LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

STANDING COMMITTEE ON HEALTH AND COMMUNITY WELLBEING

(Reference: Inquiry into annual and financial reports 2020-2021)

Members:

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

TRANSCRIPT OF EVIDENCE

CANBERRA

WEDNESDAY, 2 MARCH 2022

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

By authority of the Legislative Assembly for the Australian Capital Territory

APPEARANCES

Privilege statement

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Amended 20 May 2013

The committee met at 1.01 pm.

Appearances:

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

ACT Health Directorate
Johnston, Dr Vanessa, Deputy Chief Health Officer
Cross, Ms Rebecca, Director-General
Anton, Ms Deborah, Deputy Director-General
George, Ms Jacinta, Executive Group Manager; Health Systems, Policy and Research
Barbaro, Ms Fiona, Acting Executive Group Manager; Population Health Division

Canberra Health Services
Peffer, Mr Dave, Chief Executive Officer
Mooney, Mr Colm, Deputy Chief Executive Officer
Grace, Ms Karen, Executive Director; Nursing and Midwifery
Swaminathan, Dr Ashwin, Executive Director; Medical Services
Smitham, Ms Kalena, Executive Group Manager; People and Culture
O'Neill, Ms Cathie, Chief Operations Manager

THE CHAIR: Welcome to the Standing Committee on Health and Community Wellbeing's second hearing into the ACT government's annual reports for 2020-2021. Today's witnesses will be Minister Rachel Stephen-Smith and officials. The minister will be appearing in her capacity as Minister for Health and Minister for Families and Community Services.

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

On housekeeping, can I request that when you speak for the first time today you acknowledge that you have read and understood the privilege statement which has been sent to you by the secretariat. Should any person speaking today take a question on notice, please very clearly state, "I will take that question on notice." That helps our secretariat to chase up after today's hearings to clarify those questions.

Please note today's proceedings are being recorded and will be transcribed and published by Hansard. We are also being broadcast and web streamed live.

Welcome, Minister. I would like to remind all witnesses of the protections and the obligations that are afforded by parliamentary privilege and draw your attention to that privilege statement once again.

In lieu of opening statements, we are going to kick right off with questions. As Chair,

I will start us off. Minister, I note with pride the first stage of the government's honouring of its commitment to the Australian Nursing and Midwifery Federation on nurse-patient ratios. Of course I do not need to tell you that our nurses and frontline healthcare staff have felt the pressure, particularly over the course of the last 12 months. I am curious to know, in relation to those commitments that the government has made to recruit new nurses and meet those nurse-to-patient ratios, how does that coincide with the perceived risk of burnout amongst our current population of nursing staff and the suggestion put to me that pressures from the pandemic and other pressures have led to some nurses reflecting on their choice to be nurses, particularly in the context of the ACT system?

Ms Stephen-Smith: I have read and acknowledge the privilege statement. I just note for committee members—I think the Chair is aware of this—the Chief Health Officer will have to leave at about 2.30. If people have questions for the Chief Health Officer, if we can get it done in the next hour or so that would be great.

THE CHAIR: I did forget to mention that. Thank you for keeping me honest.

Ms Stephen-Smith: Your question, however, is an excellent one. We have got a few more people arriving, including those who will be able to help out in responding to this question. I think you were right, and the people you have been speaking to are right. We are going to see a number of interesting workforce pressures and issues coinciding here. We have made a good start on delivering our commitment to nurse-patient ratios. As you would be aware, that initial commitment is to do that in the acute surgical, acute medical and acute aged care, and mental health spaces.

From the start of implementation on 1 February, already more than 50 nurses have been recruited to support that implementation. We will have 90 in place to meet that full implementation of phase 1 of the ratios by the end of June. That is a significant commitment to ensuring that our nurse-patient ratios create a safe workplace for patients and for staff and increases the quality of care that is able to be provided. That does, to some degree, address the issue that we are talking about in terms of pressure and burnout.

We also are very conscious of the fact that our system is under significant strain at the moment and that nurses are feeling the pressure on this. I think we were all hoping that we would get through summer with the capacity for people to take a break. Instead we got a summer where we had to massively ramp up our testing capability, where our system was under pressure from COVID requirements within the hospital setting, and a lot of people did not get the summer, or indeed the leave, that they had been expecting. There is clearly work that we are going to have to do to respond to that.

I am not sure if you want to go to the directorate or CHS, first. Maybe I will hand over to Mr Peffer to talk, from the CHS perspective but also from a clinical health emergency coordination centre perspective, about how that workforce issue is being managed across the ACT.

Mr Peffer: I have read and acknowledge the privilege statement. As the minister said, we have experienced considerable fatigue across our healthcare workforce now for

some months. From the original Delta wave commencing around six months ago, it has been pretty tough going within health services, not just here locally in the territory but more broadly around the country. That has placed considerable pressure on the workforce and the expectations around our workforce. It has not simply just been the demand that has eventuated from patients coming into the health and hospital systems but it has also, understandably, been from isolation and quarantine impacts.

If you cast your mind back some months ago to the peak of the workforce impacts, we had more than 800 healthcare workers out across the system. In a system of our scale, that is significant. When that happens very rapidly, which it did in a matter of days from the outbreak escalating, there really is no lever that you can pull to scale the workforce an additional 800 workers. Very, very quickly you reach out and you access any casuals or agency team members who can be brought in to bolster that effort.

We have invested considerable time and effort as well in onboarding students, both medical and nursing, to help bolster that response. Also, I think pleasingly, we have been very grateful to receive applications from many healthcare workers who had recently retired—some I think you could probably count the number of days they had been in retirement on one hand—but who offered to actually come back and bolster the response to COVID, which was very good.

To support those efforts, with many people needing to be onboarded—and we have had rolling recruitment in place now across many of our medical specialties, nursing, some areas of allied health and administration and those support services—our people and culture division looked at a range of processing recruitments to really fast-track our ability to be able to re-recruit and then bring people in and have them commence work asap. We really could not afford weeks of time for that to occur. It had to be sped up quite considerably.

In terms of the partnership that we have then seen to manage the workforce as a whole across the territory, it has really been a united and collaborative effort, not just between CHS and Calvary but also with our private sector partners as well. I meet frequently with the general managers and chief executives of our private hospitals. We talk about demand and capacity across the system. We meet with our Calvary colleagues very frequently each week, as well as having operational-level decisions, right down to where is the next patient going to flow, to which particular hospital, given the pressures that the system is feeling at any point in time.

We have got rolling recruitment processes to support us heading into winter. We will onboard considerable workforce in that time. I think we have shown that we have been quite successful in being able to bolster the workforce. But the reality is that it does take time and we have asked a lot of the workforce who have been in place supporting that frontline response, in partnership with our public health colleagues as well. We have asked a lot over the last six months.

THE CHAIR: I have got a couple of quick, follow-up questions for you, Mr Peffer. Hopefully they are a bit enlightening for those online. How many nurses are currently employed by ACT Health—not positions?

Mr Peffer: You are looking for a head count?

THE CHAIR: Yes, please.

Mr Peffer: We might have to take that on notice. We would be able to provide that.

Ms Stephen-Smith: Could I clarify, are you talking about just Canberra Health Services across the ACT public hospital system or including the Health Directorate as well, where there are a lot of nurses employed in various different roles, including supporting the digital health record, but not providing frontline services? Are you talking about frontline nursing positions in our hospitals and health services?

THE CHAIR: I appreciate that. That clarification is important. Yes, frontline—those who are providing healthcare on a daily basis. I am also interested in the difference between the positions versus the head count. It is only anecdotal but, of course, we have heard of some instances of nurses leaving over the past 12 months. It is good to hear from you, Mr Peffer, that there are some coming out of retirement who are keen to fill those positions. But I would like a little more information to clarify are those coming back to fill positions at least replacing those who are leaving.

Mr Peffer: That is a good question. The simple answer is: in part. We have a continual churn within our workforce. We have been really proud to see that the rate of turnover in our workforce has not materially increased during COVID. That stands in stark contrast, I think, with what we observed, particularly in the Northern Hemisphere, where we have seen a mass exodus of healthcare workers. We have been replacing people who have been leaving. Overall, we have been growing the number of FTEs that we have got in our nursing workforce.

THE CHAIR: On that growing of the FTEs, I want to pick up on one point that sparked a bit of anxiety in me about these nurses coming back from retirement to work. I assume that if they are coming back from retirement, they originally retired because that was where they were at at that point in their life. I imagine we are not assuming these are people who are going to be long-term, as in for the next few decades, employees of ACT Health.

I would like to focus a bit more on what are we doing to promote—I am remiss to use the words "more youthful", but you know what I mean—a more long-term workforce to fill those vacant positions. Is there a clear link from university into ACT Health? Are we prioritising trying to recruit nurses from interstate or overseas to fill those positions? I would just like a little more clarification on that.

Mr Peffer: Thanks very much for that question. No, I do not think our expectation is that these employees will be coming back to join the team for the longer term. I think we are heartened by the fact that they do still see themselves as part of the healthcare workforce, as part of the team that they have recently left.

Online, back at the hospital, we do have Karen Grace, who is our executive director of nursing, who can talk in more detail about the recruitment campaigns and the process that we are undertaking, if that would be useful.

THE CHAIR: That would be useful. The one thing I would ask to be included in that answer, if that is okay, is the pay that we are offering and how does it relate to the pay that is being offered to nurses in other states and territories. I am sure that can be part of that answer.

Ms Stephen-Smith: Just in response to that, I am sure that we can give more detail on notice in relation to that, unless Karen is in a position to take that now. That would be fantastic. I just note that, of course, the ACT government did not go down the path that some jurisdictions did and freeze public servants' wages, including nurses' wages, in response to the pandemic. Indeed, we continued to negotiate and rollover our enterprise agreement to ensure that our staff continued to get regular pay increases.

Ms Grace: I have read and acknowledge the privilege statement. I will answer the last part of the question first, which is around the relativity of Canberra pay rates for nurses compared to rates in other jurisdictions. I will take the detail on notice but I am aware that we are either the second- or third-highest paid nursing and midwifery workforce in the country. I will take that on notice. We certainly are up in the highest pay scales compared with other jurisdictions.

In terms of our workforce planning and in terms of the retired workers coming back, that has really been their desire to contribute to the pandemic response. They were really keen to re-join us and be able to contribute. The reason I have not planned for them to work for us ongoing is, as you rightly state, they had a plan to retire, and of course we all deserve a long and fruitful retirement at the end of our careers.

What we are doing in terms of our workforce planning is we are looking at a number of different strategies, some of which are already in place and some are planned over the next one to three years. Some of this is related to ratio, some of it is related to other impacts such as the critical-services building and having to plan for our workforce into the future.

We have very close relationships with local universities and we have clinical chairs for nursing midwifery and mental health nursing that work with us and the University of Canberra on pathways for nurses and midwives into our service. We have a wide variety of options there. We also have a very close relationship with Canberra CIT for training and onboarding our enrolled nurses into our workforce.

We have a very successful transition-to-practice program, which is our new graduate program. This year we will welcome in excess of 100 new graduate nurses to the territory, starting at the beginning of February. Those nurses spend the first 12 months in a very supportive program, where they rotate to different areas of the health service and are provided with training and education and support in order to feel confident to fully contribute to the teams that they are working in.

We also have relationships and formal agreements with other universities that offer courses where we have areas of need that are not offered locally. An example of that is maternal and child health nursing. There is no maternal and child health nursing course offered in the ACT. So we have an agreement with the South Western Sydney University to support nurses through that program. We do that in partnership with the Office of the Chief Nurse who provides financial support through scholarships for

those nurses.

We are also able to offer scholarships for mental health nursing courses to help support that area of need within our workforce. We have just closed the current round of scholarship applications. I was really pleased to see quite a lot of applications coming through for areas of need such as mental health, women and children's health and some of our critical care areas.

We will also, as we move forward, be looking at re-establishing some of our national and international recruitment strategies. We have not stopped them but I am sure you would appreciate that over the past two years it has actually been very difficult to attract talent from elsewhere, given the limited movements that have been possible both nationally and internationally. But we certainly have, as part of our workforce plan, a marketing strategy to ensure that the rest of the world understands what a wonderful place Canberra is to live and work.

Off the top of my head, that is an overview of the main strategies that we are undertaking at the moment. As I say, we are looking at the short, medium and long terms and matching our recruitment actions and our campaigns against what we know is going to be our need, moving forward.

The other really important component of our workforce is the casual workforce. That is the workforce that we can call upon to fill our short, no-desk vacancies for personal leave, for example. If we are fully recruited to our establishment, our casual pool can then be used really effectively to step in and meet the shortfalls whenever somebody is unwell and unable to attend work.

When you are working in the environment that we have been working in recently with the competing demands on the service, it is actually quite challenging to be able to fill all the requirements, including new teams to support the COVID response, and to be able to manage that dynamic workforce on a day-by-day basis and implement ratios. But we have, to this point, been very pleased with how well we have actually managed to implement ratios despite all those other constraints.

THE CHAIR: I have got one last follow-up. It is for the minister. Ms Grace said that we have either the second or third highest paid workforce in the country. My cheeky but obvious question is: what is the barrier for us being No 1? Canberrans like to be No 1. Canberrans like to win. I would like to win this race.

Ms Stephen-Smith: I will take on board your view as we enter into the next round of enterprise agreement negotiations. I think the priority that the union has put through enterprise agreement negotiations has not really been on maintaining pay but really focusing on the implementation of ratios. Improving the working conditions through the implementation of ratios has been their priority in the negotiations with us. But I have no doubt that they will be taking the same position as you as we come to the bargaining process. Of course, these things move around as different jurisdictions have different outcomes from their enterprise agreements.

MS CASTLEY: My question is around the churn. Mr Peffer, I believe you mentioned that. Minister, in light of the fact that we pay the second highest wages for nursing

staff, I just want to talk about the length of service. For women, it is 7.9 years as a nurse in Canberra, and for men it is at 6.7 years. If our nurses are being paid the second best wages in the country, can you explain why we do not have longer length of service for the nurses? Would you say that is a cultural problem?

Ms Stephen-Smith: I am not sure that I would be able to comment specifically on that, in part because I do not know what the comparators are. I know that certainly we have nurses working in our system, as we do in a whole, wide range of medical professional or clinical team members, who come from overseas. We also have Australian nurses who travel overseas to work. There could be a whole range-of-life reasons why people are staying or not staying in a particular job for a particular length of time. I am not sure if we have got any analysis, or if we have done any, or what we have got in front of us.

Mr Peffer: It could be that that is capturing length of tenure in a particular employment situation, and people are moving between different employers. I do note that recently I did have the opportunity to acknowledge the great work of three of our nurses who, collectively between them, had over 100 years of service. We certainly do see many of our nursing team members come in and have a rich and wholesome career in our local health services without feeling the need to move around. But I guess that there are a range of reasons why people may move between different employers.

MS CASTLEY: But my understanding is that they all just work for Canberra Health Services. Where can they be going?

Mr Peffer: I guess there are a range of environments that they can work in. We do see workforce moving between Canberra Health Services and Calvary Public Hospital groups on the north side. We have also then got quite a number of fairly sizeable private hospitals operating in the territory as well—everything from GP clinics through to day-surgery facilities and a range of other things in between where nurses could conceivably work.

Ms Stephen-Smith: Of course nurses can also go into the policy side. We have nurses, as I said, working on the digital health record and some with significant expertise in implementing IT systems in health settings. There are a wide range of places that nurses might go if they leave the frontline workforce, either permanently or temporarily.

MS CASTLEY: My mum was a nurse for over 30 years; so I find it quite sad actually that nurses who trained for so long, who are getting paid the second highest wages in the country, are leaving after such a short time. I missed earlier the number of nurses that we have. Minister, can you tell me how many nurses we have working in our health system?

Ms Stephen-Smith: We took that on notice.

Mr Peffer: We do not have a number just yet. I know the team is scrambling, trying to pull together a couple of numbers from across the two public hospitals, as well as from QEII. We will try and get that number by the end of the hearing, if we can.

MS CASTLEY: I thought surely somebody would know the employment numbers. There was one other question going back to what Karen Grace said with regard to scholarships for mental health nurses and for maternal and child health nurses. I am wondering—maybe you could take this on notice—how many scholarships and applications for those two areas do you have.

Ms Anton: I have read and acknowledge the privilege statement. I am very happy to take that on notice. Some of that work is done out of the Office of Nurse and Midwifery at the directorate. I am happy to give you an update.

MR MILLIGAN: My question is in relation to elective surgeries. In your annual report you stated that you had a target of 16,000 elective surgeries for 2020-2021. Your actual figure was 15,334. You also described that as a record number, up from the previous year, which was 12,870. I am just wondering why the government fell short of its original target of 16,000 elective surgeries.

Ms Stephen-Smith: As you said, the 15,324 elective surgeries completed was well in excess of the previous highest figure, which was 14,015 in the two years previous. It was really a significant achievement, in partnership with our private hospital colleagues as well.

The 16,000 was a very ambitious target. When we set that target, we did think that we were going to be able to get there. But, as you would understand, 2020-21 was also a pretty disrupted year. I might hand over to Mr Peffer to talk a bit more about that.

Mr Peffer: Thanks for the question. I might also ask Mr Mooney to provide further details. One thing that I think it is really important to appreciate is for that particular financial year, with the commitment of 2,000 additional elective surgeries, that is a tremendous load that you are trying to carry through the system. We had great buy-in from the workforce. We had many of our surgeons, anaesthetists and nursing team members working additional shifts and weekend shifts really trying to support these patients to access their care.

In that year as well we did see very, very strong growth in emergency surgery. Between the growth in elective that we were able to achieve and the growth in emergency surgeries, primarily trauma and classic based, we did exceed an additional 2,000 surgeries. However, not all were strictly elective surgeries. Mr Mooney can add to that.

Mr Mooney: I acknowledge the witness statement. As Mr Peffer said, we have achieved record targets in this space. Whilst we did not achieve the actual 16,000 that was the original target, that obviously had the pressures of emergency surgery and also some of the areas of surgery such as orthopaedics and ear, nose and throat, where we have issues around the physical number of specialists in that space. From an orthopaedic point of view, we are dealing with not just the ageing population in the ACT but there are also obesity issues and also the issues relating to the wider region that we serve. There are a number of factors that impact on this.

Nevertheless, we have gone through the numbers and, as Mr Peffer said, with

everybody working together across the whole territory-wide system, we achieved record numbers in CHS, the Canberra Hospital and Calvary public—the variety of private providers. Just under 20,000 procedures were provided in that time.

MR MILLIGAN: Does the government have any figures on the number of elective surgeries that were postponed, put on hold or cancelled due to health directives that were given during the COVID period of recent lockdowns?

Ms Stephen-Smith: Are you talking about this financial year over the summer period?

MR MILLIGAN: Yes.

Ms Stephen-Smith: As you would be aware, in the ACT it was only elective surgery at Calvary Public Hospital at Bruce that was put on hold. We did not hold and pause elective surgery across the whole system. My understanding is that around 500 elective surgeries were affected. I do not have the exact number.

Mr Mooney: I will confirm that. I do not just have it to hand here now. Following on from what the minister has said, yes, primarily our Calvary public area has seen the biggest impact. That is because of cat 2s and 3s. Our plan is to recover that in this financial year.

MS CASTLEY: The annual report states that there is a goal of 60,000 elective surgeries over the next four years, which means 15,000 a year. The target was 16,000. It seems that the target has dropped, because budget statements C said that, in the 2021-22 period, there were 14,800. I am just confused about what the target actually was. Will we be dropping the target since we have not met it?

Ms Stephen-Smith: We are not dropping the target because we have not met it. The target of 16,000 was set to catch up from that period in the first half of 2020, the second half of 2019-20, where non-urgent category 2 and 3 elective surgery was paused, right across the whole system, as it was in other jurisdictions as well. The 16,000 was an attempt to catch up on that period. It was an outlier on the upward trend that we have been investing in over time.

As I said, the previous highest number was 14,015 elective surgeries in—if I am getting my years right—2018-19, before the COVID pandemic. We then had a target of 14,250 in 2019-20, which we did not meet because of the pausing of elective surgery. We only had 12,000 and something; someone gave the number earlier. We were then catching up in 2020-21, and we were aiming to get ourselves back onto a growth trajectory to deliver 60,000 elective surgeries.

That growth trajectory would look something like 14,800, 15,000, 15,200 and 15,400, so that over the four years we were delivering 60,000. There might be ups and downs in that, but the aim is to be on a more consistent growth trajectory.

MS CASTLEY: It is quite a way over the target. I have no doubt that our doctors and nurses are working their hearts out to try and meet these targets. Are you concerned that it was too high?

Ms Stephen-Smith: As has been indicated, the 16,000 target, and our capacity to meet that, was significantly impacted by the very large increase in demand for emergency surgery. It was not just seen in the ACT; it was seen around the country. As Mr Peffer has indicated, we had planned for an additional 2,000 surgeries being elective. What we got was an additional 2,000 surgeries, but some of them involved unexpected demand for emergency surgery, which then crowded out the capacity to do elective surgery.

Obviously, we had planned for that in our investments that we have made in the latest budget. We have specifically invested in growth in emergency surgery, as well as elective surgery, in order to recognise the impact. But we are still seeing this impact today in our hospital system, which is still very busy in terms of emergency surgery demand.

It is something that all jurisdictions are grappling with. All of the health ministers are talking about how to meet this significant growth in emergency surgery demand while also catching up on the elective surgery that had to be paused.

MS CASTLEY: You talked about the elective surgery. I note that, with the figure for the waiting lists for elective surgery, 430 was the number of patients still waiting for surgery, but the actual figure turned out to be something like 773. Can you explain the reason for that discrepancy?

Ms Stephen-Smith: That is a carry-on from the pause in elective surgery delivery in response to COVID and the lack of capacity for us to completely catch up, as we had intended to do. We are also seeing continuous additions to the elective surgery list.

Mr Mooney: Ms Castley, going back to the numbers that were overdue, based on our targets for this year, as at the end of January, across all of the services, we were behind by 485. With respect to that figure, we are working very closely with the private providers and Calvary Public to pull back that figure to get us to our target figure, as the minister said, for this year of 14,800.

In terms of the issues around the overdue waitlist, the figures and the targets over four years of 60,000, that is keeping pace with the annual growth in elective surgery. The goal is to maintain the status quo but also to drive it down through other means, in terms of looking closely at the overdue waitlist, and looking at where the various patients are located, because we cover not just the ACT but also the surrounding region.

We do have quite a considerable number of people who are out of region, sometimes from as far away as Victoria and Queensland. That has an impact that we need to work towards. Likewise, we also need to work with the regional areas where it is better placed to do some of the surgical procedures as opposed to bringing them into the ACT.

These are all strategies that we have in place to drive down the overdue list, or lists, in parallel with maintaining the targets, and looking towards the future in terms of the additional capacity that will be coming on board, not too far off, later in 2024, with

the onset of the critical services building in the Canberra Hospital expansion.

Ms Stephen-Smith: Mr Mooney talked earlier about the challenges that we have experienced in orthopaedic surgery and ear, nose and throat. Our relative performance varies across different specialties. One of the things we were very pleased about last year was the record number of orthopaedic surgeries undertaken in 2020-21, which was nearly 400 more than the previous record, with more than 2,000 orthopaedic surgeries completed. Those are often expensive surgeries. We have also had a really clear look at those higher-cost surgeries and how we can make sure that we specifically fund and prioritise those, because they are sometimes the ones for which people are waiting a longer time than is ideal.

MS CASTLEY: That leads me to my next question, which can be taken on notice. I am conscious of the time. Could I get figures on the cost for elective surgeries broken down into type, as you just mentioned, Minister? The common types: are we able to get a table for that—the cost of elective surgery and the different types? Also, I am very interested in why we are treating people from Queensland and Victoria, what types of operations they are and how much that costs the ACT. That can be taken on notice.

Mr Mooney: I can take that on notice, yes.

Ms Stephen-Smith: We can take that on notice.

MR PETTERSSON: Whilst we are talking about elective surgeries, what programs are in place to support patients prior to and after surgery?

Ms O'Neill: I have read and acknowledge the privilege statement. We have a number of different services to assist patients both pre-operatively and post-operatively, to ensure that they resume their normal quality of life as soon as possible.

Pre-operatively, we do a lot of work in the orthopaedic space, particularly with people that are referred for joint replacement surgery. Many of those people will benefit from physiotherapy rather than going directly for surgery. We have a team of advanced physios that assess those referrals to determine whether or not they are more suited for a conservative physio approach rather than surgery. We are looking to expand that program even further in the coming year, adopting a program that has been very successful in Denmark, called GLA:D.

One of the programs that we are using at the moment—we started it off in February 2021—is called the ERAS program, the extended recovery after surgery program. They saw 200 patients through that program last year, focusing particularly on colorectal surgery, hysterectomies and elective caesareans. They have seen significant success through that. The length of stay for the colorectal patients was reduced by almost two days. For the hysterectomy patients, it was reduced by 30 per cent.

In line with that we have also had very strong patient feedback. This program focuses on making sure that patients are ready pre surgery when it comes to their nutritional status and their physical activity status. We are seeing as a result a significant reduction in any complications, even minor complications, that allow patients to get

better and get home quicker.

MR PETTERSSON: Could you expand, very briefly, on that Danish program called GLA:D that you are intending to bring to the ACT?

Ms O'Neill: This program is run by physiotherapists and other allied health professionals that takes patients through a structured exercise program. They are seeing significant reductions in the need for surgery. We are looking to extend and expand the current approach that our physios have been using to use this best practice method that the Danes have had significant success with.

MR PETTERSSON: COVID-19 is still circulating in the community, even as we get back to a more normal way of life. How do we intend to manage COVID-19-positive patients in the ACT, moving forward?

Mr Peffer: I might start; then other people can provide some further details. We have been on quite a journey in our health service over the last couple of years in treating COVID-positive patients. A couple of years ago, if I cast my mind back, we had our first COVID-positive patient in the territory, and I remember them being security-escorted straight into hospital, straight into a designated ward, because that was the prevailing view at the time of how to treat COVID patients.

In the years that have followed, obviously, that has changed quite considerably. We have had the introduction of some very effective vaccines. That has evolved some of our thinking as well, as we have learned more about the evidence of how the virus is transmitted and how we should treat them.

In response to that question, we might talk at a broader hospital level, but then we will talk at a patient level, about how we are treating.

Ms O'Neill: There are a couple of elements regarding the way we are managing people with a positive COVID-19 diagnosis. As the numbers have increased in the territory, in line with all of the other jurisdictions, we have made sure that we have ample material available for people to self-manage at home. We know that for many people the illness is relatively mild, and they can manage it quite safely at home just with some information and points of escalation if they think their symptoms are getting worse.

On top of that, we support those people at home with our COVID at home program. This has been an incredibly successful program for the ACT in providing reassurance, support and health care to people who are positive. We think this has contributed significantly to our reduced hospitalisation rate.

We are using some technology to support this program. We have brought forward the implementation of one of the modules out of the digital health record that is not going live until later this year. That allows people in their own homes to register their symptoms. We do a risk assessment of people. If we think that they are at a higher risk of more severe disease, we send them out monitoring kits. They get a little finger probe that will measure their oxygen saturation, we make sure they have access to a thermometer, and we get them to register their temperature, their oxygen saturation

levels and how they are generally feeling. We can monitor that on a dashboard. If we start to see that trending in the wrong direction, our teams will make direct contact with those people. In addition, they will have a phone number they can ring for advice.

We have worked closely with the GP sector in making sure that we are working collaboratively together, particularly where GPs have a strong relationship with people that have been diagnosed with COVID, so that they can maintain that care, if that is appropriate.

With the management of patients in hospital, as Mr Peffer said, we have been on a bit of a journey with that. We have been constantly reviewing our own data and our own experience, and comparing that with others around Australia and, indeed, internationally. We started off managing all patients with COVID in hospitals, in designated COVID areas. But we have moved away from that slightly, particularly with the Omicron variant.

With people that are admitted, we started to see a considerable number of our COVID admissions coming in not because of COVID but with COVID. For example, we have women that have been positive and needed to birth. They obviously needed to be cared for in the most appropriate setting for that. We have had other COVID patients that, for example, have broken bones but have no COVID respiratory symptoms. We have moved away from looking after those patients in the COVID specialty ward and look after them in what we call their home wards.

We have dedicated COVID wards at both Canberra Hospital and Calvary hospital where we manage patients with respiratory symptoms from COVID. We have a multidisciplinary team that are providing care to those patients. There is a strong connection between the COVID at home team and those teams so that if COVID at home are worried about any of their patients, we can expedite direct admission if required.

The last part of our approach to managing COVID has been the establishment of the clinic at Garran surge centre. This has been another very successful program for us. The team saw their 800th presentation through there last week. We are able to manage people who have a positive diagnosis, or are waiting on a test result, that might have primary health needs or might be concerned about their COVID symptoms. We are managing a whole range of different reasons for presentation through that centre, including a reasonable number of children that are coming through, particularly where parents need some assurance that what is happening to their child is normal, and getting some advice on how to manage that.

Mr Peffer: For our patients with COVID symptoms, I will ask Dr Swaminathan to respond.

Dr Swaminathan: As well as being the acting executive director of medical services, I am a practising infectious diseases physician. I have read and acknowledge the privilege statement.

Just to add to what Ms O'Neill and Mr Peffer have said, in terms of sick patients with COVID who are in hospital, we follow a protocol that is world's best standard in

terms of the treatments available to patients with COVID, in terms of medications, in terms of PPE that is being used, and diagnostic tests.

The infectious diseases team is reviewing the latest literature on COVID treatments, and particularly using the national COVID task force, which publish what is called the "living guidelines". That is constantly reviewing the literature on what is the latest medication with the most efficacious therapy.

We have our own local guideline that we share with Calvary. It means that we are using antivirals, such as Remdesivir, which is an intravenous medication, for people who are acutely unwell with COVID pneumonia, and who are requiring oxygen. We also use immune-modulating medications, which reduce the inflammation associated with COVID pneumonia—medications such as Tocilizumab and Baricitinib. We get those medications from the national stockpile. We use Dexamethasone, which is a very strong and potent steroid medication which dampens the immune response.

That combination of therapies has proven to be very effective in treating people with severe COVID pneumonia. It meant that patients were often coming in for a few days and then going home, particularly with the Omicron variant. For those who become more unwell and need more support, we have close liaison between the emergency department, the wards and the intensive care department. Patients are taken to the intensive care department if they need advanced oxygen therapy or airway support. There is a flow of patients from ED to the wards, to the ICU and then back again.

That combination of therapies and treatments, and having specialists and trained nursing and allied health staff, has been very successful. I think it has contributed to our good mortality and morbidity rates in the ACT.

I will touch on a couple of other therapies that have been available in the ACT more recently. The monoclonal antibodies are a preventive treatment for people at risk of severe pneumonia. Before they require oxygen, if you give them this antibody therapy, it reduces the risk of hospitalisation. Over 250 doses of that medication have been provided through the COVID Care@Home program and through the hospital. More recently, we have had access to the oral antiviral therapies such as Paxlovid and Molnupiravir, which are again highly effective in reducing progression to severe pneumonia. We are moving more towards those oral antivirals as the pandemic moves forward.

MR PETTERSSON: That was very comprehensive. I have been watching the vaccination rates in recent times, and they are seemingly not going as gangbusters as they used to. Is there any thought being given to how we improve vaccination rates for youngsters?

Ms Stephen-Smith: There does seem to be, from the research that has been done, primarily interstate at this point in time, a ceiling on five- to 11-year-old vaccinations that is significantly below the community-wide vaccination rate. There is a much more significant level of hesitancy among parents around vaccination for their children. But that does not mean we cannot do better. We believe we can get to at least 80 per cent, but those last few per cent are the difficult ones.

One of the things that we are doing is continuing, as we have done with our equity to access program, specific targeted outreach to encourage parents with children who may not have good access to mainstream health services to get vaccinated. For example, we did a pop-up at Boomanulla Oval for the Aboriginal and Torres Strait Islander communities, working in partnership with Winnunga, to try to encourage Aboriginal and Torres Strait Islander families to come forward. It was not just for their children; Aboriginal and Torres Strait Islander peoples are also behind the wider population in terms of the numbers having had their booster shots.

I have just been reminded by Ms Cross that we opened up walk-in access to the AIS clinic during the Brumbies game. Originally, the AIS clinic was going to be closed during Raiders and Brumbies games, but last weekend, when the Brumbies played, they opened the clinic for walk-ins and got 300 walk-ins on that day, versus less than the 80 to 100 that they would get on a normal day. Cathie, did you want to expand on what else has been done?

Ms O'Neill: Certainly; I can talk about that from the actual vaccination clinic perspective, and our colleagues from the ACT Health Directorate might like to talk more about the equity to access program.

We all need to be particularly proud of the team that we have working out at the AIS. They have gone above and beyond to make sure they get as many vaccinations as possible into arms. They are constantly looking at creative and fun ways to draw people in, which included opening up to walk-ins for the Brumbies match. They worked very well with the game organisers to make sure there were some announcements during the game. They will continue to do that for future events that are held at the stadium.

The efforts they have gone to to attract kids into the AIS are really pleasing. If any of you have been out there with your kids, or heard about it, they have fun games for kids to play on the way in, they have a "stomp on the COVID", and they have stickers on the back of every chair. They were telling me the other day that the kids pick which chair they want to sit in, and they tell mum or dad that they have to go and sit in another chair, which makes a noise. They are constantly doing fun things like that.

You may have seen the superheroes day that we ran a couple of Saturdays ago. Whilst the numbers were down on what we would have liked, they were still one of the busiest days for kids for some time. They are working with our ESA colleagues about potentially doing a couple more of those, particularly when the second doses for children are due.

Dr Johnston: I have read and understand the privilege statement. Thank you for the questions. Previous speakers have covered it very well. As the minister mentioned, we held a very successful day in engaging our Aboriginal and Torres Strait Islander communities. The access to equity program has been highly successful across the rollout of our vaccination program in reaching out to those that are most vulnerable, and that are historically harder to reach, in terms of accessing health services and vaccination programs.

We continue to do that. The really promising sign from that day is that we were still

getting people attending for their first dose. Adults were attending for their first dose. We are never giving up on those who have yet to make a decision to start getting vaccinated, and there is ongoing community engagement there.

It is the same with our booster program. Fifty-eight per cent of all Canberrans aged 16 years and older have received a third dose or booster vaccine. We would like that to be higher, but there are a number of reasons that it might be lower than the uptake we saw for the primary course. Some of that relates to people having had COVID recently, so they are in the recovery phase and they are not yet ready to access their booster dose because they are still recovering. Others are choosing the timing of their vaccine, knowing that winter is coming and considering whether it might be of some benefit to them to wait; although our advice very strongly is that you can access that vaccine once you have recovered from COVID-19. Usually, that is four to six weeks after you have been diagnosed.

Ms Stephen-Smith: Mr Pettersson, just reflecting on the chair's earlier comment about Canberrans liking to be first, obviously, despite the numbers not quite being where we would like them to be, in both five- to 11-year-olds and boosters, we are well and truly leading the nation.

MR PETTERSSON: We like to hear that, don't we?

MS CASTLEY: Minister, I would like to chat about emergency department waiting times. On page 73 it talks about the four-hour rule. It says that the target was 90 per cent for 2020-21, but the actual figure was 57 per cent. The figures are particularly bad for category 3 and 4. We know these are approximately 80 per cent of all presentations to ED. Can you talk about why we are going backwards? The year before we were at 58 per cent; now we are at 57 per cent.

Ms Stephen-Smith: In terms of the reasons why we are seeing this significant pressure on the emergency department, we saw in 2020-21 high numbers of presentations. Over the two years—2019-20 and 2020-21; even 2018-19—we are not only seeing an increase in presentations but an increase in complexity. I am going back a little bit, but there were some quite stark figures where we were seeing significant increases in category 1 and category 2 presentations, which are more complex and generally take longer to treat. Category 3 goes up and down; category 4 and 5 were actually going down, in the context of overall increases in presentation.

That has changed a little bit over the last little while. COVID has had an impact in 2020-21 in terms of the requirements that are in place in emergency departments around needing to have those COVID protocols in place. I might hand over to Ms O'Neill to talk, from Canberra Hospital's perspective, about what is being seen. From my discussions with Calvary Public Hospital, they have seen very similar challenges in managing their emergency department demand.

Ms O'Neill: What we have seen, particularly in this financial year, is some steady improvement across all of our KPIs in the emergency department. We are still not where we would like to be, but the team is working very hard to start to achieve these numbers. We have seen in the last couple of months the NEAT finishing the month in the high 50s and early 60s, which is the first time we have consistently seen that,

month after month, for a number of years.

The team is working hard on a range of different approaches. One of the things that we commenced earlier this year—in fact towards the end of last year—was an acute medical unit model. We are—it sounds like a terrible term—"pulling" patients. That indicates we are being quite active in their management—pulling these patients where, on presentation to the emergency department, it is clear that they have a number of conditions and it will take some time to sort out what is going on for that person and determine their ongoing plan.

We are managing those people in a different area. We have moved some resources to make sure that there is a higher level of medical resource there. Dr Swaminathan might like to talk about this, given that he has established the unit. We are starting to see some significant impact as a result of that unit.

We are also doing a lot of work around flow of people through the emergency department. We have increased the seniority at the front end of when people present to the emergency department. We have introduced some senior nurse navigators and senior medical navigators so that we can make sure that we are not losing time anywhere through that whole patient journey.

We are also working very hard with primary health care to make sure that patients are not coming into the emergency department where they do not need to. We have continued to work with our community to make sure they are aware of some of the other areas from which they can access health services, and particularly the walk-in centres.

You might have noticed, particularly on some of our social media channels, that we are starting to use some case studies from the walk-in centres, because the term "minor illness and injury" is really subjective. We are trying to get some real case studies out there in the community so that they can understand what is appropriate for them to present with, when attending the walk-in centres.

Our numbers in the walk-in centres did drop off a bit during the first COVID outbreak, but they are coming back to our pre-COVID levels. We would continue to encourage the community to access those services.

Dr Swaminathan: In terms of the acute medical unit, it is an initiative that we are very excited about. We know that patients who are admitted into hospital are more complex and take longer to sort out. They are often identified relatively early on in a presentation to the emergency department; they are needing oxygen, they are needing intravenous antibiotics or fluids or they have a very complex social situation at home that will require longer than four hours to sort out in the ED.

We know that if we take them away from the ED environment into a space where there are the appropriate medical, nursing and allied health teams, we can start them on the journey of their medical admission from an earlier point and coordinate their stay in a better way. Rather than waiting until the next day or waiting for a long period of time in the emergency department, that can be done within hours of presenting to the ED.

We have set up a pilot ward next to the emergency department that we have staffed with medical, nursing and allied health staff, where we are pulling patients across, we are doing an early medical review, an early pharmacist review, to make sure that they are on the right medications, and getting all of the nursing comprehensive work-up done at an early stage.

We are working to make sure that there are clinical pathways for the common DRGs. These are common diagnoses for patients coming into hospital, such as pneumonia, COPD and skin infections, and we protocolise many of these things so that people are started on the right treatments from the get-go, and that we try and reduce the variation in care. We know that if we reduce the variation in care, we will reduce the variation in outcome. By getting them on the right treatment at the right time, managed by the right people, we will aim to reduce the overall length of stay and improve outcomes.

MS CASTLEY: My concern is not that the nurses and doctors are not working hard enough, or the other staff—pathology et cetera. I have no doubt that they are, as I said before, killing themselves to get people seen on time. Minister, my concern is about the 43 per cent of people that are not getting seen within a four-hour period. What do you say to them?

Ms Stephen-Smith: It is not that people are not getting seen within a four-hour period. The four-hour time is for either admission to hospital or discharge home. That would include your waiting time to be seen and your treatment time. That is what the four hours is measuring, and the waiting times are dependent on the category, as to how long you wait for your treatment to be commenced. I have said many times, Ms Castley, that these waiting times are not where we would want to see them, particularly for patients who are arriving in category 3. We do extremely well on category 1, as you would expect; these are resus patients. We do very well on category 2 seen on time.

It is really the category 3; as I have explained in previous hearings—and others can correct me if this is now changing—it is changing over time. There are the category 1 and category 2, which are super urgent, and we have got to see those people; then others are seen largely in order of arrival. But because the recommended time to start treatment is lower for category 3, that means you end up getting fewer category 3 people seen on time than category 4, where you should commence treatment within this time. You have this kind of V-shaped outcome in terms of seen on time.

With the NEAT, the four-hour is a different thing, because it includes both your time to commence treatment and your time to complete treatment and either be discharged or admitted to hospital. Dr Swaminathan was talking about speeding up that process of admission into hospital, coming out of the emergency department. There is a lot of work that sits behind the implementation of that model and the other initiatives that are taking place in the emergency department.

Our teams have done an incredible job in analysing the patient experience and the flow through the emergency department, and trying to understand where those blockages are, of which there are a range, but one of them is getting people admitted

in a timely way and drawing them out of the emergency department.

MS CASTLEY: What is category 3? If I bring in my daughter with a broken arm, is she part of that 43 per cent, Minister? What are the 3 and 4 categories?

Ms Stephen-Smith: I am definitely throwing to Dr Swaminathan on this one.

Dr Swaminathan: It is to do with triage categories. When you present to the emergency department, depending on the severity of your illness, you will be triaged into one of five categories. Category 3 is recommended to be seen within 30 minutes of arrival.

MS CASTLEY: What does that look like? What am I coming to hospital with, if I am classed as category 3?

Dr Swaminathan: Usually, you need some semi-urgent therapy. You might need some intravenous fluids—not intravenous pain relief, but some pain relief, because you have a backache or something like that. Within half an hour you need to be seen, as opposed to a category 2 or a category 1. In triage category 1, you might be unconscious, or you might not have any blood pressure and you need to go to the resus cubicle, or you are having a heart attack.

MS CASTLEY: I am trying to understand; Minister, these targets have not got any better. There have been so many years when they have been struggling. When Canberrans present to hospital, they are not getting seen in a timely manner or the recommended manner by ACEM. Specifically, what are you doing, and what do you say to those people that are struggling with category 3 and 4, which are so badly lacking?

Ms Stephen-Smith: One of the things we are doing is making significant investments. That includes the $23 million investment that we made in this budget into the Canberra Hospital emergency department and these related initiatives. As you might be aware, Ms Castley, in recent years we have increased the size of the Calvary Public Hospital emergency department by 50 per cent, in terms of treatment spaces. That increased the number of treatment spaces that are available across the territory by around 20 per cent.

With respect to one of the challenges in this space, we get feedback from people who have struggled with their wait in the emergency department. We also get incredibly positive feedback from people when they turn up to the emergency department and they really need care, they get that care and it is outstanding care. The majority of the feedback we get from the emergency department is really positive feedback.

Most people recognise that this is a service where you do not have to make an appointment; you turn up. There are quite likely to be people who are in more need than you of urgent care. Most people understand that if their need is not super urgent, it is quite likely that they will have to wait for a little while. Waiting for an extended period is frustrating and does not lead to good health outcomes. The feedback that we generally get is good, but we know that we need to do better, and that is why we have invested $23 million in the most recent budget in this range of measures and models

of care, as well as in additional doctors, nurses and allied health professionals. There is all of the work that is also going on across the hospitals to improve patient flow, and enable those admissions from the emergency department into the rest of the hospital.

MS CASTLEY: Minister, these are your—

MR PETTERSSON: I have a supplementary.

MS CASTLEY: targets that you set. You have set these targets, and 43 per cent of people are not being seen, according to your targets. What do you say to those 43 per cent, not the happy ones?

Ms Stephen-Smith: It is not good enough and we are working very hard to do better.

MR PETTERSSON: I want to follow up on the acute medical unit that you mentioned previously. What is the workforce involved in that unit and what does the future of the unit look like?

Dr Swaminathan: The workforce. At the moment it is a 12-bed unit in an area adjacent to the emergency department. It is staffed by nurses in a one-to-three patient-to-nurse ratio. Yes, patient-to-nurse ratio, one-to-three. And we have a registrar. So, there is a mid-level doctor, with a junior doctor through the day. The registrar is there 24/7; the junior doctor is there from 7 am until midnight. That is the current pilot.

The next step is to have a consultant in that space as well. That is when we will particularly be able to reach into the emergency department and pull the undifferentiated patients from the emergency department—patients that we are not quite sure what the diagnosis is, but we know they need to come into hospital and need more work-up. That is the next step of pulling them into the acute medical unit. In terms of other workforce, it is a pharmacist, a social worker and access to some other allied health such as an OT and dietitian, as required.

MR PETTERSSON: It currently has 12 beds. Is that because it is currently in a trial phase or is that the demand for that kind of model of care?

Dr Swaminathan: This current model is 12 beds, and we are aiming for a median length of stay of 12 hours, so it is a fast turnover unit. It is trying to pull them from ED, work them up and then move to the right ward. The future model that we are aiming for is a 48-hour model, where it will have more resources, particularly medical and allied health staff. The aim for that model is both to do what we are doing now—pulling patients from the ED and creating capacity within the emergency department to see more patients—but also to reduce the length of stay of the patients that traditionally stay between two and five days in hospital—really fast-tracking that within 48 hours.

The aim is to get all the assessments done, all the radiology and all the imaging and having that done within a 48-hour period, and then discharging them to an appropriate discharge destination such as a rapid access clinic or to Hospital in the Home, to a

community resource or back home. That is the model we are heading to, and we are hoping to have that model up by next year.

MR PETTERSSON: It sounds like a wonderful initiative.

Dr Swaminathan: Thank you.

THE CHAIR: I will move on with a substantive question. Minister, I want to talk about the occupational violence strategy. I note that one of the key achievements from CHS was the implementation of the strategy, and that it saw a 23 per cent reduction in reported operational violence incidents within the nursing and midwifery patient support services division in the last financial year.

That is great, but the reason it is top of mind for me is that at my weekly electorate office I met with a nurse last week who put it to me that, anecdotally, that figure is not necessarily borne out by their experience. I would like just a bit more insight into how that strategy is going in its implementation and then, more broadly, what work is being done to make sure the entire workforce is being brought along that process.

Mr Peffer: Yes, thanks for the question. I might lead off and then I might get some colleagues from the hospital to chime in. This has been a sort of key focus for the organisation. We recognise the importance of people feeling safe at work to them feeling productive and being able to contribute, which is why it has been central in terms of investment, but also leadership focus, over the last couple of years.

What we have been trying to create is the situation where we know that the data is sound in terms of reporting. A couple of years ago, if you talked to any of our team members, they would tell you that occupational violence is occurring across our health facilities, and not just with frontline workers either. People on the end of the phone are constantly dealing with some pretty tough stuff as well.

So we knew we had a reporting issue in terms of what we were actually capturing and what was happening on the ground. There has been a tremendous focus over the last couple of years to encourage people and provide confidence to our workforce to speak up—that this is not part of their job; this is not acceptable behaviour that we just have to tolerate day after day; that it is behaviour that has to be reported so that we can look at what controls we can put in place and then at supports for parts of the workforce.

We have seen across pretty much every division a stepwise improvement. However, we accept that that is at a global level, and that there will be teams and certain facilities within our health service that are doing it much tougher than other teams. There could be a range of reasons for that. It could be simply the time frame for when we are rolling out training or providing certain devices—that sort of thing. It could also be the patient cohort that they are dealing with. We have particular teams in our health service that deal with some really high-risk people—people with a range of challenging behaviours, people with violent behaviours—who come into the health service. They need intensive care from a variety of teams and that creates a risk environment where we have to do everything we can to protect the workforce. But just coming to that—

THE CHAIR: Mr Peffer, I hate to cut you off, but I want to ask about this. I do not think people get into frontline healthcare with any naivety about the risk of working with vulnerable people or people with complex needs; but what we have heard about for some time, and what I continue to hear about from at least some constituents, is about the bullying and the occupational violence between staff and from management. I would be really interested in fixating more on those challenges that are not only within our control but seem to be unique to our health system, whereas some of the challenges you suggest around working with people with complex needs, I imagine, would be the case in any hospital.

Ms Stephen-Smith: I do not know that I would describe instances of bullying and harassment as being unique to our health system. I think you would see—

THE CHAIR: That is probably fair, Minister. That is probably fair. I will rephrase that as being something that we have identified as a challenge for our health system—

Ms Stephen-Smith: Absolutely.

THE CHAIR: —and so I probably want to fixate a bit more on those instances.

Mr Peffer: Okay. I will shift focus slightly in terms of what is happening within our workforce. I guess it is always important to start with the data. Late last year we did an organisation-wide survey. We had in the order of 4,000 of our team members provide a response to that survey and I guess there was a glimmer of hope in terms of the direction that we are travelling. The results that came back through that survey indicate that since we started doing the survey in 2005 we have roughly doubled the level of engagement within the workforce. It was the most positive culture we have seen in over 16 years. Having said all of that, it certainly was not the case that, as a workforce or a leadership team, we sat back and thought, "Bonza, it's hands off; we can just ride this wave of mediocrity." We stepped back and acknowledged that there is still a lot more work to be done.

But drilling down into the survey results, it goes into quite a granular level of detail around bullying and harassment behaviours between team members, behaviours between supervisors and managers, leaders within the organisation and the broader workforce. We acknowledge we still have a problem in Canberra Health Services. This particular problem around bullying and harassment is not unique to our health service, but through the survey we got an indication from 4,000 of our team members that, in terms of those who had been subject to bullying and harassment or those who had observed it occurring in the workplace, there was an 18 per cent reduction. So that is real data from thousands of people.

Now, that is not every workplace. In some workplaces they will still be doing it really tough. We absolutely acknowledge that, and we have a lot of work to do to get in there and sort that out. But, broadly speaking—and the advice given to us from the survey is that it is statistically significant—we are seeing improvements, we are seeing reductions within our health service.

Coming to the point of the question about what we are doing, as a leadership team we have been really clear on drawing a line in the sand and saying, "Enough is enough;

we are not going to tolerate certain behaviours." From my perspective, and in my role, I have a particular focus on the leaders in our organisation and their behaviours and how they look after our workers. These guys are out there every day, frontline, delivering for this community. We owe it to our workforce to be looking after them and to be exhibiting behaviours that are in line with our values, being respectful and kind.

THE CHAIR: I have just one supplementary before I go to Ms Castley. I am happy if these are questions you need to take on notice. In the reporting period, how many staff have been performance managed because they have been the perpetrators of bullying and harassment, and how many staff have subsequently been terminated by ACT Health because they are the perpetrators of bullying and harassment?

Mr Peffer: I think we will be able to get those numbers for you, Mr Davis. If we cannot do that very quickly, we can provide them on notice. Just one thing I will observe: there are a number of individuals who, once we commence an investigation, will self-select to leave the organisation. So it is not always that you commence an investigation, see it through, and then termination is the outcome. We do have a number of individuals who have self-selected out of Canberra Health Services.

THE CHAIR: You may regret saying that, Mr Peffer. What I would also appreciate on notice is some indication about how many staff you believe that situation may be the case for.

Mr Peffer: Okay, we will see what we can pull together.

MS CASTLEY: Minister, given that you are responsible for the health system, how do you respond to the staff members that are subject to serious bullying and harassment? It is quite a concern. What are your thoughts? What do you say?

Ms Stephen-Smith: Like Mr Peffer, I think it is totally unacceptable, and we are working really hard to seek to address those challenges, both in relation to bullying and harassment within the workforce and inappropriate and uncivil behaviour, but also occupational violence. Going back to Mr Davis's original question, there are a range of strategies, one of which is the roll out across the system—so, in both Canberra Health Services and Calvary Public Hospital—of Speaking Up for Safety. That is a training course that others can speak a little bit more about. It is being rolled out right across the system to every level and type of staff so that everyone is speaking the same language around being able to speak up when they see something going wrong in the workplace.

Now, this is around patient outcomes and quality of care, but it is also around inappropriate behaviour in the workplace. Led by the Chief Nursing and Midwifery Officer, we have also been working on the Towards a Safer Culture project with our partners in the Australian Nursing and Midwifery Federation. That includes rolling out things like safe wards. We are piloting the safe wards program across a number of sites. That is about improving interactions and behaviour, primarily between staff and patients, and creating joint expectations and reducing the incidence of seclusion and restraint for patients, but really being able to de-escalate or prevent the escalation of conflict in those work environments. That is primarily around the interaction between

patients and staff, but it also has a positive impact on changing the work environment and giving people the skills to manage stressful conversations without them escalating. Do you want to speak a bit more about Speaking Up for Safety?

Mr Peffer: Yes, I certainly can. I think we have Ms Smitham on the line as well, who might be better placed to talk about some of the detail. This is a program that we are rolling out across the organisation. We looked for volunteers across our workforce, so we have medical officers, allied health, administrative, nursing and a range of support workers in there who have trained up to deliver the training. So it is not an external organisation coming in that no-one knows delivering the training; it is our own team members who are fronting-up in front of their colleagues, in front of our workforce, and delivering this training. Many thousands of our team members have been through that. I know Calvary Public Hospital has seen quite a good response as well. I might hand over to Ms Smitham to talk about this initiative, because it is an important one for us.

Ms Smitham: I acknowledge the privilege statement. I would like to concur that bullying and harassment is a really important issue in any workforce, and it is an issue that absolutely impacts all employers across Australia and the world. It is an issue that is also very well known to be a challenge for health services, in particular. With challenges and issues around structural influences like the way that staff move through their training and career progression in a health environment, there are some other issues that really lead to making bullying and harassment particularly challenging in a clinical environment.

There are several things that Canberra Health Services—and in shared activities with the Health Directorate and with Calvary—has done to look at bullying and harassment. The first is that we have started with our values. CHS is very, very strong on values. Mr Peffer just spoke to that in terms of expected behaviours. CHS has spent the last few years being very strong around what our values are, how those translate into acceptable and unacceptable behaviour, and how to work towards being clear with our workforce about what is expected from them. Secondly, there is awareness. We have training and onboarding when you start with us. Also, for staff and managers there has been training around acceptable behaviours, our values and working civilly with each other. Also, for managers, there has been training around working with their staff in managing appropriate behaviour.

Then the next intervention is around reporting and making sure that there is appropriate reporting. I should say, Speaking Up for Safety is one of the training modules we do. I am waiting for the latest numbers, but about 60 per cent of our workforce have been through Speaking Up for Safety, which is creating a common language amongst our workforce. From a reporting point of view, there is a range of ways that staff can report bullying and harassment. That is from doing a RiskMan report, which is in our risk reporting system. They can go to a REDCO colleague, who is someone who is trained in understanding workplace issues. That is particularly important when it comes to issues that relate to intersectionality around lateral violence and some of those sorts of more complex issues that can occur with bullying and harassment.

Also, we are in the process of rolling out Promoting Professional Accountability,

which is actually the second stage of Speaking Up for Safety. It was part of the cultural review work that has been done. Promoting Professional Accountability is where, if there is an issue around behaviour in the workplace—particularly if it is from a clinical colleague or a more senior colleague—a staff member can report it through a hotline. It is triaged and a peer is briefed and sent to speak with the senior colleague and say: "Hey, did you know that what you did the other day was not received very well? Do you want to have a think about it? Let's talk about it." So it is peer-to-peer work around improving workplace communication and behaviours.

Then there are interventions. How do we intervene? One of the things that the People and Culture team is doing now is to review every single RiskMan report that flags bullying and harassment. Our culture survey also flags every reference to bullying and harassment, and all of them are followed up to check that the manager has appropriately intervened. Sometimes managers do not know the best way to deal with this situation, so we are checking that they have appropriate HR support.

Then, finally, we have introduced a fair amount of supports for our workforce around supporting their psychological wellbeing and making sure they are supported through processes, particularly when they raise complaints, because it can be very stressful when you are raising a complaint about a colleague or someone more senior to you. So it is a holistic approach but, as Mr Peffer said, there is a lot of work to do. It is a big workforce that is working 24/7, so there is still a lot of work to do in this space, but we still have a good program of works that we are implementing to address this.

MS CASTLEY: The independent review that was done in March 2019 said that there were 20 recommendations that the government would implement. I believe that that is due in May this year, but a report to the Assembly said that we have only five of those recommendations completed. I think that was the update.

I was just wondering, Minister, if you could give us an update on where we are with those recommendations. I would like a bit of information about the pulse survey, because the staff who completed the pulse survey, when asked if they would recommend it as a good place to work, the number dropped by 10 points. So there are a few statistics I would like to know about across the pulse survey and that independent review.

Ms Stephen-Smith: I am happy to speak to the review recommendations and then I might ask Mr Peffer to talk about the pulse survey, because that pre-dates the results of the more comprehensive survey that we have just been talking about. I think the last time we talked about this in the Assembly, Ms Castley, eight of the 20 recommendations had been completed. As at the last Cultural Reform Oversight Group meeting on 14 February, there were nine recommendations that had been completed.

But that is not a full picture of the action that has been underway. A total of 92 actions were identified as being needed to be completed to implement the 20 recommendations of the review in full. Of those, 65 have been completed, six are pending approval for closure, and 13 actions are in progress and on track to be delivered by the agreed date. I think we are planning for the end of June this year to be the preferred close-out date of the culture review implementation work.

That leaves 12 actions that have been delayed by more than 12 weeks, and two actions that are at risk of being delayed by more than 12 weeks. Given the impact of the COVID-19 pandemic across our health system, it is a pretty good outcome to have completed so many of the actions that were identified. The work really had only just got cracking when COVID hit, so I think that this is a real testament to the fact that people have continued to be committed to the culture reform work and have continued to work on it while the frontline system has been very busy. Obviously, we have been dealing, within the Health Directorate, in responding to a global pandemic. I do not know if Ms Cross wants to talk any more about that.

Ms Cross: I would just add that the minister identified 14 recommendations that were delayed. They are all being actively managed, and we expect that they will be finalised by 30 June when the program ends. Ideally, they would have been finished earlier, but they should still be completed within that time frame.

MS CASTLEY: Thank you. To confirm: you believe you are on track to finalise all 20 by June?

Ms Cross: All 92 actions which relate to the 20 recommendations.

MS CASTLEY: I know they relate to the 20—

Ms Cross: By achieving that, we will have met the 20 recommendations.

MS CASTLEY: Thank you.

THE CHAIR: Great. I have just one more supplementary question. I just want to check up on—

Ms Stephen-Smith: Sorry, Ms Castley had a second part to her question about the pulse survey.

Mr Peffer: I will answer very quickly in terms of the pulse surveys that we run. Every couple of years we do a very comprehensive survey. That is the survey that I just mentioned, which was wrapped up late last year. That is a time-intensive survey for our team members to fill out. There are a lot of questions. I think it is in the realm of 100 questions that people need to work through. We cannot do that every three months, because by the time the data is collated and it is put into artifacts that we can then share with the workforce, we would be in the process of sharing the results when we were running the next survey. So we intermittently run a series of pulse surveys—I think we did roughly three in the last 12 months—to check in with the workforce and see how they are tracking. They are much shorter surveys. They have around eight to 10 questions in them. Some of those questions change between the surveys, just to give us a sense of what is going on.

The pulse survey that you mentioned, Ms Castley, is an older survey compared to the one that I was talking about. In the most recent comprehensive survey, for the first time in, I think, two decades, Canberra Health Service surpassed the average level of engagement of global public hospitals and health services. So we have actually

pushed past the average. But for us, that is really just a starting point, because we have a commitment to a great place to work. So we are on the right trajectory, but with a lot more work to be done.

MS CASTLEY: Thank you.

THE CHAIR: Ms Smitham, you mentioned supports that are provided to staff members who make a complaint about being on the receiving end of bullying and harassment. I just want to get a bit more specificity about that. Are these supports that are offered once the staff member comes forward and says, "I would like to make a complaint."? Or are they a little more proactive? Are staff aware that adequate supports will be provided and what those supports will look like more broadly across the organisation so that they can be encouraged to come forward and make a complaint if necessary? I just want to get a bit more specificity there.

Ms Smitham: Sure. We do both. We have a workplace resolution and support service that actually reports to the Office of the Chief Executive. That is available to staff to raise issues and concerns and seek support from at any time. Often that is the first port of call to go to when somebody is maybe thinking about raising a complaint or concern about a colleague or a manager.

That team is staffed with social workers and other health professionals who support the person in what are they going to do, how are they going to do it, what are the likely outcomes. They will even come to the meetings and support the person in the meetings. They are very good at actually assisting the employee to know what the best course of action is in terms of their issue, because sometimes the employee does not even know what they should do with the issue that they have got. We have that.

Then we also have Converge, which is the territory-wide employee assistance program which has recently been to tender and been awarded to Converge. They are a new provider and they are excellent. We are getting really fantastic feedback, actually, from them about a range of interventions. They have done interventions that relate to particular incidents that have occurred in the workplace. They did interventions in relation to workload pressures related to COVID, but they also provide individual confidential support to staff.

Then we proactively assign support to staff as well, depending on the situation that they are in. If you are in an injury-management situation where you are returning to work after a motor vehicle accident or something, we assign a support person to you. It depends a little on what the issue is but there is a broad range of support available, including peer support. In nursing and medicine there are Blue Buddies and Green Buddies, who are actually there to provide peer-to-peer support.

There are quite a lot of different ways that you can access support in the organisation. There is an intranet page that provides all the information about whom you can contact about what. The medicine and nursing specialties have their own pages as well in relation to their own supports that are available.

THE CHAIR: One supplementary always leads to another when I get on a tangent. What was that first group that you spoke about? Sorry for my scatterbrain.

Ms Smitham: I have got a scatterbrain now too.

THE CHAIR: Where people could go with the employee—

Ms Smitham: The workplace resolution and support. Workplace resolution and support service.

THE CHAIR: What relationship, if at all, does the workplace resolution and support service have with the union? In my mind, conventionally if a staff member was going to broker some sort of workplace conflict, I would usually imagine them to be represented or supported by a union representative. If the support is being provided by a network within their employer, I just want to know where the union interacts at that moment.

Ms Smitham: That is usually at the will of the employee. Sometimes we would suggest the involvement of the union, depending on the nature of the issue. Sometimes they are in it and sometimes they are not, because not all our employees are union members. I have had experiences with workplace resolution. Sometimes the union is with them, sometimes not.

THE CHAIR: That is good to know.

MR MILLIGAN: My question is in relation to strategic objective 2 in the Health Directorate. Under this section you mention that you are currently developing a territory-wide health services plan. I am just wondering is this replacing a current health services plan or is this something completely new.

Ms Stephen-Smith: The draft territory-wide health services plan is in my in-tray at the moment for comment. I am nearly finished sending my comments back to the directorate. We will soon have a territory-wide health services plan finalised. It is a new thing, and part of the reason it has taken a little while to get it finalised is that it is a new thing. It will then be a living document that will be updated on a regular basis.

We know that our demographic has changed; the technology changes; we identify new challenges in the system. Obviously COVID has thrown us a complete curve ball over the last couple of years, but we have also become, for example, a lot more aware of the challenges that LGBTIQ+ people have in accessing mainstream health services and the need for specific services to support transgender people and their particular support needs. Those kinds of things evolve over time. I might throw to Ms George to talk about, from the directorate's perspective, where that is up to other than the fact that it is sitting in my in-tray.

Ms George: I have read and acknowledge the witness statement. As the minister said, the draft plan has been submitted for consideration. We have worked since the consultation period in June and July last year to update the plan from feedback that we received, particularly with respect to the readability and how people were interpreting what was largely a very clinically based plan. We have done that piece of work.

Also we have needed to go back and review the content of the plan for updated

information such as how we would look to treating long-COVID or dealing with people who have long-COVID or in fact the continuing COVID pandemic. We have also, because the system has been under stress with responding to COVID, looked at the time frames that we had originally set in the draft plan for achieving some of the actions there.

MR MILLIGAN: This is something new. What did you have in place prior to the implementation of this? What type of health plan did you have, a territory-wide health plan, before this? Anything? Or not?

Ms George: There have been, at various times over the past, clinical services plans for the territory that were planning documents and not released publicly, but there has been a gap of a number of years where there has not been a plan that looks across the territory at how we will develop services.

Ms Stephen-Smith: I think the territory-wide health services plan was instigated by Minister Fitzharris actually, in recognition of the fact that there did tend to be a bit of moving from one urgent thing to the next and responding to the various calls for new activity or increased demand that did not sit underneath this bigger framework. She instigated the process of first establishing a new territory-wide health services framework, which is out and is public and sets the key objectives of the system. Sitting underneath that is the digital health strategy, the quality strategy, the territory-wide health services framework and a range of other activities.

It really is about setting out a really comprehensive strategic framework for the territory-wide health system, as opposed to the hospital a lot of the time pushing the agenda or then something else coming along and pushing the agenda. The intention of this is to give us a framework within which to understand and be able to assess the competing demands across the system, recognising that our resources are not infinite.

MR MILLIGAN: I was going to ask what led to this. Were there failings in particular areas where the government went, "We actually need something in here. We have not had anything in this space before."? Was there anything in particular that instigated this? I know COVID probably contributed to it but was there anything else? I see it is going to be over the next five years. Is there going to be any sort of review or feedback after every 12 months or something to update this plan? Is it going to be a fluid plan and how can people contribute to providing any feedback?

Ms Stephen-Smith: Yes, it absolutely will have to be a living document to some degree because, as I say, things change. Ms George might have a little more of the history part of it as to when the idea was presented as a territory-wide services plan.

Ms George: A number of planning discussions were held, I understand, in 2017 and 2018 with various specialties about how to develop a territory-wide focus to our planning. In response to your initial question, it is not unusual for a jurisdiction or a local health district to have a plan that puts in place the strategies, the priorities for moving forward for the future. I guess it was more a situation where our individual health services had plans to go ahead but, at that point in time when that work began in 2017, there was no coordinated territory-wide approach.

Ms Stephen-Smith: Part of this is driven, I think, by the increased demand that we are seeing, the need to understand the capability right across the territory and to be able to think strategically about where each service is best placed to deliver, to specialise, to take the load off one service, to redistribute activity. This is helping us to think through that.

MS CASTLEY: I find it crazy that there has been no territory-wide plan. In the smallest of projects there is always a project plan. This is Canberra's territory health plan. Did you say that you started the draft in 2017?

Ms Stephen-Smith: There were some consultations in 2017-2018, I think Ms George was saying. I think this started around how our clinical specialties start to work better territory wide. Then that developed into the territory-wide health services plan.

Ms George: That is correct. They were given the term, I think, "speciality services plan". Quite a lot of work was done by clinical teams on that, and that has now been drawn up into a territory-wide health services plan.

Ms Stephen-Smith: I think it is important to say that the fact that we did not have a territory-wide health services plan does not mean that there has not been planning of the health system. There has been a lot of planning of the health system over a long period of time. I am sure that there are former chief ministers who would be very upset at a suggestion that there might not have been planning of the health system when they were in charge.

It is about actually bringing all those bits of planning that have been done together into a framework and, as I say, rather than thinking about each service individually, actually thinking about how we deliver territory wide in partnership with our non-government organisation partners, general practice; really knitting the system together, I guess, whereas each bit has previously operated a little more with its own plans and its own priorities; and then somehow the government has to bring it together in a range of policies but without that sort of overarching analysis and framework to guide that.

MS CASTLEY: Minister, do you think that these different plans that you are now bringing together—them having all been separate as such, if I am understanding you correctly—have contributed to some of the situation we find ourselves in with the waiting times and the ad hoc building structure of the hospital?

Ms Stephen-Smith: I do not know if you could say that. I have been minister for just over 2½ years. I am not really in a position to comment on the five-years-ago situation and how decisions were being made. I certainly do not want to be casting any aspersions on that because there is always planning and there is always work that is being done to understand what the demand is in the system. That has been an ongoing thing.

This is the evolution of that work, I guess—not to say that it has not been happening, but that it is evolving and, as Ms George said, is actually now being presented publicly as opposed to being an internal planning document that the directorates are basing their decisions on. This is actually about saying to the community, "This is

what we have heard from you, this is what our analysis is showing us and this is where we are heading as a territory-wide health services planning," as opposed to the internal documentation that has always been used for planning.

MS CASTLEY: When can we see the plan? When do we expect it to hit the public?

Ms Stephen-Smith: I am now expecting it in the next couple of months.

MS CASTLEY: By June?

Ms Stephen-Smith: Yes, I hope so.

MS CASTLEY: I will hold you to that, Minister.

MR PETTERSSON: In the 2021-22 ACT budget funding was provided for Calvary public to commence a 24/7 medical imaging service. Has this now commenced and how does a 24/7 service improve the hospital?

Ms Stephen-Smith: I understand it has commenced. Ms Smitham.

Ms George: The 24-hour medical imaging service did commence on 31 January this year. That means that patients who come through during that period overnight, where there previously was an on-call service but not a 24/7 planned service, can receive their diagnostic imaging to allow them to be moved through, treated through, the emergency department and on to the care that they need quicker.

MR PETTERSSON: What was happening previously with the on-call service?

Ms George: Previously there was a clinical decision made whether the imaging department on-call service, the staff, needed to be called in to undertake imaging or whether the patients would go home and come back for their imaging when the service was next available or whether patients would remain in the emergency department or other part of the hospital until such time as the imaging staff were working.

MS CASTLEY: I would like to chat about the walk-in centres. The nurses there are working so hard. Between January and July last year there were fewer than 50,000 presentations at the five walk-in centres, which does include Dickson, which I believe is now closed until further notice. Minister, I am wondering if you could talk me through this 50,000 presentations figure and how that compares to figures since the walk-in centres opened.

Ms Stephen-Smith: Ms O'Neill.

Ms O'Neill: I will need to take on notice the specific numbers, and we can provide you information across the years so that you can see how that has changed. I mentioned earlier we did see a drop-off in presentations to the walk-in centres during the lockdowns. That was consistent not just across our jurisdiction but all jurisdictions. I think people felt uncomfortable being out and about and, particularly, accessing health services.

But we have done a lot of work with the walk-in centres to improve their visibility. We have done lots of work with the GP community to make sure they are very comfortable with what we are doing, and we are constantly reviewing the protocols that the nursing staff use within the walk-in centres to ensure that we continue to meet the need of people in the community, with one of the major drivers being reducing the triage levels 4 and 5 presenting to the emergency department.

MS CASTLEY: Minister, can you talk me through the cost of presentations for all the centres? Is it the one cost for each person to see a nurse?

Ms Stephen-Smith: For the patient themselves, it is a free service but the cost of the service obviously would vary depending on how long the person is being treated. We do have some figures on average cost that change over time and will change with the number of presentations. I do not know if Ms O'Neill has any of that with her.

Ms O'Neill: We have not done a formal cost analysis of the service for some time. The denominator has a significant impact on the cost per unit because many of our costs are fixed. They have come down significantly since the original evaluation that was done. We are sitting somewhere around the $160 per presentation, depending on volume. It is a bit dynamic.

MS CASTLEY: Is that end-to-end, that income, versus the whole cost to the government of the cost of the walk-in centre per person walking through the door et cetera?

Ms O'Neill: Yes, it does.

MS CASTLEY: Can I get some stats on how often the walk-in centre has to call an ambulance to get somebody to ED, and are those costs included in that $160 per person?

Ms O'Neill: No. The costs just involve the actual treatment and supplies within the walk-in centre. We report on what is called the redirection rate out of the walk-in centres. That includes not only those patients that are redirected to the emergency department but also those where the nurses think further follow-up is required and where they have referred them back to a GP or, if they do not have a GP, they actually actively work with the consumer to identify an appropriate GP. Again, these numbers are pretty dynamic but the average redirection to the emergency department sits at about three per cent.

MS CASTLEY: Why does the annual report not show government-set targets for the nurse-led walk-in centres?

Ms O'Neill: We made a deliberate decision in discussion with many stakeholders that a target for a walk-in service was not appropriate. We are not going to stand outside with the sandwich boards if we are not meeting the targets. We did not feel that that was a good indicator to reflect performance.

MS CASTLEY: Of course not. I am wondering more about funding, costing and

projecting—how you fund the walk-in centres if there are no targets. Is it just a finger in the wind and hope that there is enough money to cover it at the end of the year? I have one last question. I am happy for you to take it on notice. Is the Dickson walk-in centre going to be reopened at any time in the future?

Ms O'Neill: We are constantly reviewing the inner north walk-in centre. We needed to shut that centre so that we could redirect some staff to staff the Garran clinic. As we discussed earlier, we have significant pressures on our workforce. We are trying not to stretch them too thinly. The inner north walk-in centre was the most recently opened of the walk-in centres, and we are still building its clientele. Because of its relative proximity to other walk-in centres, we felt that was the most appropriate to temporarily close.

The team is currently working on the staffing model so that we can look to potentially resume the inner north walk-in centre, although heading into winter we will be, I think, requiring a continuation of the Garran centre. That is still in a bit of a state of flux.

The first question was about how we staff it and fund it. The great limiting capacity for the walk-in centres is that there are four rooms; so we cannot see more than four patients at a time. We staff according to some safe-staffing models for those rooms across each of the services. We have also become a little more mature over time in mapping the trends of presentations. For example, we know that the weekends are busier than some times during the week, and there are other shifts where we constantly see increases in presentations across the centres. We adjust the rosters to ensure we have got optimal staffing to meet that demand. That is constantly being reviewed.

MS CASTLEY: Minister, can you tell me when you will reopen the Dickson walk-in centre?

Ms Stephen-Smith: I need to be really clear that I am not going to make a request/demand of Canberra Health Services to reopen the walk-in centre when the staff are too stretched to do that; so it really will depend on what we are seeing in terms of demand across the rest of the system. As Ms O'Neill has indicated, we are certainly planning for winter at this point in time. We are seeing a lot of presentations at both our hospitals at the moment. The place is very, very busy. We also have nursing staff demand in relation to vaccinations and testing; so I am not going to make a prediction, and I will absolutely support Canberra Health Services in supporting their staff to make sure that workloads are as good as we can possibly deliver.

THE CHAIR: I have got a quick supplementary, minister, and you will not be at all surprised where I am going. Could we have an update on how the south Tuggeranong walk-in centre is progressing, please?

Ms Stephen-Smith: Just to be clear about the election commitment around walk-in health centres, they are a different beast to walk-in centres as we know them. Walk-in centres are around no appointment necessary, treatment of minor injuries and illness. The walk-in health centre model is yet to be fully developed and we fully expect that that will vary according to regions. Obviously Coombs will be coming online fairly soon. That is a very different model co-located with a general practice. The other four

that are in the planning stages will not all be built within this term of government, but we will certainly be wanting to have a conversation with the community in south Tuggeranong, in the inner south, in north Gungahlin and in west Belconnen about what the models of care and service delivery in those regions will look like and about what they really need in their region. Obviously there are quite different demographics between south Tuggeranong and north Gungahlin, for example; so it is quite likely that the services will be a bit different in those centres.

That planning is underway at the moment, as is the work around the physical reality of either building or renovating, finding something that can be renovated and appropriate to deliver those things. I cannot give you a firm time line at this point but we will be happy to keep you up-to-date as this work progresses.

THE CHAIR: Have we identified a site or even short-listed a range of possible sites for the south Tuggeranong one?

Ms Stephen-Smith: No. Mr Mooney might have a little more but no, we have not identified a site yet.

Mr Mooney: Where we are at, at the moment, is we have just appointed a consultant that is working with Canberra Health Services to develop what will be the site selection strategies for the four sites. In that process we are working with a new appointment within Ms O'Neill's team for an integrated care project director. These two streams are working in parallel at the moment, but the next step with this consultancy is to just understand the types of requirements for site, public access relative to the area demographics, the types of health needs that are required and the other integrated care options in that space. That will feed into, basically, what options are available for the territory in terms of what is out there, be it a vacant site, an empty block or, indeed, refurbished spaces. Virtual care is something that would be considered as part of these types of health hubs. There are a number of things on the table.

THE CHAIR: The minister made the point a moment ago that these walk-in centres or walk-in clinics will manifest in different ways, depending on community need throughout the city. I assume there has already perhaps been some work or an intention to commence some work collating data the directorate would already have about healthcare consumers by locality and the kinds of needs they might have. For example, we would have a pretty good idea of people who live in the south Tuggeranong postcodes who are presenting at the ED at Canberra Hospital. Has that work commenced? I imagine that would happen before this consultant works on the site-selection work.

Ms O'Neill: We are doing a number of pieces of work in parallel. The tender process for the site-selection work, as Mr Mooney said, has just been completed; so that work can commence. At the same time there have been a number of iterations of consultation around what we need. We are pulling all that data together. We are lining that up with some of the health data but we are also just commencing the planning to come back out to the communities to do further consultation, particularly with community members. Much of the consultation that occurred in that first round was with service providers. We will be looking to bring all that together over the next two

months.

THE CHAIR: That sounds good. I am interested in talking about the ACT drug strategy, Minister. I know that the action plan is due for renewal this year. What advice has been provided to you so far by the action plan advisory group about some of their key focuses for the next plan?

Ms Stephen-Smith: I have had a couple of briefings about what we are thinking of, in terms of the next plan. I might hand over to somebody to provide a more comprehensive answer on where we are up to with that.

Ms Barbaro: The previous drug strategy expired at the end of last year, and we are intending to put a new one to government for decision early to mid this year. We have been undertaking workshops and consulting stakeholders and the community sector on the plan. The key priority areas proposed for the next plan that have been coming out of that stakeholder consultation are around reducing demand for alcohol, tobacco and illicit drugs; reducing the supply of alcohol, tobacco and other drugs; reducing harms associated with those things; improving organisational and system-level responses in order to better meet the needs of the community; and addressing the broader needs of people who use drugs, their families and carers. As part of this work, we are doing a stocktake of the previous action plan and a review of that plan, in consultation with ATODA and ANU, if I recall correctly. We will also do an evaluation soon.

THE CHAIR: What would you say are the guiding philosophies behind this drug strategy? Noting that there is every chance that we might be moving to a model of decriminalisation in the not-too-distant future, how much has that separate but very relevant conversation been informing the development of the drug strategy, and has it changed or influenced some of those key strategic goals?

Ms Barbaro: The overarching aim of the strategy is about harm minimisation—similar to what the legislative process is based on. It is also about identifying options to expand services, existing services or new services, including through the commissioning approach, which is a more outcomes-focused way of delivering services to the community and measuring the impacts of those services.

We have an overarching view of priority populations and where interventions or services are most needed—for example, residential rehabilitation for Aboriginal and Torres Strait Islander people, for people who are exiting the justice system or for people being diverted from going into the justice system. The other overarching principle is that collaborative design between government, service providers and consumers.

Ms Stephen-Smith: We work within the harm minimisation concept that also guides the national drug and alcohol strategy. That is really taking the three pillars of harm minimisation—demand reduction, supply reduction and harm reduction. Our work is around both demand reduction and harm reduction. The decriminalisation work is really around that harm reduction pillar of the broader suite of harm minimisation measures, reducing the adverse health, economic and social consequences of drug use, reducing stigma, and encouraging and supporting people to access support—that is,

treating drug use as a health issue, not a criminal one. That really sits under the pillar of harm reduction and it is very consistent with it, rather than necessarily driving us in a new direction, because that is already where we were sitting in terms of our philosophy and strategy.

THE CHAIR: I probably do not need to tell you this, but the longer that I work in this portfolio, the more that I realise most problems can be traced back to recruiting and retaining good staff. I have heard it put to me by a few people who are interested in the alcohol and other drugs space that the community conversation around decriminalisation and some unsavoury contributions made by some is not just further stigmatising drug users; it is further stigmatising people who seek to work in the sector. What is the government doing to address that? Is it part of the ACT drug strategy? I know there has been some extra money allocated in the last budget specifically to hire people. How are we filling those positions? Are you hearing the same things that I am hearing in that respect?

Ms Stephen-Smith: I might hand over to Ms Barbaro to talk about the extent to which the workforce issues are reflected in the conversation with the sector to date and the work on the new strategy. That is a really interesting question because one of those challenging things, when we are driving a progressive policy to reduce stigma, is that the community conversation that is had while that work happens actually has the potential to cause harm. We need to be careful about that. I cannot say I had heard that feedback directly in that way from the sector, but it is possible that officials have. Certainly, workforce is always something that is front of mind.

Ms Barbaro: Apologies; I forgot to say that I have read and understood the privilege statement. Certainly, matters of capability and capacity have been brought up in the consultation, and the drug strategy will likely address or at least touch on those things. As with many other community sector organisations in the health sector, many are feeling the strain, particularly the strain of COVID and the impact on vulnerable and disadvantaged clients who are less likely to engage with traditional services. That is an added layer that we have seen across the whole health sector.

Certainly, funding is also a big conversation point that we are having through the development of the strategy. At some point we will move to a commissioning approach, as I mentioned—the outcomes focus. Funding forms a big part of capability and capacity building within the sector.

THE CHAIR: At the risk of opening a can of worms, I served on the select committee which inquired into the bill, and we heard a lot from stakeholders and people in the sector during that process. One of the risks that they identified was that, should the territory move to a model of decriminalisation, the intended consequence of that would be an increased demand on services. People who have difficulty with their drug use will come out of the shadows and access services. How much is that anticipated increase in demand factored into the work of the ACT drug strategy and the preliminary planning that we would have to start now?

Ms Barbaro: Again, at the highest level, in terms of developing the drug strategy and consulting stakeholders, within the current context, it goes to those questions of capability and capacity within the sector. They are certainly at the forefront of our

mind in developing the strategy and moving towards the commissioning approach. Yes, we do acknowledge that several programs delivered by government could potentially have increased demand on services, under the drug strategy, under existing programs and through the recently launched Canberra Script. We are definitely liaising and engaging with our service providers on those impacts, in order to identify them and address them as needed.

MR MILLIGAN: My question is in relation to the appearances by Dr Coleman. This year it appears she only appeared in front of a press conference twice, once on 5 January and once on the 23rd. However, her New South Wales counterpart has appeared in front of the press at least 23 times to talk about COVID restrictions and everything else. Despite the ACT having its biggest number of cases of COVID being recorded, why didn't the Chief Health Officer and the Chief Minister appear on 18 February at the press conference where the minister announced the lifting of restrictions? Why hasn't Dr Coleman appeared as regularly in front of the press during such conferences?

Ms Stephen-Smith: I might go back a couple of steps. Obviously, coming into the December period, we had come out of a very significant response to the Delta wave, and no-one knew that Omicron was coming. A lot of people were planning to take very well-deserved leave and breaks, and spend time with their families, including people who support the Chief Health Officer in her relatively small team.

We then hit the Omicron wave. People have been extraordinarily busy, trying to manage that outbreak and its impact, particularly, for example, on high-risk settings like aged care, disability and early childhood education and care. There was a lot of work going on in the background, not particularly visible to the public, to support those sectors; and, in order to understand what was happening, in attending AHPPC, Australian Health Protection Principal Committee, meetings, the Communicable Diseases Network Australia meetings, and to brief everybody.

With all of the work that was happening, and with the lower number of staff that were available to do that work, because people were having to take leave—people had families, they needed a break—there was an agreement between me and the Chief Health Officer that, given that I cannot do that work, I cannot do the supporting of aged care or supporting of early childhood education and care, what I could do was to do the media. It takes time and effort to prepare for press conferences and to do the radio interviews. There was an agreement that I would do the majority of that because the team was incredibly stretched in actually implementing the public health response.

I know that people want to put a conspiracy theory of some description on it, but it was purely about distributing the workload in a way that made sense.

MS CASTLEY: Minister, even today, I was speaking with people about the fear around COVID and the impact that it is having on business and on all other areas as well. I know Dr Hughes from the ANU said that there is a credibility factor. In light of this fear that Canberrans do have, what do you say about this absence of Dr Coleman? Don't you believe that it would have been better to have her being as visible coming out of this wave, to encourage people to go back out, to let them know that there has been a change?

Ms Stephen-Smith: Ms Castley, maybe with the wisdom of hindsight you could say it might have been better if she had made a couple more appearances in the media. We certainly were not getting that from the media at the time. When I was doing press conferences in January, and Minister Steel was taking radio interviews and doing press conferences, there was not, at that point, really high demand to have the Chief Health Officer doing those instead or as well. We were providing the exact same information that she was able to provide. She has subsequently done press conferences; she talked about the changes to the mask restrictions. She gave a very lengthy press conference in relation to that and did an outstanding job, as she always does, in explaining things.

As I say, it was purely around trying to manage a reasonable workload with what is a much smaller team than the New South Wales public health team or the Queensland public health team.

MS CASTLEY: I understand, but we have seen her for 20 months. Canberrans have got used to seeing the press conferences daily. At this time when they are trying to come out, do you not agree that they deserved continuity in messaging? We hear that communication is key.

Ms Stephen-Smith: A lot of people are making this commentary while casting back with hindsight. That is not what we were hearing at the time, in January. When we were going through that wave, she did do some appearances, and I did more appearances, Now people are casting back and trying to put some conspiracy on the fact that I was doing the media rather than her. But at the time that was not what we were hearing. I was getting, "Thank you for coming on here and doing this between Christmas and new year." Most people were on shutdown and we were doing press conferences and everybody was working. The Chief Health Officer had Christmas Day almost off. I genuinely think that people are looking back and putting something on this, and on the way Canberrans were feeling about it, that did not exist at the time.

MS CASTLEY: When does her tenure end, and are you considering reappointing her?

Ms Stephen-Smith: I understand it is a five-year appointment, and she was initially appointed not long before COVID hit. I think it was late 2019 when she formally became the Chief Health Officer.

MS CASTLEY: So we are looking at the end of 2023. Quite a baptism of fire. Thank you.

Ms Stephen-Smith: Yes.

MR PETTERSSON: Minister, what are the Care Closer to Home initiatives and how do they benefit the community?

Ms Stephen-Smith: Care Closer to Home is a very broad program of work. Ms George is best placed to talk about it.

Ms George: The project, which was stood up after the 2018-19 budget appropriation, has been a collaboration between the Health Directorate leading the project, Canberra Health Services and Calvary Public Hospital Bruce to increase the number of patients that are able to be seen through our Hospital in the Home and GRACE projects. The undertaking was to double the number of patients coming through the HITH program over the four years. We were well on track to do that before COVID hit. In 2018-19 there were 1,477 patients through the Hospital in the Home programs at both hospitals. In 2020-21 there were 2,431. This year we had targets of 1,600 and 1,400 patient separations from HITH who had had time through the HITH program. That is being impacted by COVID.

One of the specific things that have been done in that space has been to increase allied health input into both the programs at Canberra Health Services and Calvary Public Hospital Bruce, which has expanded the case mix that is able to be seen through the program and helped to give people a more multidisciplinary treatment regime. The projects also put together guidelines so that people understand HITH and so there are consistent processes and procedures being undertaken. We are in the process of undertaking a costing study to be able to give some feedback, with this being the fourth year, about how the costs of Hospital in the Home and hospital in the hospital bed compare. There has been a lot of work done by the clinical teams at both hospitals in talking to different specialties that have not been proportionally represented in Hospital in the Home program patients about what can be done to encourage patients in those specialties into Hospital in the Home and what supports would be needed. There has been quite an increase in a number of those specialty areas.

There has also been a survey undertaken of carers as part of the evaluation process. We will do a formal evaluation over the next six months to draw all of our learnings together so that care closer to home can continue to grow in the ACT.

MR PETTERSSON: What specialties have not been well represented in Hospital in the Home?

Ms George: I can take on notice the question about what specialties have and have not. It would depend on what is conducive to care at home. There has certainly been an increase in things like cellulitis and conditions like that, which can be treated with infusions at home regularly and being seen by a nurse. I can give you the full breakdown by specialty.

Dr Swaminathan: The scope for growth within HITH is really in the surgical specialties and, potentially, paediatrics. Those are two areas that are not well represented in the Hospital in the Home patient population as yet. It is mainly medical and some post-operative surgical for infections, but post-operative care is really the growth area.

Ms Stephen-Smith: Mr Peffer has a response to the question on notice earlier around nursing numbers.

Mr Peffer: With the question around frontline nursing numbers across the territory that was previously asked, the number is 4,321.

THE CHAIR: That is the current headcount?

Mr Peffer: That is right.

THE CHAIR: Do we have the number of positions?

Mr Peffer: That is FTE, full-time equivalent, yes.

THE CHAIR: Did we have the number of positions to go with that?

Mr Peffer: I do not have the number of positions, but we can come back to you on that.

THE CHAIR: Ms Castley, do you have a supplementary to Mr Pettersson's question?

MS CASTLEY: No, just a clarification of a question on notice. With regard to elective surgeries, there are 773. There were costings as well, but can I please get, on notice, a breakdown of what surgeries are outstanding?

Mr Peffer: Yes.

THE CHAIR: I thank the Minister for Health and officials for appearing at the hearing. You will be sent a copy of the proof transcript, to correct any errors. We will suspend the hearing until 4 pm, when we will hear from the minister and officials again, specifically on the Canberra Hospital expansion project.

Hearing suspended from 3.32 to 4.02 pm.

Appearances:

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

Canberra Health Services
Peffer, Mr Dave, Chief Executive Officer
Mooney, Mr Colm, Deputy Chief Executive Officer

Major Projects Canberra
Edghill, Mr Duncan, Chief Projects Officer
Little, Mr Martin, Project Director, Canberra Hospital Expansion

THE CHAIR: Welcome back, friends, to this afternoon's hearing of the Standing Committee on Health and Community Wellbeing as we continue our inquiry into annual reports for the ACT government for the financial year 2020-2021. We continue this afternoon's session speaking to Minister Rachel Stephen-Smith, the Minister for Health. This afternoon we will be discussing the Canberra Hospital expansion project.

I remind all witnesses to please give us their full name, the capacity in which they appear and an acknowledgment that they have read and understood the privilege statement on the first occasion that they speak. We will not have an opening statement; we will instead go straight to questions, and as chair I will kick us off.

Minister, in the last session we spoke a little bit about the challenge for all health systems, ours included, to recruit and retain a high-quality workforce. I would like to know specifically how the plans for the Canberra hospital extension have been designed and implemented with that consideration in mind and trying to build a high-quality workplace that clinicians from around the country, and indeed around the world, would want to come and work in.

Ms Stephen-Smith: I think that is an excellent question and a good observation about what the critical services building, as part of the Canberra Hospital expansion, and, indeed, the whole Canberra Hospital master plan ultimately can deliver for us. It is about providing a healing environment for patients and families and an environment that staff want to work in and can do their jobs to their absolute best of their ability. More broadly across the Canberra hospital master plan, it is about building things like the research training and innovation precinct, which we have made an investment in in this latest budget with the Cancer Research Centre. Mr Peffer, if you are interested—well, not in this session—could have talked about the partnerships with the Australian National University as well. So all of these things come into play in terms of thinking about how we attract and retain the best possible workforce, but with that intro, I will hand over to Mr Peffer to talk about that.

Mr Peffer: I have read and acknowledge the privilege statement. There is no doubt that a building of this scale and this quality has a large impact on the workforce, not just in terms of the built environment that they are working in. As part of a new hospital like this, a range of cutting-edge technology is introduced—the cutting-edge equipment that will propel us forward in terms of the quality of care that we can deliver.

I know, having worked through a couple of senior recruitment processes in recent weeks, how big a drawcard a hospital build like this is for senior clinicians who are considering moving interstate. They look at things like the investments that governments are making in a particular health service and what its future looks like. Something like this is, and will continue to be, a major drawcard for us in securing particularly senior leadership positions across our health service.

More generally, though, as part of our commissioning activities to bring a hospital of this scale online, we look at our recruitment strategies and we design those strategies to look at the sort of workforce that we need to bring in. We position ourselves so that we can be selective and ensure that those who we are recruiting reflect top talent, nationally, and in some cases, perhaps, overseas as well. So it is a big drawcard. It signals to the workforce that it is valued, that there is significant investment and that there is a positive future ahead.

THE CHAIR: Obviously, things have to get worse before they get better, as with any construction project. People are going to be living around jackhammers and noise and parking problems and all those sorts of things. What work has been done to consult with the current staff of the Canberra Hospital and manage their expectations and bring them along the journey of the project?

Mr Mooney: Thanks, Mr Davis, for the question. Our consultation is ongoing with this particular project and, indeed, all projects, but we work very closely with Major Projects Canberra and the team. I am sure they will talk to some of the various consultation sessions that are being run and the communication channels that we have open for people to actively have their input into the project.

You talked about one thing—parking. That was quite a sensitive issue at the Canberra Hospital campus. We have just recently opened additional car parking spaces at the CIT campus, where we have increased our overall car parking on the site to just over 4,300. That was done as part of an extensive consultation process with all staff and external stakeholders, particularly health care consumers, where we looked to optimise the space for our consumers and extend the length of time that those spaces were available, provide more accessible parking spaces in a consolidated area, and make provision for parking for our staff in close proximity to their workplace.

That is just one example of some of the initiatives that we are undertaking with Major Projects. Some other examples would be in terms of the design development of the building. Major Projects might want to talk about that work that they are doing with the Multiplex people in terms of that whole design process in relation to user input.

Mr Edghill: Certainly. Design development is certainly an area where there is an incredible amount of focus in working together with CHS, with clinical staff and all staff across the campus to make sure that we are building something which will attract people and which will serve its purpose and be a truly world-class facility. That design process extends beyond looking at 2D drawings on a piece of paper; we are going to the extent of building what we are calling a "prototype shed", although it is a pretty fancy shed. You may see it. It has come up on Hindmarsh Drive at the location of the temporary car park. It gives you a sense of how important the clinical input into

what we are doing is, in that we are building the mock-up with theatres and other spaces inside it to make sure that what we are building in the critical services building is actually going to work for everyone.

To your question, the other important thing that we are doing through the construction process is looking to cordon ourselves off from the rest of the hospital campus as best we can so that we are not getting in the way of ordinary hospital operations—even in terms of accessing the site. We are not accessing the site through the body of the hospital campus itself. We have our own construction entrances. So, to that extent, we are trying to be as unobtrusive as we can during the build process.

THE CHAIR: We have spoken about how the design is trying to work or cater to new staff. We have spoken about the consultation with staff that are there currently. I am interested as well about the immediately adjacent community—the suburbs of Garran and Hughes—and those in the apartments across the way over there at Phillip, who over the course of the coming months, perhaps even years, will see some level of disruption to their amenity while we go through the project. Can I get a bit of an update on that community consultation work.

Mr Little: I acknowledge that I have read the privilege statement and understand it. In terms of community consultation, we have been running a consultation program with the community for a number of years now, starting way back during the business case. We meet regularly with the local community to keep them briefed, not just on the design but also the land construction program, how traffic control will be managed around the site and how safety will be managed around the site. We hear their concerns. Last week we had our monthly meeting with our local community reference group, where local residents were able to be briefed on progress to date. We also looked ahead in terms of the upcoming activities, so that they are intimately aware of what is occurring. It also gives an opportunity for the contractor and ourselves to receive their feedback.

Ms Stephen-Smith: The only other thing I would add to that—I might have missed it—is the regular drops of information around the neighbourhood. I think that is a monthly update, roughly, that goes out. It may be a bit less frequent than that.

Mr Little: Yes, that is correct, Minister. They are monthly updates for the local community.

THE CHAIR: Bimonthly updates, did I hear?

Ms Stephen-Smith: Monthly.

THE CHAIR: Is it an expectation those monthly updates to neighbours will continue until the completion of the project?

Mr Little: No, we are flexible on that, and we actually asked that specific question of the community group back in December before we closed for the year last year. The feedback was that we should continue monthly, definitely for the rest of this year, and we would then relook at the frequency as we move into 2023 to tailor it to the specific needs of the project at that point in time.

Ms Stephen-Smith: Just to give you a bit of sense of what the timetable looks like, by early next year the building will, essentially, be topped out. The outer shell of the building will be completed by early next year. Then we move into a new phase, where there will still be a lot of traffic coming and going and maybe a lot of work going on internally in the building. The neighbours will still continue to be affected by that, but it might not be quite as noisy or obvious as the building part, with concrete trucks and tower cranes and all the rest of it.

THE CHAIR: If that update is happening monthly, who, specifically, are we making sure is getting that update? Is it every home in Garran, Hughes and Phillip? Is it a radius around the hospital?

Mr Little: The meeting with the local community reference group is for specific residents from Garran who are around the project, within a certain area. The monthly newsletter drop goes out to all the residents of Garran and Hughes and also goes to the staff.

THE CHAIR: Tremendous. My last follow-up question, because I have had it raised to me by a few people, is about the area in Phillip—the medium-to-high-density apartment area across the other side of the oval. I have heard anecdotally that there is an expectation or a fear that there might be some flow-on effects, particularly with traffic, to their neighbourhood. Has there been any specific consultation within that area?

Ms Stephen-Smith: I am not clear. Do you mean on the other side of Yamba Drive towards Phillip?

THE CHAIR: Yes, so between the hospital and Phillip.

Ms Stephen-Smith: Between the hospital and the former CIT, where the car park is?

THE CHAIR: Yes. It is telling that, from what I did before I got elected, I can think of all the apartment buildings' names, but I just cannot think of the streets. I am talking about the other side of the Woden enclosed oval.

Ms Stephen-Smith: Right. With respect to anything on the other side of Yamba Drive, the only impact that is potentially going to happen is not from the Canberra Hospital extension but from the approval that we got in the budget to commence work on planning, feasibility and design for a multistorey car park in the car park site on Yamba Drive. There will certainly be very close engagement with the residents, who are on the other side of the stormwater drain, if my memory serves me correctly.

Mr Mooney: I think the particular car park that the minister is alluding to is what is known as Yamba Drive South. There are two car parks on the western side of Yamba Drive—Yamba Drive South and North. Yamba Drive South is the one that has been earmarked for development as a multistorey car park as part of the master plan. The master plan was released a number of months ago following quite extensive consultation. That was through two phases of consultation, in particular. That sets out what the campus will look like over the next 10 to 20 years. Obviously, one of the key

elements of that is how we deal with car parking, so I think that was probably one of the biggest feedback items. It is very clear as part of that process that that was one of the nominated spaces for parking. Obviously, people would have seen that through both the output of phase 1 and then what eventuated in phase 2.

THE CHAIR: Great. Thank you very much. Ms Castley, I noticed earlier that you had your hand up for supplementary question.

MS CASTLEY: I did, but I had about 16 minutes on car parks. In light of the time, I am happy to move to the next substantive question.

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

MR MILLIGAN: I am happy to handball that over to Ms Castley.

MS CASTLEY: Thank you, Mr Milligan.

THE CHAIR: Try and act surprised, Ms Castley! Take it away.

MS CASTLEY: It has been six years since the hospital expansion was first announced back in 2016. We were, obviously, expecting it to be completed by 2022. It is $13.5 million over budget. Earlier in the reports hearings, Major Projects were talking about the project running to schedule and to budget. From my reading of page 11 of the annual report that is not quite true. It is just that it has been rescoped multiple times. The revised completion date for the building is now 2024, which is followed by operational commissioning. I am just wondering how long you expect that operational commissioning will take.

Ms Stephen-Smith: Ms Castley, in relation to the $13.5 million figure that you quoted, the project is currently on budget in terms of the business case that was brought forward for the building that we are building and the location that we are building it in, at $624.5 million. The money may have moved from year to year, and, obviously, there are elements of the building that have changed over time—that is absolutely true—but I just want to clarify that at this point in time the project is on budget. In terms of the timing, yes, when the project was scoped to be on this site, the intention was to complete it in 2024. That remains the intention. To go to your substantive question of how long it takes to commission the building once it is physically completed, I will hand over to MPC.

Mr Edghill: To pick up on a point that the minister made, there may have been some movement, if this is what was referred to, between the years. We were going better last financial year than we originally anticipated, which meant that we were able to draw forward some money to undertake works, but the project remains, as we said here today, on track and on budget.

In terms of the commissioning process, we are working closely with Canberra Health Services through that process. As you can appreciate, it is not as simple as we finish building and there is one day when we put all the lights on and everything becomes operational all at once. There will be a staged process as we move critical services patients and so forth into the new critical services building, but once we have finished

construction by mid-2024, it is our expectation that that staged commissioning process will happen in the second part of 2024.

MS CASTLEY: So Canberrans will be able to see the new Canberra Hospital expansion patients admitted by January 2025?

Ms Stephen-Smith: I am hopeful that it will be significantly earlier than that, yes.

MS CASTLEY: Just back to the budget, on page 120 it says the original project value was $65,524,000. The total expenditure is $79,071,000. According to quick maths that is around $13.5 million over. Is that not an over budget allowance?

Ms Stephen-Smith: No. As Mr Edghill was saying, that is, in fact, the project being ahead of schedule in terms of the spend. So it is actually bringing forward funding that was scheduled for a later year into the 2020-21 year to do that work.

MS CASTLEY: It is ahead of the rescoped schedule dates, not the original dates of 2022. Okay; that is it for that.

Ms Stephen-Smith: The date has been the same for quite some time, yes.

Mr Edghill: If I may, the figure of $65 million on page 120—and this is where there is some technical budget stuff—excluded the centrally-held provision that was released to us upon approval to enter into the main works contract, and it excludes what was at the time in the outyears. So, obviously, the project is not a $65 million project; it is a $624.5 million project, and that explains the difference.

MS CASTLEY: Okay. Thank you.

THE CHAIR: Mr Pettersson, a substantive question.

MR PETTERSSON: I have not been on the south side in a long time—I am really exposing myself here—so I have not seen any of the works that are underway. Can someone update me on what works are currently underway?

Ms Stephen-Smith: Yes, someone can. We do not have a live camera on it, do we? No. We do, but not publicly streamed.

Mr Edghill: I may pass to Martin, the project director. Not that we ever wish anybody to go to the hospital, but if you are at the hospital, you will see that there is a significant amount of work underway. As we stand today, at the site where the new critical services building is being built, what were buildings 24 and 5 have been demolished—the previously above-ground structures but also the below-ground linkages that were there.

Bulk excavation is almost complete, so we are, at least on a good portion of the site, down to the very base level upon which we will build. We will shortly see some very demonstrable progress and the building coming out of the ground. At present if you are there, you will see a very big hole in the ground, but, as the minister mentioned, 2022, this calendar year, is largely the year when the superstructure will go up. By the

beginning of next year, the structure of the building will be there. It will give you an excellent sense, by that point, as to the size of the building. Then 2023 is largely an exercise in ensuring not only that have the facade up, but that we are doing all the works that are required on the internals of the building.

It is a very big site and, particularly now that building 5 and 24 are out of the way, you can see the entirety of the footprint of the building. This a very substantial structure, which will be going up over the course of this year. I may have forgotten something, Martin, but hopefully that gives you a sense that there has been a significant amount which has happened.

There is something else that probably gets lost a little bit in it. The project as a whole not only involves the critical services building; there are a lot of services that we needed to move around the campus in order to clear the space for us to build the critical services building. So there has been a very substantial amount of work which has happened on the campus already in constructing other structures as part of the broader project—the new building 8, in particular. Building 28 has been refurbished. Refurbishments throughout the campus might not be visible from the outside, but those early works have largely come to an end now. Already there have been tens and tens of millions of dollars' worth of new structures created on the campus.

MR PETTERSSON: I might have to find some time to make a detour on the way home. Thank you.

THE CHAIR: A supplementary, Ms Castley?

MS CASTLEY: Yes. I know that there has been reshuffling and moving and things like that, but this was a promise back in 2016. Why has it taken until 2022 to get to the point where there is a hole in the ground? It does not add up to me that other structures, other hospitals, have been built in that time and we are just at the hole-in-the-ground stage. Minister, can you enlighten me?

Ms Stephen-Smith: Ms Castley, if you would like, maybe we can take on notice the timeframe for the process. You might recognise that you were not a member in the last Assembly. The commitment that was made in 2016 related to a particular part of the Canberra Hospital site. Some further due diligence was done following the election in 2016 to determine whether that was the appropriate site for the new build. It was determined that that was not going to be the best site and that the site of the former building 5 and building 24 would be a better site for multiple reasons, not least of which was the need to not move the helipad twice, and because those buildings 5 and 24 were not largely clinical service buildings. It was a site that enabled the construction to go ahead without disrupting clinical services.

Obviously, there have been some moves of services and administration as part of the early works. New buildings were built and other areas of the hospital refurbished, so there has been a lot of work that has happened since that decision in late 2018 that finalised the site, and all of that early work around planning, building those new buildings and refurbishing the sites to decant the services that were in building 5 and 24 that needed to be demolished. Alongside that was the work around design for the new building identifying an early partner, which was Multiplex, and then working

with Multiplex through the further design development, getting it to the point of development application and then going through that process before you can even start knocking anything down.

So there were a couple of parallel tracks around the early works to decant the buildings to enable them to be knocked down at the same time as we were doing the design work of what was going to be built on the new site. As I alluded to earlier, that evolved over the period where we were engaging the community in that design work. My understanding is that we are pretty much on track to where we thought we were going to be when the final decision was made in late 2018 about where the critical services building was going to go.

MS CASTLEY: Thank you, Minister. As a voter back in 2012, though, when I first started hearing about this, I am disappointed that 10 years later we are still just at the point where there is a hole in the ground. I am just wondering what you say to Canberrans about that.

Ms Stephen-Smith: I have just given you a detailed explanation of the process that we have gone through. I will take on notice to give you, in writing, a timeline of the things that have happened since 2016, or since 2018 when the decision was made about where the critical services building was going to be best located on the campus. I recognise that there have been alternative views about that, but one of those alternative views would have involved knocking down buildings 2 and 3, which are buildings that provide clinical services and beds and wards to our hospital community. The plan that the Canberra Liberals took to the election in 2016 would have seen us go into the pandemic with a big hole right in the middle of Canberra Hospital. Right in the middle of Canberra Hospital we would have had fewer beds, we would have had longer waiting lists and we would have gone into the pandemic with a big hole in the middle of Canberra Hospital campus. If that is the choice you wanted to make, that is fine, but if you want to keep going back to that choice, which would have led to a big hole—

MS CASTLEY: You are explaining that it could not be done quickly, so on your maths and timeframes it would have probably been the same thing. I also have questions about negative feedback with regard to design, if you could take that on notice, please. Just let me know what you are hearing from the professionals if there has been any negative feedback.

THE CHAIR: Do you want to frame that specifically as a question, Ms Castley and take it on notice?

Ms Stephen-Smith: Sorry, Chair. I am just not sure that we are going to be able to take that question on notice in the way that it is. There are a lot of reports publicly available in terms of the feedback that we have had, and how we responded to that.

THE CHAIR: Minister, I might ask you to take on notice to provide the committee with some of these reports about feedback, but I will rule that asking for specific feedback that has a specific answer is a bit out of order, so I will not be able to do that.

The time being 4.30, we are going to move on to our next segment, which is to speak

to the same minister, Minister Rachel Stephen-Smith, this time in her capacity as the Minister for Families and Community Services. I note that a number of directorate officials look as if they are online. Minister, do you need a room change at your end?

Ms Stephen-Smith: I do not need a room change, but officials will be leaving and coming in.

THE CHAIR: We will take a short break.

Short suspension.

Appearances:

Community Services Directorate
Rule, Ms Catherine, Director-General
Wood, Ms Jo, Deputy Director-General; Programs and Operations
Sabellico, Ms Anne Mare, Deputy Director-General; Reform
Evans, Ms Jacinta, Executive Group Manager; Strategic Policy
Pappas, Ms Helen, Executive Group Manager; Children, Youth and Families
Saballa, Ms Melanie, Executive Branch Manger
Lapic, Ms Silvia, Deputy Executive Group Manager; Children, Youth and Families

THE CHAIR: Welcome back, everybody, to today's final session of the Standing Committee on Health and Community Wellbeing's inquiry into the annual reports of the ACT government for the 2020-2021 financial year. This afternoon we have Minister Rachel Stephen-Smith in her capacity as Minister for Families and Community Services. I would like to remind new officials who have joined us that, on the first occasion that you speak this afternoon, can you please acknowledge that you have read and understood the privilege statement.

As Chair, I am going to kick us off with our first question. Minister, it is about the safe and connected youth project. In 2020-2021 the directorate undertook an evaluation of that safe and connected youth project and it found that the service was highly successful at reducing the risk of homelessness amongst young people. I would like an update, please, on the tender process for the safe and connected youth project and when will the outcome for the tender be announced. From that, when can we expect the project to be running?

Ms Stephen-Smith: I understand that Ms Evans is on the line and ready to take your question.

Ms Evans: I acknowledge the privilege statement. The safe and connected youth project, as you mentioned, has been a highly successful pilot project and was funded through the most recent budget to allow us to extend that program further. The procurement process has been underway over the last couple of months. The tender evaluation committee have considered all tenders now, and it is in the final stages of being signed off. At that point the minister will choose a date to make that announcement. I would expect that to be in the not too distant future.

THE CHAIR: I am going to be cheeky with my follow-up question. When you say not too distant future—and, Minister, maybe it is a question for you—does that mean weeks or months, could you say?

Ms Rule: I acknowledge the privilege statement. I can confirm that the tender evaluation report has come to me today for final sign-off. I will get to it in the next day or so, at which point it will then make its way to the minister. We are very close.

THE CHAIR: That is very exciting. That is wonderful news.

Ms Stephen-Smith: I think it is very exciting too.

Ms Rule: There is nothing like a procurement process to get people excited.

THE CHAIR: I wonder if you can give me any heads-up or any highlights about when you would expect the service to be running. Do you think that, based on what you know so far, that will be a this-year thing or a next-year thing?

Ms Stephen-Smith: My brief may be out of date, and Ms Evans can correct me if I am wrong. The last briefing that I had on this matter indicated that incoming services are currently scheduled to commence operation from 1 April. I am not getting corrected online; so there you go.

Ms Rule: You are correct, minister.

MR MILLIGAN: We are all very familiar with Our Booris, Our Way. There was a report handed down recently on the universal access to family group conferencing. The report states that from January to June last year there was only one family that was involved with the family group conferencing. I am just wondering, minister, how many referrals were made in that period and, more importantly, why did only one of them result in a family group conferencing being convened.

Ms Stephen-Smith: I am going to hand over to Ms Pappas for this one.

Ms Pappas: I acknowledge the privilege statement. The family group conferencing program is really an important program within the suite of programs that we can offer Aboriginal and Torres Strait Islander children and families. It is a voluntary program and you need consent of the families to participate. I will go, if the committee is okay, to Ms Lapic who can go to the substantive question that you have asked and go into some detail about that.

Ms Lapic: I also acknowledge the privilege statement. I can explain a little more about the family group conferencing program in detail. As Helen has indicated, it is a voluntary process. What that does require is a significant amount of investment in working and engaging with families in terms of the program itself. We do acknowledge that there has been some significant effort in trying to work with families to engage them in the program and really, despite best efforts over the last 12 months, consultations and referrals have not necessarily converted into actual conferences themselves. Sometimes consultations and engagement may take a couple of weeks and sometimes it has taken up to a couple of months to work with various family members to get them around the table to work through this process of engagement as well as working on getting the conference settled in a certain period of time.

We have also been significantly impacted by COVID. In terms of COVID, we have been thinking about having families either virtually meeting through the conference or face to face. It has been quite challenging.

In response to this, we have convened a family group conferencing advisory committee. We have various members that have joined us to work on how we can strengthen the pathway for families and really include new engagement strategies to think about how we can better improve those pathways. Some of those strategies that

we have been working on have focused mainly on three main areas, the first being around people, looking at our own workforce and how we can uplift knowledge and expertise around better engagement skills with families but also looking to our community partners and also community members to think about how we can better improve knowledge about the program more widely across community.

The second main area is our processes. This has really prompted us to think about can we simplify the process of family group conferencing referrals and consultations. We have done quite a lot of work in this space as well to think about simplifying our forms and processes as well as our communication material.

Thirdly, our focus area has been on our technology as an enabler to look at how we can use our IT and our own internal systems to trigger referrals much more automatically and have those consultations happen at an earlier point. We are really working hard to look at how in 2022 we can uplift and strengthen those pathways.

MR MILLIGAN: Would you attribute the lack of people participating in the family group conferencing to the government's own processes, the government's own forms and communications? Is it too overwhelming and daunting for these families to get involved?

Ms Lapic: I cannot talk to the exact nature of the rational for individual families. I think for some families there are some unknowns about what the program might be; so our engagement skills in trying to share information with families about the benefits of family group conferencing, I think, is really a focus area for us in 2022. Increasing knowledge about the benefits of the program, what it involves and how it can really improve outcomes for families is really that focus for us at the moment.

MR MILLIGAN: Minister, can you give an update on the progress on implementing each of the recommendations in the family group conferencing strategy plan?

Ms Stephen-Smith: I am not quite sure what you are referring to in terms of the family group conferencing strategy plan.

MR MILLIGAN: The evaluation plan, the draft family group conferencing evaluation plan.

Ms Stephen-Smith: Helen?

Ms Lapic: Can I just check, if it is referenced in the annual report, could you guide us to a page if you have got the annual report?

MR MILLIGAN: Yes. It is part of the review on pages 14 and 15. It says pretty much that there was the strategic plan, the family group conferencing strategic plan. From that, what sorts of improvements will you be making to family group conferencing?

Ms Stephen-Smith: Ms Lapic, are you able to answer that or do we need to take that on notice?

Ms Lapic: I can make a comment in relation to those three focus areas. The strategic plan is in relation to those three key areas and looking at how we can improve against the people, the process and the technology.

In relation to evaluation, that is on the agenda for this year and we are working together with the advisory group to progress the evaluation. That is due more than likely by the end of the year.

MR MILLIGAN: Are all current family plans as a result of the family group conferencing being honoured, reviewed and implemented, and are they ongoing?

Ms Lapic: An initial conference is held and then within 12 months a review is undertaken of those plans.

MR MILLIGAN: Are there plans directly for the families involved? Are they reviewed? Do you work through those plans individually?

Ms Lapic: Yes, that is correct. The plan itself is reviewed alongside the family.

MR PETTERSSON: What work is underway in CYPS to upskill staff?

Ms Wood: There has been a very strong focus on how we support our workforce in Child and Youth Protection Services. Particularly for the child protection component, it is about looking at how we bring people into our workforce, the induction and pathways that we develop, and making sure that that suite of induction and early training really sets the foundation, ensures that we have training for staff across the full range of capabilities they need for that work, and that there is a really clear pathway for staff about how they build those capabilities over time. That connects to the work that is being done in the enterprise agreement to establish the CYPP framework, so that there is a really clear progression of people that enables people to move through our workforce into more senior levels. Ms Lapic has led a lot of that work and she can speak to it in a bit more detail.

Ms Lapic: We do have a number of different phases. If we think about our foundational learning program, there is a 12-month program for all new starters in the area of operations, as a case manager. We also have other additional training packages specifically targeting the improvement in our cultural diversity and cultural understanding. It is our cultural development program. There has been a significant effort over the last 12 months to uplift all of the attendance on these particular programs. In addition we have other training programs specifically targeting trauma-informed care and other parts of the business that require that training.

Particularly over the first 12 months you will see case managers and new starters have a significant proportion of their day or their year involved in training. As they move through the different roles, from CYPP1 to CYPP2 and 3, there is specific targeted training around domestic and family violence and other specific courses, to uplift that training.

THE CHAIR: Minister, I would like to talk about the A Step Up for Our Kids 2022-32 strategy. Can you talk me through what engagement and consultation we have

done so far with affected communities and with stakeholders in the development of A Step Up for Our Kids?

Ms Stephen-Smith: Yes, we have done a lot of engagement with various stakeholders—including, obviously, families, children and young people, and carers—around the development of the next steps strategy. Some of that is outlined on the Your Say page that exists to support the development of the next steps for A Step Up for Our Kids. It is also fair to say that there has been a lot of engagement that has not necessarily been specifically about the next steps of the A Step Up for Our Kids strategy, but that has fed into the strategy. There is a lot of engagement with our families, children and young people, carers and stakeholder partners on a range of issues that arise in the child and youth protection and out of home care systems.

One example would be the Aboriginal and Torres Strait Islander co-design network, with which there is regular engagement. That is fed into next steps. Its purpose is not specifically around the strategy, but it obviously feeds into it. I might hand over to Ms Sabellico to respond to your question.

Ms Sabellico: I will give an opening statement and then pass over to Ms Saballa, who is also online, to give any further detail. The minister is correct in saying that we have had quite extensive consultations with stakeholders. A number of publications have been created from those stakeholder engagements which are on the Your Say website. We have one called a stage 1 listening report, which captures everything that we have heard from stakeholders of their experiences of child protection and out of home care—talking to children, young people, families, carers and service providers; external agencies who interact with the service system were included in that.

A stage 2 listening report captures information that we heard from stakeholders on how the community experiences child protection and out of home care. We have tried to look at it on the part of those from within the system and those from outside the system, in terms of how it works for them and how they interact, in order to inform consideration of what the next steps strategies will include going forward.

There is also a "what we know" overview, which has been published, and it is on the site as well, which provides a summary of the current shifts and challenges as outlined from those conversations, and from us reviewing learnings from different discussions that we have had with providers, reviewing contracts and undertaking contract extensions. All of those issues have come together to inform those pieces of work, which are available on the website.

We are currently undertaking a process of having some broad conversations with the community sector—attending their community sector forums to talk about some of the high-level principles and program areas that we wish to focus on. We are also talking to current stakeholders, including providers of service, our child, youth and family staff, in terms of how they interact with the whole system, and what are the issues from their point of view in terms of improving practice and developing more strategic partnerships, as well as regular discussions with the Our Booris, Our Way Implementation Oversight Committee about a number of recommendations that will impact on the development of the strategy going forward. Melanie, is there anything else that you would like to add?

Ms Saballa: I have read and understand the privilege statement. Thank you very much for your question. We can hear from the overview from the minister and from Ms Sabellico that there has been extensive engagement. That was over 2021. I want to make the point that that is not the only engagement that has happened over the life of the strategy. A Step Up for Our Kids was launched in 2015, and over that period of time of implementation there has been a concerted effort to engage the views of people with lived experience. There has also been a commitment to regular reporting, and that regular reporting is released.

Last year, as we heard, there were two concerted engagement pieces of work. Stage 1 had a focus on hearing from people with lived experience and within the service system funded by the current strategy. We heard from young people who are in care or have experienced out of home care, members of the Aboriginal and Torres Strait Islander community, kinship carers and funded organisations. We have also done work with ACT government directorates. We have heard from statutory bodies, the Youth Advisory Council and, of course, the workforce. That was the first stage.

When the committee met last time, we talked about the second stage of work. At that time we had not yet released the stage 2 listening report. That is now available, and that examined the intersectionality of identities on the experience of out of home care.

When we think about development of such a prominent and important reform agenda, there are many stakeholders from whom we have sought to seek views—children and young people themselves, of course, and their families. If you think about that, it is birth families, it is carers—who are absolutely critical to the smooth operating of the system—and their families, it is current providers, it is wider service providers, it is workforce, statutory bodies and staff. We have done work in all of those spaces.

More recently, there has been an opportunity to seek advice and feedback on our draft. The feedback that we heard was to make sure that we are candid about the system challenges that remain. When you look at reform of out of home care and the intersection with statutory care and protection, there are a lot of stakeholders. There is a lot of intersection of different service providers and the families, the children and the young people that we work with. We heard clear advice to make sure that, in the next phase of reform, we are clear about what the system challenges are. The next stage of reform is very tangible in how it is going to work with those challenges moving forward.

I will stop there. You can hear that there is lots to share in that space, but I will check with the minister to see whether there is anything else she would like me to add.

Ms Stephen-Smith: Thanks, Melanie. I do not think so. We are probably short of time, anyway.

MR MILLIGAN: The annual report refers to the development of an internal and external merits review system for child protection decisions, and notes that an internal review process is being piloted for 12 months. Minister, can you explain how this internal review process is set up, what decisions are being reviewed and what have you learnt so far?

Ms Rule: That is probably one for the directorate rather than the minister because the decision-making under the legislation sits with the directorate, not with the minister. I will ask Ms Pappas to talk in detail about the internal merits review process. This is an important piece of work in making sure that we have the most robust child protection system that we can have. It is important that we take the time to get it right. In fact, we had some discussions about it just today. I am seeking to get briefed on that process and to make sure that what we have learnt over the last little while actually is deployed into a system that can help to underpin good decision-making. Ms Pappas might like to give some detail there.

Ms Pappas: Internal review of decision processes has been a really interesting consultation. We have gone quite wide in terms of who we have consulted in the community sector and also gaining the feedback from our own workforce about what works and what does not work. We have really focused on how we support our workforce to understand how to make good decisions, how to document good decisions and how to communicate good decisions. We are just about to embark on a pretty comprehensive training program to make sure that we implement the policy and procedures in the way that we intend. It is also in recognition that we want to do a bit of a try, test and learn over the next 12 months, to really get a sense of what works and what does not work in terms of what we are proposing.

We have had some interesting initial feedback in terms of how we are running our complaints processes at the moment. The complaints and client services team worked really hard over the second half of last year to change the way they engage with people who want to complain about the service or the decisions that are made. They have introduced a mediation process. Instead of letters backwards and forwards and the formality of that, the team are really embracing this conciliatory approach to making decisions. They have started to run mediation sessions. We have had some real success with people who have been really dissatisfied with how the system has responded; they have gone through a mediation process and have come out of that feeling quite satisfied. They have felt heard. They might not agree that the decision is the right decision, but they have had the opportunity to have their say. We will keep building on that over the course of the next 12 months; we will learn, we will seek feedback from our stakeholders, and we will adjust accordingly.

When the external review of decisions work comes about, we will look at the internal system so that we can develop a coherent, aligned process between internal and external decisions.

MR MILLIGAN: With this pilot program, is that due to end in June this year? When do you expect the final version to be implemented?

Ms Pappas: The program will end, we anticipate, in December 2022. It might go into the beginning of 2023. It will depend on when we can finish our training program, because we do not want to implement something that staff are not trained to deliver in the way we intend. We anticipate that to be by about December this year, perhaps into the very early stages of 2023. As I said, along the way we need to finalise our evaluation program, obviously, and along the way we will get some feedback. We will take all of that feedback and adjust the system. Of course, we will finalise and

formalise the system going forward once we know what an external merits review system looks like, because it needs to be coherent and aligned.

MR MILLIGAN: It was meant to be a 12-month pilot program, but it seems that it has been extended by quite a significant amount of time. What do you attribute that to? Why is there a delay?

Ms Pappas: The delay has been about consultation, and it has been about making sure that we speak to as many stakeholders as possible. It has also been about making sure that we implement it in a way that will set it up for success. We do not want our staff to be confused about what is expected of them. We need to afford them the opportunity to engage in a conversation beyond the consultation process that we have done, to provide comprehensive training and to then capture the outcomes—what has worked and what has not worked over the course.

It has been about availability of staff, and it has been about access to be able to set that up properly. We anticipated that it would be 12 months. Ms Rule indicated that we need to have some conversations internally about finalising the procedures and the policy and then embark on the training program. We anticipate, as I said, that it will be at the end of this year or the beginning of next year. But we want it to succeed. We want staff through the process to learn, to develop and to mature their approach to this work, because it is so important for the way children and young people and their families experience the system. We are really committed to making sure that we improve the way we do that.

THE CHAIR: Minister, I read with interest the *Counting the costs* report that was released by ACTCOSS and the University of New South Wales earlier in the year. One of its many findings was that, in their opinion, the ACT government does not meet the true cost of delivering ACT programs, meaning that services cannot meet the demand or pay their staff appropriately for their skills. Those were their words. How are you hoping this report will change the way that the government considers funding of these community organisations over the next financial year? Specifically, what advice would you have for community organisations in this space who are, as we speak, preparing their budget submissions?

Ms Stephen-Smith: I try not to provide too much advice to community sector organisations as they are preparing their budget submissions, except to recognise that we cannot fund everything in every budget. With those budget submissions, we read them, and we carefully think about what people are putting forward. It often feeds into a subsequent budget process, because of the iteration and timing issues, and because people often raise similar concerns about issues that they are seeing arising in the community or areas where they are seeing unmet need in the community. Those things might not be addressed in exactly the way that they have put forward or proposed, but the broader issue of the unmet need that has been identified is then highlighted by potentially a number of different organisations.

In terms of the *Counting the costs* report, that was co-commissioned between ACT government and ACTCOSS. It was, we thought, a really important piece of work. It was actually Ms Orr, when she was the minister, who started this process, recognising that we need to understand the true costs of delivering services in the non-government

sector and the vast array of different types of services that are provided. We have had feedback from the sector for some time. We certainly know from some of our own work that there are instances where, over a period of time, demand and costs are growing and funding has not necessarily kept up with either the growth in costs or the growth in demand.

We had a lot of anecdotal evidence around this, but we did not have a clear understanding of what that looked like and the extent to which it was a demand issue versus a cost issue. The *Counting the costs* report has been useful in drawing out both issues. There is that issue around the cost of service not being fully funded and there is an issue around the demand that people have been seeing. The report does a really good job of pulling out both of those issues.

From my perspective, the first issue that we indicated in the last budget that we would work with the sector to address is the question of indexation. We committed $4 million in the last budget to address the pressures that were created by the very welcome 2.5 per cent increase in the minimum wage through the Fair Work Commission, which then flowed into awards in the community sector. We wanted to make sure that our community sector partners were able to pay that award increase without impacting on their capacity to continue to deliver services. That, obviously, is an indication of the way that we think about the indexation pressures.

The sector is currently in an enterprise bargaining process, so that will feed into our thinking about indexation as well. I will hand over to Ms Sabellico to talk a little bit more about what the process is to respond to the range of recommendations in that report, which, as I said publicly, will not be addressed in a single budget. It will be over time, and it will also be part of the commissioning process that we are engaged in.

Ms Sabellico: The process that we will undertake, given that we have done this work jointly with the sector, will continue to be undertaken jointly with the sector. As the minister said, we will take the report and the recommendations and look at how we unpack how we want to address the issues and get some further evidence to be able to build up the appropriate costs, identify exactly what the demand is, what service models we need—all of those areas. We have been working closely with the sector around our commissioning for social impact, and all of this will feed into how we go forward to look to commission for services. You do need a good understanding of what the gaps in services are, what services are required, the cost of delivery, and how we manage all of those aspects of work. We will do that jointly with them.

CSD co-chairs, with ACTCOSS, the joint community sector and government reference group, which looks at how we work together with the sector around delivery and support for services that they deliver, and what is needed in the sector to be able to develop and build capability. There is a subgroup called the industry strategy development group, which will have responsibility to support the implementation of these recommendations going forward. It will be multiyear, and it will look to address all of the key recommendations made.

MR MILLIGAN: In the hearings in October last year, we were told that the updated out of home care strategy had been delayed, but should be completed in the first quarter of 2022. When can we see that strategy completed?

Ms Stephen-Smith: I have to put my hand up for this one. We have been doing a fair bit of work to refine how we express the strategy and how we structure it. Part of the challenge that we face is that there is a lot of complexity and a lot of issues that we need to address, having broadened out the strategy from out of home care to think more broadly about the child and youth protection system, including going back to early support for families before they engage in the system, and how we support high-risk young people, for example; it is a broader strategy than the original A Step Up For Our Kids.

One of the things we have been grappling with, and working with some of our sector partners to understand, is how we articulate a relatively straightforward framework under which we can set out some of the major initiatives, including things that we committed to under the parliamentary and governing agreement, like extending care beyond the age of 18 to 21, for an automatic extension of eligibility for care and support up to 21. We already support children and young people to 25 in various different ways. There is the review that we have already funded in the budget of the Children and Young People Act, the establishment of the Aboriginal and Torres Strait Islander children commissioner, the creation of a charter of rights for parents and families—all of these things are existing commitments, but there is a whole lot of really practical work that needs to occur as well.

It is about how we structure something so that we can talk about the big structural changes and also provide an umbrella to provide transparency and assurance for the community that the practice changes that need to be made to create a more restorative system are underway. We have been backwards and forwards on how we provide a relatively straightforward structure, building on what we did in A Step Up for Our Kids, while also reflecting the feedback that we have had through all of the consultation that Ms Sabellico and Ms Saballa talked about earlier.

We have had to go through a few iterations to try to get something that brings all of that together. We are just about there now. I know I have said that before, but I am confident now that we are just about there, and we will be taking it to cabinet in the next month or so.

MR MILLIGAN: Would we expect very soon after that the opportunity for tenders for organisations and the like to be able to help to deliver the new strategy?

Ms Stephen-Smith: There will be a bit of a parallel process in relation to that. I am not sure how much I can say about that, so I might hand over to somebody else to talk about procurement.

Ms Sabellico: At the moment we are looking at what the process is that we need to put in place to be able to meaningfully commission for the services that we need going forward. We are having conversations with providers that are currently delivering services, in terms of looking at what that might look like, noting that there potentially may be a need for a transition period to be able to undertake the right level of activity around procuring for the services going forward. We are in the process at the moment of taking options to the ACT Procurement Board, to have all of those considered and endorsed for undertaking in the next couple of months.

MR MILLIGAN: As part of the procurement process, Ms Evans said during the hearings earlier this week that the Aboriginal and Torres Strait Islander procurement policy will be related to this new strategy; there will be an opportunity for that. Is there a targeted spend or a percentage that you have considered that would be made available in this particular field?

Ms Stephen-Smith: Yes. Even in the absence of an Aboriginal and Torres Strait Islander procurement policy, we are certainly committed, both through the National Agreement on Closing the Gap and through the response to Our Booris, Our Way, to growing the Aboriginal community-controlled sector in the ACT in relation to child and youth protection, and children and family services more broadly. Ms Sabellico mentioned in the hearing the other day that Aboriginal and Torres Strait Islander children, unfortunately, still comprise up to 30 per cent of children and young people in out of home care. With anything up to 30 per cent of the spend, we are looking to say, "Actually, we want to transition that to Aboriginal community control."

That is not going to happen overnight, and we had some conversations the other day about the work that is underway to develop capacity in the community-controlled sector in a range of spaces, from early support for children and families through to that statutory realm. In Victoria, they have actually handed statutory responsibility to an Aboriginal community-controlled organisation. Anne-Maree, do you want to say anything more about that?

Ms Sabellico: No, Minister. You have covered it. We are looking at a proportionate amount of funding transferring out of the current arrangements to build Aboriginal community-controlled organisation responses for Aboriginal and Torres Strait Islander children and families across the service continuum. We will look at the diversionary services in the first instance, as well as start to build for the delivery of the 24/7 services, and do whatever it is that we need to do in order to support further sustainability of all of those arrangements going forward.

MR MILLIGAN: I have a question in relation to the support that was given to care leavers. There were COVID-related extra support payments to care leavers mentioned in the reports. Were they automatically provided to all care leavers and were there some exemptions?

Ms Stephen-Smith: Ms Pappas, I think, is best placed to respond to that.

Ms Pappas: I am just not sure I can answer your question immediately. There was a process particularly for young people where the conversations happened with those young people about what they needed. It was not for all those young people because not all of them needed that support It was really about which young people were most in need of that additional support. It was really a detailed conversation between the workforce and those young people, and it was quite an individualised approach to making sure that those young people were supported. At the high level, that is what I can say but anything further than that I am going to have to take on notice.

MR MILLIGAN: Have those payments continued past the reporting period for the annual reports?

Ms Pappas: My understanding is that all those payments were expended, the COVID-related payments were expended, but the support continued. Those young people continue to be supported financially to make sure that their needs are identified. The COVID component of it was expended but the service system continues to support those young people.

MR MILLIGAN: Mrs Kikkert brought a motion forward in May last year regarding extending support to care leavers up to the age of 21. Will this be embedded in part of the new out of home care strategy?

Ms Stephen-Smith: Yes. It is a commitment in the parliamentary and governing agreement as well that we look at how we do that. I mentioned that is one of the key things that we are looking at in the next steps of A Step Up for Our Kids as well. Obviously there is a financial element to extending support to all young people between the ages of 18 and 21. That will be subject to a cabinet and a budget process; so I cannot pre-empt that. Obviously, if you look at the parliamentary and governing agreement, there is a commitment to looking at that.

MR MILLIGAN: I have a question in relation to the safe and connected youth program. What is the refurbishment of the property for the safe and connected youth program, which was completed in December, as stated during October's hearings, and has the fit-out of the property commenced?

Ms Stephen-Smith: Ms Evans, I think, has got that one.

Ms Evans: I am happy to report that the refurbishment of the building was all but completed by 31 December. There was a very small technical matter that needed to be finalised, which was not a bad thing. It allowed the responsible builders to finalise those matters in January. As earlier referred to, we do expect services to commence in the second quarter of this year for safe and connected youth. The building is in the final furnishing stage now. The refurbishment is completed. It is now around the actual furnishings. That will be negotiated with the new service providers because they may have particular ways that they would like to see the building fitted out in terms of comfort and style.

MR MILLIGAN: Is it a couple of months before it will be ready?

Ms Evans: As soon as we have completed the contract negotiations we will be able to have the conversation with the new providers about the final refurbishment matters, but the building itself is completely completed in terms of the refurbishment.

THE CHAIR: I would like to thank the minister and all the officials for appearing at today's hearing. If you have taken any questions on notice, please do liaise with the committee secretary to make sure that those questions are answered in the appropriate time frame. Equally, if other members of the Assembly have any questions arising from this afternoon's session, please do get your questions through to the committee secretary as soon as possible as well. Thank you very much again, everybody, for your attendance. This afternoon's hearing is adjourned.

The committee adjourned at 5.22 pm.