LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

STANDING COMMITTEE ON HEALTH AND COMMUNITY WELLBEING

(Reference: Inquiry into ACT Budget 2021-22)

Members:

MR J DAVIS (Chair)
MR J MILLIGAN (Deputy Chair)
MR M PETTERSSON

TRANSCRIPT OF EVIDENCE

CANBERRA

THURSDAY, 21 OCTOBER 2021

Secretary to the committee:
Mr A Snedden (Ph: 620 50199)

By authority of the Legislative Assembly for the Australian Capital Territory

APPEARANCES

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Amended 20 May 2013

The committee met at 12 pm.

Appearances:

Davidson, Ms Emma, Assistant Minister for Seniors, Veterans, Families and Community Services, Minister for Disability, Minister for Justice Health and Minister for Mental Health

Community Services Directorate
Rule, Ms Catherine, Director-General
Sabellico, Ms Anne-Maree, Deputy Director-General
Wood, Ms Jo, Deputy Director-General (COVID Response)
Pappas, Ms Helen, Executive Group Manager, Children, Youth and Families
Brendas, Ms Tina, Executive Branch Manager; Bimberi Residential Services; Child and Youth Protective Services; Children, Youth and Families
Evans, Ms Jacinta, Executive Group Manager, Strategic Policy
Murray, Ms Christine, Executive Group Manager, Inclusion and Participation
Summerrell, Mrs Jessica, Executive Branch Manager, Social and Community Inclusion, Inclusion and Participation

THE CHAIR: Welcome to the third public hearing of the Standing Committee on Health and Community Wellbeing into budget estimates 2021-22. The proceedings today will examine the annual reports, expenditure proposals and revenue estimates for community services and related support services, homeless and housing services, and the Health Directorate in relation to budget statements C.

On behalf of the committee, I would like to acknowledge that we meet today on the lands of the Ngunnawal people. We respect their continuing culture and the contribution they make to life in this city and this region.

I ask participants to acknowledge that they have read and understood the privilege statement before they speak for the first time.

When taking a question on notice, it would be useful if you could be very clear that you will take that question on notice. That will help the secretary to follow up with you.

We will begin by hearing from Minister Davidson in her capacity as Assistant Minister for Seniors, Veterans, Families, and Community Services. In lieu of having an opening statement, we will go straight to questions.

Minister, my first question is around the government's proposed reform work on the age of criminal responsibility. The obvious question for many is: if we raise the age of criminal responsibility, what happens to Bimberi? What is the government's long-term vision for Bimberi should we raise the age of criminal responsibility?

Ms Wood: I cannot see the minister. Apparently she is not here at the moment.

THE CHAIR: She was when I began speaking.

Ms Wood: I have a message from the minister's chief of staff saying that she is logging on.

MR PETTERSSON: Chair, I suggest that we suspend briefly while we wait for the minister.

THE CHAIR: Thank you, Mr Pettersson. We will give the minister an opportunity to login.

Hearing suspended from 12.03 to 12.14 pm.

THE CHAIR: Welcome back, and apologies for some technical difficulties. We are now joined by Minister Davidson and officials.

Minister Davidson is appearing today in her capacity as the Assistant Minister for Seniors, Veterans, Families and Community Services. We are examining community services and related support services, homelessness and housing services, and the Health Directorate in relation to budget statements C.

Before they speak for the first time, I ask witnesses to acknowledge that they have read and understood the privilege statement.

Minister, I have the first question for you, and it is related to Bimberi. I understand that the government has an agenda to raise the age of criminal responsibility. Many constituents have asked the obvious question: what does that mean for the future of Bimberi?

Ms Davidson: Before I hand over to officials to talk more about what raising the age means for youth justice programs, let me say that Bimberi is a place that takes people over the age of 14 as well. That means that there will still be a need for the Bimberi Youth Justice Centre for people who are 14 years and older but that they will no longer need to provide programs for people aged 10 to 13 years because we will be providing programs for 10- to 13-year-olds in the community to achieve the goals of reducing young people's engagement in harmful behaviour, making the community safer and providing better support for young people and their families through a range of programs and services that will help with all of the complex issues that they are facing.

I will hand over to officials to talk a bit more about the kinds of programs that we will need to run in Bimberi after raising the age.

Ms Rule: We might go to Helen Pappas in terms of the types of services we currently run and what any change to the age would mean within Bimberi; then Jacinta can talk about the work around the challenges around establishing a service system for the under 14-year-olds for youth justice.

Ms Pappas: Minister, you are right; the majority of young people that are sentenced or are admitted to Bimberi are between the ages of 15 and 17, so the service would continue. I am having some IT problems so I cannot get the information I need at the moment, but there is a range of programs that would continue to be delivered into

Bimberi. For example, the education program run by the Education Directorate would continue.

Tina, I might ask you to speak while I sort the technology out so that I can talk in some detail about the services in Bimberi.

Ms Brendas: I acknowledge the privilege statement.

In relation to programs at Bimberi Youth Justice Centre, upon induction every young person has a physical and mental health assessment and a risk assessment. Assessments are also undertaken by Murrumbidgee school, with a particular focus on the young person's literacy and numeracy skills.

Murrumbidgee school is the school within Bimberi that is operated by the ACT Education Directorate. They run a variety of programs for young people which include year 12 certificates; year 10 certificates; certificates in other areas of interest such as business, horticulture and hospitality; road-ready certificates; the general construction white card; and, as I mentioned, the numeracy and literacy programs for young people. There is also schoolwork from the school that the young people participated in in the community. People can continue to work within custody on the work that they were working on in the community.

We also offer a variety of rehabilitative and reintegration programs. We have programs for job and résumé application writing; interview skills; cooking classes; and music classes. We have Alan Tongue come and provide a "dream, believe, achieve" program for young people. There are woodwork and chicken husbandry programs.

All these programs will be still available to young people within the centre, even once we increase the age. Once we increase the age, we will be looking at a different cohort of young people, but all these programs will still be available to the young people. We also have Winnunga, Gugan and Relationships Australia come and provide programs to the young people. All these programs will continue to be available to the young people.

THE CHAIR: It is great to hear about the programs that are running at Bimberi. I was wondering if we could go through what we are doing to stop young people entering Bimberi in the first place, particularly around the government's justice reinvestment investment.

Ms Davidson: I might ask one of the officials to talk about the functional family therapy youth justice pilot program that we have been running this year. From what I understand, it has been really successful so far and is worth looking at in more detail.

Ms Pappas: Yes. The functional family therapy youth justice program is an evidence-based program that is being delivered that targets young people between the ages of 12 and 17. It is an intensive in-home service that works with young people, their families and their extended family network.

It works in three phases. There is an engagement phase; a treatment phase; and a

generalisation and exit phase. It is an evidence-based program. It is used across Australia and also internationally. It works on relationships and what is not working well with those relationships that might be creating circumstances where young people offend.

It is an incredibly successful program. We have been delivering it in out of home care for some time. We are running a pilot with OzChild, who are delivering the program. That commenced in February. We are getting some early signs of success in this program. Young people are challenged to think about their contribution to dynamics; their contribution to what is working and what is not working in the family; how they own their behaviour; and what they might be able to do differently in terms of engaging in more pro-social behaviour. The family work intensively. It can be up to six to eight months worth of intense programs in the home.

As I said, we have had 19 young people in that program. Four have successfully completed the program, and we have 15 young people in the treatment phase. It is early days; but, by all accounts, that program is really delivering outcomes for those families.

THE CHAIR: Has the government planned any specific intervention programs for that 10- to 13-year-old cohort once we have moved beyond raising the age of criminal responsibility, to keep them out of Bimberi? Those programs sound great, but they sound like programs that any young person across the spectrum who might currently be going into Bimberi or is at risk of going to Bimberi would be accessing. Are there any specific new investments necessary to make raising the age work?

Ms Davidson: Yes. We recognise that we will need to put in place some programs that address the needs of younger people if we are going to make raising the age work. What we are really looking for is for young people to not be engaging in harmful behaviours. That will make the community safer and it will also mean better outcomes for those young people and their families. That is what we want. We want those better outcomes.

There have been a number of things going on. The Attorney-General had a discussion paper out recently. We got lots of contributions and submissions from various community sector organisations, academic experts and people in the community who know quite a lot about working with young people who have complex needs. We are taking into account all those submissions and advice about what might be needed. There was also a review of services that was conducted by Professor Morag McArthur. There is some work that we need to do in understanding what is in that final report and where the gaps might be. That is a process that we will be working through, but it is really important.

If we do this, we want to make sure that it is done right. That means taking the time to consult with all the right people and to really understand what we are getting involved in before we start to make those changes.

I might hand over to officials to talk about the time line for that review of services and discussion paper.

Ms Rule: Jacinta, are you able to talk to that in terms of the overarching work program for this and give some time lines in relation to giving consideration to the comprehensive reports and feedback that we have received in the positive for this report?

Ms Evans: Yes, I would be happy to. I acknowledge the privilege statement.

This is a complex piece of work. When you think about raising the minimum age, you are thinking about not just the young people but the environment and the families that they are attached to in terms of how we would make changes to the service system.

The policy work that will accompany this change to legislation will require quite significant investment across a range of different directorates and our community sector partners. We would be looking at strengthening the existing services, but also there will need to be some recalibration, I guess you would say, of services that currently are used for young people.

You referred to Bimberi. With those young people who would not now be able to access those more justice responses, we need to look at what diversionary supports are available to them. That is quite a significant use of service design.

We are looking at needing quite a bit of time. The government will be bringing this piece of work forward to the Assembly; but it will be staged, looking at the immediate needs for the change to legislation to occur and what that would look like in terms of service redesign.

We are taking this as a long-term change to the way our community responds to and supports these children and their families and the communities in which they live. I am indicating that there is probably a six-month horizon with some work, and definitely an 18-month horizon for a deeper piece of policy work and system reform. Then we would be looking at the next tranche of work after that, which will require, as I said, a whole range of our community sector partners and our directorates to be working together to deliver that work.

MRS KIKKERT: I joined 10 minutes after the start, so I missed some of your questions, Chair, and forgive me if I am going through them again. Is there any funding within the current budget that is going towards the reform of the system in creating the increase in the age of criminal responsibility?

Ms Davidson: In order to understand how much funding is required for any new programs or expansion of existing programs for dealing with 10- to 13-year-olds, or even early intervention for much younger children so that they do not end up on that pathway in the first place, we would need to have reached the point where we have a better understanding of what is involved in running those kinds of programs. We will work through that, but first we are needing to better understand what programs need to run, what is going to be most successful.

MRS KIKKERT: So would I take that as a no, Minister—that there is no current funding into the reform, that you are just smoothing out the services that are currently available and what needs to be changed?

Ms Davidson: Not at all. I expect that we will be making some quite substantial changes to services in the future in order to make raising the age work.

MRS KIKKERT: Yes, I understand that, Minister, but my question is specifically about the 2021-22 budget. Is there any current funding specifically designed for the reform of the system?

Ms Davidson: Any funding that will be required for the reform of the system will go through a cabinet process once we have worked out what the actual reforms are that need to be implemented.

MRS KIKKERT: Is it the government's intention to create a two-tier system of youth justice so that the under-14s and the 14- to 17-year-olds will be dealt with in a different way? Is that the government's intention for youth justice?

Ms Davidson: The government's intention is to have well-integrated systems of family support that address complex issues, including issues with alcohol and other drugs; mental health; domestic and family violence; homelessness; and all of those related issues, and some of the intergenerational kind of trauma that we are seeing with a small number of families in our community who have really complex needs.

If we are to do this successfully for the purpose of making sure that 10- to 13-year-olds are not engaging in those kinds of harmful behaviours, that is going to involve intervening and providing support to those young people and their families from a much earlier age. That will flow on to having really good impacts for people over the age of 14 as well. We will see those good improvements over time. We are looking for a really well integrated system.

MRS KIKKERT: So—

THE CHAIR: Mrs Kikkert, you have had a good run on the supplementaries. I would like to give the standing committee members an opportunity to ask a substantive.

MRS KIKKERT: Okay; thanks.

THE CHAIR: I will move to Mr Milligan for a substantive.

MR MILLIGAN: Thank you, Chair. I am not sure if you guys are getting the video, but I am having issues with my connection. Can you hear me?

THE CHAIR: We can hear you loud and clear, but there is no video.

MR MILLIGAN: During the financial year 2020-21, OzHarvest delivered over 786,000 meals to vulnerable Canberrans. During lockdown, there has been more of a demand on their services than usual, particularly for food relief. They specifically were seeking funding for an extra van and delivery driver that would help boost their ability to provide this crucial service. Will OzHarvest receive any funding from the community support package which has been reported to support community organisations to provide a range of crisis and emergency supports?

Ms Davidson: Before I go to the officials to talk in more detail about the range of food relief programs that we are running at the moment, the Canberra Relief Network and how we are going to be delivering food relief in the ACT, moving forwards from coming out of this lockdown period, and what the new situation is going to look like, I want to say thank you to all the people in Canberra who have stepped up and been part of this through such a wide diversity of different programs.

We have had people volunteering with the Canberra relief program, including quite a number of veterans through Disaster Relief Australia. We have had staff from CSD who have gone way above and beyond what their job requires to make all that work. There have been small businesses in the ACT who stepped up to try and provide food support to people in public housing complexes during lockdown. And ordinary Canberrans have been getting together in groups and getting food out to people who really need it.

We have had some really good specialised programs for different groups in the community who have specialised needs—for example, people in our multicultural community or people whose needs are a little more complicated than just needing access to food but who need access to other material supports as well.

I will hand over to officials to talk about the range of programs and what is being planned for the next year.

Ms Murray: Thanks very much, Minister.

MR MILLIGAN: If I could just jump in quickly, though, you are talking about programs and whatnot, but the question was specifically about funding that OzHarvest has requested for an extra van and delivery driver. Is extra funding going to be provided for OzHarvest?

Ms Davidson: We have known for some time now that food relief in Canberra has needed a more integrated and well supported response. That is why a number of the organisations that provide food relief from the community sector in Canberra have been part of a network that came together over the course of the last year to talk through what the future of providing food relief in the ACT should look like and how the government can best support them to do that.

There is funding in the budget for this year to enable a database to be set up and to provide other support to our community sector partners to be able to deliver that food relief to Canberrans.

I might hand over to Christine to talk a bit more about what that funding is going to deliver.

Ms Murray: I will do a brief introduction and then hand over to Jessica Summerrell. I acknowledge the privilege statement.

The minister has summarised it very well in terms of looking at the depth and breadth of the food and material aid that has been required to be delivered across the last two

years and how we have worked, not independently but as part of a broader tapestry of the social and community network coming together, to provide a broad range of supports.

It is really important, in looking at where we sit in terms of food support, to recognise that food is only one part of the puzzle that we need to support these families. Often it is a great way of opening the door for us to provide significant wraparound services. We need to acknowledge the extraordinary work of some of our community service partners stepping in with food and also stepping in with a broad range of social supports. We have seen supports from when we first commenced the broader food support package back when COVID first hit us; they have maintained those relationships and supports through the ebbs and flows of what has been a really difficult time.

Jess, I might throw to you to talk on the detail of the conversations we have had with the sector and how the model will look, going forward, as a joint-led project.

Mrs Summerrell: I acknowledge the privilege statement.

An enormous amount of work has occurred, over the last 12 months in particular, in relation to emergency food and the food response more broadly across the Canberra community. We first saw that need arise for a more coordinated and collaborative approach in pandemic round 1, as I refer to it, in the early parts of 2020. We saw through that an opportunity to bring together a whole range of experiences across the community sector on what the food needs are for Canberrans—and not just the food needs but the material needs for people on a day-to-day basis. It is also about asking, when we see any type of crisis or stretching happening in our community, how we can lean in and support people more.

We see those vulnerabilities through winter, for example, when costs of living are higher, with heating costs. We see a higher level of vulnerability at that time. When large things like the pandemic or bushfires hit, or at Christmas, there is a whole range of things where people are pushed into a vulnerability that they may not always experience.

As a collective, through many community organisations, we have been working to better understand that and to look at what we need to do to provide an approach that allows a flexing up of capacity as we need it in those periods of vulnerability.

We have been working with a range of partners to look at what is needed on a day-to-day basis and how we can provide that support in a more ongoing sense. As the minister mentioned, there is $475,000 allocated in this budget to support that work further. That will support the development of a fit-for-purpose database. That will be the first time that we have had a database that collectively brings together a range of separate community organisations to look at the food need of people in Canberra and where that need is being most felt across our Canberra region. It will support the data migration of the database that we have been using while we have been in the pandemic response that we have had as part of our CRN response. It will also include the development of a food strategy, which will be what we turn to in periods when we see this need to flex up. That will then be a community sector-led community

response that we will support through the development of that strategy. Obviously there are other costs in there—maintenance, staffing and things—but that is what that particular funding will provide.

I am really excited. This is the first time that we have been able to get all the partners together to work on a strategy, going forward. That is a huge achievement. As Christine mentioned, the community sector has done an enormous amount of work to support our community over the last 12 to 18 months and we have learned much through that process.

MR PETTERSSON: Just chasing some of the detail of that expenditure, it is $240,000 in this budget, then 78,000, 78,000 and 79,000. Does that mean the 240,000 is to develop the database and the strategy?

Mrs Summerrell: The initial funding is to support the research and analysis that needs to happen in order to inform what that database will look like, plus the development of the database, plus the migration of the data that exists already over there and the beginnings of what that strategy is going to look like and how we are going to best be able to utilise that database based on the research that will form part of the development of that. It is not as simple as saying that it is just the database; there is a lot of work that has to happen in order to make that database the most effective database that it can be.

The ongoing funding in the forward years will support the gathering of that group in the more formal structure—the support for that plus the development of a larger food strategy that can be used over that four-year period. That is taking into consideration that we need to look at lots of factors, not just the pandemic. There is a lot of research that we have been tapping into recently around what our environmental landscape is going to look like, going forward, from a global warming perspective, in terms of fire and flood, and the impact of that on our community as well. Our food and material aid response needs to form part of that also. That will bring together some work that this group will do and also the work that has been happening in social recovery more broadly.

Ms Davidson: Can I just add to that, Mr Pettersson? This database is quite a complex piece of work. In my life before I got this job, I built a pilot version of a database for a food relief service in Canberra that is one of the organisations that is part of this network that Jessica has been talking about. It was an incredibly complicated piece of work.

When I look back on how that piece of work was delivered, I can see that it would have been done much more effectively if we had had the time to do the research and analysis to begin with. But when you are working with a community sector organisation on a very tight budget, that is quite difficult to do. By having the ACT government stepping in and supporting this, and having a much broader range of food relief partners involved in the project, we are going to see a fantastic result delivered by the end of it.

MR PETTERSSON: Is the database going to be held by UnitingCare?

Mrs Summerrell: No, not necessarily. UnitingCare Kippax is part of the group that has come together to develop this. There will be information from a range of community organisation providers that feeds into the database; but it has not really been decided at this stage. The group need to come together and work out where it best sits and how they can best access the information they need. It may be that there are multiple access points. There has been no decision about where it will sit.

MR PETTERSSON: I can gather from that that the government is not going to hold the database. It is going to be CRN in some form that is going to be holding it?

Mrs Summerrell: Yes, I would anticipate that. VolunteeringACT are one of our lead agencies in that space. They have a platform at the moment and they have the database that we will be migrating from. We would take the advice of that community organisation, amongst the other ones, about where it would best sit.

MR PETTERSSON: Cool. Minister, I was wondering how this budget delivers on the government's social recovery plan for the city.

Ms Davidson: I will hand to officials in a minute to talk more about what social recovery means and what we are planning to do, but this is going to be a piece of work that involves all the directorates to really achieve success with social recovery. It means that we have to look across what is happening with housing, education, health and mental health, as well as community and social supports, to really get that complete picture and to really ensure that what we are doing is a community-led kind of process that addresses the needs of some of the people who will be most at risk in our community, recognising that there is going to be a really long tail to this pandemic and that this will not be the last time we have to deal with a really large scale emergency in this city. There are things that we are learning from what is happening right now that we can apply to completely different kinds of emergency situations in the future—bushfires, floods and things like that.

I will hand over to officials to talk more about what social recovery means and what we are planning to do.

Ms Sabellico: In terms of the social recovery fabric, there are three different streams that I will talk about.

One is social recovery, which sits under the emergency management framework. The last time I was before this committee, we were just coming off the back of the bushfires and I do not think we would have imagined a pandemic. But we spoke a lot about our respite and our recovery centres and our evacuation centres.

It is really critical that government does not present itself as actually owning the whole picture for that. We work very closely with a number of community providers and were spending a lot of time in the recovery centres over that period of time. We were working with St John Ambulance and the Salvation Army. The Salvation Army were providing food for people who were accessing the centres, ably supported by church groups and businesses, such as hotel staff and bakeries, who were dropping food off. It is another example of how the Canberra community steps in in a crisis.

In the social recovery space, it is about some of the core functions as prescribed under the emergency management framework. Social recovery in that domain is one of the four pillars of recovery. Other people might argue, but I would say that it is one of the most critical components of that pillar of emergency recovery framework, because the reality is that if we do not have people who are safe and comfortable, they cannot participate in the broader economic fabric of the community. Social recovery is a really critical piece of that puzzle, and it sits very firmly under the emergency management framework.

In terms of the work that we are doing now, we are talking to our community partners, many of whom have been stretched over the COVID response, to ensure that they are ready and able to stand up in a bushfire or flood—or smoke or hail—like we spoke about last time we met.

We are also largely run with volunteers who man emergency management centres. Those volunteers, ACT public servants, work alongside our community partners. We are looking at retraining and training those staff, because over the course of the last 12 to 18 months we have had to recast what an evacuation centre or a relief and emergency centre looks like in a COVID environment.

When we thought that we had that down pat, Delta came along and threw our plans out, so we had to recast some work with our training to make sure that we could safely operate our respite and recovery centres within a Delta strain environment. Now we are transitioning into what it means for our respite and recovery centres if we have a high level of vaccination. We are just working through those details now.

In terms of the social recovery, that sits under the Emergency Management Act. That is one subset of the broader picture. The other, which I think the minister was broadly alluding to, is about where we go next in terms of our community recovery. That is a separate subset. You would be aware that we released a community recovery roadmap in 2020. We were happily working towards that as we came out the other side of the lockdown period. Delta threw another spanner into the works on that. We flexed back up in terms of the response phase of that plan; we are still managing that response and also stepping into the recovery phase and what that looks like.

Many of the things we did within that are items that we have continued with. The Connect in Canberra website initiative, which looks at the connection point for different groups and different activities, has had a fantastic response. The Know Your Neighbour card is something I have seen live on, with people continuing to check in on elderly neighbours, making sure that in this second wave we did not have that reactivation. It happened naturally; people already knew their neighbours and knew that they needed to have shopping delivered et cetera.

A lot of the conversations that we were having were in relation to, "Do you have someone while you are isolating who you can get to do your shopping?" "Yes; my neighbour looked after me last time and we have come up with this agreement again." On the ground, that is something that, I think, has been integrated and been able to be rolled out and flexed up as necessary.

We have all seen "Where's Wally", the teddy bear hunt and those sorts of things,

which are really critical. Some people ask whether there is science behind this, but anything that creates community cohesion and community connection is critical in this time when we are separated.

The minister commented about Canberrans stepping up and stepping in in relation to food relief. We have seen that across the board. The community connections grants, which we have run two rounds of recently, have been quite extraordinary. I have some favourites in that round, from $250 to a group of people who wanted to get together and sew masks to some of the bigger connections. The Scullin group got together and were running monthly sessions pre-Delta to create community connections, with movie nights and things at the local hall. The flexibility within those two grants programs were really well received.

Another grants program—there are a number of them—is the respite and recovery grants in the disability space. They were co-designed with the disability sector. We said, "What is needed in this space?" We had wonderful feedback. Carers ACT has chipped in some money to extend those. There is quite a lot of difference in what the community is asking for.

Again, it comes back to something that Jess said: government supports and community leads. That is a critical mix in terms of the community recovery program. We are looking to continue to take that model forward and broaden our scope of what community looks like.

We have had approaches from a number of clubs in the sector, whether that be sporting clubs or licensed clubs, saying, "We want to be part of the solution." The next stage for us is about how we leverage off the volunteers that we have, the community sector organisations that we already work with, and the broader community sector in terms of clubs, sporting clubs et cetera, and design a program of community recovery and resilience into the future. Again, it is about taking what we have learned and then strategising.

I am not sure if you want me to go into detail about the third tranche, which is the COVID response. A lot of the Delta COVID response that we are in now relates to food being an opening for a broader support package. Mrs Summerrell has spoken about the Canberra Relief Network. We have also been actively involved in responding to multi-unit properties when they have had lockdowns, making sure that it is not just food that is put on the table but other material aid and also broader and longer term social supports. We are also involved in the hotel quarantine food delivery and material aid space, and we are supporting the O'Connor facility.

Again, I say that it is not government owning and leading; it is government leading with the community sector and individuals in the community. In a nutshell, that is community recovery and social recovery, going forward.

MR PETTERSSON: It is day 5 of estimates and I think that you are a strong contender for the most thorough answer so far, so thank you.

MRS KIKKERT: The Healthy Centre Review of Bimberi Youth Justice Centre 2020 makes 27 recommendations to improve the centre's operation. Exactly how much

money in this budget has been earmarked for implementing these 27 recommendations?

Ms Davidson: Before I hand over to officials to talk about how we are implementing the recommendations in the healthy centre review, I want to note that an amazing amount of work has gone on over the course of 2020 and 2021. We have had fewer young people coming into Bimberi; a lot of training, education and improvements to how Bimberi is running would have been much harder or taken much longer to do with more young people in there.

It is one of those situations where we have found an opportunity to provide more training and support to the youth workers that are working there and made the most of that to achieve some really good outcomes, including making sure that young people going into Bimberi have the opportunity to get vaccinated.

I will hand over to officials to talk a bit more about how we are implementing recommendations from that review.

Ms Pappas: I forgot to acknowledge the privilege statement when I spoke before, but I acknowledge it now.

The healthy centre review is a forward-looking, future-focused opportunity for Bimberi. We have been working closely with all our stakeholders and our oversight bodies to continue to mature and develop the response to young people in Bimberi.

Many of the issues that were identified through the healthy centre review were already progressing through other reviews and reforms that we had identified for Bimberi. So many of the recommendations—I think all the recommendations, but Tina can correct me if I am wrong—are able to be progressed with existing resources.

In the previous budget, we were provided with some funding and we were able to employ our intelligence officer and our work health safety officer, our training officer, and consolidate our principal practitioner out at Bimberi and some money for some capital works improvements in the service. The addition in this budget of two additional control room officers will assist in how the campus is managed on a day-to-day basis. That additional capacity and the capability there are really welcomed because that will assist in supporting staff and young people—

MRS KIKKERT: Ms Pappas, I am very mindful of the time, and I only have three minutes. You mentioned the recommendations. One of the recommendations was on video calling. If video calling was not available to young people during the lockdown last year or the lockdown we have just had, was video calling available to young people?

Ms Davidson: I will hand over to officials to answer whether AVL has been available in this lockdown.

Ms Pappas: The centres were pretty quickly able to stand up the use of AVL in the centre so that young people were able to access AVL to have contact with their families, lawyers and other professionals and oversight bodies through the AVL

process. Yes, they were able to access that over the course of this lockdown.

MRS KIKKERT: One of the recommendations was for individual therapeutic support for detainees or young people when they are locked up in their cells. What support have they been given in regard to that?

Ms Davidson: I will hand over to Helen to talk a bit more about that, but I want to note that, over the course of this year, the lockdowns that have been experienced in Bimberi have mostly been in relation to young people needing to be isolated to prevent the risk of the potential spread of COVID when someone new comes into the centre and they are waiting for a test result. It has mostly been about that.

I will hand over to Helen to talk about what therapeutic supports were available.

MRS KIKKERT: Individually, when they are isolated.

Ms Pappas: Every young person that comes into Bimberi has their own unique needs, and they are assessed upon entry. The combination of forensic mental health and other health services in Bimberi provide an assessment of the therapeutic needs or the needs of individual young people. Then the centre staff, along with input through the principal practitioner, work to identify the individual circumstances that need to be addressed. It can really vary. Ms Brendas might be able to go into the detail of what that looks like. It is this concept of a case plan or a plan around individual children and young people. We are trying to accommodate their individual needs, whether they are in isolation or whether they are able to move around the campus.

Tina, do you want to go into some detail?

Ms Brendas: Yes, thank you. Just to add to what Helen has been saying, the Forensic Mental Health Service sees the young people on a daily basis. Regardless of whether they are in isolation or whether they are within the general areas of the centre, they have access to the Forensic Mental Health Service and other Canberra health services on a daily basis.

THE CHAIR: As the time is now 1 o'clock, I call this session to a close. On behalf of the committee, I thank Minister Davidson and officials for appearing.

Please remember, if you have taken any questions on notice, to provide those to the secretary within five working days.

Short suspension.

Appearances:

Vassarotti, Ms Rebecca, Minister for the Environment, Minister for Heritage, Minister for Homelessness and Housing Services and Minister for Sustainable Building and Construction

Community Services Directorate
Rule, Ms Catherine, Director-General
Aigner, Mr Geoff, Executive Branch Manager, Client Services Branch, Housing ACT
Nielsen, Mr Shane, Executive Branch Manager, Policy and Business Transformation Branch, Housing ACT
Gilding, Ms Louise, Executive Branch Manager, Housing ACT

THE CHAIR: Welcome back, everybody, to the second session of the Standing Committee on Health and Community Wellbeing's inquiry into budget estimates 2021-22. In this session we will be hearing from Minister Rebecca Vassarotti and officials, in the minister's capacity as Minister for Homelessness and Housing Services. I remind everybody that before you speak to yell out your full name, the capacity in which you appear in today's committee, and acknowledge that you have seen and understand the privilege statement.

I will kick us off with the first question. I would like to talk specifically about specialist homelessness services. I note that $8.6 million has been dedicated to specialist homelessness services in this budget, and I understand that it is the first real increase in many years. What circumstances have brought about the need for this investment and how are you hoping that this investment will change the experiences of people who are experiencing, or at risk of experiencing, homelessness?

Ms Vassarotti: Thanks very much for the question, Mr Davis. This is the first time that I have appeared so I will also acknowledge that I have read and accept the privilege statement.

Thank you very much for the question. I am really excited about this investment of $8.6 million in specialist homelessness services. Specialist homelessness services provide for a range of people who are either experiencing or at risk of homelessness. That might include emergency accommodation, case management and crisis support. So it is a really important element of the service system to support people who are in real times of trouble.

The homelessness services sector has had significant demand on its services for a number of years because of the increasing complexity of people's lives. We have come off a period where we have seen significant trauma and impacts through disasters such as the bushfire season of 2019-20 and the smoke. Obviously, the pandemic has also provided some really significant stressors for people. We know that through the pandemic there have been significant increases in family stress and in domestic violence. The shutting of the borders means that people have had a lot fewer options in terms of their accommodation, and we are in a context where we do see very high rentals in the private market.

There have been a number of demands over many years, and about nine years ago we actually saw a decrease in the support that was provided by the commonwealth. So this will be very important in terms of increasing the ability of services to meet the increasing demand and the increasing complexity of the services that they see. As a result of the housing strategy, some additional support was provided in relation to new services. Coming out of the last lockdown in the last period in 2020 in relation to COVID-19, there were a number of new services that were stood up and have continued to be incredibly important.

This injection of funding means that we will be able to provide to all specialist homelessness funding an increase of 12.7 per cent to their base funding, which means that when we take away the CPI—recognising the general annual increase in costs—we will see about a 10 per cent rise in their resources. We know that that will be used for things such as supporting additional staffing and being able to increase their capacity in terms of their IT and insurances and those kinds of things. So really be able to ensure that we get even more benefit from the great services that they already provide. I might just turn to officials to see if there is any additional information that we would like to add to that.

THE CHAIR: Before we do go to officials, one clarifying question that I would love to explore is for the lay person out there: what are some of the very specific activities that a professional working in the specialist homelessness sector does to support people living with homelessness, and how will this funding increase their capacity to do those specific activities?

Ms Vassarotti: We have a number of services that work in different areas. We have our Street to Home program. They are workers working with people who are sleeping rough—going up to them and having a bit of a chat in terms of their circumstances. The workers are working with them on what we can do in terms of providing them with connection to emergency accommodation. Obviously, we have emergency and crisis accommodation. That includes a range of services. You might have heard of our fantastic refuges such as Beryl Women's refuge, Doris's refuge or Toora. We have MacKillop House, which is one of the new services that I spoke about, which is providing emergency accommodation to women without children and women with children.

We have our Winter Lodge, which is also a new service that was stood up last year, which provides emergency accommodation to men who are sleeping rough. We have also got services such as our early morning centre, which provides material relief and also acts as a community hub, provides health services, and is able to connect people with legal services and other services as well.

So it is a very broad range of support that is provided. One of the key things that I have missed is OneLink, which operates as our central intake service. So when people need support, they go through a single point of contact and are able to be connected with the right services and with services that actually are able to support them straight away.

THE CHAIR: I will move to Mr Milligan, now, for a substantive question.

MR MILLIGAN: Thank you, Chair. My question is in relation to client service visits. In the accountability indicators, it mentions that the client service visits for Housing ACT properties was almost 2,000 fewer than the targeted 11,000 for 2020-21. I am just wondering if you can explain why.

Ms Vassarotti: Absolutely. I will turn to officials in a moment. I think that the impact of COVID-19 is primarily the reason. We were coming out of our hard lockdown period from the middle of last year, but COVID-19 and COVID-19 restrictions were absolutely impacting our ability to do client services. There were protocols in place which ensured that client visits were happening in a way that clients were feeling comfortable with restrictions.

I will ask one of the officials, Geoff, to provide some additional information about how those visits were impacted by COVID-19 and the reason they were down.

Mr Aigner: My name is Geoff Aigner, Executive Branch Manager of Client Services at Housing and I accept the statement. As the minister said, through the first quarter of 2020-21 we were limited in our ability to be out in the field up until about 23 October. The home visits that we were able to do, rather than client service visits, were really to check on people who we were concerned about or where there was significant community disruption in play. So there were very limited visits and on approval from senior directors.

From October onwards, we were out on the field in force, really, and we prioritised particular houses that we had not been to for a while, or we had not seen yet because they were new tenancies. Our aim was to get as close to a kind pro-rata amount of client services for the year, which we achieved.

MR MILLIGAN: You have indicated that COVID has had some sort of impact on your ability to get out and do these visits. However, you also mentioned that, for people who are vulnerable, it is important that you did. Shouldn't that have meant that you should have increased visits, particularly to those people who are vulnerable?

Mr Aigner: Would you like me to take that?

Ms Vassarotti: Yes, for sure.

Mr Aigner: Yes, if required. We are not the only support in their lives. Often we are a connection point. The staff who were engaging with those vulnerable clients were, generally, our tenant support staff or our intensive practitioners, and their role is to connect to others and provide channels, essentially. We were engaging with them as much as we can, but just recognising that we are not the only support in their life.

Ms Vassarotti: The other comment that I would make, Mr Milligan, is that client visits are a really important element of the work. There are a number of other contact and touch points for clients through the gateway service. Particularly for some of our multi-units where there may be vulnerable clients, the Connecting Communities program is another program where more work is happening on the ground at those sites to ensure that people are able to connect with Housing ACT people. So it is a

really important element of the work, but it is certainly not the only way that we connect with our clients.

Ms Rule: I am Catherine Rule, Director-General, Community Services, and I acknowledge the privilege statement. I just emphasise that paramount during lockdown was protecting the safety of both our staff and the clients that we serve. Like many services delivered across the community, we had to look at different operational modes to make sure that we preserved the safety of everybody involved. That is absolutely paramount for both our clients and our staff.

MR MILLIGAN: Okay. Thank you.

THE CHAIR: Mr Parton has a supplementary question.

MR PARTON: Minister, you have indicated the importance of the client service visits, and I do not doubt that. Can I just ask, if they are so important, with well over 11,000 properties and, I think, a target of 11,000 visits for 2021, why are client services visits less than one per household per year?

Ms Vassarotti: In relation to client service visits, when we look at the needs of clients, there is a balance that we need present. These are people's homes. Certainly as a landlord there are responsibilities of the landlord to ensure that things like property condition is happening. But we are dealing with people's homes. Again, I might get Mr Aigner to go into a little bit more detail in relation to that.

There is certainly a significant amount of work that goes into ensuring that we are providing support, that we are meeting our obligations as landlords and that we are able to ensure that our tenants are supported. Again, there is a range of different ways that we connect with our tenants. Client visits are absolutely part of the picture; but we also need to make sure that we are not overservicing, and actually being intrusive, in terms of people's lives.

MR PARTON: Minister, with respect, although client service visits in the private sector for rentals are basically around inspections and things, I would have thought that they would average more than one client visit per household per year. So I am not sure that the intrusive aspect of your suggestion there really holds up.

Ms Vassarotti: We try to be a social landlord, but I will ask officials to provide a little bit of information about how we make the decisions about how client visits are prioritised?

Mr Aigner: Thank you, Mr Parton. Just remember that client service visits are one type of interaction. It is a particular interaction which is looking at the property once a year and checking how things are going for the client. There are other interactions that we have throughout the year, particularly for more vulnerable clients, which are not categorised as a client service visit. That is the first thing.

The second thing is that we are talking about a physical engagement here. There are many other engagements through which our client services team interact with clients. That could be phone calls, texts, emails. There are many touch points throughout the

year, particularly with vulnerable clients. Remember that a lot of our clients pay their rent on time, they maintain their homes, and they do not need a lot of interaction with us.

MR PARTON: Cheers. Thank you.

THE CHAIR: I will move to Mr Pettersson for a substantive question.

MR PETTERSSON: Thank you. Following along the theme of accountability indicators and looking at the satisfaction with the provision of public housing, the 2021 target is 76 per cent. The interim outcome 2021-22 is 63 per cent, with a target of 76 per cent. My question is, what is the government doing through this budget to try and improve satisfaction with public housing in the ACT?

Ms Vassarotti: Thank you, Mr Pettersson, for the question. You would note that supporting our public housing program was actually a significant part of this budget. And we did see almost $100 million of investment in public housing, primarily through an injection of $80 million around maintenance and another $18 million for increasing the number of public housing places. We believe this will make a significant difference in terms of increasing the satisfaction. A lot of maintenance has happened over the last period of time, but we do have an ageing public housing stock, so the injection of additional funding is something that we believed was really important to do.

I might ask Shane Nielsen to provide a little bit more information about some key programs that we are working on in relation to really improving the experience of our public housing tenants, because it is such a key priority for us to ensure that, as a social landlord, we are doing everything we can to support our tenants to have a home that they feel safe and supported in. Shane, if are you able to provide a little bit more information about some of the additional programs we are doing, that would be great.

Mr Nielsen: I am Shane Nielsen, Executive Branch Manager of Policy and Business Transformation. Thank you for the question.

Following on from the minister in relation to the areas that we are looking at, obviously a substantive investment has been made in the quality of housing, relating to maintenance and those activities. Some of the other work that we are doing in Geoff Aigner's area is actually focusing on our process and streamlining those interactions with our clients. One of the major projects looks at our business review. That is looking at how we engage with those major interaction points, such as when we work with processing rebates, ensuring that the client has a very easy, quick way to submit their supporting evidence and that we can process those activities much quicker.

We are also looking at how we improve the way we engage on responsible maintenance. Some previous work that we have done looked at choice based letting and providing some digital capability around there as well. Some of those activities are very much focused around our model social landlord framework. And that very much focuses on empowering our clients and being at the centre of those decisions that are being made and providing consistency of decision making as well. We feel

that those elements—and providing a very key focus on them, to give the right outcomes for our clients—will allow those activities to occur within there, as well. Thank you.

MR PETTERSSON: Just a quick supplementary question. What type of feedback are you getting from clients as to why they are not satisfied with the provision of public housing?

Mr Nielsen: Minister, may I take that one?

Ms Vassarotti: Yes.

Mr Nielsen: One of the areas that we have looked at has been around maintenance and the communication of maintenance in relation to that. So one of the activities that we have spoken about is that engagement with customers, ensuring that the information we give them is proactive. It is not just about being reactive to the scenarios that can occur, but it is about being a little more predictive, looking at our data, and being intelligent around how we look at that. So we are looking at communication, early engagement and being consistent. When I say consistent, I mean not just in terms of frequency but also that the answers that we provide are consistent between individuals.

So part of the other work that we have done has been the development of an information management system, where we have just gone through a large review of our policies and also ensured that the training of our staff is up to date with the latest policy standard operating procedures so the information we provide our clients is clear, accurate, concise and consistent, in that regard as well.

THE CHAIR: Thank you, Mr Pettersson. I will move to Mr Parton, for a substantive.

MR PARTON: I am on budget statements G, page 46, and strategic indicator 1—percentage of allocations made in 90 days. In relation to the 99 per cent performance outcome for that strategic indicator, I am just struggling to get my head around that. I understand that some of these may have to be taken on notice, but how many applications were received and allocated to that greatest-need category for placement in 90 days in 2020-21? And how many are expected in the following financial year?

Ms Vassarotti: Thanks, Mr Parton, for the question. There is a level of detail around the numbers, so I might ask Mr Aigner to respond to that. Just as an opening statement, I note that in relation to the allocations, almost 100 per cent of those are absolutely going to the people in most need—and that means that people are being allocated off the priority list. Mr Aigner, if you are able to provide some detailed answers to Mr Parton, that would be great.

Mr Aigner: We will need to take the numbers on notice, particularly when it comes to the following year, to give estimates on that. The 99 per cent is actually 100 per cent for the full year, unless I am mistaken. Shane, please pipe in. And that is for urgent and critical allocations, where we exclusively have put them in a house within three months.

MR PARTON: So, Mr Aigner, that is different from the so-called priority waiting list?

Mr Aigner: No, it is the priority and high needs, Mr Parton. So of the people we have allocated within three months or less, all of those came off the priority and high-needs list. That is what that indicator is measuring.

MR PARTON: Okay. There has been a steady increase in waiting times for both allocation and transfers in the ACT. What is the expected change in waiting days, given the state of the private rental market, and the forecast decrease of social housing stock? How do we believe, looking forward, that those numbers are going to go?

Ms Vassarotti: I would just pick you up there, Mr Parton. There is not an expected decrease in social housing numbers. There is actually an expected increase in social housing numbers. As we are working through the growth and renewal program, there is some movement, and we are dynamically managing that program. But we are aiming to have an increase in the social housing program. So I just wanted to make sure that that was on the record. Mr Aigner, are you able to go into detail?

Mr Aigner: I am not able to give a prediction here, minister, or Mr Parton, on where that is going to go—

MR PARTON: All right. In closing on that line of questioning, I understand that this straddles a couple of portfolio spaces, but I think it is a question that needs to be asked. I understand that you fielded the question on this in the chamber some months ago, but since then the budget has been handed down, so I am hoping you can give a more definitive answer. You went to the election promising a home for all. What is the delivery date for that? When will homelessness end? Will it be this term? And if homelessness is not ending, why are you continuing to promise a home for all?

Ms Vassarotti: Thank you, for the question, Mr Parton. I am absolutely committed to doing everything we can to eliminate homelessness. We are working towards a position where we can say that anyone who is in that situation, particularly rough sleeping, is in a position to have a safe place to sleep at night. So there is a range of work that we are doing in relation to that. And as you know, the budget announcement does speak to that. In the February budget we did announce that we would have ongoing funding for a range of new services that have been incredibly important and incredibly useful through this latest lockdown. I would particularly look at the additional funding that we provided to OneLink to provide emergency accommodation for people that were unable to stay safely at home. And so we have seen a significant increase in use of those funds over the lockdown period. We know that some of those tools are really working.

The additional funding that has gone into homelessness services will also be important to this. And we are currently working through a co-design process, with our specialist homelessness services, to identify where the gaps are and to see whether there are things that we can do differently to make sure that we have the ability to respond with a place to sleep and that we have the really strong supports in place, particularly for people who are working with complex issues, so that they are able to get support in ways that will ensure that they will have an ongoing and a sustainable

tenancy. I continue to be extremely committed to that view that we solve homelessness, particularly around rough sleeping.

MR PARTON: Is there a delivery date?

Ms Vassarotti: It is an active conversation that we are having with our sector every day. I would love to be able to give you a date. I cannot give you a date. Homelessness is complex, and there needs to be a range of supports that are put in place. We are also not going to solve homelessness purely through the specialist homelessness sector. We do need to work across the community sector more generally. But there is work happening on a day-to-day level to ensure that we will be able to eliminate homelessness.

THE CHAIR: I will move to Mr Braddock now, for a substantive question.

MR BRADDOCK: Thank you. I am trying to understand the process around detainees at the AMC and how they are released into social community housing, particularly as they come up for parole, because to have safe housing is a decision-making factor for a parole board. So how does Housing ACT work with that?

Ms Vassarotti: Thank you, Mr Braddock, for the question. It is a really good question, and it is an area that we are putting a fair bit of emphasis on, particularly as part of the broader piece of work that is happening across government around over-representation of Aboriginal and Torres Strait Islander people in the justice system. Housing ACT is doing quite a lot of work with the Justice and Safety Commission, looking at what we are doing currently and how we can improve that.

I will look to Mr Aigner, in terms of providing the detail of how we work through that process of supporting our tenants if they are going into the AMC, because we are very conscious of housing being a fairly scarce resource, and the implications of houses sitting empty if people are incarcerated for a period of time. Quite a bit of work has happened in relation to how we work with clients while they are incarcerated, and what we do as they are coming up to parole. I will ask Mr Aigner to provide some additional information.

Mr Aigner: The engagement starts as soon as we know that a tenant has gone into incarceration. Specifically, we are talking here about tenants who do not have any remaining family or residents in the house that they were in, because that tenancy would just continue otherwise. For tenants who have a period of incarceration of six months or longer, we have begun, in the last year, to have two intensive practitioners working with staff and incarcerated tenants within AMC to try and engage them—firstly, to see if they are able to give up their tenancy so we can get it back into circulation and also to maintain the asset. We do not like empty assets—they tend to be targeted—so we seek to get the property back into circulation.

And if we are able to do that, we are working with a commitment that they can get a public housing property as one of a number of options on release. There is broader work going on beyond Housing, across directorates, to look at that release and how people come out of incarceration, and also how we can get good notice about when

parole is coming, to be able to work with the parole board on guaranteeing a housing property that was relinquished when the tenant went into incarceration.

MR BRADDOCK: So what would you do with someone who was not a tenant when they went into AMC but would need public housing when they are due to come out? How would they engage the system in a timely manner so they would be eligible for parole and have a safe home to go to?

Mr Aigner: That is a good question. And that is part of the engagement that our intensive practitioners have within AMC. They are taking applications and supporting those detainees to get onto the waitlist.

Ms Vassarotti: I also note, Mr Braddock, that there are other sorts of services that do not sit within Housing ACT—particularly Justice Housing—that also provides a pathway. Certainly Housing ACT needs to work with Justice Housing too in terms of longer-term options. But there are a range of programs, and that is part of that longer-term teamwork that is happening at the moment.

THE CHAIR: Minister, I am curious about the emergency COVID accommodation during the lockdown. Part of the government's response has been to temporarily house rough sleepers in hotels. I have heard that that equates to about 70 people. Are you able to confirm that? What is the plan for these people when that emergency COVID accommodation in hotels runs out?

Ms Vassarotti: That is a really good question, Mr Davis. As I think I mentioned, as part of the OneLink service we are able to provide some emergency accommodation within hotels and motels for people for a range of reasons. Homelessness is absolutely one of those. But we also have people who may have had COVID-related reasons why they may not be able to safely be at home. So it is absolutely the case that there has been a significant demand on that service.

I will look to officials, probably Ms Gilding, to provide details about the number of households, but it is a significant number; it is in the realm of 100 households. So with us coming out of lockdown, our understanding is that this will see some significant easing. Some of the pressure has come through issues such as people not being able to move across borders to access family and friends or other accommodation arrangements. So we know that there will be a number of people who, now that lockdown is easing, will not be in need of ongoing accommodation. But there is a significant number of people that will need long-term options.

One of the interesting things that has happened with lockdown is that there are a number of people who have been rough sleeping for a long period of time, but this has been a bit of an impetus for them to be able to engage with services in a way that they have not been able to engage before—particularly working with services such as our excellent Housing First program, which is one of those services that we were able to stand up last year and which now provides on-going services with us. That is a service where we are able to provide long-term wrap-around support as well as a home for them to live in so we can really ensure that they are able to sustain tenancy. I think I will hand over to Mr Nielsen to provide some more detail on this.

Ms Gilding: Actually, I might jump in there. Good afternoon, everybody. I acknowledge the privilege statement.Minister, you have covered the situation quite well, but I can go to some specific numbers. Since 16 August, OneLink has accommodated more than 180 individuals and households. So that is a significant demand, and it is expected during a pandemic. That accommodation was what OneLink was actually funded for. So, whilst there is a challenge in terms of exit points, what is pleasing to see is that that accommodation fund, which was funded last year, was certainly very timely when we came into this lockdown.

Now, as of this week, 70 individuals and families have exited from the hotel/motel accommodation. So you can see that it is not a process of making those bookings, and those bookings just keeping on ratcheting up and sustaining. There is a flow, and as people's situations change they find alternative accommodation. At the moment, as of this week—and these numbers change daily—we have 103 individuals and families still in accommodated in hotels and motels.

OneLink has, as the minister said, worked extremely closely with the whole specialist homelessness sector to find appropriate supports and pathways. As you might recall, Ainslie Village had some cases, so there was some pressure on those exit pathways in that the village was not taking any new tenants or clients—likewise, the Winter Lodge. The Winter Lodge provides us with at least 18 transitional places. For a period that was also where we were feeling some pressure points in terms of moving people from accommodation to that transitional place and then on. The good news is that the Winter Lodge is back up and running and does actually have some vacancies which will suit some folk.

So where have those 70 people gone? Well, they have exited into private housing; they have exited into to the crisis and transition accommodation and community housing; they have relocated interstate; and they have exited back to the housing arrangements that they had prior to lockdown. That means that we still need some options for those clients in hotels who perhaps were homeless before they went into that hotel accommodation. That is where we have been working very closely with the Rough Sleeper Working Group. They were stood up last year during the last shutdown. They continued their work until the end of 2020, simply looking at data and working together.

That Rough Sleeper Working Group consists of the Early Morning Centre, Street to Home, St Vinnie de Paul, CatholicCare with Axial, and, of course, OneLink. They have a very good idea because they have been meeting together and ensuring that they are wrapping around all the clients. They are not just providing a service at the Early Morning Centre, but they have a line of sight as to who else is actually reaching out to those folk. So when we came to this time during the lockdown, they already had a relationship, so they were able to reach out. So we support these folk as they make those transitions to hotels.

In going forward, we have been able to co-design with that group some options for government consideration as to the next steps, because we want to leverage those relationships and help those people and end the homelessness that they have been experiencing.

THE CHAIR: Great. Thank you.

MR MILLIGAN: My question relates to the budget statements G, page 47. There are strategic indicators there. In relation to the 63 per cent achievement target of those that are homeless or at risk of homelessness utilising specialist services listed to assist them in independent living, why is that percentage of those that are homeless or at risk who engage these services from the start to achieving independent living so low, at just 63 per cent?

Ms Vassarotti: My recollection is that that is the performance target, so it is meeting the performance target. I will ask officials to provide some details. I think the reflection that I would make is that the issue of homelessness is quite complex. We know that the research suggests that 100 per cent of people who are experiencing homelessness are actually dealing with trauma. Obviously, the whole experience of being homeless is traumatic, but there is often complexity in people's lives that has led them to that experience of being homeless, whether it be a mental health issue or issues around domestic and family violence.

This is an issue on which we need to work with people over a period of time. And it is one of the reasons the performance target would be set at that level—a level that you would suggest is low. I will ask an official—I think, Mr Nielsen—to provide some further detail regarding that performance target and why it sits at that level.

Mr Nielsen: I think the minister has expressed quite well the complexities that relate to homelessness. As the minister indicated, the housing component is one part. And the reason we really engage with these specialist providers is to provide the alternative support arrangements that need to be in place. We are looking at significant mental health issues—particularly when we look at rough sleepers—and alcohol and drug dependencies, and other aspects that relate to it. The number is really there to identify what the complexity is and where whole-of-government responses are needed to provide greater support to those that are looking to achieve that independent aspect. The community housing providers play a significant role there, but we do play a role to bring those other supports in.

As Ms Gilding referenced earlier, as part of the Rough Sleeper Working Group, we have been working on what those programs can be to provide those alternative supports so that there is an early engagement to look at, so that when they ultimately come into housing those other supports are in place—sustainable supports to provide truly independent living at that point.

MR PETTERSSON: The budget papers state that one of the priorities for this year is enhancing digital service delivery channels to ensure public housing tenants and other members of the community are able to access housing homelessness services. My question is: what work is underway? What is still required to get all of these services connected and online?

Ms Vassarotti: Thank you, Mr Pettersson, for the question. I know definitely that Mr Nielsen will be keen to speak to this question, because fantastic work has been going on in terms of business improvements from Housing ACT. You can imagine that with over 11,500 properties and 20,000 tenants, it is a big system that the team is

working with. And it is a service that has been operating for many, many years. So there are legacy issues, and there is a really concerted effort to address those. That is being addressed through the business improvement program. I will ask Mr Nielsen to speak to some of the really important business improvement work that is happening, particularly in the digital space.

Mr Nielsen: I think we touched on it earlier. Part of the work with the business improvement is also ensuring that our back-end processes have been streamlined and that we are able to be very predictive and consistent in how we respond to our clients. Part of the early work that we have done—and we mentioned it previously—is choice-based letting. That has been a digital service that allowed clients to look at housing, get photos, get more information, and really get an identification of being able to allocate those houses to them. They can view it before they actually go there, as well. So, again, it is looking at providing that early information. We had great success from that.

Again, a part of that trial was receiving feedback from our clients as to how they wanted to engage. One of the major pieces of work that we have at the moment is looking at our application and assessment process—being able to actually apply for housing online. A key component within there is not simply about putting the application form online; it is making sure that we are asking the right questions at the right time. We are also providing them with alternatives; it is not just about being digital. That will allow for a streamlined process and getting—through a consistent and quick response—information back to the client as to where they are missing.

What we have looked at, as well, is that a reasonable amount of supporting evidence needs to be provided. So we have been looking at how to make that simpler for our clients—as opposed to needing to scan and attach dozens of pages, how can we simplify that process? So we are looking at the application assessment. Also on an annualised assessment basis there is the updating of their rebates. Whether it be through Centrelink or any other payments, we want to streamline that process, and that will be another major piece of work. It will not only simplify it for our back-office processing staff, but, again, information will be much more transparent and will go much more quickly to the client. For example, if the application is not completed, because there is some evidence that is not available at that time, we can help guide them through that process in an online way.

I think it is also important to point out that as we do the digital process, we are conscious as to the limitations and barriers for service. Many of our cohort do not have mobile phones, as an example, and they are very concerned about engaging with government online. So we ensure that our services can be done in a digital way or by any other mechanism, such as email, phone calls, or in person through our central access point.

But those two projects that we identified are really significant pieces. They really start the process—particularly the application process—which is about that early engagement, getting the right platform set with clients as to how we will engage with them and making it easy and simple for them as well.

MR PETTERSSON: I have a quick supplementary question. One of the key points

made in the papers is being able to ensure that these services can be accessed 24 hours a day, seven days a week. I was wondering which components of what you have just described are currently not available 24/7 and would become so.

Mr Nielsen: The choice-based letting is available 24/7, and we will look to expand it. We will absolutely be looking for anything on line to be a 24/7 service. One of our other digital services is the rental bond application. Again, that is 24/7 service, and that will be very much a key component. Obviously, as we work through what supports will be needed online, if clients were struggling with applications, those supports would be in relation to business hours. But, again, a key component of what we are doing is very much simplifying that application process and simplifying the way they need to engage so that they can get answers on a 24/7 basis. So we intend the two components we talked about there—applications and rebates—to be 24/7 services.

MR BRADDOCK: That is great in terms of digital communications with your clients. I just wanted to check in terms of the back-office operations, because I had heard that Housing ACT runs off a paper-based records system. Is that correct?

Mr Nielsen: Yes, we have. There are a number of paper records that we have. That has been the history of our properties, and clients are complex. As you can appreciate, we have properties that are 20, 30 or 40 years old. We have relationships with our clients that can be that long. So we do have a number on paper. Part of the process work that we are doing is to facilitate moving into a digital space, moving forward. Then we will look at how we bring those older files into that digital space as well. But we are absolutely making progress in relation to being digitised in that regard, and all our processes moving forward are on that basis.

MR BRADDOCK: Is there a timeframe in terms of when this digitisation should be completed? Is there a specific project on hand to do that?

Mr Nielsen: I apologise, I probably have not articulated it well. Each of the projects that we are looking at are specifically related to, or also include, in essence, those paper records that are associated with those processes. We will be incorporating that into that outcome so that any new process we design is digital by nature and is in a digital-first fashion. So that will move forward, and as part of those projects we will also then look at how to bring those older paper records into it as well.

For those specific projects that we were referencing, we are looking at the first stages being delivered in this financial year. And that will continue. But we have approximately 70,000 to 80,000 paper records. A significant number of those obviously relate to older tenancies that we do not need to digitise moving forward; they just need to be referenceable as they are under our act. But, again, as we move forward we will see a change through there as well. So the first lot will be done over this financial year with those projects. Then we will continue forward with the next range of projects.

MR BRADDOCK: Given that there are 80,000 documents—not all of which necessarily need to be digitised, but I assume a substantial amount do—I would expect that to take a considerable effort. Hence, I would have expected to see a budget

line item to cover that sort of effort. Are you going be able to do that within your existing funding portfolio?

Mr Nielsen: Minister, are you still happy for me to continue?

Ms Vassarotti: If you are happy to continue.

Mr Nielsen: Yes. We had received funding in previous years in relation to our digital services. That has been part of the work that has continued to move forward. We see that being established as part of, as you said, a business-as-usual activity. We are absolutely prioritising those records. As you said, we have 11,000 properties. They would be the priority component within there. The tenancies that are associated would be a priority as well.

One of the things we are very conscious of, as we move those files across, is that some of those records consist of hundreds and hundreds of documents, and each of those can be multiple pages as well. So one of the key things we have very much focused on is not simply scanning the document and putting it in, but also making sure that it is discoverable and easily accessible for the right information. So we have put that right intention in place, and that will allow us to move forward in a business-as-usual component.

Ms Vassarotti: I will wrap up that summary. Certainly the work that is being done by Housing ACT, in terms of business improvement, we would see as really important in improving the efficiency and the effectiveness of the service. They do great work. But, certainly, legacy systems impact on efficiency, so I am really keen to work with Housing ACT to identify if there are priority projects that would require additional funding. We will certainly work through the budget processes to do that.

THE CHAIR: Mr Braddock, I would like to draw a line under this one now, if that is okay. I am cognisant of the time, and I would like to give Mr Parton an opportunity for one final substantive question before the session ends.

MR PARTON: The minister challenged an assertion that we made in a question earlier regarding a forecast decrease to social housing stock in 2021-22. I have budget statements G, page 49, and the number of social housing properties, including all Housing ACT properties whether tenanted by public housing tenants or head-leased to community services providers. We see the 2021 target at 11,691, the interim outcome for 2021-22 at 11,595, and the target of 11,570. I am sorry, Minister, but that looks very much like a decrease to me. I am not sure how you could read it in any other way.

Ms Vassarotti: Thank you, Mr Parton, for the comment. I suppose what we are looking at is our growth and renewal program, which will be seeing ins and out as we manage that program. So at a point in time we might see a particular number, but that is going to change very quickly. The point that I was making is that certainly over the life of the program we will be seeing an increase in the number of public housing properties. So, the number that will be there on 29 June 2022 will be essentially different to the one on 1 August 2022.

I will ask, maybe, Ms Gilding, to answer in relation to the reporting of that figure as a

decrease. Certainly, in terms of how we are managing the portfolio, we are not aiming to have a reduction of the social housing in the portfolio. We are actually working very hard to—

MR PARTON: But you are, according to that budget paper.

Ms Vassarotti: That is why I am asking Ms Gilding to put a context around why that number is presented in that way.

Ms Gilding: The current growth and renewal program is primarily self-funded, unlike the previous public renewal program, where we also saw quite a fluctuation of stock. So as tenants move out and as properties are sold or redeveloped and construction takes place you will see movement in those stock numbers. What this means is that an initial decrease to the total stock numbers is required before it can rise, as properties must be demolished and sold before new properties can be delivered.

MR PARTON: Chair, I am happy with that answer; I do not want to eat into the time of the next session.

THE CHAIR: I appreciate that, Mr Parton. I am glad you got the information you needed. With that, friends, I will draw this session to a close. I would like to thank Minister Vassarotti and officials for appearing. Minister and officials, if you have taken any questions on notice today to please provide answers to those questions to the committee secretary within five working days.

The committee will take a brief break, and reconvene with Minister Stephen-Smith, in her capacity as Minister for Health.

Short suspension.

Appearances:

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

Canberra Health Services
Peffer, Mr Dave, Interim Chief Executive Officer
Mooney, Mr Colm, Acting Deputy Chief Executive Officer
Coatsworth, Dr Nicholas, Chief Operating Officer, Medicine
O'Neill, Ms Cathie, Chief Operating Officer

ACT Health
Cross, Ms Rebecca, Director-General
Lopa, Ms Liz, Executive Group Manager, Strategic Infrastructure
Chambers, Ms Kate, Chief Finance Officer, Strategic Finance Branch
Coleman, Dr Kerryn, Chief Health Officer, Public Health, Protection and Regulation Division
Culhane, Mr Michael, Executive Group Manager, Policy, Partnerships and Programs
George, Ms Jacinta, Executive Group Manager, Policy, Health System Planning and Evaluation Division
Philp, Mr Alan, Executive Group Manager, Preventive and Population Health Division

THE CHAIR: Welcome back to the third session of the Standing Committee on Health and Community Wellbeing inquiry into budget estimates 2021-2022. This afternoon we will hear from Minister Rachel Stephen-Smith, and officials, in her capacity as the Minister for Health. I remind those joining us for the first time now to please, on the first occasion that you speak, acknowledge that you have read and understand the privilege statement. We will forgo opening statements and go straight to questions.

In the budget I noticed that you are funding acute streaming within the emergency department. Can you explain to me what this is likely to look like and how it is going to differ from normal triaging?

Ms Stephen-Smith: I think this is my first time before this committee; so I acknowledge the privilege statement. I will hand over to Mr Peffer to talk about that.

Mr Peffer: I acknowledge I have read and understood the privilege statement. In this budget the government has funded quite an important initiative for us related to the emergency department. It really does help us to establish some clearer roles and responsibilities but also streaming through that department.

There are a number of aspects to the budget initiative. Really, what we are attempting to do—and there has been a lot of design work that has been in flight for a while, being led by our Clinical Director and the two deputy directors in the department—is redefine the role of the emergency department as the emerging front door to the broader health service and attempt to stream, in a much more efficient way, patients

coming into the service.

As part of the design process, the ED team held a series of workshops which were multidisciplinary workshops. They were led by Dr Scanlan and his team. It involved our nursing workforce, allied health workforce, as well as the administrative team members within the department.

Through those workshops they asked the question of the department: what is the future role for emergency medicine in a health service like ours and what does that need to look like in the future? Through those workshops they then started to narrow down what is the particular value add of the department, as opposed to the roles performed by acute in-patient settings, for example, and started to redefine what it is that the emergency department should do.

A simple explanation is: if the patient presents, there are a series of diagnostic workup decisions that can be made and all of them can be made in the emergency department. Some of them can be made quite rapidly in the emergency department with our experienced emergency consultants and they can determine that yes, a patient will need to be admitted; they need acute-level care; and so they will be admitted. Then it becomes a decision: do the following-on diagnostic decisions actually get made within the department or is it more efficient to actually move those patients into our facility where some of that work can be done?

Specifically in terms of our acute medical unit, we know that we have got a lot of patients that are presenting, particularly in our categories 3 and 4 of emergency department presentations. Many of them are quite elderly or frail. They are presenting with a range of chronic conditions and really complex health needs. It is a little different when someone turns up and they have fractured an arm, for example, that can be diagnosed and the treatment commenced quite quickly. But some of these other patients do have very, very complex health needs and it can take some time for the range of tests to be undertaken.

The team has been on a bit of an exploration about where is it most efficient for that work to occur. Is it most efficient in the emergency department or is it more efficient to have that done once an early decision is made to admit the patient, to have those sorts of diagnostic workups occur in an acute medical unit? That allows us to start to stream patients that we know are coming into the hospital and we can move them through the emergency department in a more efficient and timely way.

The workforce that we would see in the acute medical unit would be a mix of positions but would include some emergency specialists and then a range of other specialities—gen med and so forth—that would all contribute to be able to make those decisions around diagnostics and then ultimately treatment.

MR PETTERSSON: Minister, I was hoping you could provide an overview of the significant increases in health funding made in this budget.

Ms Stephen-Smith: You are exactly right: this budget has seen a very significant increase in expenditure, with total health portfolio expenses set to rise to more than $2.1 billion in 2021-22. That represents an increase of almost $130 million or 6½ per

cent on the 2020-21 outcome. Recurrent funding for new initiatives is almost $180 million, and $690 million over four years.

A couple of things have led to this increase in funding. We have compared the last four years to the coming four years. There is a $1½ billion difference between those two four-year periods. This is a re-examination of the health funding envelope for the entire portfolio of health, including mental health, and having a look at the indexation arrangements for funding under what is described as the health funding envelope or the new health funding model, and then of course funding some really significant election commitments that ACT Labor and the Greens took to the election.

I do not really know how much more detail you want. Obviously there are also some significant investments in infrastructure associated with all of that.

In addition, for the Canberra Hospital expansion, which was previously budgeted, there are a range of new infrastructure initiatives as well, which are clearly smaller. But there is some planning for very significant infrastructure investments such as the north-side hospital, a $12 million investment in the planning for that as well.

MR PETTERSSON: That is a very comprehensive list. All state and territory health ministers, both Labor and Liberal, have written to the commonwealth government regarding the health funding that has been provided to the states and territories. I was hoping you could explain to the committee why that letter was written and what the implications are for states and territories.

Ms Stephen-Smith: I think, fundamentally, what all the states and territories have been experiencing, even prior to the COVID pandemic, was increased pressure across all their health systems but particularly in emergency department presentations, demand for emergency surgery. We certainly have been experiencing that at both Canberra Hospital and Calvary Public Hospital. Of course, in elective surgery, where we have done a good job in continuing to grow our elective surgeries, we continue to see increased demand as well.

There are multiple things that are driving some of these cost pressures that we think that the commonwealth has a role in addressing. One of those is to help us reduce the number of long-stay patients who are waiting for an NDIS package or an aged care bed or place. Clearly that is a commonwealth responsibility. Both NDIS, in terms of policy and accountability and rollout, is a commonwealth responsibility, and aged care is fully a commonwealth responsibility.

Working with us to help discharge some of those longer stay patients is really critical. Making sure that they are sustainably funding primary health care is vital because we are hearing from GPs—again across the country but the ACT is particularly hard hit with a low number of GPs per 100,000 population—that the funding is just simply not sufficient to support those most complex patients with chronic conditions, which means that they end up with unnecessary hospitalisation, which is a bad outcome for them and a bad outcome for the hospital system and the funding arrangements.

Then, of course, we are wanting to get some guarantees from them about sustaining their 50-50 commitment to COVID-19 funding but increasing their share of hospital

funding, more generally, to a 50-50 share rather than 55 for states, 45 for commonwealth share of funding. Those are the drivers and the conversation that we want to have with the commonwealth. Then, of course, there is significant pressure on mental health as well, which is a shared responsibility.

MRS JONES: I wonder if you could quantify, in the system, the number of these patients that are waiting to be put into NDIS care or, indeed, aged care that are creating this identified gridlock issue.

Mr Peffer: I can respond to that. I do not know this morning's figure but as of about a week ago it was 62 patients who were medically well, ready for discharge.

MRS JONES: Can you break that down by those who need to go off to NDIS care versus those who need to go into the aged care sector?

Mr Peffer: Yes, we would be able to do that. What I can do is take on notice and provide you the latest figure with a breakdown between the two.

MR MILLIGAN: My question is in relation to the strategic and financial review recommendations made back in 2006 that the ACT adopt a 6.2 per cent funding envelope for health services. Mrs Jones asked you earlier in the year and you did confirm that the funding envelope has been set that way and has been that way for the past 10 years. Is that correct?

Ms Stephen-Smith: I think what we have explained to Mrs Jones previously is that there is a health funding envelope. It has gone up and down over time. Post-2006 the growth in health funding was, for some years, significantly higher than that 6.2 per cent.

Over more recent years, that funding envelope indexation rate was set at 4.15 per cent to try to address some of the inefficiency in the system, to try to encourage more efficiency, and in recognition of the really rapid growth in some previous years that simply could not be sustained at that level in an ongoing way when revenue was not growing at anything like that rate. That 4.15 per cent was also a challenge for the health system, particularly given the demand pressures that I just talked about earlier.

Part of the health funding sustainability that we did in the lead-up to this budget was to review what those indexation levels should look like to set a new level for the health funding envelope, going forward, taking into consideration the demand growth that we are seeing, the need to continue to drive efficiencies through the system and the cost growth. Both demand growth and cost growth are taken into account in the outcomes of enterprise bargaining, for example.

The model that we then have come up with through this very detailed work between the ACT Health Directorate and Treasury, with the support of Canberra Health Services to really understand the nuts and bolts, is essentially, for future years, a funding indexation level of around 5.1 per cent. To be clear, there is a single envelope but the make-up of it took into account the increased demand for frontline health services and so set an indexation level of around 5.4 per cent for those sorts of frontline service elements. To do that we have considered the things that fit within the

definition of the local hospital network.

Then we are maintaining basically the 4.15 per cent indexation rate for the Health Directorate itself—for those non-frontline activities—giving you an overall indexation rate of about 5.1 per cent, going forward. I am going to ask if someone is going to correct me on any of that?

MR MILLIGAN: I take it that there is no correction there. What does happen, though, when the commonwealth provides funding for health care in the ACT? For example, if the commonwealth provides an eight per cent increase, then does the territory provide only a four per cent increase? Does that mean that the overall increases are just six per cent?

Ms Stephen-Smith: The commonwealth funding is driven by activity—what we actually do. They essentially then fund that activity. It is a bit more complicated than just saying that they fund 45 per cent of the activity because they actually fund 45 per cent of growth.

I might ask someone who knows more about this than I do or we might take on notice the detail of that commonwealth funding. I think it looks like we are going to take on notice the detail of why that commonwealth funding flows through the system. It is very complicated. Then we have a funding envelope, that is a whole funding envelope, that takes into account both commonwealth and ACT funding.

MRS JONES: Can you just confirm that the 6.2 per cent that was set a decade ago or so was not, in fact, the exact amount each year that the envelope grew by? Am I understanding that correctly? You mentioned the figure of 4.15 for some years, in order to catch up. Was that instead of the 6.2 per cent?

Ms Stephen-Smith: Obviously I have not been around since 2006. Sifting through all those budgets since then, obviously that was a recommendation that was made. My understanding is that, in a number of years subsequent to that, the growth was significantly higher than that 6.2 per cent. Then there was a recognition that it was not sustainable to continue to grow health funding at that higher rate. So a rate of 4.15 per cent was set to drive some efficiencies in the health system.

That has happened. We have actually seen our costs get closer to the national efficient price. We are not there yet but we are much closer to the national efficient price. While the health funding envelope, as a budget management strategy, has continued since that time, the actual number in the envelope has gone up and down.

We are joined by the Chief Health Financial Officer, Ms Chambers, who may be able to provide some further information.

Ms Chambers: I have read and acknowledge the privilege statement. Hopefully I have not missed anything during my transfer to the room. I believe part of the question was about the commonwealth contribution versus the ACT contribution. Can I just get some clarification on that?

MRS JONES: Yes. When the commonwealth contribution is higher, do we go lower

with our ACT contribution towards the envelope?

Ms Chambers: On page 177 of the budget outlook statement we actually attempt to explain the health envelope to the community. Basically, if we continue to allow the ACT government or the commonwealth contributions to go higher with activity, eventually the ACT health portfolio would consume the entire ACT budget. What occurs is that we set targets in activity throughout the year, and we reach those targets.

To insulate the territory, the ACT government will freeze their appropriation to make sure that, in those line items that you see in the budget papers on page 65, the ACT will be contributing $973 million in CRP through the OHF and the commonwealth government will be contributing $516 million. Through those two mechanisms we actually balance the territorial budget as we go. And our appropriation will be matching that activity.

MRS JONES: In layman's terms, when we reach our appropriation having been expended and the commonwealth continues to pay based on activity, then our contribution stalls at that point, on activity. Is that correct?

Ms Chambers: It will freeze us at the $1.6 billion mark, yes.

MRS JONES: So that no further money is spent by the territory?

Ms Chambers: No, because the commonwealth will be making up those contributions. As we go through time, those contributions will make up to the 45 per cent and 55 per cent allocations to our bases.

THE CHAIR: Minister, the question I want to ask is about the Calvary hospital. I understand that this budget invests in ongoing essential infrastructure at the Calvary Public Hospital in Bruce, totalling about $20 million over three years. Is the facility at Bruce owned by the ACT government, and what are the arrangements under which Calvary is funded, particularly when it comes to these infrastructure upgrades of buildings?

Ms Stephen-Smith: Calvary Public Hospital is not owned by the ACT government, but under the Calvary network agreement there is an agreement that the ACT government will fund infrastructure upgrades. Again, Ms Chambers might want to talk a bit more about those financial arrangements.

Ms Chambers: The way that we fund any territorial entity that is not owned by the ACT government is through a territorial grant. That is identified on page 17 of our ACT Health budget papers. You will see the line item there, particularly for this budget, investing more than $20 million just in infrastructure upgrades to the facility at Calvary hospital.

Ms Lopa might like to talk to any of the actual activities that are going on there. Basically, a majority of that is for the strategic asset management plan and repairs and maintenance of any of the buildings. Obviously it is an ageing facility.

There is an ICT component in there. It is also spread across some other activities. The

car park at Calvary hospital is actually owned by the ACT government and we will be making some further upgrades to that car park throughout this year and next. There are also some sterilising upgrades that will be made, and they are actually spread across LHS, and we will be actually facilitating that through CHS to upgrade the sterilisation activities. An ICT component is also held within there.

It depends on where we are doing the activities, but predominantly any capital funding paid to a building, even Winnunga, is funded through a territorial grant for their facilities.

MRS JONES: Minister, on Friday, 8 October—and I am going to page 7, of budget statements C—I asked you about your commitment in January this year to meet the 70 per cent target on ED waiting times and you responded that there had been some misrepresentation; you were not talking about having 70 per cent of all presentations in ED treated within clinically appropriate times but you were instead talking about the percentage of patients whose stay was four hours or less. Was your commitment in January this year a commitment to reach 70 per cent on the four-hour target or 70 per cent on all ED presentations being seen within clinically recommended time frames?

Ms Stephen-Smith: We will go back to this again. As I said in the chamber the other day, as I have said repeatedly, this was an extended interview with a journalist in which I talked about the plans that we had in place to achieve that 70 per cent target for patients whose length of stay in the emergency department is four hours or less—generally known as the NEAT—and that we had a plan to improve that incrementally over three months, six months, and nine months, with the aim of getting to 70 per cent. This was specifically in relation to Canberra Hospital but does apply across the hospital system. I also outlined a range of challenges that make that a challenging thing to do.

I recognise that on page 7 of budget paper C the strategic indicator is actually 90 per cent. We did have a conversation as the budget papers were being put together about this and the fact that we were stretching to reach a 70 per cent target, which is actually what Canberra Health Services in its internal reporting is seeking to do for all ED presentations. But we also have different targets for those who present to the emergency department and are discharged home versus those who are admitted to the hospital.

As you probably also recall, the Australian College of Emergency Medicine has put forward an alternative mechanism, which Canberra Health Services is working with ACEM to trial through our emergency department, on these times. I might hand over to Mr Peffer or Ms O'Neill to talk about that.

Mr Peffer: I can talk about the time-based targets. This is an initiative coming out of the College of Emergency Medicine, of which there is a local chapter. It does look at the four-hour time frame and it is considering whether that is suitable in the current environment nationally. So it is not an ACT issue.

MRS JONES: Can I just clarify something, please? We have talked about the 70 per cent and we have talked about the 90 per cent. What is the 90 per cent target then? For the four hours, is it a 70 per cent target? Which target are we currently aiming for?

I understand that there is this consideration of a different way but I am trying to understand the document that we have been given.

Ms Stephen-Smith: I think part of the challenge is 90 per cent is a target that has been set nationally and is therefore reflected in our budget papers. Our internal target is at the moment 70 per cent. We would love to get to 90 per cent. And that is our target for those people who are discharged home—not right across for those who are admitted into the wards as well.

MRS JONES: Just to finally clarify then, our outcome for 2020-21 is 57 per cent of the 70 per cent or the 90 per cent?

Ms Stephen-Smith: Yes, the outcome was 57 per cent, that is right.

MR PETTERSSON: One of the important announcements in this budget is an improvement to nursing ratios in our hospital. Why is this an important reform and how will it be delivered?

Ms Stephen-Smith: This is a very important reform in terms of transparency and a framework of nurse or midwife to patient numbers, in agreement with the Australian Nursing and Midwifery Federation about how those numbers are going to be calculated, how that is going to be implemented. That leads to rostering implications but also patient and staff safety and ability for staff to do their jobs. Ensuring that there are an appropriate number of nurses and midwives per patient ratio means that nurses can be assured and hold the organisation and the government to account on the number of nurses or midwives that are on shift and that they have the capacity not only to do their nursing or midwifery work really well but to ensure that there is appropriate supervision in place.

The framework includes a supervision or team leader component as well, to ensure that they are being given the opportunity to do the training and the supervision that is required. I do not know if Ms O'Neill wants to talk any more about this?

Ms O'Neill: I can, from a CHS perspective. This is an exciting advancement for the ACT to actually be able to supplement our nurse staffing levels in the general wards. I think it is important to clarify that we are talking about general wards, not some of our highly specialised wards, which are yet to determine the accurate ratios. On the work that our team have been doing at CHS, in conjunction with the Chief Nurse we are looking at needing to increase our FTE by around about 50—we are still clarifying the exact numbers—noting that it will be fluid, because our patient numbers are dynamic as well. We have strategies in place already to start to gradually increase our recruitment levels so that we are ready to go when the ratios become live.

I forgot to say I have read and acknowledge the privilege statement.

Ms Cross: I have read and understood the privilege statement. Just in total, the nurses and midwives will be across Calvary as well as CHS. The budget measure funds up to 90 additional nurses across the two public health facilities and a small implementation team that will actually oversee the introduction of the ratios and monitor how it is going.

MRS JONES: How many wards will have reached the ratio targets in this measure at the end of the four-year period? What is the achievement that we will get to?

Ms Stephen-Smith: The first stage of this rollout will be fully implemented, in terms of that staffing, by 30 June next year. By the end of this financial year we aim to have around 90 FTE added to the staffing for ratios. And that is across general medical, general surgical, acute aged care and the Adult Mental Health Unit.

As I think Ms O'Neill spoke to, there has not been an agreement with the ANMF yet, or negotiations in relation to the next enterprise agreement, as to what the next rollout will be and what those ratios will look like. So it is too early to tell you what, when we get to the end of this four-year term, we may have achieved in terms of stage 2 or even stage 3 of the ratio's framework rollout.

MRS JONES: I wrote to the committee to ask that Calvary be able to attend these hearings as they have an expenditure of 23 or 24 per cent of the ACT hospital network budget, and I am aware today that they are not attending. I do have some questions on Calvary. First of all, I wonder if the Chair could update us on where that discussion got to.

THE CHAIR: I am happy to let you know that the committee did resolve to write to both the Minister for Health and the Minister for Mental Health seeking clarification. The committee has received correspondence from the Minister for Health and that correspondence will be considered in our next private meeting.

MRS JONES: That can be followed up later then, I presume. On that, then, can I just clarify how much of the $973 million of funding proposed to be provided to the ACT local health hospital network will be provided to Calvary in 2021-22?

Ms Stephen-Smith: I will ask Ms Cross to address that.

Ms Cross: I might see whether the Executive Group Manager can join us, just to make sure that we get the funding right, because there is a mix of recurrent funding and the capital funding that we referred to earlier. Are you talking about the budget measure for more services at Calvary Public Hospital, Bruce, or are you talking about all of the additional funding in the budget?

MRS JONES: All funding to Calvary would be great to have broken down. Even if you have to take that on notice, that would be quite acceptable, given that they are not here.

I also note that Calvary do not report their performance data in the ACT budget papers. Are you able to come back on notice with the equivalent performance data that is provided by them to Canberra Health Services, such as ED wait times and elective surgery wait times, please?

Ms Stephen-Smith: Just on that, as you would be aware, I do release a quarterly performance report across the health system every quarter, and that includes specifically data that is broken down on those things from Calvary and Canberra

Hospital. Those are broken down separately—ACT Health Services, Canberra Hospital, Calvary Hospital. So that is reported every quarter.

MRS JONES: Were we going to get some information about the breakdown of the funding in this budget for Calvary?

Ms Cross: Yes. I might ask Ms George to respond to that question.

Ms George: I have read and acknowledge the statement. For this year, although the funding has not been finalised, our performance agreement with Calvary, our indicative funding, the current funding to Calvary will be $261.057 million, and capital at $16.225 million.

MRS JONES: One of the things that we have discussed recently about the work between Calvary and TCH is maternity services. Can you update us on how we are going with who is being dealt with in which hospital? A bit over a year ago we were dealing with the overflow in TCH. Now has that evened out? How is that going?

Ms Stephen-Smith: Overall what we are generally seeing is that those people who are expecting to give birth in a particular hospital are going to that hospital, and that demand is being met across both hospitals. There are obviously some people who specifically mean to be expecting to give birth at Canberra Hospital, because they are higher risk pregnancies. But my understanding is that that demand has now been fairly well managed across both. Of course, we implemented the maternity options process for people to get that advice early on in their pregnancy, to work out which option will work best for them.

MRS JONES: Would you like to take on notice how that is impacting on the numbers?

Ms Stephen-Smith: We can take on notice the breakdown of the numbers across both hospitals and whether there any transfers in either direction. Is that what you are really looking for?

MRS JONES: Yes. I guess I want to know if we are still blocked up at TCH or if we have actually created a solution now.

Ms Stephen-Smith: I am getting the shaking of heads here that no, we are meeting the task at Canberra Hospital.

Ms George: No. By and large the maternity options work well in terms of distributing the workload between two hospitals. On the odd occasion, either hospital might need to transfer a mother or a baby, depending on what is happening. But routinely that load is spread across the hospitals appropriately. We can give you that breakdown of births between the two hospitals.

MRS JONES: Thanks so much.

THE CHAIR: Thank you everybody. The time being 2.46, I will call this part of the session to a close. Thank you very much, minister and officials, for appearing at

today's hearing. Just a reminder to take note of any questions that you had agreed to answer on notice and provide answers to those questions to the secretary within five working days. We will reconvene at 3.15 pm.

Hearing suspended from 2.47 to 3.16 pm.

THE CHAIR: Welcome back, everybody, for the fourth session of the Standing Committee on Health and Community Wellbeing inquiry into budget estimates 2021-22. We are joined by Minister Stephen-Smith, in her capacity as the Minister for Health, and officials. I remind witnesses that, the first time you speak, please note that you have read and understood the privilege statement.

Minister, my first question is about the intersectional relationship between climate change and health care. I saw a submission from the Health Care Consumers Association on the budget where they called on the Health Directorate to establish a health sustainability team to examine the impacts of climate change on health and health care. This is particularly relevant for people in my electorate of Brindabella, who were victims of the bushfires, and the smoke that came from that. What is the government's position on the interrelationship between climate change and health care, and the establishment of such a body?

Ms Stephen-Smith: We would all agree that there is a clear intersection between health and climate change, and it goes in both directions. There are actions we can take within the health portfolio to both reduce emissions and take adaptive measures to address the impact of climate change. At the same time, obviously, climate change is having an impact, as you say, on the range of health issues, conditions and challenges that people might be facing.

Clearly, we acknowledge the Health Care Consumers Association's strong interest in this matter and the submission that they put forward through the budget process. That is something that we will continue to consider through budget processes. You are probably familiar with the pattern, and that quite often things do not necessarily get funded the first time they are put forward in a community budget submission, but they inform the thinking of the government for budgets in future years as well. It is a really important part of the budget process.

One of the key ways that we have looked to address the impacts of climate change and our environmental responsibilities more broadly is through our infrastructure and waste management. Mr Peffer may be able to talk a bit more about some of the really outstanding work that Canberra Health Services does on waste management in the hospital. We are also building the first all-electric major hospital building, I understand, in the Southern Hemisphere, through the Canberra Hospital expansion.

I saw a note the other day from the health ministers roundtable in the lead-up to COP26, where South Australia was claiming that their women's and children's hospital would be the first all-electric hospital, but it will not be finished until 2026, so we will get in first. That is really critical, especially given that we are also then on 100 per cent renewable electricity here. That is a very important part of our commitment. There are a range of other things. I will ask Mr Peffer to talk briefly about waste management and the approach we take to that.

THE CHAIR: Before Mr Peffer starts, I would like to clarify my question slightly. I am both pretty across and pretty delighted with the work that the Health Directorate are doing to manage their own carbon footprint. In response to the Health Care Consumers Association's budget bid, I am a little more interested in what the Health Directorate is doing to help manage healthcare consumers who are suffering health ailments due to climate-related illness.

Ms Stephen-Smith: Okay; I just got super-excited about telling everyone about the waste management. I might ask Ms Cross to talk about some of the work. Mr Davis, with respect to some of the deep thinking about the impact that climate change will potentially have in terms of hotter summers, there will be more heat impact and, as you say, potentially more smoke impact. Ms Vassarotti and I lead the work on the bushfire smoke and air quality strategy, which will be tabled in the Assembly in the next little while. That is obviously one key part of the response to that.

I will ask Ms Cross to talk about the work that we are doing, in thinking about chronic and complex conditions more broadly that clearly have the potential to be exacerbated by some of these climate-related things, such as hotter summers and more air pollution, including through things like thunderstorm asthma and that kind of thing.

Ms Cross: As well as talking about the chronic conditions, the public health area of the directorate has a very strong focus on the broad health of the community. Unfortunately, it would be fair to say that the Chief Health Officer has been very focused on COVID for the last 18 months. In a more general sense, she would lead a lot of our public health that is looking at exactly those impacts. The health protection services monitor air quality and look at things like thunderstorm asthma, and follow through on the impact of the smoke from the bushfire season. So we do have a very big public health focus in the directorate.

As the minister said, we are also doing a lot of work on how we can better integrate care for people with chronic conditions. In doing that, we will be working with Capital Health Network so that what we do links in with what the commonwealth does. The most common complaint is that the commonwealth and the state are not working together and that, for the person, it is a very fragmented system of support.

If we have a very strong public health focus, and if areas like the hospital are looking at how we provide care in the community, care closer to home, and if we have a focus on integrated care so that people can have all of their needs looked at by a multidisciplinary team, rather than by way of separate and duplicative supports within the system, that is probably the best way that we will be able to respond to some of these emerging issues. I think Mr Peffer would like to add something.

Mr Peffer: I might ask Dr Coatsworth to come in. We did a piece of work in response to the bushfires recently, a quite detailed study which he will be able to talk through in terms of future planning and guiding the service design for the future, recognising that that is likely to be something that we have to respond to more frequently.

THE CHAIR: While we are waiting for him, I might ask a quick clarifying question of the minister. I understand that the Health Care Consumers Association did not get

their budget submission up this time, but I would not mind getting some clarification on whether, as a government, we see value and merit in their proposal, and whether it is something that the government would be willing to earnestly consider in a future budget round.

Ms Stephen-Smith: These are all the kinds of things that we consider in budget rounds. Obviously, we do not have an unlimited supply of funds to do things. It might be something that the Health Directorate determine that they will consider within their internal structure and how teams are prioritised, rather than necessarily being a specific budget bid.

Clearly, we think this is a very important piece of work. Ms Cross reminded me that in the biennial Chief Health Officer's report they specifically focus on the impact of climate change in some of that work. It is not an area that we are unaware of at this point in time or that is not a focus of work. Dr Coatsworth is here now.

Dr Coatsworth: I acknowledge the privilege statement. In the bushfire season of 2019 and 2020, Canberra Health Services partnered with our two major universities, ANU and University of Canberra, to perform a series of studies related to bushfire smoke exposure.

The two main ones that I want to highlight are, firstly, if I remember correctly, a longitudinal study on pregnancy-related outcomes, led by Professor Christopher Nolan. The second one was led by me; it was a study of airways function in asthmatics and patients with chronic obstructive airways disease. I want to highlight those because both of those demonstrate collaboration across the university sector. A significant number of those patients in the Canberra smoke study were recruited through partnerships with primary care. It is a good example of research and care integration between CHS, and answers Mr Davis's question about the commitment to climate and health.

MR MILLIGAN: During the election last year, in 2020, you promised a nurse-led walk-in centre for Coombs. When will that be delivered?

Ms Stephen-Smith: To be clear, Mr Milligan, we committed to five walk-in health centres. We were very clear through the election campaign that these are not the same model of care as our existing walk-in centres. We have indicated that this is not the same model as a walk-in centre in the way that we think of it at the moment. The walk-in health centres are to complement the existing walk-in centres and community health centres. You would understand that, when the National Health Co-op went into administration, plans had to be effectively placed on hold for Weston Creek.

The Health Directorate has worked closely with the administrator and stayed in touch with the administrator through that process. We were very pleased when the administrator was able to announce, on 21 September, that Palm Healthcare would be taking over the clinic in Coombs. The directorate has been working in negotiations with Palm around whether they would be willing to partner with us in the same way that the National Health Co-op was going to, to establish the walk-in health centre in Coombs.

That was a very long way of saying that we will have something to say about that very shortly. In fact, I have just signed off a letter to the Molonglo Valley Community Forum, indicating to them that those conversations have been successful with Palm and that we do expect to enter into a lease with them in the next little while.

MR MILLIGAN: In relation to nurse-led walk-in centres, do you collect any data on presentations that attend a nurse-led walk-in centre that also go on to attend emergency?

Ms Stephen-Smith: Yes. I will hand over to Ms O'Neill.

Ms O'Neill: We do. Mr Milligan, did you say got redirected to emergency? Did I hear that correctly?

MR MILLIGAN: Yes.

Ms O'Neill: Yes, we do collect that data. Around four-point-something per cent of presentations that go to the walk-in centres end up being redirected to the emergency department. There is a bit of variability in that data, and I would be more than happy to give you the redirection rates.

The total redirection rate that is reported against the walk-in centres also includes any of the people that were then referred on to other services. They would have received treatment for their presenting problem, but they may have been referred on to their GP, for example, for some follow-up care. That figure sits at around 14 per cent or 15 per cent, but the majority of those people have actually had their treatment completed in the walk-in centres prior to that.

Ms Stephen-Smith: Mr Milligan, for future reference, that data is also reported in the quarterly performance report, broken down by each walk-in centre. The referral rates can be quite different from quarter to quarter and between centres.

THE CHAIR: Minister, could you provide an update on the planning for the south Tuggeranong walk-in centre?

Ms Stephen-Smith: As you would be aware, Chair, the previous budget, the 2020-21 budget, allocated $2 million for feasibility studies and planning for the other four walk-in health centres, in south Tuggeranong, the inner south, north Gungahlin and west Belconnen. I will hand over to Colm Mooney to talk about that subject.

Mr Mooney: I acknowledge that I have read and understood the privilege statement. The funding that the minister referred to is part of the integrated care program. Before we go into the full feasibility for not just the south Tuggeranong centre but also the other three that have been identified, in terms of locations, we need to develop a further model of care for what those facilities will be delivering.

Prior to COVID we had started some level of engagement in terms of the integrated care program. Unfortunately, we only got to one workshop then everything had to be put on hold. We are in a holding pattern at the moment. We need to continue with the engagement and informing what will be the model of care for the centres. From that

we will be feeding into a feasibility study that will look at site selection and early proofs of concept. That will then be taken to a further budget request at that point in the future.

THE CHAIR: Do we have a shortlist of the locations for the south Tuggeranong walk-in centre?

Mr Mooney: No.

Ms Stephen-Smith: No.

MR PETTERSSON: We have seemingly spent the past year talking about the COVID-19 vaccine. What work is currently underway to improve vaccination rates when it comes to the national schedule? Is there a chance that we could potentially team up regarding what we have been doing with COVID-19 vaccines and the vaccines that were pre-existing?

Ms Stephen-Smith: With the National Immunisation Program, and other vaccines like the flu vaccine that are provided partly through the National Immunisation Program and generally in the community through private provision, I do not know whether there is anyone here who can talk about that program. I note that the COVID-19 vaccination program rollout has been vastly different to the National Immunisation Program and the way that it works. While the National Immunisation Program is funded by the commonwealth, it is rolled out through the states and territories, who have the direct relationship with general practice and pharmacy to manage the supply, cold chain, and that sort of thing. The COVID program has been a mixed commonwealth-state primary care program. Obviously, it has been on a vastly different scale. The Chief Health Officer is here. Do you want Mr Pettersson to repeat the question?

Dr Coleman: If that is okay; I was on the move.

MR PETTERSSON: We have spent a long time talking about the COVID-19 vaccine, and we have done a very good job of getting that into people's arms. What work is underway to improve vaccination rates in general? Are there any lessons that can be learnt from what we have done with COVID-19?

Dr Coleman: I have noted and acknowledge the privilege statement. The COVID vaccine program has been a mass vaccination program, as you know, which is very different to how we roll out the NIP. I do think there are some learnings that we will take from that, and that we will be able to apply to the NIP when we try and get to a bit more of a business-as-usual model next year.

Certainly, we have done a lot of work on our equity program, and around how to increase vaccination coverage in our vulnerable communities. We are one of the leading Australian jurisdictions in that work. Particularly for the flu vaccine and some of the adult vaccines, there is some really good work that we can leverage there. We already have impressive vaccination rates in our childhood vaccination levels.

One of the biggest issues that we will face is understanding what the federal vaccine

program looks like into the future, and whether that can be integrated into the NIP as one. I must admit that we probably have not done too much on the NIP in the last year. We have been very focused, but I do know that the routine delivery of that has continued. There was a little bit of a dip in some of our levels, particularly in lockdown, and particularly last year. There was some fear and concern about people coming out. But our levels have rapidly picked up again.

MRS JONES: Minister, there are some discussions about both the human rights implications and the basis of decisions around vaccine mandates. We currently have, if I am correct, three different vaccine mandates either in place or in the pipeline, those being hospital staff, disability workers and aged-care community-based workers, and primary school teachers and those who support them in after-school care. Can you please take the committee through the exact process for the determination of the decision on making these mandates? I will then have some questions on the human rights aspect.

Ms Stephen-Smith: I will hand over to Dr Coleman to talk about the process at a high level. This is obviously a public health consideration for the Chief Health Officer. It is also a conversation with the Australian Health Protection Principal Committee. All of our decision-making has been based on advice from the Australian Health Protection Principal Committee and their weighing of risks and benefits of requiring vaccination across different population groups. I would note the ACT has not gone as far as a number of other jurisdictions—sticking very closely to that AHPPC advice. That is channelled to the cabinet through Dr Coleman. We do have that conversation in our emergency cabinet, which comprises all members of the ACT cabinet and officials from across government, to consider all of the implications of that.

Sitting alongside that, for the ACT public service we have also done a piece of work, led by the Chief Minister, Treasury and Economic Development Directorate's employment relations area. It has developed, in consultation with the unions, a process that will be applied where vaccines will be required for ACT public servants around redeployment of those people who are not able or willing to be vaccinated, what that consultation process will look like and some of the decision-making, should it be the case that ACT public service directors-general make a decision from a work health and safety perspective that they believe that vaccinations should be required for part of their workforce outside a Chief Health Officer direction.

I will ask Kerryn to talk about the process for getting to the Chief Health Officer direction part of it.

Dr Coleman: I will talk you through the considerations that I take, and that the Health Directorate takes, alongside some of the discussions that chief health officers are involved in at the Australian Health Protection Principal Committee. Overall, mandatory public health directions are a challenging decision to make. We do take a lot of considerations on board. COVID has definitely posed for us difficulty and a scale of a problem that we have never seen before.

Certainly, whenever we are thinking about this, I think about the objective or the intention of what we are trying to achieve. Overarching that has been to protect the lives and health of the Canberra community. The aim of that has been to limit the

spread and the impact on individuals. Every decision that we make needs to align with that, and acknowledge the risk—

MRS JONES: I am sorry to interrupt, but the questions that I am being asked are about what data goes into that decision. For example, it is much more obvious in the case of health workers, where there are definitely lots of vulnerable people. It is less obvious when it comes to schoolchildren, and there is a view that there has been a slight overplaying of the risks to schoolchildren by some quarters. Can you explain the medical data that goes into the decision-making process?

Dr Coleman: Sure. That goes to the risk that is posed at the moment. I am glad that people are understanding and appreciating that there are high-risk settings around our vulnerable people, who are more likely to have not only transmission of spread but also high levels of illness.

The issue with our education settings is that under-12-year-olds are the one cohort that we cannot give vaccines to at the moment. As we know, the incidence or the prevalence of severe disease in children is expected to be less, and that is what we have certainly seen internationally and in other areas of Australia. If enough kids get transmission of the sickness, we will see sickness. I think we view class groups of under-12-year-olds as a high-risk setting at this point in time for that very reason—that we have big groups of children who are unvaccinated. It will travel like wildfire. We really do need to put other protections around that.

In considering the public health direction in this space, I was very keen to limit it to the settings where under 12s were. You will notice that I did not include those high school settings, only those settings with the under 12s. We have seen quite a few outbreaks in our early childhood centres. Victoria at the moment are still seeing outbreaks in their vulnerable under-12 groups. This is only a short-term, temporary measure until we get—

MRS JONES: Is it?

Dr Coleman: At this point in time it is time limited for a couple of months, while we work through having availability, hopefully, to the vaccines for five to 11-year-olds.

MRS JONES: I am not sure that that message is getting through. If committee members have a look at their inboxes, I have just sent them a document that I was sent, and other politicians were sent, which is an explanation by some of those who are uncomfortable with the decision. Because we are not debating it in the parliament, as is the preference of the Human Rights Commissioner, it is important that these other perspectives go on the record. Could the committee consider accepting that as a tabled document? It has all of the names redacted, so there is nothing personal in it.

THE CHAIR: Thank you, Mrs Jones. I can say that the committee will accept that as an exhibit.

MRS JONES: Thank you very much. Given that we are treating the disease so much better, with the administration of early medicines once people arrive in hospital, and that we are seeing people churn through the hospital at a reasonable rate, do you feel

that we may get to a point where this health measure for primary school teachers is no longer needed, given your comments earlier?

Dr Coleman: All of these public health directions are only valid until the public health emergency is stood down. We know that, at this point in time, that is the time period for which they were enacted. I believe that, once schoolchildren have had access to the vaccine—we have had amazing take-up in the ACT, so I absolutely anticipate that for children it will be very similar, and it will follow through, when and if it is registered by TGA. At that point in time the risk-benefit profile around this, and therefore the risks to community and all of those considerations that go with making a public health direction, have a different balance. It may well be that it is considered to be no longer necessary to have the mandatory direction in place.

MRS JONES: I mentioned that I would go to the Human Rights Commissioner's comments. It is the Human Rights Commissioner's strong preference that vaccine mandates are done via primary legislation, through the parliament. The parliament is now sitting. Can we have a situation where we soon move those into primary legislation so that they can be appropriately debated? The main reason I ask is that the human rights considerations of these mandates are not, one by one, being described to the community per mandate. That is what would happen if it went through the parliament.

Ms Stephen-Smith: As Dr Coleman has indicated, all of these public health directions get made under a public health emergency declaration, and that is the same process that has been used in every other jurisdiction at this point in time. However, we are currently working on a set of amendments to the Public Health Act that would enable us to respond to COVID-19 as an endemic disease in the community, at least for the period that we will need to continue to respond to it once, potentially, the public health emergency declaration has been lifted—effectively, when we are living with COVID.

At this point in time it has not gone through the cabinet yet or been finalised, but we are certainly exploring the potential for any requirement to mandate COVID-19 vaccinations to then be, probably, a disallowable instrument. That is the way that we are thinking at this point in time. That would be accompanied by an explanatory statement and all the rest of it. That work is underway. I understand that the Human Rights Commission is being consulted as part of that work.

MRS JONES: Okay; that is a step in a good direction. Finally, on that matter, is there scope for those who are not able to be vaccinated or who have made a conscientious decision not to get vaccinated to maintain their employment whilst they are not able to be in the classroom?

Ms Stephen-Smith: Yes. The Education Directorate has been very clear, and we have been clear in our public communications—certainly, from a public school perspective. We cannot require this of non-government and Catholic school settings, or early childhood education and care.

MRS JONES: Why can't you require it?

Ms Stephen-Smith: We cannot put industrial relations requirements on non-government organisations. We do not have the power to do that. But within our own capacity the ACT Education Directorate has been clear that it will work with anybody who is unwilling or unable to be vaccinated to ensure that they are either redeployed within the public education system or in another directorate, in a different role; or they will work with them individually in relation to leave arrangements during that period. That is my understanding. Those questions are best directed to the Education Directorate, in terms of that detail.

MRS JONES: If that is not the case, people can go to you or to the education minister to seek clarification of why that is not the case?

Ms Stephen-Smith: It is certainly a matter for the Education Directorate and the minister, not for me. That is an operational issue.

THE CHAIR: Minister, I want to talk about the LGBTIQ health scoping study and implementation. I have had correspondence from local LGBTIQ organisations that have raised serious concerns with me about the veracity of the methodology and the outcomes proposed in the LGBTIQ health scoping study. I understand that this budget funds the implementation plan of that scoping study, but if the study itself is being questioned by some of the key stakeholders, how will you ensure that the implementation plan is rigorous and has community buy-in and support?

Ms Stephen-Smith: Mr Culhane is coming in to speak further to this process. Certainly, throughout the development of the scoping study, a number of organisations and individuals had expressed concern to me along the way about the process. But there has been very close engagement with the LGBTIQ+ advisory committee—I cannot remember its proper name—that reports generally to the Chief Minister. A range of organisations have been very closely involved in the development of that study. It did go through a number of iterations over time to address the concerns that were raised by individuals and organisations.

I recognise that the study has not yet been formally released. That is imminent. As you say, there is also funding in the budget to support both the development of a detailed action plan to address the findings and recommendations out of that study and to work on a gender-specific health service. I will hand over to Mr Culhane to talk a bit more about the process and how we got to where we are now.

Mr Culhane: I have read and acknowledge the privilege statement. In terms of the process, the scoping study drew significantly on previous work that had been done in the territory, both by government and by stakeholders, on LGBTIQ-related health issues. It included that literature view. It included consultation with stakeholders. That consultation was necessarily limited because it occurred during the earlier stages of the pandemic and it was very difficult to get people in a room in the way that we had wanted to. But there was consultation with stakeholders. I cannot quite remember what it was called; there was a steering group of sorts, comprising stakeholders.

The report was worked up with that steering group. I think the steering group had a couple of opportunities to review and provide input into that report. As the minister said, the report is near final at the moment.

THE CHAIR: Mr Culhane, if the stakeholders have been engaged intimately in this process and provided a lot of buy-in, do you have confidence that the stakeholders that you have been working with are comfortable and confident with the report as it stands?

Mr Culhane: A wide range of stakeholders are involved in the development of the report. It is not always possible to satisfy the wishes of every single stakeholder.

THE CHAIR: Are a majority satisfied?

Mr Culhane: That is my understanding, yes.

THE CHAIR: Okay.

Ms Stephen-Smith: I meet with these stakeholders on a semi-regular basis. My office is in regular contact with a range of stakeholders in this space. If you are hearing concerns, you are very welcome to bring those to me or my office, and we will work with you and your office or directly with the stakeholders to address those concerns.

We are also aware of some differences of view in the community about how some particular matters should be addressed. The release of the scoping study is not the end of the process. It is actually the beginning of the process of developing an action plan, and it will provide a good opportunity to bring stakeholders back together and say, "Okay, this is what we heard through the scoping study. These are the recommendations and findings, but we're working with you as a community on the action plan and how we need to implement that. If we've got something wrong, this is an opportunity to tell us." Nothing is set in concrete at this point in time. If people think that we have seriously misheard something or they have a difference of view that needs to be aired, there is an opportunity to do that.

THE CHAIR: I just want to confirm, who will be developing the implementation plan? Once it is complete, will it be made public? And, most importantly, when do we imagine that it will be complete?

Ms Stephen-Smith: It will absolutely be made public and it will be a very open process of developing it.

Mr Culhane: The directorate will be going through a procurement process shortly to engage consultants to develop the implementation plan and also to work, as was mentioned in the budget, with stakeholders to co-design the gender clinic. And the third part is to start to drive forward some of the recommendations from the scoping study.

THE CHAIR: You said that that implementation plan is going to go out to the consultants. Will there be some assurances that those consultants will have specialist expertise around LGBTIQ health?

Ms Stephen-Smith: Yes. I think that is why we would go out to a consultant in relation to this plan.

MR MILLIGAN: Minister, has the ACT commissioned or received any modelling along the lines of the Doherty modelling relating to COVID in the ACT?

Ms Stephen-Smith: Yes. Thank you very much for that question, Mr Milligan. Mr Peffer said we have to talk under wet cement about this, but I will just give a quick introduction to the topic. Canberra Health Services, through the Clinical Health Emergency Control Centre, has led the work on doing a couple of different types of modelling for us. You might be aware that Doherty has done some jurisdictional modelling. But for the ACT that did not necessarily take into account the impact of regional New South Wales and the fact that we have a tertiary referral hospital. Also, there are some constraints around the Doherty modelling in that it only looked at 70 per cent and 80 per cent vaccination rates and we are clearly heading for a much higher vaccination rate than that, for people 12 and over.

What is known as CHECC has led some work around both trying to replicate the Doherty modelling as much as we can but also having another look at the national and international evidence and experience to see how much we can understand what we expect to happen in terms of ACT and surrounding New South Wales cases and then the impact on our hospital system. I might give Mr Peffer the floor to talk about some of the assumptions that have been made in that and some of the outcomes.

Mr Peffer: Thanks very much, Minister, and thanks for the question. What we use is two distinct tools to look to the future in terms of what we might need to plan for in the health services for the territory. The first is more of a standard Doherty-type EPI model. It has a range of assumptions that are built into it, and if you have had the opportunity to review the Doherty modelling and the material that is being released around that model or the Burnet model—they are quite similar in construct—they have outlined the assumptions and evidence that they have used to frame those models. So that is the first model that we used.

The second model that we used is a much shorter term predictive model that allows us to plan rostering and the capacity that we will have open in the coming weeks in terms of the hospitalisation presentations that we might expect to see. The second model is an accurate model for a couple of weeks. But, as you start to go further out, the confidence intervals begin to expand, as you would observe in the Doherty or the Burnet model as well.

One thing I will say—and we do caveat the use of models—is that they are just mathematical representations of a series of inputs and assumptions. So they will run until the model completes its assumptions around who will get the virus and how that will be transmitted and at what rate. It is always important to then benchmark that back to what is the real-life experience that is occurring around the country and around the world to try and guide some of your planning activities.

MR MILLIGAN: It would be great if you could provide some of that modelling on notice, if possible. Referring to page 273 of the overview budget paper, it shows an estimate of the total amount of funding the ACT will receive from the commonwealth under the COVID-19 public health response partnership agreement. This estimates $36.4 million. Minister, did you provide any input into the formulation of those

estimates, such as estimated case numbers, estimated hospitalisation and so forth? If you did, are you able to provide some of that on notice?

Ms Stephen-Smith: Yes, Mr Milligan, these are our estimates, not commonwealth estimates of what they are intending to provide to us. They are based on our understanding of what our COVID-19 response will look like. As to your question of whether I personally provided any input, I am probably not the best expert to be doing that. Just in relation to the release of the modelling though, Mr Peffer, in his regular emails to the Canberra Health Services staff, has been providing an indication every week of what that modelling is showing that we are going to expect in terms of hospitalisations and intensive care impact.

We have also indicated that we will update the community weekly. Probably at the same time that the Chief Health Officer does her epidemiological update we will also provide a bit of an update on how we expect that that is going to flow through into the hospital systems. We are certainly very keen to make sure that the public and our staff understand what we are expecting to see, because more transparency of information has actually been really good in addressing anxiety that relates to the unknown.

Just in terms of the way that the commonwealth funding was assessed, I do not know if someone else can take that.

Mr Peffer: Yes. So this was a partnership between the two health directorates to construct this bid. We looked at the full range of functions that we require as part of both the public and clinical response to COVID-19. This is everything from security stations at hospitals, testing capability, pathology, additional cleaning, what we might require within a clinical service context, and then also the public health response, which Ms Cross might talk about.

Ms Cross: I think the assumption is that if we claim all of the things which we are eligible for then 50 per cent of the costs will be met by the commonwealth. It is really about constructing what we think our costs will be, determining those ones which would be eligible for commonwealth matched fundings and then the estimate is based on that.

MR PETTERSSON: I was hoping to get an update on the Healthier Choices Canberra initiative. What is the purpose of the program? And how many different entities have signed up or gotten involved?

Ms Cross: We might see whether one of the officials outside the room can come in with the detailed data on how many organisations have signed up. It is one of our preventative health measures as part of the broad public health response that we were talking about earlier.

Ms Stephen-Smith: Mr Pettersson, is there something more specific about the program that you were after or is this a broad question?

MR PETTERSSON: The key information I want to know is the uptake—how many people are getting involved in it? But it might be helpful to understand the purpose of the initiative as well.

Ms Stephen-Smith: I think the broad purpose of that initiative, relevant to preventative health, is recognising that the more we can prevent ill health and prevent chronic illness from occurring the better off we are going to be as a community, both from an individual health perspective and from a health system perspective. It goes back to the old "prevention is better than cure" dictum. That is why we spend money on preventive health programs.

Mr Philp: Thank you very much. I have read the privilege statement and acknowledge that. In terms of the program itself, as you would appreciate, during COVID we have had to pull back quite a bit of that work. But we are still talking to a range of different organisations about how we improve people's better access to food in the community and what are the implications so that we can get businesses to actually work with us in a collective around that work. I do not have actual numbers for you today. We can take on notice how many Canberra businesses are involved.

Ms Stephen-Smith: The Healthier Choices Canberra program is a very broad program, looking at businesses, schools, individuals and sporting organisations.

Mr Philp: A collective group of things that we do.

Ms Stephen-Smith: Yes, so perhaps if we take on notice, Mr Pettersson, to provide a breakdown of the organisations that are engaged in the program and the kinds of activities that we undertake with each of those different classes of organisation, is that helpful?

MR PETTERSSON: Wonderful; thank you.

MRS JONES: Can I clarify, from the question Mr Milligan asked, whether the minister and the directorate can provide the up-to-date modelling for the attempt to model for the ACT—the Doherty modelling?

Mr Peffer: We have replicated the Doherty modelling, but the usefulness of that is actually very limited.

MRS JONES: Yes; nonetheless, I am asking if I can have it on notice, please?

Mr Peffer: Yes, we can provide that.

MRS JONES: My substantive question goes to the wearing of masks. We may need the Chief Health Officer.

Ms Stephen-Smith: I might just offer a correction while we are waiting, if that is okay, to something I said earlier. I indicated earlier that the 90 per cent NEA target was a national target, and that is why we were using it as our target. Actually, I am advised that the NEAT 90 per cent ceased to be a national target in 2015, when the NEAT national partnership agreement expired. Many states have retained the measure, but it is not necessarily a target or a national measure. So it was accurate to say that it is a historical artefact in our budget papers that is 90 per cent, but it is no longer a national target.

MRS JONES: New South Wales has announced a date or a percentage of vaccination at which indoor masks in offices will no longer be required. Where is our work up to on that? I note that we will be doing away with outdoor masks from the 29th, I think. And for high school children who are vaccinated, can you update us on when we might be able to ditch the masks, given that we are headed towards, I think, 95 per cent double dose? And that might be about as good as it gets anywhere.

Dr Coleman: I think it is important to remember that masks are one of a suite of mitigation strategies that we have. While high vaccination levels will be fantastic, that actually will not completely suppress transmission of the virus. I think one of the most important things we are going to need to do over the next four weeks is to see how transmission settles down as we open up to a lot more mobility. We have anticipated needing the indoor masks on until at least the next checkpoint that we have in the pathway, when it will be reconsidered, which is end of November, early December.

Ms Stephen-Smith: The current pathway says that masks will be for indoors only from the 29th, so no longer required outdoors. And then from 26 November face masks will be required indoors only in high-risk settings. That will be the point at which the Chief Health Officer will consider what kinds of settings we might want to retain.

MRS JONES: So we may see high school children not having to wear them at that point, possibly? We may see them not required in average offices; is that correct?

Dr Coleman: Potentially, average offices, noting that we will need to make a reassessment about what the school settings look like. No-one will be at school in December-January, probably.

MRS JONES: I can tell you, kids are pretty sick of those masks. My son calls it a muzzle.

Ms Stephen-Smith: I do not think anyone is that fond of them. But at the other end of the spectrum, I am constantly asked questions about why are we not requiring six-year-olds to wear a mask?

THE CHAIR: I would like to ask about pill testing. I was thrilled to see that the pill testing pilot has been funded for six months in this budget. That is fantastic. I would just like to know specifically what the government would need to see as a result of that trial in order to ensure continuity of the program into the forward years?

Ms Stephen-Smith: Thank you very much, Mr Davis. As you have indicated, the funding that has been allocated in the budget will support a six-month pilot program in a central testing site, a fixed site, in the entertainment precinct. But the site itself is yet to be identified. So that six-month period will allow the pilot to operate for long enough for us to be able to get some reasonable data about uptake and impact.

We have also funded separately, through the research innovation fund grants program, a researcher at ANU to undertake some work alongside that to develop an evaluation model of care. Mr Philp can be more articulate about that than I have been.

Part of the reason that we are really keen to ensure that we evaluate this pilot before committing to a permanent fixed-site pill testing facility is that I think we really do need to understand the take-up of it and the impact of it. It is a significant investment of funds to do this and, as I have said before, we do not have an unlimited supply of funding for the health portfolio or the ACT budget broadly. We need to spend our funding in the way that is going to be most effective for the community, including in the alcohol and other drugs space. I might hand over to Mr Philp to talk about how that process is going to work.

Mr Philp: Thanks, Minister. In terms of the actual site, we believe that it will give us data that will be particularly important to understand the impact that pill testing will have in the ACT community, whether it is an ongoing facility that the community are seeking, and what the data is actually telling us in terms of the dangerous drugs that are identified when people come in to have their pills tested. The aim with the ANU evaluation is for us to understand in the six-month period what is actually happening at a community level and what we can do to reduce the harm associated with people taking illicit drugs.

THE CHAIR: What would the government consider to be success of the trial? I know that where pill testing has been used in other states and internationally there are many different measures of success. Is it simply the number of people that use the service? Is it the types of pills that they have tested? Is it how many particularly problematic pills that have been laced with all sorts of nasties are taken off the drug consumer? How are we going to measure success?

Mr Philp: Thank you, Mr Davis. Yes, it is all those things, essentially. We expect that people would first come into the service to utilise it. Then it is about what we are actually finding when they are doing the pill testing and also the interventions we are having. It is a process where people are actively engaged when they come into the service. We have seen it with the pill testing policy at festivals, where we are engaging with people coming in and getting them to understand the actual drug that has been identified, what are the downsides of it and what are the implications for them if they consume those drugs. So there is very much a learning opportunity. But it is also about how many people are seeking access to this service and what are the outcomes we are proposing that we are actually seeing. It is about saving lives and it is about reducing the harm.

Ms Stephen-Smith: And, Mr Davis, just to add to that, if my understanding is correct, the ANU project is not just about evaluating what we do; it is also about developing a model of care that we may want to look at funding into the future. The first thing that we do here might not be the exact model of care that we want to implement if we do something longer term and if we do something more permanent. It is actually about understanding what worked and what did not work as well. We have learned through both pill testing trials, too, but we are the first jurisdiction in Australia to be doing this as a permanent pill testing site. So we have got a lot to learn about how things work here versus how they might work in different settings in any European scene.

THE CHAIR: How does the government intend on promoting the trial? I ask that question in the context of another Assembly committee I sit on where we are meeting

with representative from the alcohol and drugs sector quite regularly who tell me that pill testing seems to fit in that unique niche where most people who would access the service in other places across the world are not necessarily people that have a problematic or unmanageable relationship with drug use. So the usual relationships you would have with the AOD sector may not target the kinds of people who would best use this program. How are we going to let people know that it is available?

Ms Stephen-Smith: That, Mr Davis, is an excellent question, and it is actually one of the design issues that we think about as well—how are people going to feel comfortable accessing it? And if it sits alongside one of those traditional other alcohol and drugs services it might not be a welcoming place for the cohort of people that we actually want to access this service. That feeds into the design as well as the communications. I think at this point we would say we are still doing that co-design work. And any ideas you have about how we promote it to the most relevant cohort would be very, very welcome.

Mr Philp: We certainly think word of mouth would be a big part of it. But it will be about how people actually perceive it when they go into the service and what the outcomes are.

MR MILLIGAN: Minister, in relation to the $50 million allocated to be spent on introducing new nurses over the next four years, what portion of that is for wards and beds, and will it actually achieve the appropriate staff-patient ratio?

Ms Stephen-Smith: If I understand your question correctly, Mr Milligan, as I said earlier, the intention is by the end of this financial year to have staffed up to meet the ratio framework across those areas that are the focus of stage 1—the general medical, general surgical, acute aged care, and adult mental health unit. We have acknowledged in our conversations with the Australian Nursing and Midwifery Federation that recruitment of mental health nurses is a challenge. But our intention is that by the end of this financial year that full 90 FTE that are required to meet nursing ratios across phase 1 will be recruited.

MR MILLIGAN: As I understand it, this money is provided by offsets. Does that mean there is no new money? Is this more of the existing money being spent on nurses?

Ms Stephen-Smith: The way that the health funding envelope works is that there is a health central provision that is allocated in the outyears, which is the growth funding for the health portfolio broadly. But that is new money. It is the equivalent of another directorate getting new money in the budget, but they do not have a forward provision that assumes what they are going to get. In the health portfolio we have that health central provision that we talked about earlier that is an assumption about how much the health portfolio will grow. But it is not allocated until those decisions are taken in the budget. So it is provisioned separately, unallocated, to Health. If it was any other portfolio, it would be new money.

MRS JONES: How does the offset work? You are saying it is money that has not yet been allocated, but it is described as an offset. So what is it offset against?

Ms Stephen-Smith: It is offset against that health central provision which Ms Chambers spoke about earlier. As we talk about the growth in health funding over time, as I talked about earlier, we have now set that at a 5.1 per cent per annum growth in health funding, but we have not allocated all that funding.

The funding that is unallocated out of that growth sits in what is called the health central provision. And it is somewhere in the budget papers—I just do not have the right page in front of me—that actually specifies what the health central provision is. Each year the health minister and the mental health minister bring forward budget bids that are then offset against the funding that Treasury has already set aside for growth in the health system over future years.

MRS JONES: So it is drawn down from future years?

Ms Stephen-Smith: No, it is drawn down from the provision for that particular year that Treasury has already made by assuming that the health system is going to grow.

MRS JONES: I may need some technical description, but why is it described as an offset and not something else, like the use of the provision?

Ms Stephen-Smith: That is probably a question for Treasury as to why they describe it that way. Effectively, what they are saying is: "We have already assumed that the health system is going to grow at this rate. We have already allocated funding in the budget for the health system to grow, and so this measure is offset from that funding that we have already provisioned." So their word is "offset".

MR PETTERSSON: I was hoping someone could inform the committee about the new model of patient navigation that you are seeking to implement?

Ms Stephen-Smith: Yes. This is a really important initiative that was developed in partnership, over the last term of government, with the Health Care Consumers Association. A couple of pieces of work were commissioned from them that are brought together in this particular initiative.

The first piece of work that was commissioned from the Health Care Consumers Association was to have a look at patient navigation models around the country. Patient navigation is often described as nurse navigation. It is a nurse or another professional, or sometimes a peer, who can work with an individual to help them navigate their needs across the health system.

Particularly for people with chronic or complex conditions, they can help them to coordinate the care that they need across the system and help them to communicate with health professionals, which can often be a daunting and difficult task for people, so that for that individual with a chronic or complex health condition their care is then better managed. Also, the navigator works with that person to help them to understand what all the different parts of the system do and how they can then become more empowered consumers of health services themselves.

The Health Care Consumers Association looked at models in other jurisdictions to determine what we could do to implement a patient navigation service in the ACT.

They recommended specifically that it should be a standalone service that is recognised across the health system and that brings together the navigators so that they are working not as individual, isolated units but within a framework and supported. We have not got an exact model for that at this point in time, but this funding delivers the opportunity to develop and co-design that model and bring together those teams of navigators to work together, with the very first one being the paediatric liaison and navigation service.

The fact that we have prioritised this arises from another piece of work that the Health Care Consumers Association did, funded by ACT Health, looking at the needs of children who receive care interstate—those very sick children who are receiving care interstate whose parents and carers have very clearly told us that they experience a fragmented system. Usually the interstate care is with Sydney's children's network. Parents experience fragmentation between Sydney children's network and health services in the ACT, including Canberra Health Services. There is also fragmentation within the ACT health services they need to support them. That might be acute care, it might be primary care or it might be community-based care and allied health, and also the social supports that they need—working with the school to make sure that they understand the care needs as well.

That service is about both liaison between the Sydney children's network or wherever else they are receiving their care and care in the ACT and also within that navigation service within the ACT. Does anyone want to add anything? Cathie?

Ms O'Neill: Only to say that I am actually meeting with the Health Care Consumers Association tomorrow to start the design work around what this model will look like for the paediatric navigation service.

MR PETTERSSON: Very exciting.

Ms Stephen-Smith: I am very excited about this one.

Ms Cross: Chair, could I provide some information in response to a question that we took on notice earlier, just so that we can deal with it during this session? It was the question about Healthier Choices Canberra.

THE CHAIR: That would be great. Thank you.

Ms Cross: Just to give you an indication of the number of organisations that are involved, at 30 June 2021 there were seven state sporting organisations and 111 local businesses participating in Healthier Choices Canberra. At that point, based on an evaluation of the program, we moved to a pledge-based arrangement where businesses make specific commitments to improving their food environments. As of 1 July, as we are transitioning to this new approach, there were 10 state sporting organisations and approximately 30 businesses that had transitioned so far. We expect that that will grow.

In addition, we have another initiative, Refill Canberra, which allows people to refill their water bottles for free at local businesses, to reduce plastic waste. We have got over 130 businesses as part of Refill Canberra. They are the organisations that are

involved, but then there are a number of new initiatives that we will be rolling out in 2021 where we will get ongoing increases in engagement.

Mr Peffer: Chair, if I may, I took a question from Mrs Jones about the number of patients we have in hospital who are currently moving to an NDIS package or aged care, and I believe I advised you 62. The number is, in fact, 61; one has been discharged in the last week. You can see that it is not a high turnover population of patients. The breakdown is 34 currently awaiting an aged-care placement, with the remainder waiting for NDIS.

THE CHAIR: Thank you, Mr Peffer.

Short suspension.

THE CHAIR: Welcome back to the Standing Committee on Health and Community Wellbeing inquiring into budget estimates 2021-22. I will kick us off with a question about quit smoking programs. How much money has been allocated in this budget for quit smoking programs?

Ms Stephen-Smith: Specifically as budget measures or in the overall budget for the year?

THE CHAIR: I suppose you have just pre-empted a supplementary question. I am interested in whether there was any new specific money for quit smoking programs and then, more broadly, I would be interested to know what the directorate is doing for smoking cessation.

Ms Stephen-Smith: As far as I can remember, there is no specific funding in this budget for quit smoking programs. However, a recent round of healthy Canberra grants had a focus on tobacco use and quitting smoking. I do not know whether Mr Philp is around. I think I responded to a question on notice by you, Mr Davis, recently, and provided a breakdown of the amount of funding that goes to organisations like Winnunga, for example, which we fund to do quit smoking programs, and also a breakdown of those healthy Canberra grants programs. If I can find that and dig it out, I can answer your question.

THE CHAIR: That is okay. I do recall some of those questions on notice. I suppose they were for the last year. I am just interested to know whether there is any new money in the coming year. I think one of your officials in the last estimates period spoke of the stubborn six per cent or seven per cent in Canberra whom we just seem unable to get to with our smoking cessation program. So knowing that that is a stubborn figure, I am interested in whether any work has been done to try and address that.

Ms Stephen-Smith: I think that was also in the context of the targeted funding through the healthy Canberra grants, which are really focused on some of those areas. I will take the question on notice and come back to you on that.

THE CHAIR: That would be great. Thank you, Minister.

MR MILLIGAN: Minister, can you tell us how the duration that a COVID-19 patient stays in ICU in hospital has evolved over the duration of the pandemic, as treatments, no doubt, have improved?

Ms Stephen-Smith: Mr Peffer can definitely do that.

Mr Peffer: Thank you for that question. I will just quickly try and bring up some data. In terms of what we are seeing, obviously those patients who present to hospital have a longer stay when they find themselves admitted to ICU than if they were just admitted to a general ward. The length of stay then increases for those who are ventilated, as opposed to those who are not. We have a number of patients who have presented who only required a stay in the ICU of one to two days. But for those who are ventilated, they can be there for some weeks, because of the severity of the disease and requiring multi-organ support in an ICU environment.

MRS JONES: Can I just clarify: Mr Milligan's question was about how the treatments have evolved from the beginning of the pandemic to now.

Mr Peffer: I might get Dr Coatsworth to join us. Obviously, we have seen great advancements in terms of how we are able to treat COVID patients. If you cast your mind back to early 2020, it was a disease that, around the world, people knew very little about, including the treatments that had an effect and were successful. As the pandemic has progressed through the months, the data, the evidence and the ability to treat has improved. I will get Dr Coatsworth to expand on the range of treatments and how they work.

Dr Coatsworth: There has been a range of, I guess, new novel treatments and improved understanding of COVID-19. If I can separate it into pre-hospital or the early phase of the illness, the point of hospitalisation and then intensive care admission, noting that our executive director of research, Professor Mitchell, is also available to discuss that in more detail.

From the national medical stockpile, we have a drug called Sotrovimab, which is designed to be given to those who have not had the opportunity to be vaccinated yet. It needs to be given within five days of symptom onset. We have successfully delivered that to 90 consumers in the ACT. Only two of those have gone on to develop any sort of respiratory problem after that. We will continue to monitor the effectiveness of that program to identify patients who are eligible, because that really is important for those who are unvaccinated.

Regarding the evolution of treatment in hospital, particularly with the use of the steroid Dexamethasone, we have seen a 30 per cent mortality reduction. We have the anti-viral drug Remdesivir. We have the inflammatory inhibitor Baricitinib and, of course, oxygen therapy—in fact, getting a patient when they are not on a ventilator to turn themselves, which we call proning, to make their breathing more comfortable. It seems to be very effective. My own experience is that if the patient does not go to intensive care then their length of stay in hospital is substantially less than it was last year. I cannot speak for the intensive care length of stay.

Mainly from an intensive care point of view, there is a real focus on how to ventilate

patients, which is slightly beyond my expertise, but there is a particular way that COVID-19 patients need to be treated when on a ventilator. The experience that has been gained nationally with our Intensive Care Society means that, overall, patients with COVID-19 are doing better; there is less morbidity and mortality than there was last year.

MR MILLIGAN: Dr Coatsworth, are we getting to a point where COVID-19, for most people, is a manageable disease?

Dr Coatsworth: COVID-19, for the majority of people, has always been a manageable disease. The issue has been, and continues to be, with the proportion of people in the community who are non-immune, which, as you know, originally was the entire global community. It still remains relatively significant, even if you take into account that it is going to be between one and 10 and one and 20 people in Australia who are not vaccinated. They are still at risk of getting significant disease and it is the burden, therefore, on the healthcare system.

If they are able to access health care—and, by the same token, we have to keep our healthcare system open for non-COVID pathologies—certainly the case fatality rate now is coming down to approach what influenza would be. It is coming down with treatment, but you have to remember that, if you spread that across an entire unvaccinated population, you still can potentially have a significant burden on the healthcare system. We are incredibly well-placed in the ACT because of our vaccination rates.

MR MILLIGAN: Do we, as a society, have to learn to manage the risk of COVID-19? And at what point will that actually start to really come into effect?

Ms Stephen-Smith: I think that is starting to come into effect now as we are easing out of lockdown, while we have cases of community transmission and we have people in our hospitals, and we are expecting to see more people in our hospitals. One of the issues, as Dr Coatsworth has indicated, is not only the question of are we going to be able to treat people who acquire the Coronavirus and develop COVID-19 and become unwell but also what is the impact on our health system of doing that—how many beds does that take up; how much resource does that take up?

This is why it is really important—it is one of the reasons as, obviously, there is a personal morbidity and mortality impact as well—that we try to manage the spread of COVID-19 in our community as much as we can so that we do not see a really significant escalation in cases and a really significant impact on the health system and so that other people who require support in the health system can receive that.

We have seen, in both New South Wales and Victoria, the impact on other parts of the health system when they have seen a significant escalation of COVID-19 cases—the cessation of elective surgery being the most obvious thing, but a range of other impacts as patients have to be moved from one hospital to another in order to manage the demand on the hospital system.

MR PETTERSSON: I was hoping to get an update on the development of the next ACT drug strategy action plan.

Ms Stephen-Smith: I will ask Mr Philp to join us, but I might ask Ms Cross to start.

Ms Cross: The question was about the drug strategy action plan and where we are up to with implementing that?

MR PETTERSSON: Implementing the current one would be good and then the development of the next one.

Ms Stephen-Smith: Just in terms of the development of the next one, that work is underway. We are very conscious of the fact that a range of stakeholders have put forward the view that they want to see the development of a new drug strategy. Part of the thinking about the next iteration of the drug strategy action plan is how do we put some more context around the beginning of that that really outlines the principles and the objectives, without having an entire consultation process for us to determine that our focus needs to be on harm minimisation, harm reduction, supply reduction and demand reduction. We already have a national strategy that outlines that, which we have signed up to and, from a principle perspective, it is very much where we want to head.

What we have heard from the sector is that they would like to see a bit more of that discussion about the principles and the directions, as well as the actions that we are going to take. I might hand over to Mr Philp to talk about both where we are up to in implementing that and the development of the new one.

Mr Philp: The next drug strategy action plan is starting to be pulled together now. We anticipate that over the next six to eight months we will have a new final draft for government to consider. As you would appreciate, there is quite a lot going on in the drug and alcohol space at the moment, and we are trying to understand all those issues.

We are also looking at an evaluation of the current plan that is in place and making sure that we have done all the things that we indicated that we could. It has obviously had an impact on some of the deliverables. Certainly, some of the work that we have done, like the joint funding for Capital Health Network and the John James Foundation to set up a mobile primary health clinic, has been important.

The work we did on the feasibility study for the medically supervised injecting study has been important, as well as the work that we are doing with Aboriginal and Torres Strait Islanders in the resi rehab space, working with Winnunga around models of care. There is actually quite a bit happening in the background. The fixed pill-testing site and looking at what we do more broadly about reducing harm within the community is some of the work that will inform the next drug strategy action plan.

MR PETTERSSON: I was hoping to get a bit more clarity on what the process is to develop the strategy. What is the actual work that needs to be undertaken? Is there formal consultation with stakeholders? Is there community consultation? What is the process that we will be going through?

Mr Philp: Certainly, the consultation is going on. Because of the inquiry that is currently happening, there is a lot of information from the community around what

they are looking for. That will generate interest in actually understanding what we need in terms of some of the measures going forward. We are looking to have a very slimmed down version of the next drug strategy action plan so that we can give it to government and say, "These things can be delivered over the next three to five years."

We must also understand that the broader environment in which we are working in the drug and alcohol space is quite a challenging environment, particularly with COVID, because we have seen increases in alcohol use. The other drugs in the community that people would not necessarily see as the harmful ones are, in fact, our most challenging ones, alcohol and tobacco being those.

Over the next few months we have the inquiry coming down which will guide some of the work that will inform the next plan itself. We are now in October and I anticipate that over the next six months we will have some further consultation. I know that the sector is very keen and is talking to us on a regular basis about that work. There are the treatment areas as well that are being challenged by the sort of work that we are doing at the moment.

THE CHAIR: It would be useful to understand how the funding allocation for the Watson health precinct redevelopment has been modelled and whether the $803,000 that has been allocated will be enough for the design and redevelopment of three facilities; I understand they are Ted Noffs, Catholic Care and the brand new Aboriginal and Torres Strait Islander residential rehab centre.

Ms Stephen-Smith: I am definitely handing this one over to Ms Lopa.

Ms Lopa: Thank you for the question, Mr Davis. I have read and acknowledge the privilege statement. I am really excited about the work that we are doing at Watson. You are probably aware that it is one of our older facilities and probably it is not, from an infrastructure point of view, a very good building.

We undertook some work last year. We got $200,000 out of the COVID stimulus to do some work on the Watson precinct and some master planning. We thought the block in Watson was a really lovely place to deliver health services. It is at the base of Mount Majura. It is a really lovely place for people to go to heal and get the treatment that they need. But the building probably does not communicate the worthiness of the people—that the people who are there are worthy of getting their lives back on track and turning their lives around.

We did the work with the stimulus funding that we had to master plan the site. It is a really big site and it is not utilised very well, so we undertook work to look at what else we could fit on there. We thought it was a really lovely site as well for an Aboriginal and Torres Strait Islander residential rehab facility. Winnunga, when we took them there, also thought it was a really lovely site. There is some connection to country there. There is some bushland.

This money that we have is the next step to start designing. We have done a little bit of design through the master planning process and have looked at what could fit through blocking and stacking et cetera. The Catholic Care and Ted Noffs buildings are quite residential in nature and in feeling for the youths that are there. We think that

we have enough money to design those next steps. We will also need to do a bit of work on the block as well. We would like to put another entrance into the block. We think we have enough money to do that, and we will be coming back to budget next year to implement that.

THE CHAIR: Just a couple of clarifying questions. You mentioned Winnunga and that you took them out to the site. So Winnunga would be the ones running the eventual rehab facility on that site?

Ms Lopa: Alan might be a better person to talk to about that. Winnunga have been involved in the model of care work and informing the model of care. That is why they were involved in looking at the site and we sought their advice on what would be an appropriate site for the residential facility.

Ms Stephen-Smith: We have been really clear with Winnunga. We recognise that Winnunga Nimmityjah are the only Aboriginal community-controlled health service in the ACT. While they have never run a residential alcohol and drug rehabilitation facility, they have connections with Aboriginal community-controlled organisations who do that work. There has been a partnership between the Health Directorate and Winnunga to develop the initial model of care work. This funding of $803,000 includes $503,000 for Winnunga to support a project manager and alcohol and other drug adviser and an alcohol and other drug worker. We envisage that, as the only Aboriginal community-controlled health service in the ACT, they would be running that facility. But that work still needs to be finalised with them, obviously.

THE CHAIR: Would you mind talking me through the consultation that is happening with both Winnunga and the two organisations currently on the site, Ted Noffs and Catholic Care? Not just on the redevelopment of that site but any risks or opportunities that might present in the future redevelopment of those three facilities being co-located in such a way? I just want to get an understanding of how much they are involved in the development and the planning.

Ms Stephen-Smith: Each of the organisations has been involved in the work to date. One of the issues that have come up is in relation to having young people on the site at the Ted Noffs and Catholic Care facility and then having an adult residential alcohol and drug facility. As Ms Lopa indicated, it is a large site and it is sort of a long site, with the current facilities being in the middle of the site. The idea is that Teds Noffs and Catholic Care would be redeveloped at one end of the site and the Aboriginal and Torres Strait Islander residential rehabilitation would be at the other end of the site and they would be quite separate facilities. I think Ms Lopa has had a conversation with Catholic Care about that.

Ms Lopa: I think it is really important to understand just what the minister said there. We are not planning on co-locating the three services. We are planning on subdividing the block and having a separate entrance to the Aboriginal and Torres Strait Islander residential rehab, so they would be like a next-door neighbour. The distance between the services is about 100 metres, so it is a long way away. As we go through the design processes over the coming 12 months, I think Catholic Care in particular will be very reassured about how the site will come together and be developed.

Unfortunately, some of our language in calling it a precinct might have made them think that they were all being co-located, but they are not. Catholic Care and Ted Noffs now have an excellent relationship, so they will continue to co-exist on one end of the site. In fact, there is such a large portion of land between those services, between Ted Noffs and Catholic Care, down one end and the resi rehab up the other, that we will probably put some other buildings in there over time, whether they be admin buildings or something else. They will be quite separated. I think we can be reassured about the cohorts not mixing as we go through the design process, but we will involve them every step of the way in that design.

THE CHAIR: That sounds great.

MRS JONES: Minister, to go to the issue of fit testing of masks, my understanding is that, in order for the N95/P2 masks to be effective against aerosols, which is the concern of COVID living in the air, essentially, for a period of time after someone who is infected has breathed it out, staff need to be fit tested. When they put the mask on, they need to be fit checked to ensure that they are sucking in and out and it actually fits properly. Minister, in relation to an answer to a question I asked you, it seems that in the week ending 5 September, 40 staff were rostered onto COVID wards in that week without having been fit tested, in the week ending 12 September, 16 staff were rostered on and in the week ending 19 September, eight staff were rostered on. Can you explain why these nursing staff were exposed unnecessarily to risk if we have been planning for this emergency for many months?

Ms Stephen-Smith: I will hand over to Mr Peffer to talk about that in detail.

Mr Peffer: We have been undertaking fit-testing for some time. It is the case that we have been planning for the pandemic response, but the pandemic itself has changed throughout. The response to Delta in terms of what the health services need to do is quite different to what we were planning for at the beginning of 2020. That has impacted a range of things that we have had to consider, be it infrastructure, workforce models, models of care and PPE as well. While it is fair to say that we have been planning right throughout the pandemic, the pandemic itself continues to evolve and change and that necessitates an evolution of the planning that we have to do and the protections we put in place.

MRS JONES: Why then do we still have, some weeks into this whole situation of having to fit test nurses, nurses being rostered on who are not being fit tested?

Mr Peffer: The process of fit testing is not necessarily a simple process that you can just—

MRS JONES: Correct.

Mr Peffer: scale and switch on overnight. People actually have to be trained to go through the procedure to be able to fit test another person. We went through a train-the-trainer process and we now have quite a large cohort of individuals who can provide that fit-testing service. At the moment, I believe we are doing around 500 to 600 fit tests per week to get through the workforce. I know that more than 4,000 of

our healthcare workers have been fit tested at this point in time. We have moved very quickly since the beginning of the outbreak to put in place the best protections we can and certainly to have the policies now that anyone cannot work in our designated red zones unless they have been fit tested. Sometimes that means—

MRS JONES: Was that policy put in place after 19 September?

Mr Peffer: I am not sure it is necessarily the case that we had people going into these—

MRS JONES: That was the answer to a question on notice. That is a document of the parliament, actually, Mr Peffer.

Mr Peffer: We would have had rostering in place with people moving into these zones, but we would have been undertaking the process of fit testing as people were deployed to work. It is the case that across the country, not just here in the territory, fit testing was in pretty short supply and we had to respond to that as quickly as we could. We have seen that the use of surgical masks and face shields in and of itself has been quite effective in terms of transmission that has occurred in the hospital. We have had COVID positive patients coming in right throughout the outbreak. N95 masks are that added layer of protection—

MRS JONES: Correct.

Mr Peffer: and then with fit testing and fit checking per shift, they are all just incremental improvements in the protections that we are providing.

MRS JONES: So you cannot guarantee that all staff on the wards will be fit tested before they work on those wards?

Mr Peffer: I can absolutely guarantee that.

MRS JONES: Right.

Mr Peffer: Anyone going into a red zone will have been fit tested before they start their shift or at the start of their shift.

MRS JONES: Right.

Mr Peffer: Before they are permitted into a red zone, they will be fit tested.

MRS JONES: And does that include ED?

Mr Peffer: Yes.

MRS JONES: In relation to the brands of N95/P2 masks that are currently used in Canberra Health Services, I understand that there are some brands that are currently unavailable or in limited supply. Is that correct?

Mr Peffer: That is correct.

MRS JONES: Have staff been advised to substitute one mask for another mask, specifically substituting Trident for 3M?

Mr Peffer: Yes.

MRS JONES: Have those staff, if the fit checking was insecure—if the fit was insecure on the fit check—had the opportunity to fit test which Trident mask was correct for them?

Mr Peffer: Yes, we have provided that opportunity. The transition from a 3M mask to a Trident mask I think originally occurred in Victoria—the ability for someone who wears a 3M mask to just pick up their Trident mask and for it to be essentially the same fit. It is a very similar design of mask in terms of how it fits around your nose and chin. It is essentially the same, so—

MRS JONES: The feedback that I have had is that they are not the same. Even though the company may be saying that, the feedback that I—

THE CHAIR: Mrs Jones, there have been a few occasions in this line of questioning—this is the fourth time now—when Mr Peffer has not been able to finish the answer to your first question.

MRS JONES: Mr Davis, I think it is reasonable for us to try and get to the point of our questions. We could be here all day otherwise.

THE CHAIR: On the fourth occasion I have to pull you up and let the person presenting finish the answer to the question.

MRS JONES: I will be very keen to hear whether he thinks that they are the same when I have heard that they are not.

THE CHAIR: Mr Peffer, you have the floor.

Mr Peffer: Thank you.

Mr Mooney: Mrs Jones, I might just support Mr Peffer in relation to the question and provide some more detail about the masks. In relation to the P2/N95 mask, we have a range of suppliers, and at this stage six different types of masks. We are competing against everybody else in the states and territories—

MRS JONES: Correct.

Mr Mooney: in terms of the supply of these. Through our process we have managed to get adequate stocks. We are running at about nine weeks of stock now, based on our current usage level, which is about 70,000 a week. If you scale that up, that is roughly similar to what New South Wales are doing in terms of their quantity of masks.

In terms of the actual issue of the Trident mask, we had a number of masks, one of

them being the 3M mask. That was basically the most comfortable mask that people used. When we started fit testing, we did not have an alignment with the variety of masks that were available, as in the supply, versus what would be offered to those individuals getting fit tested. So that was an improvement that we put in to make sure that we did not just go with one fit tested mask; we would get others fit tested as well, just to manage the supply issues. As I said, that was an improvement opportunity that we implemented.

In parallel with that, as part of our research into other masks, we identified one particular mask from Victoria. A company called Industry Group supplies it. Its trade name is Trident. The Trident mask is not identical to the 3M mask but, in terms of its structure and, more importantly, its actual performance in a fit testing check or fit testing result, it compared either equivalently or better in all of the checks that we did. These were not just our own internal checks within our own fit testing area; we were also taking advice from three different health districts in Victoria.

It was on that basis that we followed up with priming our supply chain with these masks. We had a high level of confidence from our own checks and also the advice given by clinical people in Victoria health to confirm that, to address the shortfall that we had in the 3M mask, this particular mask would be an equivalent replacement. We were able to offer that to individuals who were only tested in the 3M mask.

MRS JONES: Can I just clarify: people have been fit tested in multiple brands now?

Mr Mooney: Correct.

MRS JONES: And if someone is being asked to use a Trident and they do not believe the fit is correct, there is fit testing available for them on request?

Mr Peffer: Yes.

Ms Stephen-Smith: Yes.

MRS JONES: Thank you.

Mr Mooney: I would also add that we have been in touch with the supplier. They have worked with our own people who do the fit testing, with regard to giving best advice as to how you should wear them and how you should put them on in order to improve the feedback. We have been working closely with the supplier to make sure that any issues have been addressed. Certainly, any feedback that I have had since that type of consultation has been much improved.

MRS JONES: Thank you.

THE CHAIR: My question is about the Heart Foundation. The Heart Foundation made a budget bid for the very first time, I understand, this year. In their bid they asked for funding to help improve active travel advocacy in the ACT, particularly walking groups. Unfortunately, they were unsuccessful in their budget bid. Are there any budgeted funds that they might be able to apply for, or that other similar groups might be able to apply for, that would help with that kind of work?

Ms Stephen-Smith: Obviously, I am aware of the Heart Foundation's community budget submission. The question of active travel really sits across Health in terms of preventive health. Minister Steel had the title of minister for active travel at one point. I do not know whether he—

THE CHAIR: I did clarify, though, before asking the question and I understood that I would ask Minister Steel in the context of infrastructure. But in the context of establishing and promoting these walking groups, I understand that would fit within Health, if I am not mistaken.

Ms Stephen-Smith: It may well, although some active travel programs that have specifically sat within Health have transitioned to the active travel portfolio. The ride or walk to school activity and another activity have transitioned to TCCS, as part of the active travel portfolio. There is probably a little bit of a grey area there.

Having said that, the healthy Canberra grants program is the kind of grants program that supports organisations to undertake activities that promote good health in the community. Those grants rounds generally have a specific focus. I do not think we have got one at the moment that is focused on the type of activity that the Heart Foundation is wanting to support. We will continue to work with the Heart Foundation and all of the other community organisations and stakeholders that have made budget submissions to think about how we best manage the demand for services, service improvement and preventive health across the community.

THE CHAIR: You might want to take this supplementary on notice. I just wonder whether this kind of budget bid would work as part of the government's social recovery program, and I am only speaking anecdotally here. We know that, anecdotally, there have been a lot of Canberrans who have taken up walking; at least, my walks around Lake Tuggeranong during lockdown suggest that. It would be wonderful to see that, as we transition back to our normal lives, that new habit that many Canberrans have taken up is maintained.

Ms Stephen-Smith: Mr Davis, you could even consider that to be a matter for the Minister for Mental Health, as well as addressing the COVID kilos which I know many of us have put on over the period of lockdown. You make a fair point and we will feed that into our considerations.

THE CHAIR: My last supplementary relates back to my earlier question regarding the Health Care Consumers Association, who also were not successful in their budget bid. Does the government provide advice to these community organisations who are unsuccessful in their budget bids on why they were unsuccessful and what they might want to consider in future?

Ms Stephen-Smith: There is a process of engagement with community organisations that is led by Treasury in terms of all of those people who put in community budget submissions. You might want to ask the Treasurer in more detail about how that process works. That is a process that is led by Treasury. Anyone who wants to get feedback can also do that.

As I have indicated, we really value community budget submissions. Often it is a conversation over time; directorates do not suddenly come up with a budget in February for a budget to be brought down that year. There is a lot of planning that goes into budget bids. While some things will be picked up from community budget submissions in the year that the submission is made, more broadly, submissions feed into the consideration of how we address the priorities.

Of course, we also have the wellbeing indicators framework to support through the budget process. I would encourage anyone who has put in a community budget submission that did not get funded in that particular budget not to be disheartened about that. I think it is all part of the conversation about how we, as a community, address our priorities against the wellbeing indicators and the various priorities that we have across government.

MR MILLIGAN: Can you provide some information on how you are using devices known as medihoods?

Mr Mooney: A medihood is effectively like a little negative pressure environment that sits on top of the patient's bed, with the patient in the bed. It has a plastic cover and air is extracted out through a small extraction fan, through a HEPA filter. It provides an environment that reduces the amount of viral load that is dispersed in the particular room.

It was an invention that came from a collaboration between a Victorian-based university—I cannot remember the exact one—and clinical professionals in Victoria. I think it is called the McMonty medihood. We have taken receipt of 18 of them at this point. We have another balance on order that we expect to get in over the next four to six weeks. They are quite a popular device across Australia. It is a relatively small company that is making them. They are in high demand. We have found them useful. All of our clinical staff have taken to them very well.

MR MILLIGAN: Does it require any specialist training for staff to use them effectively? With the quantity that you have ordered, how did you come to that figure? What was the basis for the number that you have ordered?

Mr Mooney: The actual quantity was based on our planning in terms of capacity. Mr Peffer talked earlier on about the modelling. We are looking at the modelling and what that translates to in the number of beds across the territory, not just in the Canberra Hospital. That is what has informed the final figures. I will bring them up in a moment. I do have them to hand.

With regard to how easy they are to use, this is a really simple device to use and that is reflected in how well it has been embraced. Literally, the assembly of the units did not take any more than about an hour for people using them for the first time. The device is just positioned over a standard size bed. In terms of its use thereafter, you set it up, turn it on and then it is in place until such time as that particular patient is taken away from the medihood. At that point the plastic cover—the tent, if you like—is basically taken off. We have a stock of them to be able to swap out, or we can actually clean them and re-use them for the next patient.

MR MILLIGAN: How many times can they be re-used? Is there a limit?

Mr Mooney: In terms of how many times have they been re-used?

MR MILLIGAN: Once used, you clean them—

Mr Mooney: In the initial samples that we got in we had three units, with three plastic covers per unit, in order to have one that was in use, another one available and a spare. They are cleaned. The disinfecting process is not that onerous on them and they can be re-used.

MR PETTERSSON: Can anyone enlighten the committee on walk-in centre presentations and whether or not we are meeting our targets?

Ms Lopa: We are probably not going to hit the targets, as such. It is probably a bit of a misnomer to have a target against a walk-in centre, because it is not like we are going to go out there with sandwich boards and encourage people to come in. It is more of a planning figure than a true target that we want to hit.

We have seen, through the lockdown, that presentations across the walk-in centres have decreased. They are on their way back up. We have also seen, now that we have managed to return the Weston Creek Community Health Centre to the Weston Creek Walk-in Centre, that those numbers are now starting to come up as well. I can provide you with the exact numbers, if you would like them. It is probably better that I take that on notice, though, than read out a whole stack of numbers now.

MR PETTERSSON: It is quite all right. How are wait times tracking?

Ms Lopa: Wait times are very good. The median wait time has actually reduced with the corresponding drop in presentations.

MR PETTERSSON: What would you say is the best measure of their success? Is it the number of presentations we are getting or is what is happening in the ED a better thing to keep an eye on?

Ms Lopa: There are a range of measures that we look at to evaluate the walk-in centres, one of which is the number of people that are redirected to emergency departments. That helps tell us that we have got our marketing right so that we have the right people turning up. Obviously, we do not want people turning up to a walk-in centre if they are critically unwell and should not have gone to the walk-in centre. It is rare that we would need to call an ambulance to redirect somebody from a walk-in centre to the emergency department. We are comfortable that we have got that marketing right. That is one aspect.

We also do consumer satisfaction with the walk-in centres. That is very positive. We look at the trends in presentations and the types of things people are presenting with. What we are noticing over time is that there are starting to be more and more acute presentations to the walk-in centres—things like fractures, for example—as opposed to colds and coughs. It is allowing the walk-in centres to practise more of their full scope, which is very encouraging. The other thing that we can take from that is that

they are presentations that would otherwise have had to go to the emergency department if we did not have the walk-in centres available for them.

MRS JONES: Minister, can you give us an update on the culture review recommendations? How many have been implemented and how many do you expect to have completed by the end of this calendar year?

Ms Stephen-Smith: I might hand over to Ms Cross to talk about some of the numbers. You will be aware, Mrs Jones, that the culture reform oversight group meets every two months. The papers from that group are publicly released, subsequent to the meeting, just after the next meeting. Those include a tracking of all, I think, 92 actions that are associated with the 20 recommendations of the report. I did have the numbers on me the other day, but I do not have them with me. I do not know whether Ms Cross does?

Ms Cross: I have not got them with me because there was nothing in the budget specifically about the culture review.

MRS JONES: Well, there was. There was $643,000 rolled over from 2020-21.

Ms Cross: That was just a rollover of funds. It was not a new measure, so I have not—

MRS JONES: I am asking questions about what is in the budget documents and what it means and what—

Ms Cross: Sorry, I am not disputing the fact that you would ask questions. It is just that I do not have a specific brief on that because I have briefs on all of the individual new measures. We can take on notice exactly where we are up to with each of the recommendations. There will be a report shortly made public, in any event, that goes through that in some detail.

MRS JONES: So today there is nobody at the Health building who can come and tell us where we are up to with the health review recommendations?

Ms Cross: We can see if we can get someone into the room in the next couple of minutes for you that can respond on the specific numbers.

MRS JONES: Given that it has now been nearly 1,000 days since this report was brought down, I think there are many people in the system who would love to have had these recommendations all implemented and proven to have been effective. I am looking forward to that work being done.

Ms Stephen-Smith: What I can let you know is that, from the papers from the 29 June meeting, of the 92 implementation actions across the 20 recommendations, at that time 58 of those actions had been completed, 32 were on track and two were identified as either being delayed or at risk of delay.

Since that time, of course, two more actions have been completed. The remainder continue to be monitored. I am aware, from just recently looking at some papers for

the next culture reform oversight group meeting, that we are now looking at delays—from memory, an additional about four or five. We are now looking at six or seven individual actions, not recommendations, out of those 92, that are experiencing some level of delay.

You will appreciate, I am sure, that the response to this outbreak has drawn a lot of staff from roles that might have been specifically related to responding to the culture review into the frontline or administrative support roles, like logistics or resourcing, for what has been a very large response to the COVID-19 outbreak.

MRS JONES: Of course, but it does not—

Ms Stephen-Smith: We can take it on notice and provide those updated figures in terms of how many of those actions are now delayed.

MRS JONES: I would like to know how many of the recommendations have been completed and, with the delayed actions, which recommendations they are in relation to. Also, when do you expect this body of work to be completed? I also ask, even if it has to be taken on notice, whether you are collecting commensurate data, which could be compared to the original report, that will show any change in behaviours and experience of work by staff in Canberra Health Services?

Ms Stephen-Smith: As at the 29 June meeting, eight recommendations had been fully implemented and good progress had been made on the remaining 12 recommendations, as indicated by the number of actions that had been completed. Some of those recommendations cannot be fully completed until the end of the three-year implementation period because part of completing that action involves evaluating the actions and their impact.

As you would be aware, the last large-scale culture survey was conducted in 2019, in around November, for Canberra Health Services and the ACT Health Directorate. Calvary Public Hospital conducted theirs a little bit later, in February 2020, if memory serves me correctly. Since then, Canberra Health Services has been conducting pulse surveys; so there is a regular measure of those issues that have been identified through the culture review. That information is shared with staff on a regular basis.

MRS JONES: Can I please ask, then, as well, on notice, for the results of the pulse surveys since November 2019?

Ms Stephen-Smith: Yes; we can take that on notice.

MRS JONES: Thank you.

Ms Stephen-Smith: In relation to the agenda for the next two culture reform oversight group meetings, in terms of comparable measures of proxies for culture across the system and in terms of human resources-type data and information, it has taken some time to identify measures that could be accurately gathered and prepared, or consistently gathered, across Calvary Public Hospital, Canberra Health Services and the Health Directorate, where relevant.

The draft of that framework is going to come to the next culture reform oversight group meeting. It has been discussed a number of times before, but it has been further refined and developed. We are hoping to have a dashboard of those data indicators. That should be completed by the end of this year, as a dashboard. I absolutely acknowledge that that work has taken longer than any of us would have liked, but that is a result of having quite different systems and quite different things that are measured across the organisations.

MRS JONES: Will the dashboard be able to be compared to the data that was collected in the original report?

Ms Stephen-Smith: It is unclear whether that will be the same data. We might take that question on notice, because a lot of the information that was provided in the original report came from qualitative conversations that Mick Reid and the panel had with staff, in addition to the—

MRS JONES: I wonder whether Mr Reid could be re-engaged to update that study that he did at the time because, in the end, if we could see that there had been a complete turnaround, that would be ideal. The best way to prove that would be with the same type of research so that it can be compared.

Ms Stephen-Smith: As you are aware, one of the recommendations was that there be an annual review of progress.

MRS JONES: Yes.

Ms Stephen-Smith: The most recent annual review of progress is almost finalised. Ms Renee Leon undertook that work. I think she consulted with you.

MRS JONES: I took a briefing from her, but it was unfortunate that at the time her view was that, while quite a few underlying baseline steps had been taken, there really was not much achieved yet.

Ms Stephen-Smith: That report will be tabled in the Assembly in November. It is going to be considered by the next culture review oversight group meeting. Clearly, the COVID-19 pandemic and the busyness of the work around that has had an impact on being able to implement some of these things.

There are going to be some similar findings from Ms Leon's report, as there were from Mick Reid's first annual review. Some of the strength of the foundational work that has been done by the team, with ANU and internally, to develop a framework and organisational culture improvement model is exactly what you are talking about, Mrs Jones, in terms of understanding the maturity of our systems to improve culture. What we are hearing, as you are, is that there are still too many people on the front line who are not seeing the impact of this foundational work.

The rollout of Speaking Up for Safety has been a really important initiative across most of Calvary Public Hospital and Canberra Health Services, but we know that one course is not going to be sufficient. There is also significant work rolling out leadership and management courses, because we understand that that is a really

important layer of the organisations to ensure that they understand how to support their staff appropriately and what their responsibilities are in this space. We talked before about the fact that people often get promoted in the health service on the basis of their technical skills and expertise, but they do not necessarily get that support to get in really good managers and leaders in the organisation. So that is a phase of work.

When Ms Fitzharris was the minister and the report came down and the $12 million over three years was allocated in the 2019-20 budget, that was a clear indication that this work was going to take time. We wanted to develop a really strong framework around it and not rush in and do half a dozen unconnected things that were just going to confuse people. We are absolutely on the same page, in that we now need to be seeing the impact of this on the front line, not just in nice reports around the framework. That is the focus of this work this year. I will take all those questions about numbers on notice.

MRS JONES: Thank you. I would like to know who decided, in the middle of a global pandemic, to spend $50,000 to rebrand Canberra Health Services.

Mr Peffer: Are you talking about the brand audit, Mrs Jones?

MRS JONES: There is a $50,000 contract that was notified on the contracts register of government and it is for the rebranding of Canberra Health Services.

Mr Peffer: If you come out to the hospital, albeit not at this point in time, because we have visitor restrictions—but had you gone to the hospital a couple of months ago you would have seen a variety of logos, names and badging across the various facilities that we have. The feedback that we have had through our consumers and consumer representative organisations is that that confuses people in terms of the services they are accessing and it actually matters.

For us, it is important that we have clear and simple branding for the organisation so that people understand where they are and the services that they are accessing. We engaged a group to support doing an audit of where we are at currently to help us figure out what are the priority initiatives that we should put in place to resolve some of the branding confusion which, in turn, then confuses consumers.

Ms Cross: Just to add to that, our staff are also telling us that, as part of that whole culture work, their sense of belonging is a little bit disjointed, and we know branding is part of that.

MRS JONES: Given that we have only seen eight of the recommendations implemented in nearly 1,000 days, you can understand why some people might be a bit concerned that the robust brand management strategy for $50,000 may not necessarily be the one thing we should be putting most of our eggs in one basket for. But I know there are plenty of other things going on at the moment.

THE CHAIR: Mrs Jones, I did not hear a question in there. We are going to take that as a comment.

Ms Stephen-Smith: Chair, can I provide some updated numbers for Mrs Jones on the

culture review?

THE CHAIR: That would be great. Thank you.

Ms Stephen-Smith: The latest numbers I have are that, of the 92 actions, 60 have been completed, 26 are in progress and on track to be delivered by the agreed date, one action is at risk of being delayed by more than 12 weeks, and we now have five actions that are delayed by more than 12 weeks. That change is specifically an impact of the outbreak.

MRS JONES: Thanks very much.

Mr Mooney: Chair, can I just clarify a figure for Mr Milligan in relation to the medihood orders. We have got 61 on order to complement the 18 already in stock.

MR MILLIGAN: Thank you.

THE CHAIR: Friends, I would like to thank all of the ministers for appearing today—Minister Emma Davidson, Minister Rebecca Vassarotti and Minister Rachel Stephen-Smith—and all the officials. Thank you very much for your time.

If any witnesses throughout the day have taken any questions on notice—and there were a fair few in this session—could you please get those answers through to our committee secretary and support office within five working days of your receipt of the proof Hansard for today? If members of this committee or across the Assembly wish to lodge questions on notice, they will need to be sent through to the committee support office and our secretary within five working days of today's hearing, being Thursday, 28 October.

The committee adjourned at 5.32 pm.