringing people into the conversation, but then also creating the space for community to have its own conversation. So there are a number of stages, and we need to create the space for people to work that through at a pace which works for them.

MR BRADDOCK: Thank you. I am interested in the Yarramundi Cultural Centre. What is the future of that centre, and how the ACT is going to be using that, versus the First Nations people?

Ms Rule: Thank you, Mr Braddock. There has been a significant piece of work to look at the future of the cultural centre, with an external consultancy to work with us on establishing a vision and an approach to community engagement for the centre, starting with a range of conversations that help shape a draft vision. That then needs to be taken back to community and really worked through. That is one project that has been significantly impacted by COVID. The original consultancy was impacted in terms of its ability to do the community engagement, because that was happening over late 2020 and early 2021. Then our lockdown last year really shut down the opportunity to do the next phase with community. That is a piece of work—that next phase with the community—that is still to be done.

There is a range of interests from community in how that space could be used. One of the groups that is interested in looking at that space is the language group, to establish the language centre that we are also committed to working on. We have taken the first steps with the language group on that. Exactly how it will be used is still to be worked through with the community, but there may be some opportunities, earlier, with some of those groups to start to make use of that space.

MR BRADDOCK: Has the next phase been budgeted for? Is that going to happen this financial year?

Ms Rule: That next phase is covered in the original project plan. It is just that it has been delayed. We will aim to do as much of that as we can this financial year. It really is about the capacity of the community to engage with us, because there has been a

whole range of other work happening with community, as well as the COVID impacts. It is just getting to the point where people are ready to have that conversation.

MR BRADDOCK: So, we do not have a milestone for the completion of that phase?

Ms Rule: I will ask Ms Graham if we have an updated time frame, but now we have to re-scope when we can get out to community, amongst the other consultations that are happening with the elected body and others.

Ms Graham: I have read and acknowledge the privilege statement. We do not have a specific time frame. As Ms Wood said, it is about looking at when we can get out and consult with community around Next Steps.

DR PATERSON: My question is in relation to page 133 of the budget outlook—construction of the purpose-built facility with the Gugan Gulwan Youth Aboriginal Corporation. It looks as if this is $19 million. I was just wondering if you can, Minister, outline this project and how it began and where it is at now.

Ms Stephen-Smith: Thank you, Dr Paterson. I probably will not go back through the full history, given Mr Milligan's comments about keeping answers short. This has been a long time in the making, but I am so pleased that we have the full funding to deliver a really outstanding building. I do not know if you have had an opportunity to look at the renderings through the development application process, but this is a really exciting design co-designed with Gugan Gulwan and the families that use that facility. I might get Ms Graham to provide a very quick update on where that is up to at the moment.

Ms Graham: The development application was lodged on 4 May and went out for public notification on 2 June. It has since closed. There are a number of issues that are being addressed around trees and water issues, but the architect is working through some of those issues. We are just in the process of getting the request for infrastructure procurement to go out. It is progressing and will be finalised shortly.

DR PATERSON: So what is the time frame? When is it expected to be built?

Ms Graham: Part of the RFIP will be looking at who can come in and do the knockdown and the build. The design has been finalised. I think we are looking at a knockdown this year but, sorry, I have not got the date for the final.

DR PATERSON: What sort of programs will be run out of this facility in the future?

Ms Stephen-Smith: Gugan will run its programs funded under the Child, Youth and Family Support Program—a range of youth and family-based programs. They obviously run a functional family therapy program with OzChild as part of the child and youth protection response that is connected to child and youth protection services. One of the opportunities in this new build will be to enable them to have the space to expand some of the things they do. I think that is not yet defined in terms of what that expansion might look like; but I am really pleased that Gugan is engaging in the conversation around Next Steps for Our Kids and the Our Booris, Our Way implementation in terms of where they might want to play a further role connected to child protection and whether that is in the early support space. Those conversations are

still in the early days between the Aboriginal community-controlled organisations in the ACT and government, around what service expansion will look like, for whom and where. I think that would be a great opportunity for Gugan to expand their service provision in the way that works for them and in the way that they think they can best deliver their expertise. They already deliver that range of youth and family services.

One of the things that they have previously talked about is that they are a youth Aboriginal corporation. They are currently not funded for a lot of programs for younger children and that may be a space they might want to move into, but those are still, sort of, future conversations.

MRS KIKKERT: Minister, two changes to appropriation on page 26 on the budget statements G showed that a combined $464,000 of the Healing and Reconciliation Fund that was intended to be spent last year has been shifted to this year. What exactly was the money supposed to be spent on, and what caused the delay in its usage?

Ms Stephen-Smith: As you have indicated, when you add up the funding, it is a combination of different things. So $8,000 is around the establishment of the Healing and Reconciliation Fund. That is about establishing the governance arrangements. We have talked previously in hearings about some of the delays in the recruitment of staff to undertake that work, but that is now underway, I understand. Yes, I am getting nods on that. The $384,000—that is, revised funding profile for Healing and Reconciliation Fund, I expect is around the language centre development. Again, I am getting nods on that.

I think we have talked about the capacity for a very busy community to engage in a wide range of projects. While we have allocated funding for the development of a Ngunnawal language centre, it just has not been possible to engage in the way that we needed to expend that funding for that project in the past financial year.

MRS KIKKERT: What was the total cost of Professor Arabena's treaty report contract, and did any money from the Healing and Reconciliation Fund, fund his contract?

Ms Stephen-Smith: Yes, so her contract was funded out of the Healing and Reconciliation Fund funding. I do not have the final figure, but it is available on the Tenders ACT website. Ms Wood might have it in front of her.

Ms Wood: Sorry, Minister, I do not have it in front of me, but we can provide that one on notice.

MRS KIKKERT: Thank you; and Minister, just a final supplementary question. Minister, at this point how much of the $20 million of Healing and Reconciliation Fund has been spent?

Ms Stephen-Smith: We will take that question on notice, Mrs Kikkert. It is all publicly available in budget documents and will be up-to-date in terms of the moving of funds in this particular budget but also the areas it has moved into. So it would be quite possible to calculate, but we can take that question on notice.

If I can just respond to the previous question taken on notice, my meeting with

Professor Arabena was on 23 May—around the same time, Mrs Kikkert, that you were indicating that you had been hearing concerns from the community. I think it is fair to say that we were concerned, ourselves, so I was probably raising concerns with Professor Arabena around the narrow group of people with whom she had held lots of deep workshops and had done some really good work, but with a smaller group of people than we had intended.

We, ourselves, identified that as a concern, and I started becoming aware of some very significant concerns in the community in early June. The first thing I can find on my phone is around 3 June but it may have been before that.

Ms Wood: Minister, I have the contract amount. For the contract with Karabena Consulting the total contract was for $150,311.

THE CHAIR: Just in the last couple of minutes, I am wondering if I can get a bit of an update and plan for the Ngunnawal Bush Healing Farm.

Ms Stephen-Smith: That sits with me in my responsibility as Minister for Health, but I am very pleased to say, Mr Milligan, that the budget does allocate some funding in the health portfolio for the expansion to residential services at the Ngunnawal Bush Healing Farm. The model of care for that is just being finalised with the advisory board. That funding includes just over $1.9 million in expense funding over the four years for commencing the transition to a residential program and the associated evaluation of that.

THE CHAIR: What type of residential program, specifically, is it? Is it going to offer medical treatment? Is it what was the original plan or has it changed?

Ms Stephen-Smith: No, as you would be aware, the zoning does not allow the provision of clinical treatment on the site; but we are also, of course, working with Winnunga Nimmityjah to establish an Aboriginal community-controlled residential drug and alcohol rehabilitation service at the site in Watson that has been redeveloped, and that also has received funding in this budget.

THE CHAIR: It is good to see some progress happening in that space. On behalf of the committee, I want to thank Minister Rachel Stephen-Smith and her officials for their attendance today during this session. If witnesses have taken any questions on notice, could you please provide answers to the committee secretary within five working days.

Short suspension.

THE CHAIR: On behalf of the committee, I want to thank, once again, Minister Rachel Stephen-Smith and her officials who are attending here today. In this session, we will hear from the minister in the portfolio of health.

Before we start, we need to go through some housekeeping matters that I wish to bring to your attention. Please respect the stated room limits and physical distancing requirements that are in place in this building as part of the Legislative Assembly's COVID-safe measures. Please allow the cleaner to clean the desk and seats between witnesses. Please practise good hand and respiratory hygiene.

Witnesses are to speak one at a time and directly into the microphone, for Hansard to be able to hear and transcribe them accurately. The witnesses, the first time they speak, will need to state their name and the capacity in which they appear. I ask that witnesses who speak via Webex do the same, but also each time they speak, to mention their names. It will help with Hansard in transcribing. Please be aware that proceedings today are being recorded and transcribed by Hansard and will be published. Proceedings are also being broadcast and webstreamed live.

When taking a question on notice, it would be useful if witnesses could use the words, "I will take that as a question taken on notice," or words to that effect. This will help the committee and witnesses to confirm questions taken on notice from the transcript. I also remind witnesses of the protections and obligations afforded by parliamentary privilege and draw their attention to the privilege statement in front of them. I ask that they confirm that they understand the privilege implications of that statement when they speak.

As we are not taking opening statements, we will proceed straight to questions. Today's health session is an extended session; it goes until 5 o'clock today. The committee is happy for people who are asking a substantive question to then have three supplementary questions after that. And I will pass my substantive question across to Ms Castley.

MS CASTLEY: Thank you, Chair. Minister, my first question is with regard to paediatric cardiology services. Last month, on 5 July, five-year-old Rozalia Spadafora died in the hospital. I refer to a letter that you sent to Rozalia's mother, offering your condolences on August 2—almost a month later—after question time, when I asked you about condolences and the incident. My first question is: why did you wait almost one month to offer your condolences to the family?

Ms Stephen-Smith: I have read the privilege statement. As we discussed after that question time, Ms Castley, I was not aware that the family was expecting that contact until it became public in the media—unlike you, who were aware of this because the family had contacted you and had spoken with you, and you were aware that they were feeling unsupported. You were aware that they were expecting senior contact from the minister or the directorate. You did not pick up the phone to me, you did not text me, and you did not email me to let me know this.

This is in stark contrast to the way your predecessors would have behaved, and, indeed, the way other members of this place have behaved when they have been in contact with families and individuals who have been in distress. They have contacted me directly and have asked me if I would be willing to meet with those people. Other members of this place have understood that people will reach out to different people in the community and that they, as MLAs, have an obligation to support those people in the community who are in distress, and to try to help them with whatever it is that they are asking for.

MS CASTLEY: Thank you, Minister. My job is—

THE CHAIR: Can I just firstly let Ms Rachel Stephen-Smith respond. Then I will deal with the question itself.

Ms Stephen-Smith: Had I been aware that the family was expecting contact, I would certainly have been in contact with them, and I would have been very happy to meet with them, if that was their wish.

MS CASTLEY: Thank you, Minister. To clarify—

Ms Stephen-Smith: As you indicate, Ms Castley, I did email them on receiving your question in question time and becoming aware that that was their expectation. And I offered to meet with them. I have not heard back that they would like to do that. Prior to that question time, we had obviously heard publicly that the family had expected to receive senior contact and the chief operating officer of Canberra Health Services had written to the family as well, offering a meeting with her and/or the chief executive officer of Canberra Health Services.

Again, it is my understanding that the family has not sought that meeting, but they are very welcome to, at any time, if they want to take up that offer—absolutely. I and my officials want to ensure that any family who is experiencing such a terrible distressing situation gets the support that they need. If, on becoming aware of this prior to it hitting the media, you had let me know that this family was not feeling supported, we would have absolutely ensured that people who had been in contact with the family, people who knew the family, got in touch with them to understand what they were experiencing and what additional supports could be provided to them.

MS CASTLEY: Thank you. Minister, why did you—

THE CHAIR: I think the minister has answered your original question appropriately. I advise that your next supplementary is not just a continuation of the first; that there is some substance to it that might—

MS CASTLEY: To clarify, it is not my job to ask you to contact people and offer condolences. That is not my job.

Ms Stephen-Smith: Chair, this is—

MS CASTLEY: Thank you, Chair. I will move on. My next question is: how many deaths have there been in the paediatric cardiology ward?

Ms Stephen-Smith: Sorry, Ms Castley—

THE CHAIR: Ms Castley.

Ms Stephen-Smith: We run a health service. In health services, people die and people have terrible experiences. And there are processes that are in place to support those people. Those processes were implemented. I do not want to speak about specifics in relation to this individual matter, but I believe that all members of the Legislative Assembly, when they are contacted by a constituent who could be supported in some way, have an obligation to try to seek that support. You have my phone number; you have my email. You could have done that; you did not. That was my only point.

THE CHAIR: Do you have a supplementary question?

MS CASTLEY: I do. Minister, how many paediatric deaths have had to be reviewed in the past three years?

Ms Stephen-Smith: I will refer that question to Mr Peffer or Ms O'Neil.

Mr Peffer: I acknowledge I have read and understand the privilege statement. With respect to the number that have been reviewed, I do not have those numbers in front of me, but those numbers are very small. As a hospital team, we obviously look at the standardised morbidity and mortality ratio of our health service in comparison to other hospitals operating around the country to determine if there is any variation. At this point in time, certainly in the area of paediatrics, we are performing very well, which is a good quality and safety indicator. But I am happy to take on notice, Chair, the specific number.

MS CASTLEY: Thank you. And just—

THE CHAIR: One more supplementary; yes.

MS CASTLEY: Just one more, that is right. Minister, are you aware of another child dying in the Canberra Hospital since Rozalia on 5 July? Is that one of the numbers that is under review?

THE CHAIR: Ms Castley, we will just let—

Ms Stephen-Smith: Ms Castley, I am not sure how to answer that question.

MS CASTLEY: You need to answer—

Ms Stephen-Smith: You might be aware that there are regular conversations, now, publicly about still births, for example. I am sorry, Mr Braddock. People die in hospitals; it is part of delivering a hospital service and—

MS CASTLEY: And do they—

Ms Stephen-Smith: And I am not advised every time an individual dies in hospital. If there is a specific incident and concern, or an event that is likely to need to be investigated, then I will receive a briefing on that, as I did in the case that you are talking about. I received a caveat brief to advise me that this event had occurred and that investigations were underway.

THE CHAIR: A substantive, Mr Braddock.

MR BRADDOCK: I am interested in the announcement of investment in alcohol and other drug treatments, and how that will meet the demand that was identified within the demand and service modelling projects analysis and also in terms of the workforce. Is someone able to provide some information on that for me?

Ms Stephen-Smith: Someone will absolutely be able to provide some information for

you on that matter, Mr Braddock. I am really pleased about this investment. I am particularly pleased about the additional investment in methamphetamine treatment—a co-design of a new treatment service with the alcohol and other drugs sector to enhance the integrated services for methamphetamine dependence and the co-occurring physical and mental health issues that can occur in relation to that.

There is also some investment in expanding and continuing residential rehabilitation to support residential rehabilitation services in the community to grow over time. There is also some funding for a family and carer support service through family drug support services. That is something that, obviously, the sector has been calling for, for some time, and something that the family and friends of people with drug dependence have been calling and advocating for. That came through in the inquiry into the Drugs of Dependence Bill and through the alcohol and other drugs sector. The additional funding in that particular measure is for some system enhancements to Canberra Script. If there is any more detail on any of those, someone will be able to help.

MR BRADDOCK: I am particularly interested that the demand and service modelling project analysed and found that about 50 per cent of people trying to access the treatment for these services were able to access the service. How will this additional investment meet that unmet demand?

Ms Stephen-Smith: In relation to residential rehabilitation that is a growth in service over time. On that front, I would also point to the funding for the redevelopment of the Watson precinct and the work we are doing with Winnunga Nimmityjah to develop an Aboriginal and Torres Strait Islander-specific residential rehabilitation service. That funding includes some early funding for Winnunga to develop alcohol and other drug expertise. I am just looking on the screen, if we go online. I do not know who wants to take this.

Ms Barbaro: I have read and acknowledge the privilege statement today. It is slightly crackly where we are listening. Could you just mention what you wanted me to elaborate on?

MR BRADDOCK: I can narrow down the question. Could you please provide me the number of additional people who will be able to access services underneath this investment, and also how many workers will be employed as a result of this investment. That would be great.

Ms Barbaro: I do not have the exact data on the number of people who will be able to access the service from the investment. What I can say, though, is that survey data to date shows that we have relatively high rates of access to treatment—well above the national average. Hopefully, by the end of the session I can get you the number of extra service places. In terms of additional FTE, there would be four additional FTE—one in allied health and three in administration.

MR BRADDOCK: Thank you.

DR PATERSON: I have a supplementary. I was just wondering—we are debating the legislative reform in this area. Going forward into the future, how responsive will the government be to changes in the community that we may see as a result of the

legislation?

Ms Stephen-Smith: Thank you, Dr Paterson. I think that we will keep monitoring demand for services. Obviously, we do that as we roll out a bunch of different changes across the community. One of the great potential benefits of the decriminalisation legislation is that people will feel more comfortable in coming forward and getting support. Still, we will obviously monitor any increased demand, particularly working with our non-government partners, who tend to see that demand coming through.

We have certainly seen that, for example, in the establishment of the drug and alcohol court. We have used the full-service capacity. As that has got up and running—the drug and alcohol list—that full-service capacity has been utilised. And that is a really good thing. That is achieving really good outcomes. Minister Rattenbury released a report on that not very long ago. But we are also continuing to work with the sector through the new drug strategy action plan development. We are hearing from them exactly what they are seeing, and we are co-designing with them to identify the priorities for new investment.

DR PATERSON: With these newer programs, like the specialised methamphetamine program, will there be evaluations of these programs as they go ahead?

Ms Stephen-Smith: I might throw that question back to Ms Barbaro.

Ms Barbaro: There will be evaluation for these programs. Also, just to touch on the question that was asked previously, because we are still in a co-design phase with the sector and will be for these additional initiatives, it is not possible to identify how many treatment places yet, because that is still to be determined. For some of those other initiatives that do have funds for additional staff and the additional development of staff, the same goes that we are still in a co-design phase for that. Over time we will work with the sector to see exactly what that looks like in terms of FTE.

DR PATERSON: Minister, I was wondering if you could provide an update on the work of the Canberra Hospital master plan and update us on this investment through the 2022-2023 budget? How will the plan benefit the ACT community?

Ms Stephen-Smith: Thank you, Dr Paterson. The master plan was released in December last year. It lays out a plan for the redevelopment of many of the older buildings in the hospital, creating a really healing space for people and a great space to work. It is obviously going to have to be a staged implementation, and we got some funding in the previous budget for the development of the Yamba Drive car park, which is coming along swimmingly.

In this budget, we have got an investment of $52.4 million over four years for the full phase 1 planning for the master plan. That is the design and fit-out of the 64-bed inpatient units, two wards—the shell space that was previously provided for in the Canberra Hospital expansion critical services building—to be fully fitted out. That will then enable some of the moves that will be required for further development. The design work, the detailed costings and the demolition to develop a new pathology building to be built on the site of the current building 6. Design work and detailed costings for a new inpatient building. Demolition and planning for building 4, and, obviously, we will

have to work with our partners at the Australian National University in relation to that. They currently occupy space in building 4, and that teaching and training element of the campus is really important. There will be a whole range of work around decanting and moving things around as the master plan progresses.

One of the things that we got a lot of feedback on through the consultation was the need for better wayfinding across the campus. It is a bit of a warren at the moment, and there are a whole lot of different signs that have been put up over time with different branding, different font, and different this and different that. So, doing a full wayfinding strategy for the hospital will be important, and then that staging and decanting, as I talked about. There is going to be different development over time and things are going to have to move around. That is probably reasonably comprehensive. I do not know if Ms Lopa has anything to add to that. Maybe I will let you ask a supplementary question and see if there is more detail.

DR PATERSON: I was wondering if you could provide an update on other infrastructure projects on the Canberra Hospital campus that are currently coming together underneath the master plan.

Ms Stephen-Smith: Related to the master plan or more broadly that are currently underway?

DR PATERSON: Related to the master plan.

Ms Stephen-Smith: I will hand over to Ms Lopa.

Ms Lopa: Thank you, Minister. Good afternoon, everyone. My name is Liz Lopa. I am the Executive Group Manager of Infrastructure, Communication and Engagement at the ACT Health Directorate. I have read the privilege statement and I acknowledge it.

As the minister has said, the Canberra Hospital master plan was a comprehensive piece of work that was undertaken and finalised in 2021. We did a large amount of community consultation, with almost 2,000 people giving feedback to us about what they would like to see on the Canberra Hospital campus. Now we are moving into that implementation phase for the master plan.

This budget funds, as the minister said, over $50 million to start implementing the master plan for a range of projects, including some new buildings on the campus and the demolition of some old ones.

While it enables infrastructure, one of the things that it truly does is enable the modernisation of the health services that we deliver. That is a journey that we have been on with Canberra Health Services and the community—to talk about how well the campus operates, how it can be improved for our workforce and how it can be improved for our patients and our visitors to the site.

From the community consultation that we undertook, the number one issue that people raised with us was car parking, closely followed by wayfinding. What they were relaying to us is that it is difficult to find a car park on the site, and once you do find a carpark, it is difficult to know where you are going to find your health service.

As the minister mentioned, last year's budget funded the first project under the master plan implementation, which is a car park on Yamba Drive. That is opposite the hospital where there is currently a surface-level car park. We are currently designing a multi-level car park to go on that site. We are in the middle of that design at the moment, and we will be coming back to government with some designs and some funding options. That will provide a lot more car parks on the site—we are hoping an additional 2,000 car parks, but, as I said, we are still in the middle of designing that car park. That will free up parking in that multistorey car park that is on the campus, and it will also provide more parking for staff that will be connected to the campus from an overhead bridge over Yamba Drive, meaning that staff at the hospital do not have to be at road-level, crossing those intersections. That is an infrastructure project that is underway now. And we have the Canberra Hospital Expansion project that is being delivered by Major Projects Canberra, which is providing a new acute care building to be opened in 2024.

DR PATERSON: In terms of public transport accessibility to the hospital, how has that been taken into consideration through the master plan?

Ms Lopa: When we were doing the master plan, we did a lot of consultation with the community but also with Transport Canberra and City Services, and the planning directorate, around public transport groups to and from the hospital. Obviously, with the issue of parking being such a big issue, there will always be people who need to drive to the hospital, but it would be excellent to have very good public transport links as well.

The master plan does outline a number of new bus stops throughout the campus at the achievement of the master plan. Lots of conversations have been had about interim measures that we can put in place while the campus is being redeveloped. Those conversations are continuing with agencies and between CHS, Major Projects Canberra and ourselves to make sure that we are improving accessibility from public transport to the campus.

THE CHAIR: Ms Castley, a substantive question.

MS CASTLEY: Minister, I have some questions about the cardiology department in the hospital. Between January and April this year, did you have a specialist and senior specialist staff that had all the skills, qualifications and credentials to carry out all of the services that are required of the cardiology department?

Ms Stephen-Smith: Mr Peffer?

MS CASTLEY: Do you not know, Minister?

Ms Stephen-Smith: Ms Castley, the way estimates works is that officials are here to answer questions on which they have detailed knowledge. Mr Peffer is the relevant official to answer your question.

MS CASTLEY: Thank you, Mr Peffer.

Mr Peffer: Thank you for the question. We did have a full suite of skills within the

department to carry out a critical range of services. Resulting from some of the actions and the processes that we commenced during that time, we did have an impact on our workforce. That did impact a number of the services that were previously available through our cardiology department.

As a result of that we worked with colleagues in New South Wales, which is not an unusual thing for us to do. We do that in a range of specialities in areas within the health service, to have any urgent patients requiring treatment transferred to New South Wales.

MS CASTLEY: How many of those patients were transferred? How many were affected?

Mr Peffer: It certainly was not a large number in terms of the procedures that were undertaken through our interventional team, but I am happy to take the question on notice for the specific number.

MS CASTLEY: That would be great. I have a couple of supplementary questions. How many adverse cases have there been in the past six months compared to the period from 2016 till now?

Mr Peffer: I would have to take that question on notice.

MS CASTLEY: Thank you. We had a representation that there was a staff member who was approved and paid for to be treated at a local private hospital during this period by an appropriate specialist even though there were some public patients that had been refused their treatment. I am just wondering if you could give me some clarification on that.

Mr Peffer: I cannot. If you are able to pass on the details of the particular patient, I am happy to look into that and come back to you through the minister.

MS CASTLEY: And to the previous question where you said people were transferred, can you also let me know, taking on notice, how many have been transferred to Sydney—just to be clear. I am keen to understand.

Mr Peffer: Yes, sure.

MS CASTLEY: Thank you.

THE CHAIR: In relation to having the experienced staff, qualifications and everything else, are there budgetary measures that are restricting bringing on these personnel, these professionals who are desperately needed in the cardiology area?

Mr Peffer: The short answer to that, Mr Milligan, is no. There is no budgetary constraint. Some of the skills that we are talking about are specialist skills. They are not widely available. So to recruit individuals and to bring those skills in, the team needs to work through that.

There is also a credentialling process. We do not bring in medical officers and have services provided until they have gone through quite a deliberate process to look at their

qualifications and experience, and to ensure that they are safe to provide whatever services they might be providing.

THE CHAIR: What is the government doing to attract these professionals? Are you broadening your scope from just in the ACT? Are you looking nationally? What are these professionals looking for in terms of a working environment?

Mr Peffer: Are you talking specifically about cardiology or are you talking about more broadly?

THE CHAIR: Yes, cardiology.

Mr Peffer: With the disruption within the workforce, the director of the unit engaged a number of locums from outside the territory—these were not individuals who reside here—to cover some of those shortfalls and provide some of those interventional skills that we required in the unit.

It is certainly not that we would look just locally when we do recruit. We have had a range of recruitment actions, not just within that speciality but across a broad range of medical specialities. We have been looking not just nationally but, in some cases, internationally, as well.

THE CHAIR: How does the ACT compare to what is on offer in other states? What is the salary package like in comparison? Does the working environment come into effect when people want to come across and move from one state to the territory?

Mr Peffer: The packages are certainly very competitive, and within the past 18 months we did do a benchmarking analysis across all jurisdictions in Australia looking at what constitutes those packages, the working conditions and clinical and non-clinical time. I might ask Dr Grant Howard to provide some comments on that as well.

Dr Howard: Good afternoon. My name is Dr Grant Howard. I am the Executive Director, Medical Services for Canberra Health Services. I have read and acknowledge the privilege statement.

Just to reiterate much of what Dave has said: there is a fairly strict onboarding procedure so that we make sure we get staff who are credentialled to do the things that we need them to do. There is a fairly strict process around that.

With respect to cardiology, we have been able to support the services with a series of locums while we have had workforce challenges. At the moment, we are managing to deliver a service that is safe and that I have very few concerns about.

With respect to attracting medical staff or specialist medical staff to CHS, it very much depends on the staff group we are looking for, and we are competing on an Australasian, if not worldwide, stage. With respect to finding procedural cardiologists and cardiologists, at the moment we are pretty competitive in what we can offer in Canberra and from a package point of view.

THE CHAIR: Any other supplementary questions?

MS CASTLEY: I just have a follow-up question on that. Is there any consideration to bringing a paediatric cardiologist and setting a unit up as well?

Ms O'Neill: Thank you. I have read and acknowledge the privilege statement. We undertake long-range clinical service planning for subspeciality units. It is really important to have a sufficient case load of these subspecialised services in order to maintain a safe service.

We do not believe we are there yet, at the moment, for paediatric cardiology, but we will continue to review the case data and continue to factor that into our clinical services plan.

MS CASTLEY: Will we get a look at the case data? How many cases will it require, and do we need, for it to be viable for us not to have to take kids to Sydney?

Ms O'Neill: It is not always just a discrete number. The data that is used to inform the clinical services planning that is available are the technical papers that accompany both the ACT health plan and the Canberra Health Services clinical plan. We can make both those documents available. They are publicly available.

THE CHAIR: Thank you very much. Mrs Kikkert, substantive question.

MRS KIKKERT: I understand that the Calvary oncology unit closed, or will be closing, and patients from there have been transferred over to the Woden hospital. Does the Canberra Hospital have enough room, staff and treatment facilities to look after these Calvary cancer patients?

Ms Stephen-Smith: Thank you, Mrs Kikkert. I believe you are referring to the Zita Mary Clinic, and there has been some misinformation circulating publicly in relation to this. Some services have been transitioned out of there to Canberra Hospital, but there is also some transition of services into Calvary as well, as part of that process. Jacinta George is the right person to talk about that in more detail.

Ms George: I have read and acknowledge the privilege statement. Patients who were receiving cytotoxic or chemotherapy treatment at the Zita Mary Clinic were transferred for treatment at the Canberra Region Cancer Centre at Canberra Hospital.

During the year, the last patient received cytotoxic treatment at the Zita Mary Clinic on 21 July this year. In that process, patients from the north side of Canberra, in particular, who were receiving transfusions other than chemotherapy are now receiving that care in Zita Mary Clinic, so there has been a movement of the types of patients between hospitals.

MRS KIKKERT: Why was that service closed down at Calvary Hospital?

Ms George: There was a desktop review of the new clinical standards for medication governance at Calvary Hospital. When we looked at the work needed to bring that clinical governance system up to the standard quickly, it was decided that those patients receiving chemotherapy were better and more safely able to be treated at the Canberra

Region Cancer Centre, and that it would enable more patients from the northside to receive their other therapies closer to home, so a project was put in place to enable that transfer of those patients.

MRS KIKKERT: You mentioned those cancer patients from north Canberra will be getting treatment closer to home, but you are asking them to travel to Woden. If you ask a cancer patient to travel further than 10 minutes than what they are usually accustomed to, it is actually quite painful.

When you are closing down a service that is providing chemotherapy for patients in north Canberra and asking them to travel to south Canberra—for all of us in this room who are healthy and capable that is an easy ask, but, when you are asking cancer patients who are receiving chemotherapy, it is a painful journey for them. Will there be a review process to make sure that this sort of chemotherapy service will be available for north Canberra patients?

Ms Stephen-Smith: Just to clarify, Mrs Kikkert, in relation to the services delivered closer to home for people on the north side, what Ms George was saying was that, while the review of the revised standards indicated that the standard for delivery of those particular cytotoxic chemotherapy services could not be met in the longer-term at the Zita Mary Clinic without some very significant changes and investment, and those patients have transferred over to Canberra Region Cancer Centre, other patients who live on the north side, who had been having to go to Canberra Hospital, are now able to be treated at Calvary for different types of infusions. For those patients, their care is being delivered closer to home.

We can take on notice to get some numbers for you as best we can in terms of the number of patients. My recollection is that it is, in fact, a larger number of patients who have been able to move to the north side to get their care closer to home than the number of patients who have had to move, but I could be wrong about that. I do not know if Ms George has any information on that?

Ms George: I do not have those numbers on me, so I will take that question on notice

Ms Stephen-Smith: Thank you.

MRS KIKKERT: A final supplementary question: after the review, will the ACT government be able to fund the service provider to reach its standard so that patients from north Canberra can actually attend Calvary Hospital to seek their chemotherapy treatment?

Ms Stephen-Smith: As Ms O'Neill touched on in her response earlier, there is a constant process of clinical services planning and evaluation of what can be delivered where. We are a community of 450,000 people that has a Canberra Region Cancer Centre, and we do need to be aware of delivering cost-effective services for our community, because we do not have an infinite bucket of money to spend on anything in the ACT, including health care. There always has to be an understanding of: (a) the first priority, "can the service be delivered safely and in accordance with standards?"; and (b) "what is the additional cost of providing a very specialised service to a very small number of people? What is the opportunity cost of doing that in terms of the other

services that could be provided for that funding?".

These are the kinds of complex decisions that we work through all of the time. I do understand what you are saying about north side and south side, but I would also note that people come to the Canberra Region Cancer Centre from right around southern New South Wales from Cooma and Bega, and all around the place. It is an unfortunate reality for many people that they do have to travel to receive health services.

While a key focus for us is delivering care closer to home as far as we possibly can, we also need to be aware of the cost of doing that sometimes when it is a very small patient cohort.

THE CHAIR: Any other supplementary questions?

MS CASTLEY: I have a supplementary question. I understand that radiation has become significantly worse over the past few months and to try to get that under control, or to get back to normal times, you were going to limit palliative care to one session. Is that correct? Did that happen? How many people did that impact?

DR PATERSON: This is not a supplementary question. This is a different question.

Ms Stephen-Smith: Ms O'Neill will take that.

DR PATERSON: It is a different question.

MS CASTLEY: It is oncology—

DR PATERSON: It is palliative care.

Ms Stephen-Smith: It is a completely different service, and a completely different type of treatment, so from that perspective it is not really a supplementary—

THE CHAIR: I will allow it. Minister, are you happy to answer that question now?

MS CASTLEY: We are talking about services moving, things being reduced, it is all on the same—

THE CHAIR: Or would you like to take that as a separate substantive?

DR PATERSON: It is a separate question. It is a substantive.

Ms Stephen-Smith: It is a substantive question. If you are happy for us to take it, Chair, we can take the question.

MS CASTLEY: No, that is okay, we can put that on notice—that is fine.

THE CHAIR: Back to myself for a substantive question. Can I get an update on the number of senior executives in the Canberra Health Services and ACT Health Directorate? According to a review of senior executives in the service, Canberra Health Services had 445 non-SES staff that were receiving SES-level salaries in 2022. Can you

provide an update on this number and a list of the enterprise agreements that these highly paid, non-SES staff are employed under, and the classification of the employees in Canberra Health Services?

Mr Peffer: Yes, I am happy to take that one, Mr Milligan. What you would be talking about there is our specialist medical workforce that is across a broad range of specialities. I think you would find they are covered under the medical practitioners enterprise agreement. They would generally be at the levels of staff specialist or senior staff specialist, where they are receiving an equivalent salary to an executive salary.

THE CHAIR: Could I also get the total number of Canberra health staff that received attraction and retention initiatives?

Mr Peffer: Yes. I would have to take that question on notice.

MS CASTLEY: A supplementary question, Chair, if that is okay.

THE CHAIR: Yes, Ms Castley.

MS CASTLEY: Can I clarify: are we talking about doctors and nurses or are we talking about—

Ms Stephen-Smith: We are talking about doctors.

MS CASTLEY: We are talking about doctors—okay, so in the hospital, working on patients at the moment?

Mr Peffer: That is correct.

MS CASTLEY: So with regard to the attraction and retention initiatives, I am wondering, you probably would need to take this on notice, but can we get a list of the enterprise agreement for each one of those and the classification of these employees for CHS.

I note the attraction and retention, there are a few different rates. So it could be enhanced pay rates, it could be privately-plated vehicles for people to park et cetera. Can we get a breakdown of what retention, attraction and sort of things that they are getting for each person or for each block of people.

Mr Peffer: Certainly, so what we will be able to put together is a breakdown of the categorisation. In some parts of our workforce, we have got group ARIns that apply to an entire specialty that have been negotiated over time, but we will be able to break that down and provide it.

MS CASTLEY: Just out of interest, why does CHS have so much more than—so the closest directorate I think is education with non-SES staff being paid at an SES level, why is the health directorate so different? I think it is something like 334 more people. That is quite a lot. Do their contracts not get—

Ms Stephen-Smith: Because Canberra Health Services employs doctors and in order

to attract them, you need to pay them a competitive salary.

Mr Peffer: So by and large, we are paying competitive market rates and, as Dr Howard mentioned before, we are competing not just in the national but in some cases an international market. So they need to reflect whatever the going market rate is across specialties, and that is what essentially dictates the packages that are provided to our senior medical work force.

THE CHAIR: Any supplementaries?

MS CASTLEY: I think so. So this happens—this is supplementary—for specific doctors, it is not across the board, so why would it not be part of the package of someone coming in to work for the Canberra Health Services?

Mr Peffer: Yes, so what we do have in specialties is called a group ARIns, so it applies to all of the specialists within that particular part of the workforce. For example, so it may be that within anaesthetics we have done a market benchmarking exercise and looked at what is a competitive package. And so then a group ARIn at some point in time has been introduced for that cohort of the workforce to ensure that we remain competitive in the market.

Just to be clear, Ms Castley, we are not going through a process of re-negotiating individual amounts for hundreds and hundreds of medical practitioners each year.

MS CASTLEY: No, I guess my point is that if this is required, why would it not be part of the normal budget?

Ms Stephen-Smith: Chair, Chair. This is a debate. This is a debate.

MS CASTLEY: You know, if this is what is required to get doctors from overseas, then it could be part of the budget—

Ms Stephen-Smith: Chair. Chair. She is debating me.

MS CASTLEY: and if this is what we expect to pay doctors of this calibre, then let us allow for that.

Ms Stephen-Smith: I think some of these arrangements—as I think Mr Peffer kind of touched on—some of these arrangements are sort of historic arrangements that have been put in place over time, that some health professionals that are still in the service are still continuing to get individual ARIns. There are some group ARIns that have been put in place.

One of the things we look at through every enterprise agreement process is, you know, how do we formalise all of these arrangements into the enterprise agreement? But at the same time, relating to our earlier conversation, we are competing in a global marketplace for some of these professionals and so we need to have the capacity to do that, to compete in that way. And that might not be able to be accommodated within an enterprise agreement that has to cover everybody. You know, you cannot really have an enterprise agreement that is going to cover every single specialty and subspecialty:

that would not be realistic.

MS CASTLEY: I have no problem with that. It is just about if that is what is expected, just let us do that.

THE CHAIR: Thank you, Ms Castley. We might move onto the next substantive, Mr Braddock.

MR BRADDOCK: I am just interested in more detail on the making medical and surgical abortions more affordable item that was announced. Can you describe how that will work and also what safeguards will be in there to prevent those who have been coerced into those decisions from perhaps taking up the service?

Ms Stephen-Smith: In terms of surgical abortion, we have only one provider in the ACT, Marie Stopes. In terms of medical abortion, there will need to be a process that will be gone through for expressions of interest to participate in that program. I will hand over to Michael Culhane.

Mr Culhane: Thanks. I have read and acknowledge the privilege statement.

In terms of the part of the question around what is often described as reproductive coercion, Marie Stopes has, I understand, arrangements in place to deal with that; and they, in Australia, have published papers on the issue of reproductive coercion, so it is no stranger to Marie Stopes as an organisation. If you wanted more detail on that particular aspect than I have provided, I would need to take it on notice.

Ms Stephen-Smith: I think it is important to recognise that that kind of coercive control can work both ways. So this measure of enabling people to get an abortion without the payment, without having to come up with hundreds of dollars that might be monitored, is actually a good thing for those who might be experiencing coercion in the opposite way, where their financials will be closely monitored and any capacity to find that money to pay for an abortion would be very difficult.

MR BRADDOCK: Thank you. Sorry, I am just going back a step, in terms of there is only one provider in the ACT? This is not provided to Canberra Hospital or Calvary?

Ms Stephen-Smith: There is only one provider of surgical abortion as a service, so that is through Marie Stopes. Late-term abortions and abortions for sort of medical, urgent need can be provided at Canberra Hospital.

DR PATERSON: How many years is the funding for?

Ms Stephen-Smith: It is ongoing.

THE CHAIR: Any other supplementaries? Dr Paterson, a substantive. We have got four minutes left.

DR PATERSON: The 2022-23 budget includes permanent funding for the Good Living with Arthritis program. I am just wondering if you can tell us what that program is and what benefits have been realised to date.

Ms Stephen-Smith: Absolutely. Who wants to take this good news story?

Ms O'Neill: I will take this one, Minister. So the GLAD program is the Good Life with Osteoarthritis program and it actually originates from a program that was successfully run in Denmark.

Canberra Health Services have been running some programs for people with osteoarthritis to be able to help prevent the number of surgical interventions. This GLAD program just takes that to the next level.

It is a full, multi-disciplinary program but predominately led by our physiotherapists. This program will occur in the community, so again away from the hospital campus. We expect significant reductions in the number of people requiring hip and knee replacements as a result of this program, based on the success overseas.

DR PATERSON: Thank you. What will be the ongoing funding to deliver this program?

Ms O'Neill: I do not have the facts in front of me, sorry.

Ms Stephen-Smith: Thanks for your question. I do not have that in front of me. Just give me one moment. So the funding through the budget—I do not have that in front of me but I will. In one moment.

DR PATERSON: Was this a pilot program and now it is a fully-funded program?

Ms O'Neill: Yes, this is recurrent funding.

DR PATERSON: So everyone who comes into the hospital with arthritic-type problems, they will go through this program first and then—

Ms O'Neill: The referrals will be screened by our extended scope physiotherapist to determine the extent of their osteoarthritis and the likelihood of success from this program, and we will redirect patients accordingly. Those that have reached such a stage that surgery is inevitable, those referrals will then still be forwarded to the specialists.

DR PATERSON: How intensive is the sort of physiotherapy that these patients receive?

Ms O'Neill: It comprises both a group and individual sessions, and that will be tailored to some extent per patient. We can get you the breakdown of the actual program.

Mr Peffer: Sorry, just to answer the financial side of things, so that is in the order of $400,000.

DR PATERSON: Thank you.

THE CHAIR: Given that the time is now 12.59, we will draw the session to a close.

We want to thank Minister Rachel Stephen-Smith and the director of staff for your attendance today. If witnesses have taken questions on notice, could you please provide answers to the secretary within five working days. We will start back up with Ms Castley and a substantive, so the committee will now adjourn for the lunch break and reconvene at 2 pm.

Hearing suspended from 12.59 to 2 pm.

THE CHAIR: Being that it is 2 pm, we will get started.

Welcome back to the public hearing this afternoon on estimates for 2022-23. In this session, we continue to hear from the Minister for Health, Minister Rachel Stephen-Smith, and welcome back all officials. Once again, if there are any new officials present, can I remind witnesses of the protections and obligations afforded by parliamentary privilege and draw your attention to the privilege statement. Of course, when you first speak, can you mention your name and position that you are representing, and also the acknowledgement of the privilege statement.

We might go straight into questions. From the end of the last session, we were up to Ms Castley on a substantive.

MS CASTLEY: Thank you, Chair. Minister, I have questions about elective surgery joint replacements. I am wondering about the budget funding. What has been allocated to elective surgery joint replacements—specifically the program—in this current budget?

Ms Stephen-Smith: Thank you, Ms Castley. There is a fair bit of detailed information and, I think, good news about the elective joint replacement program. They got through almost 500 elective joint replacements last year, which is really fantastic and was above what had been planned for last financial year. In this financial year, there will be a drop-off from that number. Ms Zagari can go through the detail of that.

Ms Zagari: There is a reduction in the elective joint number for this year on the back of last year, to allow for the implementation of the Digital Health Record and the associated slowdown with that. We are finalising numbers at the moment on what the final number will be in the joints program. It will be in the region of 340 joints for this year, to allow for some slowdown for the Digital Health Record implementation.

Ms Stephen-Smith: Just to expand on that slightly, because you might ask, as I did, as to why the implementation of the Digital Health Record in the public system would impact the elective joint replacement program in the private system. It is because we have to then move some of the other surgeries that would normally occur in the public system, particularly in Canberra Hospital, into the private system, and there are capacity constraints in the private system in terms of being able to do those additional other elective surgeries in the private system, on top of the joint replacement program. So it is a capacity issue across the system in relation to the implementation of the Digital Health Record.

MS CASTLEY: Over 500 were done—

Ms Stephen-Smith: No—just under 500. Around 500.

MS CASTLEY: Just under 500, over both public and private, and now—

Ms Stephen-Smith: No—through the elective joint replacement program.

MS CASTLEY: And that elective joint replacement program is only doing 340 due to the Digital Health Record. Professor Paul Smith wrote to the minister on 12 August with his concerns about the program. He wanted to meet with you to resolve this disastrous situation. I have his letter here. I am wondering: have you met with Professor Smith about this?

Ms Stephen-Smith: Yes, I have.

MS CASTLEY: You have met with him recently?

Ms Stephen-Smith: Yes. I have met with him, as has Mr Peffer. I listened and I heard his concerns. I explained some of the challenges that we are facing. Mr Peffer has had a further meeting with him and went into some significant detail, I understand, about exactly what the ons and offs are in relation to these matters.

MS CASTLEY: There are something like 630 on the waiting list. This is obviously going to blow out the waiting list more. Is there any other way that more than 340 could be allocated? Obviously, when someone waits for a joint, it is usually pretty bad and involves elderly people, and the longer they wait the worse the recovery is et cetera. I am wondering what you have done to try and blow that out a little bit.

Ms Stephen-Smith: That is exactly the conversation that we have been having. That is why Ms Zagari indicated that the numbers are not finalised.

Mr Peffer: Initially, we had thought that we could provide for in the order of 300 joints through that program and we have revised that up, and we are continuing to look at what it is we might be able to do through that program, given the capacity constraints and comments that have already been made. We are also looking at a partnership with New South Wales and whether there are some orthopaedic procedures that could be taken across the border, particularly given, when you look at our wait lists, we do provide a service into the region. So we are looking, with our partners in southern New South Wales, at whether we could take quite a number of orthopaedic procedures for New South Wales residents across the border.

MS CASTLEY: When will you know that? When will we have answers on that?

Mr Peffer: Actually, before we came to the hearing, we sat down with the team in southern New South Wales and commenced discussion about that occurring during this financial year. I think there is an intention for that to occur as quickly as possible.

THE CHAIR: One last supplementary, if you have one.

MS CASTLEY: Only to confirm it is New South Wales patients that you are looking at getting treated within New South Wales, and you hope to have an answer on whether

we can do that within the financial year—so, sometime in the next—

Mr Peffer: No, we will have an answer much earlier than that, but those procedures will be done this financial year. And I understand from Southern that the Ministry of Health has agreed to make funding available to take some of those procedures across the border.

MS CASTLEY: Okay. Thank you.

THE CHAIR: Any other supplementaries? The substantive comes back to me. Minister, I understand you went to Singapore recently.

Ms Stephen-Smith: I did.

THE CHAIR: I obviously have some questions around that: what was the trip about; what was the cost; who went with you on that trip; what was the purpose of it; and what was the outcome?

Ms Stephen-Smith: Thank you, Mr Milligan. The Chief Minister puts out a media release when he or other ministers travel overseas. We put out a media release when we travel overseas. The Chief Minister did put out a media release in relation to the Singapore trip that outlines the costs of his travel, with his officials and his staff, and my travel, which I am just trying to find. My recollection is that my travel cost was in the order of $13,500—estimated. Obviously, there will be a reconciliation in relation to travel allowance and that kind of thing as those costs are finalised.

The purpose of the trip—and I was accompanied on the trip by the members of the ACT Health and Wellbeing Partnership Board: Ms Cross; Mr Peffer; Darlene Cox from the Health Care Consumers' Association; Ross Hawkins, the regional CEO from Calvary; Russell Gruen from the Australian National University; Michelle Lincoln from the University of Canberra; and Megan Cahill from the Capital Health Network—including our commonwealth primary care responsibility partner on that. It was a very useful trip for everyone to have the same experience.

We went there for a couple of reasons. Primarily, there are a couple of hospitals there that have recently rolled out the Epic Digital Health Record, which we will go live with in November. There was one that had gone live a few months ago. Some of our officials were over there during their go-live and recommended that we go and talk to them.

My staff have confirmed it was approximately $13,500 for my trade mission.

THE CHAIR: As a whole, for everyone?

Ms Stephen-Smith: No—that was for me and my staff. One staff member came with me.

One of the hospitals had gone live some months ago with Epic, and another one had gone live just before our arrival in Singapore. We are hearing from their senior officials about how their go-live had rolled out, what lessons they had learned from that, and what advice they could provide in terms of how we manage that. That was very useful.

We were also looking at—as per this morning's discussion we have the Canberra Hospital master plan and we also have planning for north side hospital at the moment—so we were looking at infrastructure developments in relation to hospital planning. There are some interesting and innovative ward designs, for example, that we were looking at.

We were also looking at health innovation. We visited a centre for health innovation and talked to some teams around research partnerships that one of the clusters in Singapore is invested in, and how they are using that partnership to engage clinicians. We were talking earlier today about how we attract and retain our clinicians and having the capacity to engage in research was a really important part of that.

We also visited a centre that brought together a number of health and wellbeing facilities including sports facilities, a swimming pool and what they call a "polyclinic". A polyclinic is a bit like a combination of our community health centre and an urgent care centre; providing care for people with chronic illness but also providing urgent point of care where you can turn up without an appointment/walk-in treatment.

So there were a range of things that we looked at, and I will obviously be providing a report to the Assembly, as you do after every overseas trip. It has been a long time since we have had to do that but that is a standard part of the process.

THE CHAIR: Okay. From this, you might look at policy change, legislative change, new initiatives or programs; something that might come out of this trip?

Ms Stephen-Smith: We just recently released our ACT health research strategy, "Better together", and CHS has also fairly recently released a research strategy. So, certainly, the things that we heard there will inform the implementation of those strategies.

We also made some really good connections with people who might be able to support the implementation of those initiatives. Professor Gruen at ANU, he actually came to ANU from Singapore; he had some really good connections, people that he could introduce us to. Meeting those people, having those quite detailed conversations and then getting an understanding of who was interested in providing us with some advice and staying engaged with us as we implement those things, was really useful as well.

As I said, I think one of the real benefits—and I think the other thing is as we plan for, and to deliver our walk-in health centre election commitment with the new centres in North Gungahlin, Inner South, South Tuggeranong and West Belconnen—looking at the polyclinic model of care as we implement the new physical infrastructure, as well as our focus on integrated care and better integrating acute services in the hospital with our CHS community-based services and our hospital-in-the-home services and then partnering with primary care, there were some really good lessons there. Their primary care system is quite different to ours, but some good lessons learned.

Having everybody on the partnership board together to be part of those conversations means, I think, that will be really productive as we have those policy and implementation conversations here. People will not be talking at cross-purposes

because some people had the experience and others did not. So, overall, I think it was an extremely valuable trip.

THE CHAIR: Any supplementaries?

MS CASTLEY: Yes, I have a couple of supplementaries.

THE CHAIR: Ms Castley?

MS CASTLEY: Thank you, Chair. Minister, since I have been here, there have not been any overseas trips; is it normal to take a staff member with you, for you personally, for a minister?

Ms Stephen-Smith: Yes, most ministers will take one member of staff. Usually, it is the chief of staff, but in this case, I took one of my senior advisors. Just because it was her specific area of responsibility.

MS CASTLEY: All of the other people that you said attended, did they individually fund their trips, or does that come out of your health budget?

Ms Stephen-Smith: I might get Ms Cross to speak as to who paid for what, but the government funded Darlene Cox, the Executive Director of the Healthcare Consumers' Association.

Ms Cross: I have read and understood the privilege statement.

The answer is yes; David Peffer and I paid for our own travel. The Health Directorate paid for Darlene Cox. For Darlene and me, the total was around $14,000.

MS CASTLEY: You talked about a few things that you are bringing back—and it is good to have the whole team there. What will you immediately implement off the back of this trip? I know you said that there are strategies that you have already started on. From a taxpayer perspective, what are Canberrans going to notice immediately that you learnt from your Singapore trip and how will it help them?

Ms Stephen-Smith: I think there are a number of things. We are obviously in the design and planning process for new inpatient facilities. This is not going to be immediate, in the sense that people are not going to see a new hospital on the north side built tomorrow. But the information that we gleaned and the knowledge that we have about the way the various hospitals that we visited operated and the design of their infrastructure will feed into those conversations about what kind of infrastructure we need to build in our hospitals, how that operates and how that is staffed.

In terms of integrated care, I think there were a lot of lessons learnt. One of the things about this kind of study trip is that you are not necessarily going to see an immediate change in models of care as a result of this, but it will inform a whole lot of planning. So, again, talking about the delivery of the health hubs or walk-in health centres across the city, I think we all took away ideas about not only how that physical infrastructure could be delivered but also what combinations of services and how that could inform reviews of our own community care programs.

These are generally trips where you learn a lot and it feeds in over time. As an example, Ms Cross—in her former job—and I visited the UK and Ireland in 2018, and I am still drawing on things that I heard and learnt during that trip. As we do child protection reform and children, young people and family services reform more broadly, that knowledge continues to inform the policy development and implementation process.

MS CASTLEY: Ms Cross, thank you for the information on your costs. I am wondering if I can get the total cost, Mr Peffer—what it cost for the whole trip for everybody. I am happy for you to take that on notice, if you need to.

Ms Stephen-Smith: We are happy to take that on notice.

Ms Cross: We will have to seek that information from the other individuals and, assuming that they are happy to give it to us, we can provide that to you.

Ms Stephen-Smith: Just to clarify: are you talking about the cost to the ACT government; that you do not need the costs that the ANU and the commonwealth—

MS CASTLEY: No; just the total costs for all.

THE CHAIR: Thank you, Ms Castley. Substantive, Mr Braddock?

MR BRADDOCK: I am interested in how we are progressing against the ACT Preventive Health Plan. Are we still measuring performance? Can you please let me know how we are going?

Ms Stephen-Smith: We will go to Bowes Street on that one, though they might not have heard it.

THE CHAIR: Fiona Barbaro, over to you.

Ms Barbaro: So where are we with the Preventive Health Plan? We have our three-year plan in place, which has just recently expired. We have done a review and evaluation of that against the five key areas, which are supporting children and families; enabling active living; increasing healthy eating; reducing risky behaviours including smoking, risky alcohol consumption; the transmission of STIs and blood-borne viruses; and promoting healthy aging.

At the moment, we are developing the second action plan under the strategy. That is pending government consideration. We hope to have that finalised towards the end of the year. We have also got the mid-cycle review underway, which we expect to complete by the end of this year. The work that we have underway is building on the success of the first plan. A major feature of the first plan is the Healthy Canberra Grants scheme. In the past 12 months we have released several million dollars in funding for reducing risky behaviours and supporting children and families in terms of their health.

MR BRADDOCK: Will that evaluation be published?

Ms Barbaro: That would be a decision for government. But, in the past, they normally

would be, yes.

MR BRADDOCK: Is there any funding in this budget, or from previous budgets, that still provide the funding for the Preventive Health Plan?

Ms Barbaro: Yes, there is. There is an ongoing investment of at least $2.3 million annually that largely goes to Healthy Canberra Grants and there is an ongoing operational budget within the population health division that also invests in measures under the Preventive Health Plan. There are also initiatives across the whole of government that align with the plan, such as those under the draft First 1000 Days strategies for children and families and the Healthy Schools programs that are delivered in education.

We have at least 40 current grants that we are managing in small and large organisations across the territory. There are also grants managed in the office for sport and in the Chief Minister, Treasury and Economic Development Directorate that align with the plan also. There are also initiatives under the drug strategy that align with the risky behaviour plan. There is approximately $20 million over the life of the drug strategy in additional funding that the government has invested and at least $13 million in this current budget. That is for new drug and alcohol initiatives.

MR BRADDOCK: This might be a difficult ask, but is it possible to get a picture of all the contributing initiatives towards the Preventive Health Plan and how much they cost across government?

Ms Barbaro: I think we would be able to get that at a high level from the mid-cycle review that is currently underway. It would be difficult to quantify all of the programs that are delivered across government, because the strategy and the plan provide an overarching approach to guide government decision-making in all aspects of decisions, but then there are some specifically funded initiatives that are under the plan. So it would be very difficult for us to quantify the full amount. I think the best approach is through that mid-cycle review, which looks at how we have implemented things and what requires improvements and looks at whether there are opportunities to do things differently.

MR BRADDOCK: I hope I get an opportunity to read it.

THE CHAIR: Dr Paterson, on a substantive.

DR PATERSON: Thank you very much. My question is in respect of the digital health record. That is a very significant investment in the budget over multiple years. I was just wondering if you can explain where that funding is actually going and the implementation process of the digital health record.

Ms Stephen-Smith: I am going to hand straight over to Mr O'Halloran for that one.

Mr O'Halloran: The funding that is being provided for the digital health record is going to a number of places. There is obviously the cost of the software vendor Epic, which is the primary cost. There are also costs for ICT infrastructure, such as the servers that host it and the like, and there are over 1,000 servers hosting the full solution. There

are also ancillary software licences—for example, some dictation software licences and those types of things that go along with it.

There is also a substantial proportion of funding for the staff to actually implement the program. There are implementation teams at both Calvary and Canberra Health Services as well as a core program team in the ACT Health Directorate. It is a team of about 150 or a bit more across those three plus the trainers. There are also the various costs for training. There are staff being taken out of clinical service to do training and there is funding provided for backfill of those staff and some realignment there. And then there are all the other usual pieces that go with the project—everything from barcode scanners, to label printers, machines that go 'ping' and sort of brackets to mount on anaesthetic machines, theatres and the like.

DR PATERSON: Does the digital health record mean that an individual's health record can be accessed by any medical professional in the ACT?

Mr O'Halloran: In essence, yes. At the moment, we operate over 250 clinical ICT systems across the ACT public health system. With the digital health record, on day one, we will decommission over 40 of those systems, which is equivalent to the vast majority of day-to-day IT usage that any clinician in the wards or in a clinical service would use. What it does is bring together all of that clinical information about the patient and the administrative information, and that is accessible to the treating team, wherever they are, across the public health system.

DR PATERSON: Have you been pre-training and preparing health workers in the system before it is implemented?

Mr O'Halloran: Absolutely. This has probably been a three- or four-year journey. The procurement process for the digital health record is where we really started actively engaging clinicians. The requirements of the request for tender and the evaluation plan were actually heavily informed by clinical input and design. The tender evaluation team was primarily composed of clinicians. We even had town hall meetings where they actually saw the software being demonstrated. We commenced training and we now have over 70 trainers on board.

Training for our 'super users'—staff from the floor who will go back to the floor, and the clinical floor—across the health services starts next Monday. We have nearly 1,600 super users who we are commencing training with. On 12 September, we then start training the rest of the public health workforce. So, by the time we go live on 12 November—which is 80 days today, which is awfully soon—we will have trained over 14,000 people.

DR PATERSON: What sorts of backups are in place to ensure that nothing sort of slips through the gaps and that there is oversight of the implementation process?

Mr O'Halloran: There is a whole range, whether it is from the clinical process and how the workflow and the system is designed. That has all been informed by subject matter experts. Over 500 subject matter experts from the clinical services have gone through and tested those processes. They have put them through everything from what they call a table read, which is stepping through how each of the steps work, to actually

using it to try and see where there is a problem. They will even do what is called shadow charting, closer to go live, where they will actually sit there and shadow what actually happens in a real case and try and use the system to see how it works and identify any problems. So, from that clinical perspective, that is that whole piece there.

There is also a quality and safety focus very much on the team, and there are working groups that also look at that and are looking at any other things that could slip through the cracks. A lot of the design is also heavily informed by what we have seen elsewhere, the feedback that we have had from other sites that are doing these systems and our own experience in doing it.

From an IT perspective, we have two major ways we are dealing with it. The first is, we have rollback plans to enable us, if something does go wrong in the system, to roll back to the old systems. We hope never to use it but we always have that plan and we will exercise it. Secondly, in terms of the actual infrastructure that hosts the IT systems, we have a second data centre that will actually host a full copy of that.

So we have a range of different ways we are trying to make sure that nothing slips through the cracks.

DR PATERSON: In terms of privacy and security of the system, is that an un-hackable kind of thing?

Mr O'Halloran: We have done a fair bit of work on the privacy and security aspect of it. The digital health record is very much being designed from the ground up with both security and privacy in mind. We have had a full privacy impact assessment undertaken by an external legal team, which will be published on our website when the system goes live. The PIA steps through in intricate detail how we are meeting our requirements under the legislation and how we will operate, and that has actually informed the operations and the design of the system. So, from a privacy perspective, that is where we have gone. The Consumer Engagement Committee has been heavily involved in that. In fact, we have a representative from the Health Care Consumers' Association on the program board who is also quite vocal and active about those things.

From an ICT security perspective, we have established a separate hosting environment called the 'health enclave', which is being set up with an external third party. We have set up the servers and the systems there to be equivalent to, in the commonwealth, what we would call a 'protected' level, with a range of additional security treatments, 24/7 monitoring and a whole range of other elements there.

DR PATERSON: And will individuals be able to access their own data?

Mr O'Halloran: Individuals can currently access their own data in their health records, going through the health information management teams in each of the health services. The process will be the same in the future with the digital health record. Some elements of their record will be available directly to them online through the patient portal, MyDHR. But the full record will be available through the health services, as it is today.

DR PATERSON: Thank you.

MS CASTLEY: Minister, in the media you said that there would be significant improvements when MyDHR is up and running—in elective surgery wait times and ED. I am just wondering when you expect to see that improvement and what that looks like to the average Canberran.

Ms Stephen-Smith: Where was that quote from, Ms Castley?

MS CASTLEY: I think I have read it a couple of times, and I know when we had our briefing we were told that this will significantly improve wait times.

Ms Stephen-Smith: I do not believe that I have ever made that statement in relation to the digital health record. I stand to be corrected on that. I hope that it does have an impact, but one of the things that it will really do is help staff to do their work with less paper, to start with, and a better understanding of a patient's prior experience in the system. I guess I could give you a really, really, simple example. When I presented at the emergency department and needed to be referred to the eye clinic, I literally had a piece of paper in my hand and walked from the emergency department to the eye clinic and handed them a piece of paper. The emergency department and the eye clinic will now be on the same system and will actually be able to see that electronically. So there will be a whole lot of things that are simpler in the system and bring together information.

As we progress with the rollout—so not from day one—there will also be the capacity for a person's general practitioner to be able to see what is in their digital health record from the ACT public health system, hospital system and community health system. So that will give them real-time information about what is happening with their patient and improve the quality of the discharge notes that are forward to GPs.

So there will be improvements in the system. I think it is probably too early to say whether we will see an immediate improvement in things like wait times. It may be that it contributes to improvement over time. But it may also be that in the first two weeks, when people are still getting used to the system, we might not see any improvement and we might in fact see that some of the recorded times are not as good because of people getting used to using the system. We just do not really know the answer to that yet. I think what we all expect, though, is that it will ultimately make the job easier for staff.

MS CASTLEY: So communication from a GP to the hospital is happening? For instance, if I have a child with an elevated heart rate and the GP says, 'Get to the ED,' the ED will see that information and not just take a temperature and a finger prick test; they will know to check the child's heart rate?

Ms Stephen-Smith: I might hand back to Mr O'Halloran. Certainly, initially, the communication will not work in that direction.

Mr O'Halloran: For immediate, particularly emergency, presentations, there will be no immediate change in how the information is provided to the emergency department from clinicians outside the public health system. The digital health record will really interact with that primary care sector by improving the quality and quantity of the discharge summaries that are provided to GPs. That is provided through an electronic interface, in most cases with GPs directly into their practice management software. That

will continue. There are other aspects as well where additional information will be provided by fax—unfortunately, some GPs still prefer fax—and there will be other portals over time for the GPs to do things such as lodge referrals and also to have access to additional information.

THE CHAIR: I think it is your turn for a substantive, Ms Castley.

MS CASTLEY: Fabulous. Minister, I have some questions about the process of engaging Ms Deegan for a couple of reviews that have gone on and to understand the relationship with the directorate and Barbara Deegan. I have a couple of FOI documents. They are lengthy. I will read them because I want the dates—

Ms Stephen-Smith: Not the whole thing, I hope.

MS CASTLEY: No, no; specific dates. On 15 October 2021 at 2.52 pm, Kalena Smitham, the Executive Group Manager for People and Culture, sent an email to Jacqui Taylor, Executive Director of Medicine, stating that the CEO had accepted a PA review of the cardiology department, adding, 'We will progress to a range of brief and scope'—so just giving the team a heads-up, obviously. Earlier that day, at 9.40, Jim Tosh sent Barbara Deegan an email asking her if she was available to lead the review. Mr Tosh added in the email that he really values her approach to such matters. Later that day, Ms Deegan replied to Mr Tosh, saying that she had capacity.

So my first question is: is it common practice to ask a consultant that you have previously spoken to to conduct a review before that briefing and scope is ready to go?

Ms Stephen-Smith: Sorry; this is probably not a question for me. Did you want to take it or—

Mr Peffer: Yes, I can respond to that, and Ms Smitham might want to add some things. When we gear up to undertake these sorts of processes you might expect there would be a few things happening in parallel to essentially bring it together to ultimately determine who would undertake the PA. Ms Deegan obviously has a lot of credibility, given her past extensive experience in these sorts of matters to sort of present us with a high-quality output as part of that process. If it were to be the case that she did not have capacity, we would look at someone else who had a similar skill set and experience.

MS CASTLEY: On 4 January this year, at 9.41, Mr Tosh again emailed Ms Deegan with another offer for her to conduct a review into the intensive care unit and this time provided Ms Deegan with a scope and a preliminary assessment. Peter McNulty, who works for Ms Deegan, confirmed her availability and informed Mr Tosh that he would provide a quote the next day. Was there no competitive tender for both of these reviews? It seems like a direct email to Ms Deegan. Is that the way it goes?

Mr Peffer: I may have to take that on notice in terms of the process that we went through. But, in terms of people with that level of experience and the qualifications to undertake these reviews, it is not a long list that you would look at in terms of sort of ex-commissioners who have that experience. I am happy to take that on notice and come back to the committee with a response on that.

MS CASTLEY: So, to just confirm, that Ms Deegan was engaged to conduct the review via email—if that was the case?

Mr Peffer: Quite possibly.

MS CASTLEY: Quite possibly; okay. Then, on 30 March this year, the Australian Salaried Medical Officers' Federation, ASMOF, emailed you, Mr Peffer, and other senior executives. I have the letter here. It says:

> It was reported to ASMOF that the CEO stated at that meeting that the employment contracts of some cardiologists may and likely will be terminated. That statement, if correct, anticipates the outcome of the Deegan review and raises real questions about the objectivity of the brief provided for that review and the intentions of the executive in undertaking the review.

Minister, how do you respond to those serious concerns and allegations of the anticipation of the outcome of the Deegan review?

Ms Stephen-Smith: Mr Peffer can speak a bit more to the background of this and Ms Deegan's review. The preliminary assessment was not the first step in this process. So it might be helpful for Mr Peffer to give a bit of background to what had occurred before this step.

Mr Peffer: Prior to the engagement of Ms Deegan to undertake a bit more of a deep dive preliminary assessment or to provide a report that would enable some decisions around whether to pursue individual investigations, there had been a range of surveys that culminated in a review of the Department of Cardiology. It highlighted some concerns within the workforce about the nature of the culture, the experience of individuals working within that unit on a day-to-day basis at times enduring some very challenging behaviours, and some of those comments indicating that those behaviours had occurred quite a length of time.

Our intention through these processes is to bring a level of objectivity, which is why we are actually engaging people like Ms Deegan or law firms through the public sector unit within the Chief Minister's Treasury and Economic Development; so that they are not done in-house and that we avoid any sense of a pre-determined outcome or objectivity not being present as part of that investigation.

At the moment it is the case that some of these matters are being heard through various forums. I think the question of objectivity and how we are undertaking the process here is on full display and being heard by the Federal Court, and there has been a recent preliminary ruling in that respect.

THE CHAIR: Just in relation to that, how much did this thing cost anyway?

Mr Peffer: We would have to take that on notice. I will that on notice and provide that.

THE CHAIR: Excellent; thank you. The *Canberra Times* reported on 28 July that public hospital patients had been transferred to aged-care homes to create more space. When did you begin transferring patients from the Canberra Hospital into aged-care homes and how many have been moved?

Ms Stephen-Smith: I think it is important to recognise that there is constant movement between residential aged-care facilities and hospitals and there is also a longstanding issue of people who are unnecessarily long-stay patients in hospital settings because there are barriers to their discharge to a more appropriate setting, whether that is through the National Disability Insurance Scheme or to a residential aged-care facility.

This was really about ramping up efforts even more to ensure that those people who were ready for discharge and no longer needed acute hospital care were able to be discharged to a more appropriate setting. We were working very closely with the sector to try to find a residential aged-are facility that was able and willing to take people even if that might not be the final residential aged-care facility that they might end up in, so that we could work with people to temporarily locate them to a different aged-care facility while they looked for the most appropriate final residential aged-care facility for them.

It is really important to recognise that these are not acute hospital patients that we are asking residential aged-care facilities to care for; these are people who are appropriately accommodated in residential aged care and trying to address the barriers to discharge that exist across our system. The last I heard was that we had about three people successfully transfer through this effort. Ms O'Neill might have an update on that.

Ms O'Neill: I do, Minister. We have so far transferred nine people under that arrangement, three of whom have now found permanent placement, and we are working with those remaining six to find them permanent placements as well.

THE CHAIR: What support has been given to those aged-care homes to care for these hospital patients?

Ms O'Neill: We are transferring their full care to the aged-care facility. These are people that have already undergone their aged-care assessment to determine that they are suitable for aged care. We are then supplementing that care with some social work in-reach from Canberra Health Services to make sure that we can continue to find their permanent destination and help them and their families get them to that final destination.

THE CHAIR: What are the costs associated with transferring and treating public patients in aged-care facilities or homes?

Ms O'Neill: We have got agreements with each of the aged-care providers that we are working with. At the moment we are working with three, but we have made that offer available to any aged care. We are paying them the per diem rate of about $350 per person per day.

Ms Stephen-Smith: The fact that we are paying that does speak to some of the barriers that individuals and families face in trying to make that transition to aged care if there is not a space available where they want to be longer term. It is quite costly and there are some barriers to temporarily going to one aged-care facility and then transferring to another. This is about facilitating that capacity.

THE CHAIR: What does that $350 cover?

Ms O'Neill: That is higher than the per diem rate that the commonwealth is paying an aged-care facility to care for people. We have paid slightly above that rate in recognition that we are bypassing those initial arrangements that normally happen through the commonwealth, including things like accommodation bonds and those sorts of things. There are no out-of-pocket expenses charged to the patients whilst they are there, from CHS funding.

MS CASTLEY: You said that nine people have been moved into aged-care homes; three are now permanent. Are we definitely talking about people who are old enough to be aged-care people? Did they have COVID when they left? This might seem simple, but these are questions that people have been asking me, so I do not know whether or not it has been clear in the media.

Ms Stephen-Smith: I think I have clarified that a couple of times, probably to the constituent who has been asking you about this, Ms Castley. Ms O'Neill said that these were people who had already been through an aged-care assessment team, an ACAT assessment. Yes, they have been assessed through the normal aged-care process, and they are also tested for COVID before they are discharged.

Again, I would emphasise, Ms Castley, in relation to this, that people are admitted to hospital from residential aged care and returned to residential aged care just about every single day. There may be a day when it does not happen, but it is a very regular occurrence for people to transfer from an aged-care facility into the hospital and back to an aged-care facility. These transfers occur all the time.

MS CASTLEY: With regard to that, with these patients who you mentioned were possibly long term and taking up space, and needing to move them out, it is my understanding that there are still six people who have moved from the hospital—being unsettled and being moved elsewhere. They are waiting there; they are going to get unsettled again. My understanding of people who need aged care, especially if they have been crook, is that they should not be constantly moved like that. Have you been doing this in consultation with the families?

Ms O'Neill: Yes, all of these people have transferred voluntarily.

Mr Peffer: The nature of an acute hospital like this is that you have a concentration of very unwell people and a range of infectious diseases. The question always needs to be: is this the most appropriate and safest place for them? When it is not, that is when we look to move those patients out, and when they are medically well, and an assessment has been undertaken. They may be waiting on something for their preferred aged-care facility, and this is an interim step before we move to that.

MR BRADDOCK: On page 31 of the budget you talk about developing a model of care for gender-based health care aligned to ACT government policy. Could I get more detail on that? Also, does it incorporate the idea of gender diversity?

Ms Stephen-Smith: I will hand over to Michael Culhane. You may need to repeat the question if they did not hear it.

MR BRADDOCK: My question was about the proposal to develop a model of care for gender-based health care aligned to ACT government policy. I am also keen to learn whether it incorporates gender diversity.

Ms Stephen-Smith: The quick answer to your second question is yes, but we will get more detail.

Mr Culhane: I have read and acknowledge the privilege statement. Just to clarify, are we talking about the model of gender-based health service that came out of the LGBTQI scoping study; is that what we are referencing?

MR BRADDOCK: I am not sure. It is referred to on page 31 of the health budget.

Mr Culhane: Bear with me for a moment.

Ms Stephen-Smith: Sorry, Michael; it is a CHS question. There is a fair bit of work outlined in this space. There is some whole-of-government work that the Health Directorate is doing and CHS is doing some specific work.

Ms Freiberg: I have read and acknowledge the privilege statement. We are working on this closely with ACT Health. ACT Health have done the piece on the gender scoping study to work on a co-design level of care. We are working on the final stages of preparing a budget piece that goes with that. We have done the final piece of consultation and it goes to our care committee within CHS next month. We currently provide a service. This is an enhancement of the current service provision. Is there a specific question?

MR BRADDOCK: In terms of the consultation, who have you been consulting with?

Ms Freiberg: We have been consulting with A Gender Agenda, Meridian and the team at ACT Health. We attended all of the co-design workshops that were run from the ACT Health group under KPMG.

DR PATERSON: My question is in relation to COVID-19 and how we are addressing that going forward in terms of funding in the budget for services, particularly the COVID surge centre and addressing long COVID in the community.

Ms Stephen-Smith: I might go first to the long COVID issue. These are a little separate; there is a specific long COVID clinic, and I will go to Ms O'Neill. We will go to the business case and management of COVID in the community.

Ms O'Neill: Our rehabilitation team out at University of Canberra Hospital has been working very closely with Capital Health Network and our GP colleagues to come up with a model of care for the provision of a long COVID recovery clinic. It is very much based on, if you like, a pyramid approach. Most people with long COVID symptoms can be safely and effectively cared for by their primary health physicians, and that is the way we want to keep it. But there will be a small minority of people who need some expert care.

We went live with the long COVID clinic in August this year, out at the University of

Canberra Hospital. We currently have 64 active patients. They have discharged 11 patients from that service. They have a waiting list; they have received 170-odd referrals so far. High priority wait time at the moment is less than 20 days, which compares quite favourably with our jurisdiction partners across Australia.

They are also undertaking a parallel research project, particularly on the first 100 patients through this clinic, to gather more. At the moment there is a pretty sparse evidence base for the management of people with long COVID. They are working with their colleagues both nationally and internationally to make sure we can further the evidence base.

Ms Stephen-Smith: Dr Coleman can talk about the budget measure, recognising that, at the time the budget was being put together, it was not entirely clear what was going to happen with the funding for national partnership agreement with the commonwealth, which has now largely been extended to the end of December; nor was it clear what was going to happen with the second Omicron wave. We continue to monitor what we will need to spend on the ongoing response to COVID.

Dr Coleman: I do not know that there is much more I can add.

Ms Stephen-Smith: You could say what it is being spent on.

Dr Coleman: I have read and acknowledge the privilege statement. In addition to Cathie's comments about long COVID, it is a really interesting question, and one that is certainly being asked nationally as well. In addition to looking at clinical services, from both a hospital perspective and how best we support primary care, we need to look at whether there are any research needs in this area and how we will coordinate national efforts around that. We need to look at data collection so that we can monitor trends, and at the severity of illnesses.

There is a whole lot of other stuff in there which is certainly getting national priority. Hopefully, over the next couple of months, there should be much further work done to get a national, consistent picture and progress work in this space.

DR PATERSON: What about testing and vaccination programs in the ACT? How have they been budgeted for in this budget?

Dr Coleman: We have had full funding for rolling out mass vaccination and testing clinics. It would be best to refer specific details about funding amounts to the chief executive who is in charge of that. I can talk generally to where we think we are going and how we might look at that, if that is more of what you are after?

DR PATERSON: Yes.

Dr Coleman: With vaccination in the ACT, we have certainly got to a saturation point, at this point in time, where the demand for mass vaccination clinics does not justify us having availability of the strength that we did have. Primary care, particularly pharmacy, have really stepped up and responded to those needs.

We are very much focused on supporting primary care to continue to roll out and deliver

those COVID vaccine doses, as well as flu doses, as we need to, moving forward. There was the recent addition to the six months to under-fives, for those higher at-risk individuals at the moment. We work with both primary care GPs and some of the special clinics in Canberra Health Services, who are used to and can identify those children.

We will continue to monitor the advice around the vaccine program. We are not sure what will happen in terms of recommendations for COVID doses into the future. There is some excitement about the new bi-vaccine that has come out, but as to its role, how frequently and who we need to give it to, I think we need to maintain a flexible and adaptable response to that.

Testing is a little more complex at this point in time. We currently run mass testing clinics to provide PCR testing. The role of PCR testing will need to change with time. It is actually a very expensive service. It has been fantastically useful for us to monitor the prevalence and incidence of disease as we move forward, but in the longer term, and actually in the intermediate term, we will get to a point where it is most important for people who need to get funnelled into treatment to have the proper testing. We are looking at the moment at how we can start that transition process, and at whether there are any aspects of what the ACT government does that still needs to be funded in this space—how much of that, hopefully, can be done through the normal system of private pathology and GP prescribers—and what is the role of RATs into the future.

I think there are lots of different levels. That is why, as I think the minister was alluding to, our business cases and our planning for funding are evolving as we move through those issues.

DR PATERSON: While we are not out of winter ourselves, I am assuming we will be watching very closely what happens in the Northern Hemisphere coming into winter. Will there be planning that is conducted over spring-summer for next year?

Dr Coleman: Yes. We are constantly doing ongoing planning moving forward. Our current focus is on trying to balance the difference between acknowledging there is likely to be another wave and not knowing what that wave might be. My feeling is that we will get a smaller wave, probably associated with reducing immunity to our current Omicron. Equally, it is just as likely that we will get emergence of a new variant that puts another barrier in our pathway, and we have to pivot yet again.

We will maintain a baseline degree of ability to respond to that, while noting that the community has also moved on quite a long way in terms of how we need to deal with COVID. Our COVID smart behaviours, and all of those kinds of things, are embedded there.

Certainly, we have a great commonwealth government in terms of liaising internationally in these spaces. We get a lot of information through AHPPC about lessons learned in experiences from overseas.

DR PATERSON: There is a lot of reporting around other diseases and viruses. In terms of watching these things overseas, what is happening in planning, in case there are other things that come our way? Are we doing all of that here in the ACT?

Dr Coleman: Yes. It is a really busy space at the moment, isn't it? We have had to respond in the last 12 months to both MPX and JEV—we like our acronyms!—the Japanese encephalitis virus. We are certainly working very closely with New South Wales in particular, as well as the commonwealth, to look at what is the consistent, national approach to this. Also, how does that relay to an appropriate contextual response in the ACT?

We need to rely a lot on the commonwealth to do that horizon scanning and reaching into those countries to get us the specific information. But we certainly take that on board. I am on the phone most days to Dr Kerry Chant in New South Wales and Dr Paul Kelly. We are constantly doing that engagement work to make sure that we have as comprehensive an approach as we possibly can.

MS CASTLEY: Minister, I have some questions about the intensive care unit and the survey that was done. On 27 January this year there were some preliminary survey results. The results showed that the Canberra Hospital intensive care unit ranks in the bottom 10 per cent of scores for community safety measures compared to other hospitals across the country. The survey of ICU staff asked them to respond to questions such as, "People in my work unit exercise good judgement about when to escalate a deterioration in a consumer's condition." I am wondering when you first became aware of the result that the Canberra ICU was in the bottom 10 per cent.

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

MS CASTLEY: Have you heard of this survey? Do you know that that is where we are ranked at the moment?

Ms Stephen-Smith: I am briefed on a lot of things, and I am not entirely sure what you are reading from. I will have to go back and check. It would be helpful if you were able to advise what document you are looking at.

MS CASTLEY: Sure. We have an FOI document here, from Lisa Gilmore, CHS, Executive Director, Surgery, and preliminary survey results from 27 January.

Ms Stephen-Smith: As I said, I have taken the question on notice.

MS CASTLEY: Okay. What is your reaction to that? What are your thoughts regarding immediately fixing that, if our staff are concerned about the escalation when deterioration is occurring? What do you say about that?

Ms Stephen-Smith: Obviously, we are always concerned about results like that. There has been quite a lot of work done at Canberra Hospital in relation to deteriorating patients. I will hand over to Dave to talk about that.

Mr Peffer: There are a couple of things that we have going on within the organisation. First, at a more global level, there is a program called Speaking Up for Safety. It is a collaboration that we have with the Cognitive Institute. We have had more than 7,000 of our team members now undertake that training. That training is geared to providing a common language and creating an environment where we have team members who are confident about and comfortable to escalate concerns, if they do have concerns over

a patient's condition or the care that they are receiving.

We are about to commence implementation of the second module in that program of work. It is called "promoting professional accountability", and it provides a mechanism for all team members, if they are not comfortable, for whatever reason, to raise a concern in that immediate moment; there is an anonymous mechanism that will support that concern being raised and then a colleague-to-colleague discussion with whichever team member it might be about.

Specifically with ICU and in parallel with that program, we have done a deep-dive cultural review. It did come out in the November-December 2021 cultural results that there has been a pervasive culture of blame within that team. It has been that way for a number of years, and that is the reason why we undertook that review. It has identified a program of work—a range of recommendations to be implemented within that team, within the organisation. We are in the process of implementing that and working with the team to rectify that.

MS CASTLEY: You mentioned staff would not be comfortable raising concerns. Why would they not be comfortable raising concerns?

Mr Peffer: I think this comes to the heart of the culture that you try and build in a very large, very complex organisation. With any team you will have people of varying levels of expertise and seniority. All of these things in no small way colour or influence our team members' ability and willingness to speak up in the moment.

This is not something that is unique to the healthcare industry, but it can have pretty significant implications when things go wrong. For Canberra Health Services, and I think for a lot of organisations globally—recognising that this Speaking Up for Safety program is not just being implemented here in Canberra; it is now being picked up by hospitals and health services around the world—there is that recognition of focusing on creating a supportive and collaborate environment where people can raise those concerns when they arise.

MS CASTLEY: Can you give me information, since around 2018, as to how many times the hospital has been sued over this issue? If we are tracking so low, what is the impact for Canberrans? Can you let me know how many legal actions have come as a result of someone who has deteriorated and was not escalated in time?

Mr Peffer: That might be a little hard to separate out, but I will take it on notice and see what we can usefully provide.

DR PATERSON: In terms of the steps coming out of that report that you mentioned, and the recommendations, could you speak to what work is being done? What are some of those recommendations and what is Canberra Health Services doing to address that?

Mr Peffer: I will get Ms Smitham to talk to that.

Ms Smitham: I have read and acknowledge the privilege statement. There was a range of recommendations that came out of the report. Some of them were around clinical practice; some of them were around the way that the team worked with each other, right

through to things like rostering, shift patterns and things like that. There were a range of different things. The main emphasis is around teamwork and the way that the team work in different situations.

We are working on it directly with the team. The team have been part of the way in which these issues can be overcome. They are a very strong part of the program of work. They are putting together a working group from the team. They are starting to form up the things they would like to do to resolve those issues. They are being supported by the organisation. If they want to do things like team development, the people in the culture team will support them with that. We are also supporting them with consultation around their 12-hour shifts, for instance. It depends on what they come up with, but we will support them as they go through.

DR PATERSON: How proactive is the hospital in working out that there is a problem and then addressing it? How on top of these things are we?

Ms Smitham: That is a great question. We have a range of measures that we use to monitor workforce. Probably the biggest measure is the workplace culture and engagement surveys that we do. That is a very long survey, and it is something that we publish and share with the workforce. It gives us signals about where areas are improving and where they are not improving.

That was how a couple of the areas that we did deep dives into this year came up. There were teams that were either having subsequent years of falling culture or they had a really big drop-off. You always have to be concerned that culture has an alignment to performance and to consumer satisfaction. Those things all relate to each other. That is how we monitor and keep an eye on what is going on.

We also keep an eye on things like risk reporting. Staff and clinical risks are reported all the time. My team keep an eye out for things like bullying and harassment risks that are lodged. The clinical governance team keep an eye out for clinical risks and what is going on there. You start to see things in an active monitoring process that tell us we need to look a bit harder.

THE CHAIR: How many complaints have been made through customer feedback this year in ICU?

Mr Peffer: We will take that on notice.

Ms Smitham: We would have it but not to hand.

Ms Stephen-Smith: We might also provide for you, Mr Milligan, alongside how many complaints there have been, how many compliments have been received. I think it is important to balance those things.

THE CHAIR: Of course. Moving on, page 57 of budget statements C mentions that the government will deliver more care to where people live by increasing the number of nurse practitioners across five walk-in centres—one of those, obviously, being in my neck of the woods, in Gungahlin. When can Gungahlin expect to receive more nurse practitioners?

Ms O'Neill: We are excited about this chance to expand our nurse practitioner workforce within the walk-in centres. This will allow us to be able to roster a nurse practitioner on every shift in every walk-in centre. The team is constantly recruiting nurse practitioners. They are a very scarce resource right across Australia. Locally, we have put in place a training program so that we can assist aspiring nurse practitioners to transition. Unfortunately, we do have some movement in that workforce as well, as they go and seek other opportunities. I do not have the latest figures as to where we are up to with that recruitment, but I know it is very active. I can get you a time line for when we expect to have those positions filled.

THE CHAIR: Is it $119,000 for 2022-23?

Mr Peffer: That is right, in terms of the funding profile.

THE CHAIR: Yes. It is not going up by very much, is it?

Mr Peffer: In terms of recruiting? The FTE profile, Mr Milligan, for information, steps up over time. It is one nurse practitioner, it then moves to three and it then moves to six, through the years.

Ms Stephen-Smith: That figure is for the admin staff.

Mr Peffer: Minister, that is correct. That is an admin staff member for Molonglo.

Ms Stephen-Smith: Yes.

Ms O'Neill: We currently employ nurse practitioners at all of the walk-in centres, but there are not quite enough for us to cover seven days a week for the double shifts. That is what we are increasing with this money. As mentioned, $119,000 is to increase administrative positions at the Coombs centre, not the walk-in centres. There is a different line item for the nurse practitioners.

THE CHAIR: What has the demand been? Are you meeting demand?

Ms O'Neill: Demand for?

THE CHAIR: For nurse practitioners in our walk-in centres.

Ms O'Neill: They run an integrated model in the walk-in centres. We have advanced practice nurses who are supplemented by the nurse practitioners. It is not that there is no service when there is no nurse practitioner there. They work through a process whereby an advanced practice nurse will assess and treat the patient, but if their needs are at a higher level, they will consult with the nurse practitioner on shift to complete that episode of care.

THE CHAIR: Has this been developed through feedback? How did it come to this resolution? Was there feedback in terms of what was needed at these walk-in centres?

Ms Stephen-Smith: It is consumer feedback. One of the things that nurse practitioners

can do, for example, that our fabulous advanced practice nurses cannot do, is prescribe antibiotics, for example. I did get feedback from one consumer who took their daughter to a walk-in centre. They were correctly diagnosed with pneumonia, but there was no nurse practitioner at the walk-in centre who could prescribe, so they had to go to another walk-in centre to see a nurse practitioner to prescribe the antibiotics that were required. It is in response to that kind of feedback—that there is that bit of difference in the scope and practice between the advanced practice nurses and the NPs.

DR PATERSON: In respect of the Molonglo centre, which is operating now, how has that been going over the last few months?

Ms O'Neill: It has been going well. We have managed to move some of our existing women's, youth and children's program. The intent behind Molonglo was to have the focus on women, youth and children. We are now running clinics for our antenatal services, our maternal and child health services, some women's counselling and some asthma education for children. We are continuing to look at what services we will put out there in those rooms.

DR PATERSON: It has been engaged with well? The community has been attending?

Ms O'Neill: Yes.

MS CASTLEY: I am wondering where you are hoping to recruit the nurse practitioners from. I am concerned that we are losing so many of our senior nurses, and we know that they are needed to train our junior nurses. Will they be coming from the Canberra Hospital?

Ms O'Neill: We advertise, and it is up to any nurse to apply for these positions if they are qualified. A nurse practitioner is the highest level of clinical nurse there is in Australia. Canberra employs a significant number of nurse practitioners. It is actually quite attractive for nurse practitioners to move into the ACT. Our nurse-led walk-in centres are the only service of their type in Australia. We enjoy being able to import nurse practitioners, but, as I mentioned, we are also committed to growing our own. We have a transition program where we are supporting nurses that want to become nurse practitioners through that training.

MR BRADDOCK: The Health Care Consumers Association, in their budget consultation submission, suggested that the development of a new critical services building as part of the Canberra Hospital expansion project "presents the ideal opportunity to implement geriatric streaming to meet the unique needs of older consumers presenting to ED". I am just wondering what consideration has been given of that idea and what analysis of wellbeing around that idea has been undertaken.

Ms Stephen-Smith: Thank you, Mr Braddock. I know that certainly has been considered in the emergency department model of care. I am just not sure who might be in a position to speak on that.

Ms O'Neill: I am happy to take that. We are currently working with our emergency department colleagues as well as emergency department colleagues around Australia, on how we should establish the models of care for the new critical services building.

We spend a lot of time looking at the concept of streaming, specifically the aged cohort. What the evidence is suggesting to us at the moment is that that, in itself, is not going to necessarily gain significant improvements. What we need to do is stream according to condition severity.

One of the things that we have already started a pilot model of is an acute medical unit which allows us to move the patients with complex medical needs, which includes many of the older people presenting, through to a ward-based area much quicker than we are currently doing. It is a very small-scale pilot at the moment, but we are testing that pilot in the lead-up to the critical services building. At this point we will not be looking at specific geriatric streaming; we will be looking much more at acute medical unit streaming. That does not mean we will not be responsive to the needs of older people in the ED. We will continue to evaluate the outcomes of these models and be quite agile in the way we can change that. It does not impact on the way the emergency department is either staffed or designed. We have that flexibility built in so that we can be quite agile with these models.

MR BRADDOCK: Thank you.

DR PATERSON: I have a question regarding the $4.8 million to boost specialist services for children and young people, with specific mention of more outpatient clinics for Aboriginal and Torres Strait Islander children. I am just wondering what that looks like and how that will be run.

Ms Stephen-Smith: As you have indicated, there are a couple of elements to that. As part of the COVID-19 catch-up work, we were working to catch up on some outpatient services, particularly for Aboriginal and Torres Strait Islander children, and had some really successful GP-led initiatives there. I particularly want to acknowledge Antonio Di Dio, who drove some of that work. The GP-led multidisciplinary outpatient clinic for Aboriginal and Torres Strait Islander children and young adults is a further development of the work that was part of that COVID catch-up. I do not know if there is more that Cathie wants to say about that.

This particular budget measure also includes additional resources for specialist therapeutic treatment for children and young people with harmful sexual behaviours, and their families and carers, through the Child at Risk Health Unit. That is a response to a recommendation from the Royal Commission into Institutional Responses to Child Sexual Abuse. That is a recommendation that the health portfolio has had responsibility for. I am particularly pleased to see some more investment in that space. We know how difficult that circumstance can be.

The last element of that budget measure is the neurodevelopmental and behavioural assessment and treatment service in community paediatrics. That is the largest chunk of this budget measure. I do not know who would be best placed to speak to the detail of that service.

Mr Peffer: I can add a little bit more. In terms of the neurodevelopmental and behavioural assessment and treatment service, we are looking at recruiting an additional 7½ FTE to support that service. That workforce would comprise specialist medical, nursing and allied health roles; it would a multidisciplinary approach. That will work

alongside our community paediatricians to provide triage, assessment and treatment for the cohort of children referred to the community paediatrician service.

MS CASTLEY: Minister, I would like to chat about nurse-to-patient ratios. The government has struggled to meet the ratios set out. From July there was meant to be full compliance. I am just wondering: has that happened?

Ms Stephen-Smith: How it happened that it is not fully compliant?

MS CASTLEY: Has it become fully compliant since July? That is my latest information. We are in August now.

Ms Stephen-Smith: I expect that it is not 100 per cent fully compliant for every shift, for every measure. The reason for that is the same reason that every other hospital around the country is under pressure at the moment: as a result of staffing issues associated with COVID-19. Through winter we had a very steep wave of influenza and we had the significant impact of RSV on our community, with parents having to stay home to look after children affected by RSV. So there have been a range of reasons that ratios have not been met on every ward on every occasion. Someone probably has the updated numbers in relation to ratios. Ms Smitham?

Ms Smitham: I do not have the numbers to hand.

Ms Stephen-Smith: Okay. I will have a quick look through my notes to see if I have got some of those numbers. The last numbers I saw were variable, but I think one of the things about our reporting, as compared to others, is in reporting to the advisory group working group that is overseeing this. That includes the union. We are reporting against all of the different elements of the ratios framework and working towards reporting through shift rather than just at roster or at the start of shift, recognising that things can change through a shift. We have heard from the union and from our workforce that they want a true assessment of whether or not we are meeting the ratios.

Mr Peffer: Minister, I might be able to provide a greater level of detail in terms of numbers. For July, which I believe is the question, for our reporting period—I do just have to clarify that it is from 4 July to 31 July—73 per cent of shifts at Canberra Health Services were compliant against all three elements of the ratios framework. 81 per cent of the elements were met across CHS, so it might be that we met supernumerary team leader and staff-to-patient ratios but not the skills mix on some, for example.

MS CASTLEY: Fifty-five people were supposed to be employed to get the ratios happening. Has that happened—the 55 staff? All 55?

Ms Stephen-Smith: Yes. In fact, it is 90 because we do not only have Canberra Health Services; we have another hospital in the ACT, run by Calvary, and they also were to employ 35 staff to deliver ratios. So it was a total of 90 FTE positions and they also recruited to meet those positions. I do not think anybody here has got their most up-to-date ratio numbers.

Ms Anton: I acknowledge the privilege statement. We had a meeting this morning with Calvary. Can I take that on notice so that we can make sure that is accurate? We are

just working on the July numbers now.

MS CASTLEY: Minister, these were your ratios. You keep blaming COVID. I do understand that people have been sick, but when will you be able to assure the union and the nurses that are working really hard that you will make good on your promise that these ratios will happen?

Ms Stephen-Smith: Thank you, Ms Castley. The ratio framework was established through the enterprise agreement framework. It was a commitment of the government that we would establish the framework, in partnership with the union, through the enterprise agreement framework. I certainly would not describe it as "my framework"; it is an agreed position.

MS CASTLEY: You are the minister.

Ms Stephen-Smith: It is certainly a government commitment to deliver on ratios. We committed $50 million in the last budget to do that. The staff have been recruited. But every jurisdiction across the country is facing these challenges. Other jurisdictions have stopped reporting on their compliance, presumably because they are not compliant. Obviously, it is our commitment to deliver on ratios but we, like every jurisdiction, are facing challenges, so I cannot give you a date at which we will be fully compliant. But I can assure you—and I have assured the unions and they are well aware; they come to the meetings—that we are working as hard as we can to do that.

What I can say is that, when I have gone onto the wards and I have spoken directly to the nursing staff, some of the feedback I have received is: "It is great to know. We can see that people are trying really hard to do this. We know what the challenges are; we are the ones who are at the workplace. We are the managers or we are the staff who are getting the texts and calls, the managers who are trying to fill shifts. But what we are seeing is that people are genuinely trying to deliver ratios and even that is something that makes us feel good about this implementation. People are trying to deliver it." That is seen as a positive, even though they recognise that it is not being met on every shift.

MS CASTLEY: Yes, we know the nurses are working so hard in the situation they have got, but what do you say about the patient care? How is that suffering?

Mr Peffer: Obviously, it is our strong desire to be able to meet the commitments made through the ratios framework. The minister has outlined that there is a genuine endeavour within the workforce to do that. We also acknowledge the pressures that puts on people on days off, putting their hands up to do the additional shifts to try to narrow the gap, where we are not able to fully cover workforce needs.

Within the health service we monitor a range of quality and safety indicators. We do that on a continual basis. We look at that through whole-of-organisational-governance measures and right down into department and divisional team quality and safety meetings as well. That highlights for us how we are benchmarking and performing against peer hospitals around the country. It will highlight for us if there is any variation or area for concern that we need to go and investigate. For us, in terms of our quality and safety performance at the moment, it is not bad.

MS CASTLEY: Practically, do patients have to wait longer for their Panadol or longer for a bandage to be fixed?

Mr Peffer: COVID has had a big impact on people's experience through the health service; there is no doubt about that. I think we have had a range of compounding factors impacting, not just the shortages in the workforce that we have carried. We have also seen the departure of many of our volunteers, who played a critical role in supporting people and their experience through the service. Also, throughout the last two years, there has been a very, very challenging range of circumstances where we have actually had campuses locked down. The engagement and support of carers and loved ones, family, at times has not been available to patients. All of those things have had quite an impact on the experience of our patients day to day.

THE CHAIR: Given that the time is now 3.30, we will break for afternoon tea. On behalf of the committee, we wish to thank the Minister for Health, Ms Stephen-Smith, and her officials for everything so far. We will see you very shortly.
Ms Stephen-Smith: I thought we were getting an early mark!

THE CHAIR: Obviously not! Any witnesses taking questions on notice, please provide answers to those within five working days, to the committee secretary. The committee will now take a short break and reconvene at 3.45.

Short suspension.

THE CHAIR: In this last session today, we will continue speaking with the Minister for Health and officials. If there are new officials present, I remind witnesses of the protections and obligations afforded by parliamentary privilege and draw your attention to the privilege statement. When you speak, can you please acknowledge the privilege statement. We do have one witness here who just needs to acknowledge the privilege statement, as that was missing from her response earlier.

Ms Zagari: I acknowledge that I have read and understood the privilege statement.

THE CHAIR: Thank you. All right. I will start off. The *Canberra Times* reported more than three months ago, on 18 May: "Surgery halt to come for strained system". When did the government suspend elective surgeries and why? It must have been back in May.

Ms Stephen-Smith: There have been a couple of suspensions and slowdowns in elective surgery this calendar year. I do not have the dates in front of me, but from January into February there was, effectively, a cessation of non-urgent category 2 and 3 elective surgeries at Calvary Public Hospital in Bruce, in response to the first Omicron wave and the impact of that on our health services. More recently, as you indicated, around that May-June period there was a slowdown in elective surgery. That was not a cessation in any particular space. It was more a reduction in elective surgeries on a day-by-day basis. I think at the time Mr Peffer indicated that it was probably affecting about 11 elective surgeries a day.

THE CHAIR: Okay.

Ms Stephen-Smith: That is presumably Monday to Friday days. I think we estimated

at the time that the impact of the Calvary reduction in surgery was that about 500 elective surgeries had to be delayed in that January-February period. Probably about another 300 were affected by the slowdown in the later part of the financial year. Overall, though, despite all of the challenges that we have faced, the budget report indicates 14,013 elective surgeries. The latest number I have is 14,031 elective surgeries. It takes some time for that data to catch up, because it does not come through until people are discharged from hospital; that is my understanding. So despite all of these challenges, we have actually had the second highest number of public elective surgeries performed that we have ever had.

THE CHAIR: Is a slowdown just a drop in the number of surgeries by 50 per cent? What does slowdown mean?

Mr Peffer: Just to confirm: the slowdown that we had in Calvary was between 10 January and 21 February. The reason for that slowdown was based on bed utilisation across the territory. We had a growing COVID load at the time and considerable workforce dislocation with the case load. Since that time there has been no deliberate slowdown. However, we have continued to see theatre activity impacted. It is a day-to-day prospect, with members of our team having COVID and whether we can rapidly replace those individuals. At times that is simply not possible, so there will be days when we do not have all theatres across the territory running as they normally would.

THE CHAIR: When public elective surgeries are not operating, how does that affect the bottom dollar, the budget allocation? Does that money just get put to the side, potentially?

Mr Peffer: There will be an impact, but ultimately it will depend on the contractual employment arrangements of the individuals who are affected. As a general rule, we have a workforce that is employed. They are employed full-time, most of them, and some of them part-time. If they are unwell, they are of course entitled to sick leave, so we do not bank that funding. It is not unspent funds. They are taking sick leave that will impact their numbers. The impact through January and February was in the order of 500, but it does not necessarily generate unspent funds, with the workforce remaining employed.

THE CHAIR: So what do these employees do when the government decides to suspend elective surgeries?

Ms Stephen-Smith: The reason that the elective surgeries are suspended is that there are not sufficient staff to undertake both the elective surgery planned load and the emergency load and other hospitalisations, like maternity, that are all coming into the hospital at once. It is about not actually having the workforce available to undertake those elective surgeries. There might be visiting medical officers who would come in and do that surgery who might not be able to come in and do that surgery because there is no other workforce available to support them. The reason that the surgeries get delayed is that there is not a sufficient workforce to support them.

THE CHAIR: So it is not COVID related?

Ms Stephen-Smith: This was definitely COVID related. There are staff members who have COVID-19, staff members who have children who have COVID or are otherwise unwell and they take their carer's leave, and staff members who have to quarantine as a result of a household contact. I think during January-February it would have been close contacts as well, who were on COVID leave. A lot of that is the direct impact of COVID-19 on workforce availability.

The other thing I was going to say in relation to the financial aspect is that we contract Calvary to undertake its public hospital services. We have an annual performance agreement with them that indicates how many elective surgeries we expect that they will deliver. If they are under that number, which obviously they were in 2021-22, we negotiate with them on whether there is any capacity for them to catch up in the subsequent financial year. I do not know that we are at a point where we can say what that looks like, but certainly part of the conversation with Calvary is: "You did not do as many last year as you thought you were going to do. Do you have the capacity to catch up on some of that this year?"

MS CASTLEY: You briefly touched on the process of getting elective surgeries done in private hospitals. Could you talk a bit more about that? If I am looking at the figures right, the goal is 15,000 elective surgeries for the year. I think we missed out on about 800, due to the slowdowns and closures. Is that right?

Ms Stephen-Smith: The target for the last financial year that we are reporting on was 14,800 and the current number that we have, which may still increase slightly as people come through the system, is 14,031.

MS CASTLEY: So there has been no decline in the number of elective surgeries we have done?

Ms Stephen-Smith: The target was 14,800 and what we have achieved so far, from our numbers, is 14,031.

MS CASTLEY: And what about the other private hospitals, or is it just Calvary?

Ms Stephen-Smith: Calvary is a public hospital.

MS CASTLEY: So do you get Calvary private to do any?

Ms Stephen-Smith: Yes. There is a private provider program. The elective joint replacement program that we were talking about earlier is delivered through Calvary John James. Calvary John James also delivers other surgeries under the PPP. I might hand over to Mr Peffer to talk about the other private hospitals that are involved in that.

Mr Peffer: Thank you, Minister. Ms Castley, we have a panel arrangement. Essentially, we go to tender and private hospitals come back with a response, in terms of what they think they can do, and arrange the prices. We access that panel to transact private procedures. It includes not just the two private Calvary hospitals, including Bruce private on the north side, but also the National Capital Private Hospital and Canberra Private Hospital. There may be a few other, smaller facilities as well that are on that panel arrangement.

MS CASTLEY: Okay. So are you able to tell us whether those private hospitals in your panel arrangement have had spare capacity, and could they have picked up more of the slack? Can you give us reporting on those figures?

Mr Peffer: I can't give you reporting on the private hospital figures, but what I can relay is an almost daily conversation that we have with facilities across the territory, particularly as we were looking for bed capacity to support COVID admissions. There was very little capacity, if any at all, in the private hospitals. Where we were experiencing significant workforce shortfalls, that equally was being experienced across all private hospitals. That was impacting their business as usual throughput and it meant that their ability to flex up, scale the throughput, just was not a possibility.

DR PATERSON: I am just wondering if you could speak to how the hospital manages recovery after surgery, particularly with COVID.

Ms Stephen-Smith: I think Ms O'Neill can talk about the Enhanced Recovery After Surgery program, ERAS?

Ms O'Neill: I can; thank you. I have read and acknowledge the privilege statement. We have been running a range of programs over the years, but, more excitingly, in the last year we have commenced a program called ERAS, the Enhanced Recovery After Surgery program, where we have targeted some of the more complex surgical procedures where we know that people, if they are not at their peak health prior to that surgery, can have an extended recovery period. The sorts of things that we have been targeting are elective caesareans, hysterectomies and colorectal surgery, and we will soon be starting head and neck surgery and lung resections.

The program involves, again, a multidisciplinary team that works with the patient prior to them having the surgery, to assist their nutritional status, their physical health. We have physiotherapists, nutritionists, occupational therapists and the medical staff, and we have had really pleasing results. I can give you a few of the stats. We have seen across those conditions about 160 patients, which has saved 400 days in hospital. We have shortened their length of stay, their length of requirement of hospitalisation by that amount, and we have also reduced their need for ICU admissions by more than 30 per cent, so it has been quite a significant program and we are looking to expand that.

MS CASTLEY: Thank you.

THE CHAIR: Is the government aware of any situation where a private hospital has had empty operating theatre rooms where they could have picked up some of the slack from the public hospitals? What sort of dialogue or communication do you have with private hospitals to work collaboratively to pick up any slack there is in terms of elective surgeries?

Mr Peffer: Thanks for the question. Our teams are talking weekly with private hospitals about their capacity and their ability to pick up additional work. My understanding is that over the first half of this calendar year there was limited ability in some facilities but a small capacity that we could pick up, which we did access in a number of private hospitals, to the tune of a couple of hundred procedures. But it was not sufficient to

offset what essentially got squeezed out of the system with workforce shortages.

So would there have been time in operating theatres in private hospitals? Quite possibly. My understanding, though, and certainly the discussion I have been having with general managers and chief executives of those facilities is that they have had quite significant challenges in putting up the workforce to actually open beds, at times, to increase capacity.

THE CHAIR: So you communicate on a weekly basis with these hospitals?

Mr Peffer: Yes. Between our institution and leadership teams or executives, or even at a clinician-to-clinician level, recognising many of our medical officers do work across those private institutions as well, there is that ongoing open dialogue between our hospital and theirs, yes.

THE CHAIR: Thank you very much.

MR BRADDOCK: I have a question about the northside hospital development. I notice there is a revised funding profile for that project, and I would be keen for an update and a reason for the delay effectively.

Ms Stephen-Smith: I will throw to Ms Lopa in relation to the funding profile, but the project is progressing quite well.

Ms Lopa: The planning for the northside hospital is well underway. The changes to funding profiles are simply timing issues as far as what we thought we would spend in the first year compared to when we got procurements out, got consultants on board and recruited our staff. There is no delay to the project. It is just a profiling issue of when we are spending the funding.

The project is progressing well. We have our technical advisers on board doing all the due diligence around the planning for the hospital. We are undertaking the service planning for the hospital and looking at the scope of what will be in the hospital. We are also looking at the planning across the territory and what might be delivered in a community setting versus in a hospital setting and what is being delivered at Canberra Health Services.

We have a team of people that have been recruited into the ACT Health Directorate to help with this planning work. We are also working very closely with Major Projects Canberra and leaning on their expertise as far as early infrastructure planning. So all of that planning is on track at the moment.

MR BRADDOCK: So what is the actual outcome at the end of this project?

Ms Stephen-Smith: At the very end, we have a new northside hospital.

MR BRADDOCK: Sorry; by 23 December 2023, I should say. What do I expect then?

Ms Stephen-Smith: Liz, do you want to talk about this funding?

Ms Lopa: This funding is to fund what I call the business case work, which is doing all of your due diligence, doing your scoping and doing your concept planning to go to an infrastructure business case to say to government, "Here is the case for northside hospital: the visits; how many beds we think it should have; and the services we think it should offer." We have done that first concept design, which was about high-level design, and had a cost plan done against that to go towards a business case to get, I guess, the green light to then progress the project to detailed design, when you are getting right into the nitty-gritty of what it will all look like and then through to construction. So the end of this process is to have the scope of the hospital bedded down—no pun intended on beds—to have that proof of concept or early concept done, and to have a block plan to go to for a business case for the construction of a hospital.

THE CHAIR: A supplementary?

MS CASTLEY: Yes.

THE CHAIR: Ms Castley.

MS CASTLEY: I am struggling to hear you. Did you say that the proof of concept would be at the end of 2023?

Ms Lopa: No, Ms Castley. We are planning on having that proof-of-concept design to inform a business case later this year or early next year.

MS CASTLEY: Okay. Is there no community consultation? I expect that people would be in contact with the minister as well about a specialised paediatric ward or that sort of thing. How are you going about including those things or excluding those things in your design?

Ms Stephen-Smith: Ms Castley, there is a public consultation open right at the moment. So I certainly encourage you to share it with your constituents and encourage them to engage in the process. I do not want to say it is the first step, but you might have seen a couple of weeks ago that we released the ACT Health Services Plan. That has been a few years in the making, and we have talked about that before. We have then gone out to the whole Canberra community to ask about people's experiences in the health system and what they would particularly like to see in terms of care closer to home. We will then be refining that down into two streams of consultation. One of which will be specifically focused on northside clinical planning and the northside hospital. Liz, do you want to talk about how that is going to work?

Ms Lopa: Yes, thank you. Absolutely we will be doing community consultation and a lot of consultation with our stakeholders and our clinicians as well. We will also be working very closely with our Health Services planning team to look at the services that will be in the northside hospital. The community is a really important part of that in listening to what health services the community wants and how they access them and understanding what the community wants to see.

Another really important part of that is consultation with our workforce and the clinicians. When you are looking at some services the question is: do you duplicate services and have them in Woden and have them in a northside hospital, or is it actually

safer and better not to split your workforce across two sides and actually have the other specialist service delivered in one hospital rather than across two sites? That is the work that we are doing now.

In planning the hospital we absolutely will be doing community consultations. This first round of consultation is open now and then we will be doing stakeholder consultation and also doing wider community consultation. So, like what we did with the master plan, we are planning on doing some popups in shopping centres et cetera to engage people who normally would not elect to go to a meeting to talk about these things.

Also, it is very early planning of what a building will look like. So we just need to be very careful at this stage of the project that we do not raise expectations with the community about what something will look like. We have many, many years of design to go through after this. At the moment, we are looking at those very high-level conversations, but we will definitely be talking to the community and our stakeholders about all of that.

MS CASTLEY: One last supplementary if I can?

THE CHAIR: Yes.

MS CASTLEY: Thank you. If I am understanding the northside hospital correctly, you are looking at greenfield sites as well as the Calvary site. If the Calvary situation goes ahead, is the intention that the government will be building a hospital for Calvary to run or, if it is a greenfield site, is the intention that the government will be building a hospital for not Calvary to run or for the government to run it like Canberra Hospital?

Ms Stephen-Smith: These are all conversations that are currently underway with Calvary. We do have a contract with Calvary. The Calvary Network Agreement is a contract that has another 76 years to run. It requires us to pay Calvary to run a public hospital on the north side of Canberra and has a range of requirements in it. So, obviously, we are working very closely with Calvary to understand what a new northside hospital would look like and their role in that. Those conversations are ongoing.

MS CASTLEY: I just wonder whether it is normal practice—

THE CHAIR: Sorry; we might move on to the next substantive, but I am happy to come back and address this question.

DR PATERSON: Thank you, very much. Minister, a key ACT Labor commitment in the last election was to develop a disability health strategy. I noted in the budget that there is some funding for this, and I was just wondering where things are at with the development of that strategy and where things are heading.

Ms Stephen-Smith: Thank you very much for that, Dr Paterson. As you probably are aware, this is something that I am very personally interested in seeing come to fruition. Again, there are two streams of work here. There is the disability health strategy, and the budget has funded some specific work. That does not mean that work has not already been underway in relation to the disability health strategy—it certainly has been. But

we identified that there was a need for specific funding, in a similar way as the Disability Justice Strategy was funded.

Sitting alongside that, Canberra Health Services has been working on a disability action inclusion plan to specifically look at how Canberra Hospital and the community-based services that CHS runs can be more inclusive of people with disability as patients, as families and carers and as staff. That is almost at the final stage, whereas the disability health strategy is at a slightly earlier stage of work. But the first phase of that work has been completed, and this funding in the budget is really looking to implement the second phase with this $260,000 for the current financial year. I might hand over to Michael Culhane to talk about what that next phase of work funded through the budget looks like.

Mr Culhane: At the moment we are partway through the second stage of developing a disability health strategy and a first action plan. The disability health strategy will likely span a 10-year period and the first action plan will cover probably the first three years of that strategy.

We have established a disability health strategy steering committee with 24 members on it. We have on that steering committee five community representatives who are people with disability or carers of people with disability; nine community disability service providers and advocacy groups; and seven government representatives with an interest in this area, including the CSD Office for Disability, Canberra Health Services and DACCS.

We are working with that steering committee at the moment. In the near future, we will be taking to them and engaging on a co-design strategy about the next steps. That is going to be considered by them, I think, at their meeting on 1 September. We are also taking to them an abridged version of a scoping paper that was developed as part of stage one. The full scoping paper was about 30 or 40 pages; very informative, though not necessarily very accessible for everybody. As such, we have developed an abridged version for that committee.

We are going to take to them proposals around co-design activities that we will be undertaking over the September-October period. Those activities include workshops facilitated by people with a disability and carers of people with a disability. It will include a survey, the opportunity for people to make submissions, and a kitchen table conversation starter kit. All of those engagement and consultation processes will occur over the September-October period, we anticipate.

In the November-December period, or through the September-October-November period we anticipate developing a draft of the strategy and the first action plan. Once we have that draft, we will be taking that back to the steering committee to sense test it and make sure it resonates with them and reflects the feedback we have got through all of the engagement through September and October. Then, we have got a finalised strategy and a finalised first action plan, or finalised content for that, there will be quite a significant process of ensuring that that is available in a number of forms, so that it is accessible. We will be putting that in, if you like, easy English and translating it for the blind community and there will be a number of other measures to ensure it is accessible. We anticipate its release shortly after the finalisation of the royal commission into

disability.

Ms Stephen-Smith: I just want to add one thing to that. The director has been working very closely with the Office for Disability. So some of this strategy around community engagement might sound very familiar to the ACT disability strategy work that is being done as well.

THE CHAIR: Substantive, Ms Castley?

MS CASTLEY: I have a question about the culture survey and some information that we have found through FOI documents about the executive management team and how it ranks compared to other executive managers in hospitals across the country. This includes a negative 30 per cent swing for the question: "My manager is a role model I look up to and learn from". Minister, almost one in five of your CHS executive management team disagreed with that statement. Who are these executive managers that the staff are talking about in this survey? It is a workplace culture survey.

Ms Stephen-Smith: Ms Castley, my recollection is, and correct me if I am wrong on this, there was a freedom of information release that had the three different work stream outcomes: nurses and midwives, medical officers and the executive team. So, you are looking just at the executive or the non-nurses and midwives and non-medical officers team; is that right?

MS CASTLEY: If that is what that means; the executive management team. Who are they? Are they working in the admin of the hospital?

Mr Peffer: Ms Castley, are you inquiring as to who would be captured in the executive management team?

MS CASTLEY: Yes, who the survey is about. Is it nurses answering this question? Is it doctors answering the question?

Mr Peffer: No, that is a question asked of the entire organisation including executives. Depending on the team that you talk to and, in fact, even within a team, depending on the individual you talk to, they will have a construct of what the executive management team is in their workplace. In certain workplaces, people will think of that as their direct-line supervisor; in others, they might think of that as myself or a member of the executive team.

MS CASTLEY: Have you been able to go through that data and work out where there is a pocket of trouble and why people are so unhappy? Are there pockets of teams that are reporting this information or is it just across the board?

Mr Peffer: No, it varies across the board, and it is a trend that you do tend to see in large organisations. The further the proximity from a particular decision-maker, the level of trust declines just because you have not met that individual or you do not know who they are or what they are trying to do.

Some of how we have responded to what has come through within the culture survey

is through our internal communications efforts. We have really tried to step that up and make that relatable so that people can understand what is coming in the pipelines and what the decisions are that we are making. It could be operational decisions that are impacting today in terms of bed profile, opening, closing and moving teams between wards. But, equally so, it could be about some of our larger strategic projects—for example, the digital health record. It is about being clear about what is coming down the pipeline to try to give people a sense of what is going on in the organisation, not just in their immediate vicinity and workplace.

Some of the other feedback that we have had is around the design and implementation of change initiatives. Within an organisation of this complexity, there is a lot that happens day to day, and there are a range of projects and reforms that will be in flight—changes to model of care and, of course, some very large investments like building a new hospital. The feedback has been really clear about ensuring that we engage the workforce as part of those discussions and consult and collaborate as we put together the plan for delivering on some of those reform objectives.

Ms Stephen-Smith: I just want to clarify, Ms Castley, what page you are talking about. I am looking at the EOFY release in relation to the executive management team and the question that you have pointed to, "My manager is a role model I look up to and learn from". The answer was 57. Sorry; you were talking about the number that disagreed. That is 19 per cent. Is that the question you were looking at?

MS CASTLEY: Yes.

Ms Stephen-Smith: I would note that that is at the top half of the bell curve for public hospitals and healthcare services.

MS CASTLEY: So we are doing okay in that area?

Ms Stephen-Smith: It is just that you were indicating comparatively. It has got worse. I absolutely acknowledge that.

MS CASTLEY: It does not sound good.

Ms Stephen-Smith: I think we just need to have all of the information on the table.

MS CASTLEY: Yes. My understanding is it is below that for the executive management. There is another here where we have ranked below average: "My manager helps me to set realistic performance objectives, reviews on progress and achieving objectives, and conducts annual performance reviews." We have ranked really low on that. Minister, you are the ultimate executive manager. Do you review your executive team? Is that where the problem is? Is that what this survey is telling us?

Ms Stephen-Smith: I do not think anybody completing this survey would have considered that I was their manager.

Mr Peffer: No. Perhaps I could respond to that in terms of that feedback. We have had that feedback from our workforce about the performance development process that

previously we had instituted across Canberra Health Services. Some of the feedback was that the forms and format of that process were overly cumbersome and perhaps did not reflect the healthcare setting that we are actually operating in. Since we have had that feedback, we have done a lot of work. I do have to acknowledge the good work of the team to restructure that process into a strengths, engagement and development process—our SED process. The form is now much simpler. It is designed for a healthcare workforce. The feedback that we have actually had in response to that change has been very positive to date.

THE CHAIR: Dr Paterson.

DR PATERSON: Thank you. Minister, could you provide an update on the Culture Review Implementation program and where that is up to at the moment?

Ms Stephen-Smith: Yes. We are currently in the process of undertaking the third annual review of the implementation of the culture review. Glenys Beauchamp is undertaking that—a former secretary of the Commonwealth Department of Health. She is talking to a range of people about that and undertaking staff engagement. Ms Cross might be the best person to talk about the detail of that process.

Ms Cross: Before I talk about Ms Beauchamp's project, I would also like, for the record, to note that the original review had 92 actions and 20 recommendations, and they have all been signed off as complete. Ms Beauchamp's project is to look at how well the intention of the recommendations has been met and whether we have actually embedded the new arrangements into our business as usual so that, as we finish this year, all of the good things which are done as a result of that review are actually incorporated into the normal practice of Canberra Health Services, Calvary and the Health Directorate. She will consult with stakeholders, unions—a number of people—to form an independent report to the Culture Reform Oversight Group.

DR PATERSON: When is that review expected to be completed?

Ms Cross: I think we are expecting to get a report towards the end of this year, and then the consideration of whether any further implementation actions are needed will be late this year or early next year.

DR PATERSON: Great. Thank you.

Ms Stephen-Smith: The aim is to have a way to embed implementation of all of the streams of work into business as usual, so they continue to be overseen, but the culture review is completed.

DR PATERSON: Great. Thank you.

MS CASTLEY: I would like to chat about midwives. I am referring to a *Canberra Times* article on 7 August this year, entitled "Canberra's midwife crisis". The article spoke about chronic understaffing, a lack of staffing being at crisis point, lack of skills mixed with experienced staff leaving, stress and burn-out and midwives fearing that deaths will occur. These are really alarming reports, Minister. I am just wondering what you say about this. Does this not point to your failure as the minister and the failure of

your health system—if nurses are afraid to go to work because they are wondering if today is the day that a baby will die? Tell me what your thoughts are on that, please.

Ms Stephen-Smith: Thank you, Ms Castley. Obviously, I have met with midwives across both hospitals to hear their concerns. It is absolutely the case that, again, nationally, there is a shortage of midwives. When you talk to midwives and when you talk to the union, they will acknowledge that this is in fact a national issue—that there is a shortage of midwives.

One of the ways that the services are seeking to address this issue is with additional graduate workforce recruitment. Of course, that changes the skill mix, and that is something that has been raised with me, but it is one of the strategies that need to be employed. Across both hospitals, the information I have is that, in 2020-21, there were 18 graduate midwives who were employed in graduate positions. In 2022 that increased to 30 midwives brought on as graduates. That is one of the ways in which our hospitals and our health services are seeking to increase the number of midwives.

You would be aware, Ms Castley, that, in releasing the Maternity in Focus strategy, one of the commitments we made—again, in consultation and from listening to the feedback from midwives themselves and from the unions—was to fast-track the negotiation with the union and the discussion about the implementation of maternity ratios. That would make us the first jurisdiction in the country to implement ratios in the maternity space. Of course, we would still have to recruit and retain the midwives to meet those ratios, but that is something that they have been calling for. Our commitment to that, and the establishment of a ratios framework in midwifery, is something that will help us to attract additional staff.

There have to be a range of measures. We talked earlier about the work that is happening in broader nurse and midwife recruitment—creating a recruitment campaign to encourage people to come to work in the ACT and establishing the benefits of that. It is also the case—and this has been acknowledged in both hospitals—that there is work to do around culture in maternity. That work is underway in both hospitals and in Health Services.

I do not know whether anyone wants to talk from a CHS perspective or whether there is anything we can say from a Calvary perspective on that. Calgary has had some good news in relation to recruitment, but I am not sure that I am in a position to talk about that.

Ms Freiberg: As the minister has talked about, it is quite difficult at this point to recruit midwives nationally. There is a shortage of midwives nationally. Some of that is around midwifery students getting placements and getting their birth numbers. The universities have done quite a lot of work on that, on actually matching that. There is also a workforce coming out who have done a bachelor of midwifery and want to work in continuity programs. At CHS we are committed to continuity programs. Midwives are walking with their feet and are going towards more continuity programs.

One of the barriers we have had to that in the ACT is the enterprise bargaining agreement. That does not allow graduate midwives into our continuity program. We are currently undergoing negotiations on that, so that we can get them straight into graduate

programs and within continuity. That is one of the biggest barriers that is only an ACT thing. However, in the ACT we do pay them quite well. They are the best paid nationally, in terms of continuity programs. People will want to come here; we just need to get more graduate positions and get that enterprise bargaining process finished.

Canberra Health Services offer a range of ways for midwives to come in. We have registered nurses who become midwives. We support them going through working as a registered nurse. We also take bachelor of midwifery students straight in. We have increased our graduate numbers and we have increased our student numbers. We are currently working with the universities in terms of improving and increasing those placements.

Ms Stephen-Smith: There are a couple of other things that I would add in relation to the Maternity in Focus strategy. That strategy absolutely recognises that, in order to deliver good maternity care for consumers, staff are critically important. There is funding within the implementation of the maternity plan to support workforce planning and more scholarships to support professional development.

As Susan has indicated, midwives are very much motivated by the type of work that they are able to do. It is about enabling them to access scholarships, professional development and additional continuity. The Maternity in Focus plan commits to continuing to expand access to the continuity program so that 50 per cent of birthing people in the ACT have access to continuity within the next few years. I cannot remember the exact time frame; I think it is 2028.

MS CASTLEY: I understand all of that. I know about COVID; the whole country—and the world—is struggling to get nurses. But this was highlighted years ago, in 2018. Under the previous health minister, we had midwives back then saying something which was very similar—that lives were being put at risk by chronic overcrowding, and warning of adverse outcomes for mothers.

You mentioned we have the best paid midwives, which is awesome. That should be encouraging people to want to move from everywhere to come and live in Canberra and be a midwife. But we see that you have allocated $7.2 million to improve staff safety, addressing occupational violence. I hear stories of midwives who will no longer be in a birthing suite. Graduates are doing their placements and saying, "That's it; I do not want to be a midwife anymore." They finish their training, and they walk away and get another job.

What is the occupational violence situation like? Why aren't these midwives wanting to come to Canberra or stay in the profession after doing their training?

Ms Stephen-Smith: By way of context for the actual figures, the advice I have is that the headcount for midwives has increased for CHS by 24.7 per cent—almost 25 per cent—from January 2020 to 25 May 2022. That is a very significant increase in headcount. It is probably a bit of a stretch to say no-one wants to come and work here. Also, the average tenure for midwives at the end of May was more than eight years, so people are staying in the profession—

MS CASTLEY: The average?

Ms Stephen-Smith: and people are coming to work as midwives. As I have already acknowledged, Ms Castley, there are some issues that need to be addressed in relation to both the model of care that midwives are able to work in and the culture across the maternity services. Those things are being actively worked on. These are not things that you can turn around overnight.

The really important thing, I think, in relation to listening to our midwives and their union, is what has happened when they have told us about the challenges they face. You have pointed to the money that we are specifically putting into the next phase of implementation of Nurses and Midwives: Towards a Safer Culture. That has tripled the funding for Towards a Safer Culture that we do in partnership with the Nursing and Midwifery Federation. It is very much driven by the voices of those staff—those nurses and midwives. I do not know whether anyone can comment on the occupational violence numbers for nurses and midwives.

MS CASTLEY: I am just staggered at having to triple the amount. What is going on?

Ms Stephen-Smith: Yes, I have had confirmation that I was right about 2028 for the continuity commitment.

DR PATERSON: In respect of the Maternity in Focus plan, and regarding the continuity of care model at Canberra Hospital, you said it is highly competitive for midwives wanting to work in this area. I know from my own experience that you have to call up pretty much the very first week or day that you find out you are pregnant to get into that program. Is that still the case? Are we able to expand that program to ensure that midwives can work in that part of the system that they obviously really want to work in, and that pregnant people can enjoy that service?

Ms Freiberg: One of the things that came out of Maternity in Focus was for us to look at a program that we used at Canberra Maternity Options. We have just had an external group from Sydney come and review that. It is a one-stop shop where women can ring and they are booked in to the service. We have been working with the nursing and midwifery office on that review, and we are expecting feedback from that in the coming weeks.

One of the things we have identified there is that women are wanting the continuity of service model. One of the things that CHS is looking at is that currently it is a very low-risk model. The actual number of women who would qualify for that service is very low. We are looking at moving that to an all-risk model. We are currently in the process of doing that.

With the results, in terms of midwives wanting to work in that model, the current midwifery programs bring midwives out ready to work in that model, but some of the health services still have their graduate year where they go into a birth suite model. We need to work on that as well and move the graduate program out into a continuity model, like they do in New Zealand, and have the secondary processes in a normal birth suite.

DR PATERSON: Again, with respect to the Maternity in Focus report, the planning is for 2022-23. Is this part of a broader plan or will there be another plan for the following

year developed this year, given that it is only a one-year plan?

Ms Stephen-Smith: Could you repeat your question?

DR PATERSON: With the Maternity in Focus ACT Public Maternity System Plan 2022-23, will there be another plan for 2023-24?

Ms Cross: The plan itself is for 2022-32, and the first action plan is for 2022-25.

DR PATERSON: I have it written wrong. Thank you.

Ms Stephen-Smith: In terms of a question that I took on notice earlier, Chair, I can advise, in relation to the cost of the Singapore trip, that the total approximate cost, at this point—I like the fact that is approximate and it is down to cents!—is $36,153.75. That includes me, a senior adviser, the director-general, the CEO of Canberra Health Services and the Executive Director of the Health Care Consumers Association. There are some additional incidental expenses that are yet to be reconciled, so the final cost might end up being slightly different. But that is a ballpark figure.

THE CHAIR: Are you still providing additional information on that or are you satisfied—

Ms Stephen-Smith: Would you like us to continue to take that on notice? It is up to you. If you consider that question answered, that would be very helpful for us, but we can take it on notice for the final figure. We will get responses back as quickly as possible, so we will probably get that back in 24 hours with the same number.

THE CHAIR: If there are any further clarifications needed of that, a question on notice can certainly be submitted by the member.

MS CASTLEY: An editorial in the *Canberra Times* on 7 August stated that the government needed to address the problem—midwives—urgently, and that it may be that an outsider should be brought in to do that. Do you agree? Do you plan to bring in an outsider to help address the midwife problem? I know you are saying that things are getting better, but from all we are hearing from midwives working in Canberra Hospital, it is not getting better, and they do not want to be midwives anymore. They might not be telling you that. I am concerned.

Ms Stephen-Smith: Ms Castley, I indicated that I have met with midwives from both Canberra Hospital and Calvary Public Hospital, and I am concerned as well. That is why we are committed to ensuring that midwives have good places to work and enjoy their work as midwives. That is why all of this action is underway.

It is not entirely clear from that quote what you mean by bringing in someone independent. The teams work with the unions and with staff to understand the challenges they are facing and to seek to address those challenges. It is not clear to me what that "independent" would be.

MS CASTLEY: Just to clarify, are you happy that you have done everything you can to make this work and you do not need anybody else?

Ms Stephen-Smith: It is frustrating when you ask questions like that, Ms Castley, and put words in my mouth. We will always continue to talk to our staff and talk to their unions, and to improve where we can. We know that we always will have things to do that will continue to improve our hospital services and the workplaces for our staff. This is an ongoing thing. It is never going to be finished. We are never going to be satisfied that everything is 100 per cent tickety-boo. There will always be more to do. That is the nature of government. That is the nature of complex service delivery.

MS CASTLEY: To be clear, my job in opposition is to ask you these questions. I am not just doing it for fun here.

DR PATERSON: This is a debate. It is not necessary for Ms Castley to do this.

Ms Stephen-Smith: There are ways to ask questions that elicit answers that are useful to the world.

MS CASTLEY: As well as answering without being personal. Thank you, Minister.

Ms Stephen-Smith: And there are ways to put words in people's mouths.

THE CHAIR: We might move on to the next substantive.

MR BRADDOCK: My question is about the air quality sensors we have here in the ACT, whether four are sufficient and whether we are getting the information we need from those sensors to inform the public health.

Ms Stephen-Smith: I will hand over to the Chief Health Officer for that one.

Dr Coleman: We currently have the number of air quality sensors required by the national environmental protection monitoring advice. You may be aware that we are also running a trial at the moment into some lower cost, easier to work sensors out in the community, to see whether they are reliable and whether they provide us with additional information.

We have enough to provide us with the information to meet our requirements under the regulatory requirements. However, there potentially may be a role for these lower cost reliable sensors, if they prove to be so, to assist us with a little bit more nuanced information around some of the different pockets and areas in the ACT. We understand that the community do have a lot of interest in having that information. It may assist some members of the community, who are a little more vulnerable to poorer air quality during some periods of time when we have smoke in the air, in managing their activities outdoors. I am not quite sure when that monitoring period will come up, but once we have that information, we will be sharing that as well.

MR BRADDOCK: Thank you; you have predicted my next question. Is the idea that we will be gathering input from community owned and run sensors into our systems?

Dr Coleman: We are actually looking at the moment at some lower cost sensors out there in the community, to see whether they are reliable. Do they actually provide us

with information that is equivalent or similar to our other much higher cost, more quality-managed sensors, or how much can we rely on those?

Sometimes, in order to provide the level of information that you need, you may not need the same level of reliability as we do to inform some of those bigger decisions around monitoring the environment from a commonwealth perspective. It might be a little bit more qualitative in order to assist people to make those decisions.

We still need to do a bit of work around the role of those sensors, because we do not want to be communicating to people an action from a sensor if there is nothing different that they can do and it has no meaning. We are still working through that process to see what added role community sensors can play.

MR BRADDOCK: Thank you. I look forward to hearing the results of it.

DR PATERSON: Minister, can you speak to what the ACT government is doing to improve access to primary care for vulnerable Canberrans with complex and chronic health conditions in this year's budget?

Ms Stephen-Smith: I certainly can, Dr Paterson. Thank you very much for that. You might have seen that I made an announcement on this today. It is a really positive combination of an initiative in this budget, which is an additional $3.4 million to continue the successful programs that we have delivered through Directions Health Services, Anglicare's Junction Youth Health Service and Companion House.

For Directions, for example, that is funding three days of the Chat with Pat van out and about in the community. It is co-funded. I think ours is three and theirs is two—Capital Health Network fund the other days. So, it is an example of a good partnership between the primary health network and the ACT government funding. For Junction and Companion House, those are expansions of services recognising the demand that they are facing. That was originally funded under a 2019-20 budget measure. I am going to go to Mr Culhane to correct me if I am wrong in any of these numbers and dates.

We also announced today a further $900,000 in grants that came out of that original budget measure. So that was money that has sort of flowed over the years. For Meridian, $280,000 to establish a culturally-safe, gender-affirming primary health care clinic. Next Practice is $250,000 to provide integrated primary for up to 250 house-bound ACT residents who have complex and chronic health care needs. They will be working with home-based aged care providers and NDIS providers to identify people who might be housebound and need that access to primary health care that they cannot get because of those travel difficulties, and also potentially as a result of financial barriers as well.

Anglicare are looking to establish a mobile health clinic as well. So, building on the success of the Directions' clinic, Anglicare are looking, with the Junction, to establish a mobile clinic for young people aged 12 to 25 who are experiencing or at risk of homelessness.

And there is increasing funding for Companion House, so just over $170,000. It is a really interesting initiative to recruit community pools of general practices who are willing to take referrals of people from refugee backgrounds for long-term care, or on

arrival, for assessments in short-term care. This is recognising that people who arrive in the ACT as refugees and asylum-seekers, but particularly refugees, who are going to make Canberra their home, often, will get their initial primary health care through Companion House. We are a refugee-welcome zone. We are a welcoming city. Companion House do an incredible job supporting refugees who have had an experience in trauma. They provide trauma counselling services, but they also provide primary care. But then the clients often have difficulty transitioning to a mainstream general practice, again because of a range of barriers. Those might include language; they might include whether that GP is operating in a trauma-informed way and they might include financial barriers.

So, Companion House is working with general practices who put their hands up to be interested to take over the care of some of those refugees and asylum-seekers as they settle into the community so that Companion House can support more of the new arrivals.

There are a range of measures, but I think what this really all recognises is the difficulty that people in the ACT often have in—and the barriers that people face to—accessing primary care in the ACT. We have the lowest proportion of GPs per head of population. We have the lowest rate of bulk-billing in the country. People can face financial barriers, but they can also face barriers about their own living situation or their cultural needs. Particularly for those people who are supported by Directions or the Junction, for example, who might have quite complex and chaotic lives, taking care to them where they are is going to work better for them than trying to figure out which doctor is going to bulk-bill and then try and make an appointment and keep that appointment to go and see them.

So, it really is about supporting some of the most vulnerable people in our community with primary care. That is better for them but it also reduces unnecessary visits to the emergency department or use of emergency and acute services, if we can keep people well in the community.

DR PATERSON: Thank you for that answer. Is one of the ideas that these sort of outreach services will capture the vulnerable populations and then gradually bring them into your local GPs and those types of health networks, or will they continue to use these outreach providers?

Ms Stephen-Smith: It will really depend on the client group. So, certainly for the Companion House project, that really is building up and supporting the capacity of GPs to become the primary carer.

Others might transition, so young people might get really great support from The Junction that helps them during the period of difficulty, and then they get back on track with their lives and become more able to engage in mainstream services and transition into those mainstream services. There will be other people who will continue to have complexities in their life, where they will not be able to make that transition.

Michael, did you want to comment more in relation to that?

Mr Culhane: No, not really. I think you have said it all.

THE CHAIR: That is a first!

DR PATERSON: One of the things in the media statement was around reducing stigma in accessing services. One of the things that strikes me about these services is that it is really about building trust in relationships with vulnerable people. Is that a key component of these grants?

Ms Stephen-Smith: Yes. It is something that I think really came to the fore during the response to the Delta wave of the pandemic in particular. When we had some vulnerable community members affected by COVID—either COVID-positive or had to quarantine—and the partnerships with our non-government organisations—our trusted non-government organisations, like CAHMA, like Hepatitis ACT, like Directions—really built the bridge between the ACT Health Directorate, Canberra Health Services and those individuals in the community to ensure that they could get the wrap-around support and services that they needed. We had a range of other community partners who were involved in that as well, providing different types of care.

It really highlighted the importance of the connection that those non-government organisations have with some of the most vulnerable members of our community and that we need to be using and building on those connections, not expecting that people will just be able to get themselves to mainstream services.

As you say, there are a range of those issues that created disconnect. The Meridian service, for example, supports gender-diverse people but also sex workers, who have a different type of barrier to accessing services, where they may face significant judgement and stigma accessing mainstream services. So, the barriers are quite different, and we need to work with a diversity of services to recognise and address those.

DR PATERSON: Thank you very much.

MS CASTLEY: Thanks, Chair. I have a question, Minister, about questions on notice and the process with regard to that.

In August 2020, former MLA Vicki Dunne asked you to provide, on notice how long are waiting lists for children's health services in the ACT, for each service, and what is the median wait time for each list? You provided a list of services at that time, without including any ambulatory care; so it was all about everything but!

I asked the same question a couple of times—one about paediatric and one for general elective surgery waiting times—question on notice No. 675 and question on notice No. 771. They were very similar questions, but I was just hoping for recent, updated figures. However, this time it was assumed I was only interested in ambulatory care. So, I am just wondering about the process. Who answers these questions? How do we get to the point where almost identical questions just a few years later are assumed differently? Can you help me with that?

Ms Stephen-Smith: Well, it was not the same question that was asked. I think is the answer to that, Ms Castley. If you want the same information, ask the same question, and it is much more likely that you will get the same information.

MS CASTLEY: To clarify—

Ms Stephen-Smith: If it is slightly different, it may be an interpretation issue. I can assure you that it is not a deliberate effort to try to not answer your question. Often questions are worded in a way where we have to use our best endeavours to figure out what information people are seeking. We use our best endeavours and we try to provide that information.

MS CASTLEY: To be clear, Mrs Dunne's set of questions were: "What is the median wait time for each list?" The other one was: "What is median wait time for each list?"

DR PATERSON: Is this a pressing budget issue?

Ms Stephen-Smith: For each list of what?

MS CASTLEY: One was paediatric wait times and the other was general surgery wait times. Can we resend these questions?

Ms Stephen-Smith: Ms Castley, if you would like to send the question in, referring to previous question number that Mrs Dunne submitted and saying you would like an update of the same information, that would probably be the easiest way to get an update of the same information.

MS CASTLEY: To be clear, this is to do with budget. If that is the problem—

Ms Stephen-Smith: Can I just make the point that, again, Ms Castley, my office provides and organises briefings with you. You have contact with my staff. If there are things that you want to know and there are things that you want to figure out how to ask, your staff can always talk to my staff about that.

MS CASTLEY: We have, Minister. We have.

Ms Stephen-Smith: That is the way we operate in the Legislative Assembly. We are actually quite collaborative. Other members of the Assembly would be aware that—

MS CASTLEY: That is why we are here asking again: my staff have asked your office, so where else do we turn? My staff have asked your office. We will submit the questions again.

THE CHAIR: Yes. Maybe submit the questions again. I am not quite sure how this necessarily though relates directly to the budget.

MS CASTLEY: The minister is the Minister for Health. These are health questions. Anything to do with this health—

THE CHAIR: Yes, but—

MS CASTLEY: I am allowed to clarify, Chair. If the committee are allowed to comment, surely, I am allowed to comment and defend myself in my role. As opposition,

my job is to ask these questions.

Ms Stephen-Smith: I am now inviting you, Ms Castley, for your staff to speak with my staff and figure out how a question can be asked to elicit the information that you would like.

THE CHAIR: We might have a resolution there then.

MS CASTLEY: Thank you.

THE CHAIR: We have four minutes left of this session. Is there a committee member who has a substantive that they would like to ask?

DR PATERSON: Just around the hydrotherapy pool. Minister, I would be interested to know about the budget commitment towards that.

Ms Stephen-Smith: This is really good news—that we have the full commitment of funding for the hydrotherapy pool. I am going to throw to Ms Lopa to talk about where that is up to and how the process will work from here.

Ms Lopa: Yes, we are all really thankful to get funding for the hydrotherapy pool provided in this budget. We have been undertaking an early design process where we involve members of the community to design the facility.

We have an early concept design and that design will be in progress through to a more detailed designed before going off to tender for construction of the facility. We will continue as we go through the detailed design process, in collaborating and consulting with users of the hydrotherapy pool, as well as our stakeholders, to make sure that we are getting the design right and that the pool will be somewhere for people to be able to access to do their exercises and have some relief from chronic pain and all the other reasons that people use a hydrotherapy pool.

The next step is to get our design more populated at a more detailed level now that we have got project certainty and surety of funding and then go out for tender for someone to construct the pool.

DR PATERSON: The pool is going to be in Tuggeranong—is that correct—or is planned to be?

Ms Lopa: Yes, that is right. It will be part of the leisure centre that is already at Tuggeranong. The plan is to have it as part of that development so people can access the normal swimming pool. There is also a kids playground area et cetera. They will also be able to access the hydrotherapy pool.

The design process has taken into account all those extra things that we will need for the pool, including larger changing facilities et cetera to make sure they are accessible to everyone. We have also taken into account travel distances within the pool so that people with a disability do not need to be walking past all the kids doing swimming lessons. Their carers do not need to be taking them, other way for change facilities et cetera. We will make sure that all of those principles follow us through the design of

the pool. Hopefully we will be handing it over as soon as possible for people in Tuggeranong, and all over Canberra, to access.

DR PATERSON: Fantastic.

THE CHAIR: Given it is now 5 o'clock, it is with great sadness that the committee must end today's hearings. On behalf of the committee, we would like to thank Minister Rachel Stephen-Smith for attending, and other ministers, statutory holders and officials who have appeared throughout the day. If witnesses have taken a question on notice, would they please get those answers to the committee support office or the secretary within five working days of receipt of the uncorrected proof. If members wish to lodge a question on notice, please get those to the committee support office or committee secretary within five working days of the hearing. It is now adjourned.

The committee adjourned at 5 pm.