LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2025-2026

(Reference: Inquiry into Appropriation Bill 2025-2026 and Appropriation (Office of the Legislative Assembly) Bill 2025-2026)

Members:

MR E COCKS (Chair)
MR S RATTENBURY (Deputy Chair)
MS F CARRICK
MS C TOUGH

PROOF TRANSCRIPT OF EVIDENCE

CANBERRA

THURSDAY, 24 JULY 2025

This is a **PROOF TRANSCRIPT** that is subject to suggested corrections by members and witnesses. The **FINAL TRANSCRIPT** will replace this transcript within 20 working days from the hearing date, subject to the receipt of corrections from members and witnesses.

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

By authority of the Legislative Assembly for the Australian Capital Territory

Submissions, answers to questions on notice and other documents, including requests for clarification of the transcript of evidence, relevant to this inquiry that have been authorised for publication by the committee may be obtained from the Legislative Assembly website.

APPEARANCES

Privilege statement

The Assembly has authorised the recording, broadcasting and re-broadcasting of these proceedings.

All witnesses making submissions or giving evidence to committees of the Legislative Assembly for the ACT are protected by parliamentary privilege.

"Parliamentary privilege" means the special rights and immunities which belong to the Assembly, its committees and its members. These rights and immunities enable committees to operate effectively, and enable those involved in committee processes to do so without obstruction, or fear of prosecution.

Witnesses must tell the truth: giving false or misleading evidence will be treated as a serious matter, and may be considered a contempt of the Assembly.

While the committee prefers to hear all evidence in public, it may take evidence in-camera if requested. Confidential evidence will be recorded and kept securely. It is within the power of the committee at a later date to publish or present all or part of that evidence to the Assembly; but any decision to publish or present in-camera evidence will not be taken without consulting with the person who gave the evidence.

Amended 20 May 2013

The committee met at 9.00 am.

Appearances:

Inspector of the Integrity Commission
Principal Officer of the Judicial Council
ACT Ombudsman
Anderson, Mr Iain, ACT Ombudsman, Inspector of the ACT Integrity Commission and Principal Officer of the Judicial Council
Dwyer, Ms Katrina, Senior Assistant Ombudsman Defence, Investigations, ACT and Legal Branch
Ramsay, Ms Georgia, Director ACT Strategy and Inspector Defence, Investigations, ACT and Legal Branch
O'Connell, Ms Erin, Director Reportable Conduct and FOI Defence, Investigations, ACT and Legal Branch

THE CHAIR: Good morning and welcome to the public hearings of the Select Committee on Estimates 2025-2026 for its inquiry into Appropriation Bill 2025-26 and Appropriation (Office of the Legislative Assembly) Bill 2025-2026. The committee will today hear from the ACT Ombudsman, Inspector of the ACT Integrity Commission and Principal Officer of the Judicial Council, from Canberra Memorial Parks and from Ms Rachel Stephen-Smith MLA, the Minister for Health and Minister for Mental Health.

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

This hearing is a legal proceeding of the Assembly and has the same standing as the proceedings of the Assembly itself. Therefore, today's evidence attracts parliamentary privilege. The giving of false or misleading evidence is a serious matter and may be regarded as contempt of the Assembly. The hearing is being recorded and transcribed by Hansard and will be published. The proceedings are also being broadcast and webstreamed live. When taking a question on notice, it would be useful if witnesses use these words: "I will take that question on notice.". This will help the committee and witnesses confirm questions taken on notice from the transcript.

We welcome the ACT Ombudsman, who is also the Inspector of the ACT Integrity Commission and Principal Officer of the Judicial Council. We also welcome the officials in attendance. Please note that as witnesses you are protected by parliamentary privilege and bound by its obligations. You must tell the truth. Giving false or misleading evidence will be treated as a serious matter and may be considered contempt of the Assembly.

As we are not inviting opening statements, we will now proceed to questions. On this occasion, I will pass to Mr Rattenbury to kick us off.

MR RATTENBURY: Good morning. In your funding proposal, you stated at appendix A, page 3 that a slight reduction in FTE for ACT Strategy, ACT Policing is solely due to an internal reallocation of funding to better meet the needs of the functions as well as the allocation of funds to specific costs. Can you explain to us what that practically is and what that re-prioritisation is that you have done?

Mr Anderson: In essence, it just refers a slight change in levels of staffing. If we fill a position at one level, as opposed to at a higher level rather than a lower level, it might cost more money but it might mean that we end up with slightly less FTE. So, if we choose for people at higher levels rather than people at lower levels, we can afford slightly less FTE. But it is a very small adjustment overall. The actual changes are minimal between any of the different functions within the ACT Ombudsman overall function.

MR RATTENBURY: Thank you. Are you seeing any trends in freedom of information requests, in your role as a reviewer? Are there any particular issues emerging that the committee would benefit from hearing about?

Mr Anderson: We have seen an increase in the number of requests for reviews coming to us in the last financial year as opposed to the year before that. The absolute numbers are still relatively small. I think, roughly 42 to 51 were the numbers involved. So I would not draw too much significance from that increase in requests, although it might look a significant percentage based on the initial number. We did, in the last financial year, overturn or vary a higher proportion of the matters that came to us on review. Again, I would not read too much into that.

Some trends that we do see, though, go to a few things like agencies not necessarily taking the steps that they are required to take but instead leaping to a conclusion without doing the necessary preliminary work. For example, if an agency is of the view that all the documents are likely to be documents or information that should not be released, not doing a proper search to confirm that all the documents are that but leaping to the conclusion that they are not going to release anything. On a couple of occasions, we have had to go back to agencies and say, "You are required to do a proper search first, because there might be documents or information in there that are not in fact containing cabinet material or something that, for whatever reason, is going to be information that is not in the public interest to release." So that is one issue. With the cabinet information, agencies are sometimes being too quick to assume that an entire document should not be released; whereas, there might be purely factual information in the document. It is about applying the specific requirements of the legislation, in some instances, and not just leaping ahead to the conclusion that this should not be released and therefore none of it will be released.

MR RATTENBURY: Thank you. There is one last thing I want to just ask you about, for the time being, and I will hand to my colleagues. Your report on the use of force in the Australian Federal Police contains some, I guess, concerning findings. Without hashing over those, I am interested in what response you have received to that report and what engagement you are having with the Australian Federal Police or ACT Policing specifically about their response to that report?

Mr Anderson: I would distinguish here between the formal response and the substantive response. For a range of possible reasons, ACT Policing felt that they could not necessarily wholly agree to all of our recommendations. But I was quite satisfied that the substance of their responses actually showed that they were going to do the things that we were asking them to do in terms of providing more training, better guidance and support, acting on their internal oversight mechanisms and things like that.

While I understand from an ACT Policing perspective that they firmly believe that they should not be the first responder when there are mental health issues, we made recommendations about improving the capability of ACT Policing officers to deal with mental health issues because, as a matter of reality, there will be times when they are the first responder. They chose not to actually accept that recommendation, but I am still satisfied that they are considering how to build the capability of their officers. As a matter of substance, I am quite satisfied.

MR RATTENBURY: I am pleased to hear that. One of the issues that has sort of flowed from that is we have a seen a number of high-profile incidents in recent times where there has been perhaps inappropriate use of force and other issues by ACT Policing, and then there is no public disclosure of the subsequent disciplinary proceedings or the outcomes of those investigations. You spoke in your report about these issues undermining public confidence in the police. Do you have any advice as to how police might better maintain public confidence around these disciplinary proceedings? Is that something you have discussed with them?

Mr Anderson: We have had some discussions about that. Of course, as Commonwealth Ombudsman, I do an annual report which gets tabled in the commonwealth parliament about, broadly, the AFP's handling of complaints against their members. So there is already some information that is publicly available about whether we are satisfied that they are properly dealing with professional standards issues. At the same time, though, I did say in my most recent report, as Commonwealth Ombudsman, that I think that the AFP needs to improve how it handles complaints against its members generally. So there are some issues there. I think by analogy, though, it is by analogy with issues involving, for example, sexual harassment within organisations. In the past, they have been shrouded in confidentiality and secrecy. What that means is people do not know what happens—"Are there complaints, and what happens with those complaints?"

So I will be talking with both the Chief Police Officer for ACT Policing and with the Commissioner of the AFP about that question of "Can the AFP publish more information itself?" They do not have to publish, necessarily, details of outcomes, but more information about numbers of matters that they have considered, and then what some of the outcomes were that came from that—just as a way of building a notion of safety for people who might wish to make complaints, so they are comforted that their complaint will be looked at, and then also some knowledge of what the outcomes are.

One of the issues with complaints about use of force or about members generally is that there are times when complaints might not be well founded, and it is important to also demonstrate that, if matters are being not well founded, there has been a proper investigation and the officers have been exonerated. That is also important for the public

confidence.

MS CARRICK: There have been some cases—and I think of a particular case—where there was force and we hear that there is an investigation. Are they obliged to let the public know when an investigation has been completed and the outcomes? It just seems to go on for years and slip through the cracks.

Mr Anderson: A persistent theme in our comments to ACT Policing and to the AFP has been that they are not doing enough to communicate with complainants and they are also not doing enough to communicate with the officers, the members, who are themselves the subject of complaints. We have been urging them to get better at communicating in a more timely and in a more useful manner as to what is happening with the process and, when it concludes, what the outcomes are.

MS CARRICK: What about the public? Some of them have been publicly high-profile cases. You follow them up and you get emails and you follow them up and the minister will say, "There is an investigation," and then that is it; you never hear anymore.

MR RATTENBURY: That is the issue. The final result is considered to be private and confidential.

Mr Anderson: That is the issue that I was just talking about with Mr Rattenbury. There is not an obligation to inform the public, but I think it would be a useful thing for ACT Policing to be doing more to inform the public, whether that is an annual statement—and, of course, I do my annual report on complaint handling, which is about the AFP at large—or something like that as a way of shining a light of transparency, to say, "Here were the types of matters that we had complaints about and here were the ways those matters were resolved." I think that would be a useful thing.

MR RATTENBURY: It does strike me that there is some irony in the justice system where, if somebody is charged, we have an open court process but at the other end of the spectrum it is considered to be private and confidential.

THE CHAIR: When you are looking at those communication issues, to what extent do you consider the resourcing constraints and the capacity that, as an organisation, the AFP has to actually invest time in doing better with communication?

Mr Anderson: When we are making recommendations and suggestions, we try not to make recommendations or suggestions that impossible to comply with. Do we do try and take a pragmatic lens. But, at the same time, it is a very easy response for any agency to say, "We would not be able to do that." Sometimes they might need to have a negotiation with ministers and government, for example. We are not going to hold back from making recommendations if we think that they should in fact be made to improve how an agency deals with something. But, as I say, at the same time, we are trying to be pragmatic and not set a bar that would be completely impossible to comply with.

THE CHAIR: What I am trying to understand is that sometimes there may not be sufficient capacity to do it in the current context and they may need to seek additional

resources from a minister to do so or it might result in trade-offs in another area.

Mr Anderson: The process we have where we make recommendations—and we publicly make those recommendations and we publish the agency response—gives the agency the chance to say, "This might take six months or 12 months to, in fact, implement and it might require consultations," and things like that. Then we will follow up and we will publish, without judgement necessarily, what they have done and whether they have done what they said they were going to do. So at least there is that transparent process and the agency can offer whatever explanation or rationale for whether they will or will not implement it. That way, at least the Assembly and the community knows what the outcome has been.

THE CHAIR: I might go to the follow-up to the *What's fair? Collecting historical debts* report, which was tabled on 20 May. The Revenue Office has committed to implementing all four of your recommendations. Have you discussed further with the Revenue Office when each of those recommendations will be fully implements or any steps that are being taken in the meantime?

Mr Anderson: We are in the process of establishing what those timelines might be. There has been some further engagement between me and the head of the Revenue Office, both about that and also about whether we can provide further assistance to them to develop their complaint-handling skills, for example. We have referred them to our self-assessment tool, for an agency to self-assess how well they engage with complaints and we have offered potentially working with them on training and things like that. The discussion around timeframes is part of that.

THE CHAIR: That report is largely around historical rates and land tax. When you were doing that investigation, were any concerns raised regarding historic collections and reassessments of other taxes, duties or levies?

Mr Anderson: We have certainly had some complaints about other types of debts, particularly since we published that report. We primarily had reports about the historic land tax at the time that we did that investigation, and that is why we focused on that. We are also engaging with the Auditor-General, who is of course looking at other types of historic debts being recovered by the ACT Revenue Office. So we are sharing information with them.

THE CHAIR: I assume that you would have been receiving some of the multitude that I am receiving around stamp duties and that side of it?

Mr Anderson: We have certainly had some complaints about that, yes.

THE CHAIR: In your process of following-up, is there any indication that the lessons that are you suggesting be learnt from this report are being applied to the entire spectrum of issues?

Mr Anderson: I think it is too early to say whether they have been fully learnt, but that is what we have been encouraging the ACT Revenue Office to do. If we do one report, we always say, "Take this away and think about your other operations as well. Are these

lessons going to be relevant, and don't just look at it as this is only about historic land tax."

MS CARRICK: In the budget papers, you have resourcing broken down to six different matters. As the population grows and potentially more complaints come in, what is the trend in receiving complaints and how does your resourcing stack up to deal with increasing complaints for you to address or investigate should that be the case?

Mr Anderson: Complaint numbers fluctuate. They are up at the moment, and the year before that they were down. Over the last three financial years, we had one number and then it came down and then it has gone up again significantly. It is hard to predict overall complaint numbers. We do not fully investigate every complaint. With some complaints, it might be that the complainant needs to go back to the agency and engage with them. The agency can, of course, change their initial decision. With other complaints, it might be that, when you first look at them, you think, "Actually, the complainant should go to ACAT," or there is some other remedy that is available to them. Alternatively, it might just be the person is dissatisfied but the agency has acted properly. So we do not fully investigate everything.

From a resourcing perspective, the greatest concern is actually about getting new functions. We can absorb, to some extent, fluctuations in complaint numbers, and we do not always meet our KPIs in timeliness. That is unfortunate. We would like to always be meeting our KPIs. If you get an entirely new function, that is more of a challenge—because how do you absorb that to set something up completely new? As part of, for example, the ACT NPM, the National Preventative Mechanism under the Optional Protocol to the Convention Against Torture oversighting places of detention under the control of the ACT government, we received one FTE for that, which is a coordinator for the three agencies—ourselves, the Human Rights Commission and the Office of the Inspector of Custodial Services.

So we received one additional person to help the three of us work together as the NPM, but none of the three of us received any additional resourcing for that function. So that is hard for us, and it is hard for those agencies as well, if you get given an entirely new function without any resourcing, because that certainly drags resourcing away from complaint handling and other functions. Whereas, a change in the number of complaints is not such a challenge for us, because we can better absorb that as an organisation.

MS CARRICK: Thank you.

MS TOUGH: We heard from a witness on the community day earlier in the week that the ACT has what could be described as some of the best safeguards in place for the early childhood education and care sector, with the combination of CECA, the regulator, and the Reportable Conduct Scheme. How does the Reportable Conduct Scheme operate in its role in safeguarding children?

Mr Anderson: Entities who are subject to the scheme have a range of obligations; in particular, they are required to report any allegations, and they are required to properly investigate them. We look at the reports that we are receiving, and we look generally at what we are seeing across the sector, to see whether it looks like entities are

understanding their obligations and complying with them properly.

We take action to educate. We have forums for entities. We did a survey of religious entities, in particular, because we were concerned that there might be a lower level of understanding, amongst some of those organisations, of their obligations. There is targeted follow-up with different sectors that are subject to reportable conduct.

The obligations to report include reporting to police, so there is that dimension. We certainly look at how the entities themselves are treating those obligations. We called out Barnados, for example. We published a report about an investigation they did which we thought was very unsatisfactory. It ended up in a result that did not assist the people who were the alleged victims of behaviour, and it did not assist the alleged perpetrators either. No-one came out with a satisfactory outcome, and that is not what you want to see. You want to see everyone being able to understand whether something wrong happened, whether it was appropriately dealt with, and whether everyone involved has learned from that.

Overall, we work with the entities and with CECA, and we work with the police, to make sure that we can share information with them and they can share information with us. We think that there is a good level of maturity, in terms of the information sharing that we see. We think that the system generally is working reasonably well, but there is always more to do, to make sure that entities are continuing to understand and act promptly on their obligations. I will see whether one of my colleagues wants to say anything more about that.

Ms Dwyer: I will add to what the Ombudsman was just saying. That monitoring piece that we do is really important. We are regularly engaging with other bodies in the space. CECA is one; the working with vulnerable people team in Access Canberra is another one. We also monitor media. If something comes to our attention, and it appears that a designated entity has not notified us of an allegation, we can and do proactively reach out to them and ask them to engage with us.

MS TOUGH: I was going to follow up on whether you have a role in going out to entities and saying, "We think there might have been something and you haven't told us about it."

Mr Anderson: Yes. In fact, at the moment, we are taking a look at one particular entity where we think there are likely to have been reportable conduct issues that have not been reported.

MS TOUGH: What are the consequences for people if they are not reporting, when you find out that something may have happened?

Mr Anderson: In terms of our role, there is the big consequence that we might publish someone, and it would be transparent that they have failed to apply their obligations. There can also be other legal consequences, in terms of offences, if they have failed to report. That is not a matter for us, in terms of acting on offences, but we will share information with the other entities who look at those sorts of things. Certainly, Barnados were not delighted that we published something about them, but our impression is that

they took it very seriously when we did.

MS TOUGH: That transparency of being basically named and shamed; thank you.

MS CARRICK: With the reports that you receive from the childcare sector, 325 are reported in the Productivity Commission's *Report on Government Services*—RoGS—data. Are those the ones that are coming through to you?

Mr Anderson: Not just child care, of course. There is a range of different sectors. Schools are the source of the biggest number of reportable conduct complaints in the ACT. I would have thought it was more than 325. We might need to take the precise number on notice.

MS CARRICK: Yes. I am not trying to get to what the precise number is; that is the number that was in the RoGS data for child care. My question is: our number in that particular graphic is higher than the other jurisdictions per capita. Is that your understanding, that we have high reporting, and is that good? It could be bad, because bad things are happening, but it could be good, because people report in a good way.

Mr Anderson: There is a slight data challenge. We collect data about education and child care, and there is also a separate category of child care. There is one category which is effectively occasional child care, and there is another category which involves preschools, long day care and things like that. Some of it could be happening in school settings, in a preschool, but preschool programs can be delivered in long day childcare centres as well.

It might be reported as child care when in fact it is not all strictly child care. Some of it could be in formal school settings as well. That could be potentially distorting the picture. We have been engaging on this, and we get questions about this from time to time, in terms of what we mean when we say "education" and "child care". We have to keep explaining that it is not all what you might think of properly as being child care.

Ms Ramsay: My understanding, Ms Carrick, of the report you are referring to is that those numbers might be referring to breaches of the Education and Care Services National Law, and breaches around regulation of that law. Breaches underneath that are not necessarily reportable conduct which would be reported to us, so it is a different category of issues that might be reported underneath that to CECA, as the regulator, versus to us as reportable conduct; so our numbers will not match.

Mr Anderson: With the matter that we took on notice, I can give you an answer. In 2024-25, we had 199 notifications of allegations of reportable conduct. That figure of 325 that you mentioned, clearly, is something more than reportable conduct.

MS CARRICK: Yes; I think it is CECA compliance.

Ms O'Connell: You mentioned whether it was a good thing that we get numbers. It is a good thing. A positive reporting culture in the ACT is a good sign that people are taking their obligations seriously and reporting allegations of reportable conduct to our office.

THE CHAIR: Do you have a feel as to whether it is driven more by the reporting culture or more by the prevalence of issues?

Mr Anderson: I think it is driven more by the reporting culture. I think that entities continue to improve their understanding of their obligations and to err on the side of reporting everything. We did see, early on, entities being too ready to dismiss allegations—for example, "That's just a child they know," "That's about someone we've known for a very long time who's a trusted member of staff." Now, more appropriately, they are saying, "Each allegation needs to be reported and properly investigated." I have quite a degree of comfort that entities are continually maturing their understanding of their obligations.

THE CHAIR: That is great to hear.

Ms O'Connell: We also do a lot of education with the entities under the Reportable Conduct Scheme, to highlight that it is an allegation-based scheme. It does not have to be proved et cetera. If you receive an allegation that, on the face of it, is reportable conduct or looks like reportable conduct, that enlivens their obligations to report to our office.

MS CARRICK: Do you know how we stack up with respect to other jurisdictions? Because we have a positive reporting culture, perhaps we report more than other jurisdictions.

Ms O'Connell: That is a very hard question to answer, because it is not comparing apples with apples. The schemes operate slightly differently. We were initially modelled from the New South Wales Reportable Conduct Scheme, and Victoria came on at about the same time as the ACT. But there are significant variances in the way the schemes operate. For example, New South Wales does carve-outs. Employees within certain designated entities are not included, whereas Victoria has an all-in perspective. We would not be able to give a very accurate comparison of those schemes. We are also smaller.

THE CHAIR: On a slightly different angle, I want to ask about the financing arrangements between the ACT and the commonwealth for the Ombudsman service. It is under a service agreement; that is my understanding. What was the 2024-25 fee from the ACT government under that agreement?

Mr Anderson: In 2024-25 it was roughly $4.7 million. If you want the precise figure, I will need some help with that.

Ms Ramsay: For 2024-25 it was $4,739,367.

THE CHAIR: How is that indexed? Is it direct indexation?

Mr Anderson: No. We ask for a particular figure, and we incorporate indexation into that. Part of that is wage indexation and part of that is on-costs.

THE CHAIR: Is there any change expected to that model or will that continue? Do you seek a certain amount that relates to the activity that you are seeking to deliver in the period?

Mr Anderson: We engage actively with CMTEDD, in particular, about the activities we are carrying out and the cost of those activities. We report. We have had six-monthly reporting; we are moving to an annual report which we publish on our activities, in addition to our own annual report to the Assembly.

If we think we need more resourcing, we will raise that with CMTEDD and we will have a discussion about that. As I indicated earlier, in response to a different question, generally, we are not seeking significant increases, unless it is tied to a completely new function. We have those kinds of discussions.

THE CHAIR: Have you had any resource shortfalls similar to those cited by other state integrity bodies—anything that would impair the ability of the organisation to oversee ACT agencies?

Mr Anderson: I mentioned the ACT national preventive mechanism function, where we received one FTE, but it takes more than one FTE to deliver that function. Similarly, with the oversight of the Integrity Commission and our inspector role, we have 1.2 FTE to carry out that function.

Ms Ramsay: It is 1.7.

Mr Anderson: 1.7, sorry. It often takes more than 1.7 FTE to carry out that role. That means we have to find the resources internally, and it means that resources get pulled away from things like complaint handling or investigation. There is an impact, and we manage that as best we can, but we do raise that with CMTEDD in those discussions.

THE CHAIR: When those new functions come into your organisation, it sounds like there are efficiencies that can be achieved. Are there particular costs that the government should be considering that maybe it is not considering at the moment? It sounds like there has been a layering of functions that have not been fully accounted for in the increase in funding.

Mr Anderson: It is not an uncommon thing for agencies to be asked to find efficiencies somehow and absorb additional workload, and we are not necessarily any different in that regard. But it has not been of significant concern in the sense of being completely unable to do things. It is just that we are being stretched.

There was a situation a couple of financial years ago when we did not get our on-costs when we asked for them, and about a third of our budget was taken away for that financial year. That was very significant. If something like that happened again, there would be problems.

MR RATTENBURY: I want to return to your report on ACT Policing and the use of force. I was particularly concerned by comments on the use of body-worn cameras. You made an observation around ACT Policing failing to comply with the law and

undermining the legislative intent for any accountability in protecting the safety of both police officers and members of the community. You made an important point that cameras operate in two ways, and I think that is their absolute strength, in showing both sides of the story. Can you talk to us a little bit more about the shortcomings that you found there and, again, perhaps the response you have seen?

Mr Anderson: I will say something briefly about that, but I will turn to my colleague Ms Ramsay to give more detail. Sometimes it is about body-worn cameras being turned off regularly. ACT Policing said, "There are times when we don't want to be capturing private conversations between our officers," for example. If they are not doing anything actively, and they are having a chat between themselves, should that be captured?

On the other hand, if you see a situation where something is actively playing out and not all the cameras are turned on, or not all the cameras are turned on for the same periods of time, you have to ask: why is that? We are more concerned about those scenarios where it would appear active decisions are being made by officers to not have their cameras on at certain times.

We have had a reasonably good response from ACT Policing about that, but they have also tried to assert that perhaps we have missed the point that their officers should be entitled to privacy, if they are having private discussions between themselves. We think they are probably putting too much emphasis on that, particularly when it comes to something actively happening that is involving those officers. They are not just sitting back and having a chat; they are actually pursuing a suspect, and there is use of force happening.

Ms Ramsay: The only other aspect that I would add is that the original guidelines for body-worn cameras were written before amendments to the legislation, and the guidelines have not been updated. That is one of the things that our report points to—needing to update those guidelines to ensure compliance with the legislation. We have suggested in the report that they also consider some of the other elements about when they use them in engagement with different people, as to when they turn them on and off, as part of that update.

MR RATTENBURY: Do they have battery capability to be on the whole time, or is there—

Ms Ramsay: When they leave the station, they are fully charged at that point. They are recording, essentially, all the time, for 30 seconds, but they drop for 30 seconds until somebody turns them on, at which point it starts storing the recording for the period that the body-worn camera is on. That video footage is stored during that period.

While the video is being stored, they can turn the audio on and off. As the Ombudsman indicated, that is one of the things that certainly impeded oversight of a couple of particular instances, because we were getting very spotty audio coverage, and the individuals had alleged that there had been an inappropriate conversation happening around them, and we could not hear that conversation at that time. If we had the audio, we would have been able to confirm that or, equally, have a finding in support of the police in those particular situations.

We have certainly had those situations where there have been allegations, we have looked at body-worn camera footage and said, "There really isn't anything to see here." The short answer—and ACT Policing will provide more detail—is that the battery can; it is a matter of choice about when they start storing the video, and there are limits around the data that they can store on their systems, once they actually take the footage back to the station and start uploading it.

Mr Anderson: We do think that body-worn cameras are a very positive initiative.

MR RATTENBURY: Yes, I agree with you.

Mr Anderson: And beyond Policing as well. With respect to Corrective Services, their use there could be expanded as well.

MS CARRICK: With your oversight of the police, they will often say that they do not have the police numbers, the resources and the police stations in which to operate, to react in time. With police numbers, they have to triage what cases they go to. Do you have any views on those issues that the police raise and how should they be addressed?

Mr Anderson: I do not have a view on their absolute numbers, in terms of their absolute size. Certainly, we engage with them about the questions of adequate numbers for particular shifts and what that means in terms of people doing a lot of overtime or not having as many people as they had anticipated having for particular duties.

In terms of their facilities, we have certainly commented in some of our NPM reports about the aged facilities. The watch houses at police stations, for example, are very old and in some cases that is making it hard for ACT Policing to deliver a proper service, in terms of detaining people without ill treatment. It might be that they are not trying to ill-treat people but, with the conditions themselves, there might be a pervading smell of sewage and things like that. Sometimes there is a lack of proper CCTV and all those things. That stems from having facilities that have not been updated sufficiently over the years.

MS CARRICK: I want to ask about the childcare complaints. When they come to you, what happens then? Potentially, there are some serious issues, and we have heard about the issues happening in New South Wales and Victoria; it has been in the media a lot lately. What do you do with them then? If there is an issue in a particular childcare centre, how do you address it? I suppose you report it to the police?

Mr Anderson: The obligation is actually on the entity itself to report it to the police. The first thing is to ask: have they reported it to the police? If we see something that looks very serious, it is a matter of asking: are the police also aware of it? What we are looking at is: has the entity complied with its obligations? They have reported it to the police and they have reported it to us; have they done a thorough investigation themselves?

We also have the ability to share information within the ACT with prescribed entities. We can, if necessary, reach out to the police and say, "Are you seeing what we're

seeing?" If they have reported it to the police and if they have done a proper investigation themselves, we will generally at least be satisfied that they have complied with their obligations.

Ms O'Connell: That is correct. When we get what we call the section 17G notification, which tells us about the allegation, we assess it based on risk and we also ask what we call the designated entity to provide us with an investigation plan and a risk assessment. We make an initial assessment of that risk assessment and the investigation plan to see whether, on the face of it, it looks like they have considered all the things that they need to consider. If that happens, we do what we call oversight, so we leave them to go and conduct the investigation.

As Ian said, if it looks like a criminal matter, we ensure that the designated entity has notified the police. If it looks like it needs to be reported to the regulator, we ask, "Have you reported it to the regulator?" We make sure that those steps are taken and that our other oversight agencies have been informed of the allegations.

Particularly with criminal matters, we ask the designated entity to liaise with the police, to make sure that it is okay regarding when they conduct their investigation. Obviously, we do not want that designated entity to contaminate any police investigation. Those are the steps that we take when we first get the notification. If we are not satisfied with their investigation plan or their assessment of risk, we do what we call "monitoring". That is where we work closely with the designated entity in regard to the next steps about what they are there to do and how they are to handle things.

Once they have completed their investigation, they provide us with what is called a section 17J final report. That outlines what evidence they have collected, their assessment of that evidence, the balance of probabilities as to whether they think that the allegation occurred in the manner that was alleged and whether it gives rise to reportable conduct, and they are required to make a finding. They provide that finding and any actions taken to our office, and we make an assessment of their investigation based on that information.

If we find that further investigation needs to be done, we work with that designated entity to continue that investigation or we question the findings or the balance of probabilities. If we think that it is satisfactory for that individual investigation, but we see some systemic issues that they need to address, we will also provide them with feedback in regard to future investigations, and what they need to consider.

MS CARRICK: How are parents kept informed throughout the process?

Ms O'Connell: That mostly lies with the designated entity. As part of that initial risk assessment and part of the information that is provided to us, we get the designated entities to inform us about what supports they will provide to the person that is the subject of the allegation, and what supports will be provided to the alleged victim. We do ensure that those supports are in place for the parties involved with the reportable conduct allegation.

Further, in our legislation, we have the ability to share information with the alleged

victims, guardians and parents, which we have done. We confirm that the parent is the parent, their identity is confirmed; we then share that information with the parent.

MS TOUGH: As Ombudsman, you have a dual role as the Inspector of the Integrity Commission as well. How does that role work? When you do investigations into the Integrity Commission, such as the recent one about procurement, what process does an investigation follow? When you make recommendations, how long does the Integrity Commission have to respond, and to say whether or not they agree to that? Is there any follow-up after that process?

Mr Anderson: We receive monthly reports from the Integrity Commission on their operations. I should clarify that that does not go into their actual investigations; it just talks about the numbers of things and their activities at a higher level. That informs us. We meet with them regularly to talk about what they are doing and what they are seeing. We have obligations to report to the Assembly on an annual basis about whether they are complying with their legislation, for example; we do that sort of thing.

Investigations are an unusual thing, rather than a common thing, in the role of inspector. There have been times when I have simply reached out to the commissioner and raised something informally. We thought they could improve their witness support measures before their first public hearing, and they were very receptive to that. When we formed that view, it was because we had looked at other integrity bodies around the country who had articulated procedures for supporting people who were subject to allegations, because that can be a very stressful time, and people have self-harmed in that scenario in other jurisdictions.

We can raise things informally, and they have been receptive. But if we are concerned about something and we do not feel that they are being receptive to it, it is more likely to turn into a formal investigation. The investigation that led to that report with respect to procurement was the first special report that had been carried out in the four or so years that—

Ms Ramsay: It was the first own-initiative investigation. Correct me if I am wrong; you are currently talking about own-initiative investigations?

Mr Anderson: Yes.

Ms Ramsay: We also do complaint investigations, which can result in special reports.

Mr Anderson: Yes. Thank you for that clarification. The procurement report was special and, so far, unique, in that we had not done an own-initiative investigation like that. We have certainly investigated a number of complaints. The complaints are typically about things like people reporting allegations of corruption and feeling that their allegation has been dismissed without being properly considered. We have given the commission both formal and informal advice about how to, in our view, improve their communications with complainants, how to provide a better explanation of why they have chosen not to further investigate an allegation of corruption. We think that would be a useful thing.

If it is an own-initiative type investigation, the act prescribes procedural fairness processes. A minimum of six weeks needs to be provided to an entity such as the commission that might be expressly or impliedly criticised in a report. With that report, we went through two rounds of procedural fairness. Roughly five months were taken up with procedural fairness processes. The commission had, in my view, a lot of time to digest what our proposed findings were and where I was going with the recommendations. The recommendations did change in the course of that process, but they did have quite a number of weeks to consider whether or not they wanted to agree with those recommendations.

Ms Ramsay: The procedural fairness obligations in the act apply to any special report that will be tabled in the Legislative Assembly, and it is more than just the entity that it applies to. If, in a special report, an individual is named, even if it is relatively benign, we have an obligation to consult with them or provide them with procedural fairness for six weeks, regardless of whether it is a single reference or whether or not there are findings against them. That is one of the recommendations for amendment that is currently with government from Ian Govey's review of the Integrity Commission Act.

MS TOUGH: You mentioned how, with the complaints going to the Integrity Commission, they could explain things better to people who report potential corruption. Has the Integrity Commission acted on that and are they changing how they are replying to people—communicating?

Mr Anderson: They have made some changes. I think they could continue to improve in that regard. I appreciate that, from the Integrity Commission's perspective, there is a tension. They do not want to disclose too much about why they are thinking that something might or might not have grounds for investigation.

At the same time, as an Ombudsman, we see that a very common outcome that really satisfies people is having that better explanation. Agencies of all descriptions, not just the Integrity Commission, can do better at communicating, and at using plain English rather than simply referring to a section of the act and saying, "Your complaint has not been proceeded with because of this section." We did find sometimes that they were using the wrong section as well, which did not help. It is better to use plain English, and we would encourage any agency to keep working on their communication.

MS TOUGH: Is that something you have suggested to multiple agencies over the years about complaints—better communication with complainants?

Mr Anderson: Absolutely. Back in 2023, as both Commonwealth and ACT Ombudsman, I released a very short report called *Room for improvement*. It said that there are five things that we see as themes across all complaints, all agencies, all governments. There are things like compliance with the law, communicating better, training staff better, and keeping better records. There are common things. I sent a copy of that report to the director-general of each directorate in the ACT.

THE CHAIR: Have you seen tangible improvements since the publication of that report?

Mr Anderson: I have seen more consciousness of some of those issues, which is pleasing. Complying with the law is one that is a little bit challenging, in that agencies should always comply with the law. Public servants should not need to be reminded. But we have seen, through that report and through some other reports, agencies being perhaps readier to look at what they are doing and not just assume that they are complying with the law. I think that is a positive.

Of course, we do have agencies still finding that they are not complying with the law. Almost invariably, it is inadvertent, but there is always more room for improvement there. I think that agencies were surprised to even think that they were not complying with the law, but they now seem to have taken on board, in my view, that they need to assure themselves better that what they are doing is in fact what the law requires.

THE CHAIR: You said you sent that report to all the directors-general?

Mr Anderson: Yes.

THE CHAIR: Was that when it was first published?

Mr Anderson: It was when it was first published, and I was invited by the Head of Service to address a meeting of all the directors-general, and I spoke about that, amongst other things.

THE CHAIR: Would there be benefit, given there have been significant machinery-of-government changes and movements of staff, in recirculating that report to all the people who are new to the roles?

Mr Anderson: I think that is a great idea. We might look at updating it.

THE CHAIR: I want to go back to functions that are outsourced to you from the ACT and get your sense of how well that has been working, from your perspective, and what sort of benefits or, indeed, drawbacks that relationship brings versus the ACT having its own dedicated office set up to deliver the functions that you do.

Mr Anderson: I might be the wrong person to ask, in terms of assessing the benefits. If you look at our funding, our funding enables us to have 27-odd full-time equivalent staff. That is for seven different ACT functions. I think the ACT gets a lot for that funding. If you had a micro-agency of 27 people that was needing to do everything that an agency does, as well as deliver its functions, that would mean that you would get less return for that funding.

At the same time, I am fully appreciative of the fact that it is a matter for the ACT to decide how best to meet its own needs. If the ACT were to say, "We want our own Ombudsman, we want our own inspector, we want our own principal officer for the Judicial Council," I would have no concern about that. That is entirely a matter for the ACT.

I do think that we can provide a service that means, because we are a much larger organisation, as the Commonwealth Ombudsman, we can have some ebbs and flows

and, if we have particular spikes in the ACT side, regarding things we want to do, because a lot of our activities are discretionary, we can move resourcing in from the rest of the organisation. In the year when we did not get our on-costs paid by the ACT, I covered that from our commonwealth funding. While I would not encourage the ACT to cut our funding on the basis that I will keep doing that, it did mean that, as a one-off, I was able to adjust it.

In the last financial year, for example, we carried out a lot of activity in the ACT space. We published reports on a number of significant investigations. I think that demonstrates that we can deliver a lot, and we can hopefully assist complainants, as well as assisting the Assembly and the ACT public service to improve.

THE CHAIR: That goes to my next question, which is about managing workload conflicts between ACT and commonwealth. It sounds like what you do is basically to shift resources in order to have a balance. Do you ever come into direct conflict where the commonwealth has a very high load and the ACT does as well, at the same time?

Mr Anderson: As both Commonwealth Ombudsman and ACT Ombudsman, I have the discretion at any point as to what to investigate and how to investigate it. I have good staff who help me to make decisions as to what things I will prioritise and in what ways. It is about making sure that we do not have everything peaking simultaneously, and we can schedule things, so that we can make sure that we have a consistently high level of activity, as opposed to peaks and troughs.

It is not about having a direct conflict. I do have enough resources to be able to manage. I can always do the things that I think I most need to do, but I also have to make choices all the time. I can never do all the things that I would like to do. We have, effectively, a reserve list, much like the Auditor-General does. The Auditor-General has a list, and it says, "These are the topics we're going to audit and these are the ones that are on our reserve list." We always have that. We do not publish it, but we always have something else in mind; if we start doing an investigation and find that it is not what we thought it was, we have something that we can substitute. Alternatively, if something arises that is super important and that we need to look at right now, we can de-prioritise something in the background.

THE CHAIR: It sounds like having that degree of flexibility in the arrangements is important.

Mr Anderson: It is crucial to have that discretion to make those decisions from time to time. It does mean, as I said earlier, that we are not meeting some of our KPIs. That is not my preference, but it does mean that we can deliver across a broad range of functions.

THE CHAIR: It sounds like you are prioritising the strategic objective over the specific KPIs.

Mr Anderson: Yes.

THE CHAIR: Do you think there is scope for the ACT to be able to use those

arrangements for other functions? Is this something that could be applied in other areas?

Mr Anderson: There is certainly scope. Obviously, it would be a matter for negotiation between governments. I am aware, for example, that the Office of the Australian Information Commissioner was providing privacy oversight for the ACT and it is no longer doing that. It is a matter that would need to be agreed.

If we are asking whether the commonwealth has an entity that could do ACT services as a small part of its overall remit, and the ACT could get that benefit from using its expertise and applying that without having to set up a micro-organisation, I think that is a model well worth considering. We should not be too precious, necessarily, about saying, "It's a separate government," because we do not find that there are any actual conflicts. We find that there is great utility.

For example, with ACT Policing, which Mr Rattenbury was asking about before, there is no doubt about my ability to look at ACT Policing. They cannot say to me, "Hang on, we're a commonwealth body." I can say, "Guess what? I'm a commonwealth body, too, so I'm looking at you either as Commonwealth Ombudsman or as ACT Ombudsman." There is no doubt about my ability to provide that coverage, and I think that is a good thing for the community.

Ms O'Connell: Can I go back to Ms Carrick's question about numbers for the early education and care sector? As the Ombudsman said, there were 199 notifications in the 2024-25 financial year. Of those, 44 were related to the early education and childcare sector.

MS CARRICK: That is great; thank you.

THE CHAIR: On behalf of the committee, I thank you for your attendance today. If you have taken any questions on notice, please provide your answers to the committee secretary within five business days of receiving the uncorrected proof *Hansard*. The committee will now suspend the proceedings for a break.

Hearing suspended from 9.59 to 10.17 am.

Appearances:

Canberra Memorial Parks
Guthrie, Mr Neil, Board Chair, Canberra Memorial Parks
McMurray, Mr Kerry, Chief Executive Officer, Canberra Memorial Parks

City and Environment Directorate
Clement, Ms Sophie, Executive Branch Manager Infrastructure Delivery

THE CHAIR: We welcome officials from Canberra Memorial Parks. We have many witnesses for this session. Please note that, as witnesses, you are protected by parliamentary privilege and bound by its obligations. You must tell the truth. Giving false or misleading evidence will be treated as a serious matter and may be considered contempt of the Assembly. As we are not inviting opening statements, we will proceed to questions.

MR RATTENBURY: Regarding the priority for the authority, budget statements E states:

> Ensure the financial viability of the Authority by increasing its share of the cremation market by developing new memorialisation option services and facilities to meet the needs of the market and provide additional income streams.

Can you tell us more about why it is stated that the priority for the authority is to win a greater share of the private market?

Mr McMurray: I have read and accept the privilege statement. There are two pieces to the puzzle. The first is that there has been a significant move over the last 12 years from burial to cremation, to the point where we are probably looking at 75 per cent of the market share being cremations. The balancing 25 per cent are burials. That has moved significantly in the last three years for the authority. Previously, we probably had 75 per cent being burials and 25 per cent being cremations, so we have seen a very significant shift. For the authority to remain financially sustainable, we need to buy into that market. Thus, the crematorium was built in 2021. The reason behind the crematorium in 2021 was that the private competitor across the road had not been meeting the needs of the community for religious and cultural reasons and a number of complaints had been received. As a result, in 2021, the authority completed the construction of the crematorium at a cost of about $2.85 million.

The process for the authority moving forward was to build product that supported providing service to the community. We are currently in the process of constructing a memorial hall and condolence lounge at the Gungahlin Cemetery to be able to offer full service to the community, which is something the authority has never been able to do. As a result, that will increase our market share, because, until now, the authority has been restricted to two things in terms of cremations: direct cremations—that is, no service and no attendant—or religious groups that wish to use our viewing room in the crematorium to commit.

MR RATTENBURY: Thank you. Presumably, your financial situation changes with the reduced number of burials, because that is the expensive part of running the

service—essentially, the perpetuity maintenance of the memorial gardens and the burial sites. So I presume your financial equation is shifting.

Mr McMurray: It is. Obviously, the area of land involved in a burial is significantly greater than that for interring ashes. However, the expectation from the community is a higher quality and level of finish for ash memorialisation gardens. We have just completed Sanctuary Creek, which is a $1.8 million ash memorialisation garden. The density of interment per hectare is significantly higher than that of burials, but the level of required maintenance for the gardens and everything else also increases significantly. On a square metre rate, it is probably not that different.

MR RATTENBURY: Thanks. You talked about the private cremator not meeting demand. What is the current utilisation rate of your cremator, and are you aware of what the utilisation rate is of the private facility?

Mr McMurray: We are not aware of the numbers across the road. In terms of ours, we have capacity. This year, we have done 650 cremations. We have only been restricted by the fact that we have done—

MR RATTENBURY: Sorry—is that in the calendar year or in the financial year?

Mr McMurray: The financial year.

MR RATTENBURY: The one just gone?

Mr McMurray: The one that has just gone. But we were restricted because we did not have a memorial hall and a condolence lounge to offer full service. As a general rule across Australia, direct cremations represent between 20 and 25 per cent of the total cremation market. With the construction of the memorial hall and condolence lounge, we would anticipate it moving towards 1,000 or more a year. We have just turned over 2,000 cremations through that cremator since 2021.

MR RATTENBURY: How many could you do in a year?

Mr McMurray: In a normal operating environment—

MR RATTENBURY: Assuming you had that memorial hall.

Mr McMurray: Yes—we can do about 800 to 850 with the single cremator we currently have. When the crematorium was built, it was built to take a second cremator, so it is already plumbed and set up for a second cremator.

MR RATTENBURY: I believe there was a study done about five years ago to see whether Canberra needed two crematoriums. You have obviously responded to that. We have had the additional one built, so we have two, but we may have four in a few years. There is a proposal for Southern Memorial Park, which you are responsible for, and a private InvoCare facility in Symonston, if it is built. What impact will that have on capacity in the ACT?

Mr McMurray: The study that was done five years ago was at a time when there was

about a 60-40 split: 60 per cent cremations; 40 per cent burials. Now cremations are a significantly bigger portion. There is increased demand for cremations. Last calendar year, the death rate in the ACT was 2,564.

MR RATTENBURY: Individuals.

Mr McMurray: Individuals. That data goes to the number of people whose death was recorded in the ACT. There is actually a variation because it also includes people for whom this was not their usual place of address; they came here to get particular services and passed. So the actual number of Canberrans is probably a bit less than that number.

MR RATTENBURY: But it gives us a reasonable proxy.

Mr McMurray: Yes. There is a whole range of factors. We are the only cremator in the ACT that can do bariatric. As to how many we can do, it can take up to six hours for one bariatric cremation, depending on the size of the individual involved. We have certainly had one or two that have taken six hours, so that is a whole day for one cremation. The numbers vary. As a general rule, everything being normal, you would say you could do four a day if you did not have bariatric type situations.

MR RATTENBURY: In terms of the number of crematoria in the ACT, when granting licences, does the government consider the need for services or is it just a case of building one? Do you have any insight into that?

Mr McMurray: Neil Guthrie was around when it was approved.

Mr Guthrie: I have read the privilege statement and accept it. It is a matter for the regulator. However, I am sure those sorts of issues are taken into account. Mr Rattenbury, I am familiar with the study five years ago that you mentioned. We were putting in a second cremator for the town. It was my opinion at the time that three operators could actually be working and there would be enough to pay the bills. It is a competitive market for the organisation and it has nothing to do with the authority; it is a decision for the regulator. As to my personal opinion, I think there is capacity for three right now as the town continues to grow. Kerry has outlined the fact that there is a decline in the number of burials and an increase in the number of cremations, so there is growth happening naturally.

MR RATTENBURY: Thank you. This is my last question. I should let my colleagues jump in. That is helpful insight. If the Cemeteries Authority is due to build another one at Southern Memorial Park, does having even more in the market become a significant financial risk for you?

Mr McMurray: Direct cremations?

MR RATTENBURY: Yes.

Mr McMurray: It would become a more competitive market because, with direct cremation, people, with the greatest respect, probably have less care about where that cremation occurs. Those who are looking for a full service will value, over everything else, the quality of the facility and the services they are provided, which is the purpose

for building our memorial hall and condolence lounge and installing a second cremator in our existing building.

MR RATTENBURY: Sorry; this is the last question. What is the timeline for building a cremator at Southern Memorial Park?

Mr Guthrie: It is part of phase 2, which would be some time in five to 10 years after phase 1 has been completed. It is at least a decade away. The project has not received any funding to date, so that timeline would be five to 10 years after phase 1 of Southern Memorial Park is completed. We are talking about today, but in 10 years the population will have grown again. The trend towards cremation is probably slowly trickling higher, so there is a market share, if we are just talking about the numbers.

Mr McMurray: In that timeframe, I think we will see further development of alternative technologies to standard cremation.

MR RATTENBURY: Yes. I have heard about those in the past. I should hand over to my colleagues.

THE CHAIR: It sounds like you are operating in a competitive market at the moment. You said that there is capacity within the market and there would be sufficient demand for three operators today. Is that right?

Mr Guthrie: That is my personal opinion from looking at the numbers. From a strategic perspective, my personal opinion is that there would be space for three cremators. The margin would be less, but there would still be a margin.

THE CHAIR: As a government provider of the service, is it a priority to maintain your market share? How do you look at your role within that competitive market, where you are up against private operators, in essence?

Mr McMurray: There are two pieces to the jigsaw. The direct cremations will generally go to whoever is providing the best price for the service, because it is a simple delivery: cremation and collection of ashes. There is only one player in the marketplace at the moment that provides a full crematorium service, and that is Norwood Park. The hall and condolence lounge that we are building now will detract from that, because there has only been one option all the way along. Our facility is nowhere near the size of Norwood Park's facility. We purposely targeted not to compete directly with the big end. We are talking about 275-plus people. They would still go to Norwood Park because the facility we are building cannot accommodate that sort of number. There are people who will look for full service and having choice, and that is where our market will grow.

THE CHAIR: You said the original driver for opening a publicly funded crematorium across the road from the existing one was around cultural—

Mr Guthrie: There were a couple of reasons. First, culturally there was a significant gap in meeting the needs of the Hindu, Buddhist and Sikh communities, in terms of their religious practices around cremation; and, second, long waits were starting for people to access the crematorium when they wanted a service. When I was bought up,

if someone in the family died, you would be at their funeral in two or three days. People are waiting up to two to three weeks to access those facilities. They had a monopoly share of the cremation market. The town needed a second cremator probably five years before it was built.

THE CHAIR: I am interested in how you are making sure that the space you are targeting in the market is focused around that cultural side of things when there was no alternative.

Mr McMurray: We engaged with all the groups in the design of the memorial hall, the same as they were consulted when the crematorium was constructed. We have had people from all over Australia coming to look at the viewing room. In terms of meeting cultural needs, about 22 per cent of all our cremations use the viewing room, which is significantly higher than anywhere else in Australia.

THE CHAIR: That is a fairly good indication.

Mr McMurray: Yes.

THE CHAIR: Thank you. Are there any other supplementaries on this one?

MS CARRICK: Yes. Thank you, Chair. When are ACT cemeteries expected to be at capacity for burials?

Mr McMurray: Gungahlin will be the longest lasting cemetery. It probably has 25 years left. There are about 40 hectares. It may get to 30 years. The reason for that uncertainty is that, if the trend with cremations over burials keeps continuing, the density of internment per hectare will be significantly greater, so you could get more time out of Gungahlin. Woden Cemetery is basically at capacity. There is certainly no more developable land within the current boundaries of Woden Cemetery. There are 292 allotments generally available. They are not all burial allotments. We settle about 350 to 370 a year. There would nothing left to sell in Woden by maybe June next year. Hall Cemetery has one burial plot left and 26 ash internments left.

MS CARRICK: Thank you. In the budget papers is an amount of $390,000 for Southern Memorial Park detailed design. Is that right? It is on page 268. I wonder whether it is supposed to be Southern Memorial Park or the Gungahlin one.

Ms Clement: I have read, understand and accept the privilege statement. That is part of the existing budget for the Southern Memorial Park detailed design that we have been working on for a few years. That is the outstanding budget that is left as we complete that project. It is intended for and has been allocated to Southern Memorial Park.

MS CARRICK: When will the detailed design be finished, and does it go out to the public for any consultation?

Ms Clement: We did a masterplan for Southern Memorial Park. It was completed a few years ago. We then received funding to do the detailed design for stage 1. We had public consultation on the master plan, and for stage 1 we went out to consultation with the

community on the progress of that design in 2021. We submitted a DA last year, in August, for stage 1 of Southern Memorial Park. That was publicly notified through the DA process. It is currently continuing through that assessment process. A DA of that complexity would normally take six to 12 months. We will probably have that approved in the next couple of months. There have been a few RFIs around aspects of the design that we are working through with entities, but we have about two months until that will be approved.

MS CARRICK: What is an RFI?

Ms Clement: It is a request for further information.

MS CARRICK: Okay. And when did you say it was submitted?

Ms Clement: On 28 August 2024.

MS CARRICK: That is some time.

Ms Clement: It is a complex project. It is largely an estate development. We are building a new road entry. There are quite a bit of civil works. We need to get services to the site, including power and water, and work through the waste-water management, so there is quite a level of complexity. There are also environmental values and heritance values on the site. It is within what we would expect for a timeframe of a DA of that complexity. A longer period is required.

MS CARRICK: Could I check the number of crematoriums there will be. You will have two at your facility in Gungahlin and InvoCare will have two?

Mr McMurray: I think there are two in their drawing, but whether that development proceeds—

MS CARRICK: And Norwood has—

Mr McMurray: Norwood Park are currently building a new crematorium on their site, but it is not additional. The two cremators they have now are at their end of life. They are replacing stuff that cannot be updated any further.

MS CARRICK: Two new ones to replace two old ones?

Mr McMurray: Two new ones to replace two old ones.

MS CARRICK: What happens to the two old ones?

Mr McMurray: I cannot answer that question. That would be a question for Norwood Park.

MS CARRICK: Okay.

MR RATTENBURY: I think your view would be that they would be decommissioned.

Mr McMurray: My view would be that they would be decommissioned and pulled apart. The bricks and pieces would be taken away.

MS CARRICK: How many will you have at Southern Memorial Park in a decade or so?

Mr McMurray: Stage 2 does not have detailed design, in terms of the number of cremators. In 10 years, I would expect different technology to be available, which we would certainly look at, rather than standard cremators.

MS CARRICK: What is coming onto the market with different technology?

Mr McMurray: In Australia currently, there is aqua cremation. It is the use of water, acid and other chemicals. There is one, and its name escapes me, that is about snap-freezing a body and then using microwave to break up the body, and there is work around what they call human composting, which is a long-term process—a 12- to 16-week process—of breaking down a human into compost.

MS CARRICK: Is your authority looking at those options as services that you might offer in the future?

Mr McMurray: It certainly is part of our consideration for Southern Memorial Park. Earlier, we went down the path of looking at electric cremators. At the moment, the cost of an electric cremator is nearly three times that of a gas cremator, and there are none in Australia. From talking to the overseas companies that provide them, they have no service agreements for them, so, whilst we would certainly like to look at them and explore them further, we are really not of a size to be on the bleeding edge of an electric cremator. I would be happy for someone to put one in and see how it works. If it substantiates, we would certainly look at that as well.

MS CARRICK: Presumably, that is more environmentally friendly than gas. I assume there are the same particulates.

Mr McMurray: Yes. It is complex. The newer the cremator the better the technology. At the moment, you cannot move away from gas. We use LPG gas. Trials are being done in Victoria on exactly the same cremator we have but with a mix of hydrogen and gas. Again, the challenge is that, from an environmental perspective, you would be looking for green hydrogen, and the problem then is that you need to be guaranteed a supply of green hydrogen, because you cannot say, "Sorry; I can't do it today because the supply did not arrive." If it existed, we could change the burners on our cremator at the current time and run a mix of LPG and hydrogen. A new gas cremator has been installed in Adelaide. They have a full water filtration system connected to it which reduces the emissions by 92 per cent.

THE CHAIR: I am very keen to jump in with a couple of supplementaries on this and then I will hand to Ms Tough. We are stretching it for time at this stage. In the statement of intent for the Cemeteries and Crematoria Authority, a potential strategic risk is: "Delays in the development of Southern Memorial Park Stage 1". How would a delay in that development, similar to that is 2021, affect the ability of the authority to meet its stated objectives?

Mr McMurray: It is probably not about us not being able to meet our stated objectives; it is more about the potential impacts on the community of Canberra. When Woden Cemetery reaches full subscription in the next 12 months, there are no alternatives in the south without Southern Memorial Park. The flow-on impact would be that all interments would occur at Gungahlin, and, as a result, it would start shortening the life of Gungahlin, subject to the parameters that I gave before—depending on the ratio of burials to creations—but, having said that, there are a number of religious groups for whom burial is the only option, so that market constantly exists. The impact is that we will still be able to inter, but it would potentially only be at Gungahlin without Southern Memorial Park or some other option.

THE CHAIR: I may have missed this before: is the construction of the project fully managed by the authority or does Infrastructure Canberra have a role?

Mr McMurray: For Southern Memorial Park?

THE CHAIR: Yes.

Ms Clement: The master planning and the detailed design was done by TCCS at the time, so it was done by the government through the directorate. Stage 2, assuming it is likely to cost more than $25 million, would be delivered by iCBR under the new administrative arrangements last year. It would need that trigger to move across to iCBR, if the budget is more than $25 million.

THE CHAIR: Will the burial infrastructure and business plans for the development be made public?

Ms Clement: It would go through a regular business case process, in terms of seeking funding for the construction stage, and I think that would be subject to the usual privileges around that process.

THE CHAIR: In respect to the environmental questions that were asked before, is there an intent to make Southern Memorial Park carbon neutral?

Mr McMurray: It certainly is something that we have been looking at. We have gone down the path of looking at our carbon footprint for our current operations to better understand where the driver is. In terms of stage 1, if you are talking about the operation rather than the construction carbon component, stage 1 should not be too far out from being carbon neutral, because there is no cremator in stage 1. There are 2½ thousand allotments. That includes a natural burial area and significant planting of gardens. The only infrastructure going in stage 1 is a depot.

THE CHAIR: Stage 2 has been considered more broadly for the project as well. Will that have an impact on the cost or timeline to deliver—

Mr McMurray: Stage 2?

THE CHAIR: Yes.

Mr McMurray: Stage 2 does not even have detailed design.

THE CHAIR: So we are looking somewhat into the future?

Mr McMurray: That is right. You are looking at 10 years out.

MS TOUGH: Earlier this year, Sanctuary Creek opened at Gungahlin Cemetery. I understand it won an award. Could you elaborate on what that award was for and how Sanctuary Creek is different to the gardens?

Mr McMurray: Sanctuary Creek is our first dedicated area for ash memorialisation. Whilst we have done ash memorialisation forever, basically your choice was to buy a rock and put a plaque on it, and it was scattered in a garden around other areas. This is a dedicated area that is all about ash interment. It has just won the award for excellence at the CCANSW conference. Probably the key pin for it was that the board and the authority had the view that people choose to live in Canberra for what is here. The board adopted the view: "What if we could build something that reflected exactly the same thing for people who want to inter a loved one?"

If you look at an aerial photo of Sanctuary Creek, it is circular. It is based on three roundabouts. The niche wall is a 20-tonne piece of granite. If you look at it side-on, it has a wave pattern through it. Because it has recesses for ashes, people thought it was Indigenous artwork. The curves are actually the contours of Mount Ainslie turned on its side; thus, we have called it the Ainslie Wall. The verticals that we have in place have a steel cut frame on top of them and they reflect three things: one is Telstra Tower, one is the gang-gang cockatoo, and the other one is the royal bluebell. So it has a sense of Canberra, and that is what the community have embraced since we released it.

MS TOUGH: Wonderful. CCANSW is the—

Mr McMurray: The Cemeteries and Crematoria Association of New South Wales.

MS TOUGH: Thank you. That sounds lovely.

THE CHAIR: We will wind up there. On behalf of the committee, thank you for your attendance today. If you have taken any questions on notice, please provide your answers to the committee secretary within five business days of receiving the uncorrected proof *Hansard*. Thank you very much.

Short suspension.

Appearances:

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

Health and Community Services Directorate
- Rule, Ms Catherine, Director-General
- Hudson, Ms Robyn, Deputy Director-General Policy and Transformation
- Coleman, Dr Kerryn, Chief Health Officer
- Travers, Ms Maria, Acting Executive Group Manager Population Health Division
- Jacobi, Ms Skye, Executive Group Manager Health System Innovation and Performance Division
- Stoddart, Ms Chloe, Executive Group Manager Policy, Partnerships and Programs Division
- Nagle, Ms Dannielle, Acting Executive Branch Manager Mental Health Policy and Strategy
- Cidoni, Associate Professor Anthony, Chief Psychiatrist, Office of the Chief Psychiatrist
- Buchanan-Grey, Associate Professor Marina, Chief Nursing and Midwifery Officer, Office of the Chief Nursing and Midwifery Officer
- Dorrington, Dr Melanie, Chief General Practitioner and Primary Care Adviser, Office of General Practice and Primary Care

Canberra Health Services
- Zagari, Ms Janet, Chief Executive Officer Canberra Health Services
- Aloisi, Mr Bruno, General Manager Mental Health, Justice Health and Alcohol and Drug Services Canberra Health Services
- Hughes, Ms Rosalie, Chief Finance Officer Canberra Health Services
- White, Mr Andrew, Executive Branch Manager People and Culture Canberra Health Services
- McKenzie, Ms Katie, Acting Deputy Chief Executive Officer Canberra Health Services
- Rady, Dr Kirsty, Director Clinical Training Canberra Health Services

THE CHAIR: We welcome Ms Rachel Stephen-Smith MLA, Minister for Health and Minister for Mental Health. We also welcome the officials in attendance. Please, note that as witnesses you are protected by parliamentary privilege and bound by its obligations. You must tell the truth. Giving false or misleading evidence will be treated as a serious matter and may be considered contempt of the Assembly. As we are not inviting opening statements, we will proceed to questions.

I want to go straight to the forecasted estimated expenditure. Last year's budget forecast estimated expenditure of $2.5 billion roughly, but the outcome shows expenditure of $2.8 billion, as has been fairly extensively observed. How were the expenditure forecasts so wrong?

Ms Stephen-Smith: Mr Cocks, we have been through this multiple times, including in yesterday's hearing, that we have seen both cost increases and demand pressures on health systems. As I noted in yesterday's hearing, this is consistent right across the country. The Independent Health and Aged Care Pricing Authority has estimated an

increase in the national efficient price of delivering health care from 2024-25 into 2025-26 at more than 12 per cent price growth. That is the national efficient price, which we, obviously, do not deliver at.

That, combined with demand growth, which we do not have a complete explanation for and probably results from a number of factors, including a post-COVID impact, has resulted in every jurisdiction seeing an increase from their 2024-25 budgeted amount to their 2025-26 budgeted amount of between nine and more than 14 per cent—except New South Wales, which I think is over six per cent, but every other jurisdiction is between nine and more than 14 per cent. At 11.7 per cent, we are right in the middle of every Australian jurisdiction.

So everyone is facing the same thing. Everyone has experienced these cost and demand pressures. They are a result of a range of factors that are not fully understood yet. This is an interesting epidemiological question as to what is driving the demand. People speculate that deferred care from the COVID period is part of the reason. But we do not actually know exactly what is driving the increased demand. We do know that there are increased costs.

Obviously, as inflation has increased, demand for wage increases across the country has also been higher than it has been in previous years. But input costs have also gone up. I cannot off the top of my head remember, but we have had some quite specific examples of input costs going up really dramatically. When I went and visited the renal unit recently, they gave me a really good example of some equipment where the cost increased dramatically because it has to be brought from Europe and they had to go around the Horn of Africa. This considerably increases the cost of delivery. So there is a wide range of things are driving both cost and demand increases.

THE CHAIR: I guess my concern is that this is not something that came out of nowhere. There have been multiple years where costs in health have been higher than the original budget. It has been on a trajectory, and the increase this year is not dramatically out of line with the trend over multiple years.

Ms Stephen-Smith: Well, it is, but—

THE CHAIR: But it is not a one-year effect. It was that not we hit the end of last year's budget period and suddenly people started turning up to hospital more.

Ms Stephen-Smith: No, but in last year's budget we also increased funding for the 2024-25 year compared to the 2023-24 budget by more than six per cent. It is not like we were not recognising that there was both an inflationary and demand impact. So we did increase the CHS budget from 2023-24 which had already had a boost the previous year. As you say, Mr Cocks, every year we had been increasing funding. We increased that funding by six per cent. We gave our best estimates, like every other jurisdiction did, about what would happen to demand. I think everyone was expecting that that post-COVID increase in demand that we would have seen would flatten off a bit, but we did not see that. But we are in the same boat as everyone else on that front.

THE CHAIR: You have mentioned other states a couple of times now. Does the ACT benchmark its forecasts against other states?

Ms Stephen-Smith: I might hand over to Ms Hudson to talk about how we work with the independent pricing authority, the National Health Funding Body and the other jurisdictions to try to understand and forecast what is happening—because we do provide forecasts of activity as other jurisdictions do as well.

Ms Jacobi: In terms of talking about our forecasting methodology, the ACT looks at its demographics, which are changing very much at the present, and we then apply a utilisation methodology in terms of how we understand different population groups actually utilise health services to understand as well as looking at past trends. Obviously, forecasting in any environment has its challenges—the events of COVID and unexpected sorts of situations like the fire that occurred in one of our operating theatres. We have also experienced an uplift in terms of our improved counting methodology in the ACT. So we are also seeing some activity captured that we previously had not accounted for. But that is considered a very positive thing as we go forward.

THE CHAIR: What changes have you actually made to the forecasting for this budget compared to what you would have done previously?

Ms Jacobi: I think it is quite a consistent methodology. As I said, it is looking at what we see the demographic profile to look like, understanding some of the utilisation rates and what we have seen in terms of patterns of last year. We learnt a lot in terms of, as we said, capturing more activity. We continue to refine and improve our understanding of our health utilisation within the ACT.

THE CHAIR: So that would account for what has been observed in the budget? It seems like there is basically a one-off increase and then the growth trajectory stays essentially the same. Is that an unreasonable observation?

Ms Jacobi: I think there has probably been relatively constant growth in the ACT. We are seeing in all jurisdictions, as the minister said, some interesting patterns as we have come out of COVID. It has changed in terms of people's utilisation of the health system. Being a provider of last resort, we also see demands on our health system that we cannot necessarily always control in terms of the interfaces, as we are part of a broader service continuum across aged care, disability and primary care.

THE CHAIR: This is something that was certainly observed in the Pegasus report—and I am just trying to find the exact reference in here. There were certainly some concerns that maybe the trajectory forecast over the forward years may still not be enough to deal with demand in the health system. Does that remain a risk?

Ms Stephen-Smith: Yes, and it is identified as a risk in the back of the *Budget outlook*—and I have managed not to tab that page. Every year, the *Budget outlook* identifies fiscal risks, and, again, ongoing increasing demand for hospital services is explicitly identified as a fiscal risk by Treasury at the back of the *Budget outlook.* Ms Zagari has the page—305.

In terms of looking at the trajectory that we have got, we have also been really clear, Mr Cocks, that meeting CHS's budget over the next four years and staying within

budget is going to be a challenge and that we are going to have to do work on being a more efficient health service. That is why we have allocated in the budget $13 million—$3 million this year and $5 million in each of the next two years—specifically for a transformation program to work with clinicians, consumers, carers and experts on how we deliver a more efficient hospital and health service.

That is a range of things. There is no silver bullet here. We know—from our own experience and from experience of jurisdictions around the world—that, ultimately, we want to move people to a position of staying well in the community and reducing demand on acute hospital services. But we know that we cannot just stop funding our acute hospital services and that some of those are quite demand driven. So we need to work with clinicians about how we do that—things like the implementation of the integrated operations centre, driving better efficiency through our theatres, better efficiency into our outpatient clinics, things like fewer missed or cancelled or "did not attend appointments" in outpatients so that a clinician's time is used as efficiently as possible. Each of those things makes a small contribution to what is going to be quite a big effort overall.

THE CHAIR: What are the tangible steps beyond "trust me; we are going to do better" that you are taking around cost controls?

Ms Stephen-Smith: I might hand over to Ms Zagari to talk a bit about that.

Ms Zagari: Thank you, Minister. We are undertaking a piece of work in engaging with our clinicians and then we will engage with the community, including in partnership with the directorate, around what the opportunities are for reform. There are some really good ideas from the clinical workforce about opportunities for cost constraint, particularly in relation to non-employment costs—for example, costs of purchasing and costs of procurement around clinical devices. We will be guided by our clinical experts in that space. Then there are some strategies around revenue and invoicing, and we can ask Ms Hughes, who is the CFO, to speak to that, if you would like additional detail. There are also a number of controls in place around employment growth to ensure that budgets are being observed and there is not growth outside of that which is approved and agreed.

The work that we need to do and that we need to work together with the Canberra community on is the demand management pace we are seeing—ongoing increases in demand through the emergency department. We have some very busy hospitals and our broader health services at the moment. We have not seen a reduction in demand from last year. Indeed, we are continuing to see growth. There are also the strategies around development, in partnership with the directorate, on virtual care, care closer to home and care outside of the immediate hospital environment.

THE CHAIR: You said you are already seeing growth.

Ms Zagari: We are.

THE CHAIR: Is that within the predictions that are built into the budget, or is it above what was expected?

Ms Zagari: I am going to ask Ms Hughes to come and comment on where we are sitting, understanding that—

Ms Stephen-Smith: Noting it is only 24 July.

THE CHAIR: Which is why I am somewhat concerned if we are already seeing growth that is not what we were expecting in the budget.

Ms Zagari: That is the caveat I would apply. Ms Hughes will be limited in what she can say given that we have not even finished the first month of the year. So we are anecdotal.

THE CHAIR: I understand that.

Ms Hughes: First of all, on the sustainability initiatives, we have a signed-off suite of seven initiatives that are underway. We were targeting to deliver $27 million at the end of 30 June 2025, and we delivered in excess of that. Those initiatives covered off agency nursing costs. One very successful initiative has been to reduce the number of agency nurses and increase the graduate nursing intake dramatically. So far, we reduced our costs in the second six months by $15 million just by doing that, and we have more nurses on the floor. So that has very much been a win-win.

We are also working at looking to other itinerant labour—that is what I call it, but other contracted work forces that are not inhouse that might come from outside, and so we have extra costs—and how we can have a more Canberra-based workforce. So we are looking at those things but also working with medical staff around how we can be more efficient; how can we have shorter lengths of stay for some things that also will then have a better outcome for patients but cost less; and procurement.

THE CHAIR: I am sorry to interrupt. I know there is a lot of interest in this session. Are those initiatives specified within the budget, or is that something that you can provide on notice—detail of what those seven initiatives are and what they are delivering?

Ms Hughes: Yes, we can provide that on notice. They are inherently in the budget because they are in the forecast numbers.

THE CHAIR: Yes, but detail of what those saving measures or initiatives are is not in the budget, and we will need to see it on—

Ms Hughes: We can provide that on notice.

THE CHAIR: Thank you. Just coming back to the forecasts, is there an acceptable error rate or tolerance within the budget—an acceptable deviation from what the forecast is?

Ms Stephen-Smith: I do not know that the Treasurer is going to accept a lot of deviation from where the forecast is. I am not quite sure what you mean by—

THE CHAIR: Hospital funding, clearly, is largely demand driven and there are limits

to how much you can control at this point, I assume. If you are running, say, three per cent over the forecast versus 15 per cent, when is it that you are going to take steps to intervene and do something to get it under control?

Ms Stephen-Smith: We will be taking steps all year. We will be monitoring that. I get a regular financial sustainability update. I have been getting that all this year, I think, and we will be reporting through to the Expenditure Review Committee as well and, internally, the directorate, CHS and Treasury are coming together in a sustainability task force, I guess, to continue to both look at what the outcomes are in terms of activity and cost and also continue to monitor the measures that are being put in place to constrain that cost growth.

THE CHAIR: Okay; wonderful. Are we already over the predicted—

Ms Hughes: In terms of the financials, we are not. Our last result, which was the June result, was better than we had forecast when we did the revised business case. We have prepared a detailed budget that is very much bottom-up, reflecting the activity-based funding and the activity that we have. It will be tight and it will be challenging, but we have accountability levers in place and we have a level of funding that I can sit here and say we should be able to deliver. But, then again, if we have a 10 per cent uplift in activity— We are not seeing what you would expect at this time of the year with emergency departments and winter ills, anyway. So what we have done is phased the budget to reflect that.

THE CHAIR: But the specific question was around growth in demand up to this point.

Ms Stephen-Smith: If I might, Mr Cocks, I will take the question on notice about whether that is outside of our expected parameters—

THE CHAIR: Wonderful.

Ms Stephen-Smith: to the best of our ability to answer at this point, in the first month of the financial year.

THE CHAIR: Absolutely acknowledged.

MR RATTENBURY: I wanted to ask about the initiative in the budget around bulk-billing for patients under 16 years old and get any analysis you have that is about the impact this will have on bulk-billing rates and the thinking behind it.

Ms Stephen-Smith: This reflects our election commitment, and part of the thinking behind it when we made the election commitment was reflecting on (a) the importance of early childhood and adolescence in terms of long-term health and wellbeing, and that we do not want parents avoiding taking their children to the GP because of the co-payment—and parents do not want that either; this is a stressful thing for families—but also recognising the fact that, at the time, the commonwealth government's triple bulk-billing incentive was available for children under 16 and concession card holders. So it was building on the commonwealth's initiative around children as well.

We do not have actual projections of what we think the increase in bulk-billing would

be. In those practices that we partner with, we would be aiming for 100 per cent bulk-billing of children, but it will depend on their starting point, the outcome that we achieve and how many practices we are able to attract to this initiative. We are still working through what co-designing that will look like. I might hand over to Dr Dorrington and Ms Stoddart to talk about that process.

Ms Stoddart: In terms of the implementation for the $1.5 million over two years grant program for the bulk-billing, it is a pilot program and we will work, as the minister said, in a collaborative process to design that program with both the PHN, so Canberra Capital Health Network, and also with practices, practice managers, GPs and the sector.

We are limited under the Health Insurance Act in that we cannot top up MBS payments. So it is working with the sector to design the grant program to be able to get the outcome that that we are looking to and work with them what the best way is to actually get that outcome of that increased bulk-billing for children under 16.

MR RATTENBURY: So there is no actual delivery model at the moment?

Ms Stoddart: No, we will work collaboratively with the sector in terms of how we best target this funding to get that outcome?

Ms Stephen-Smith: Dr Dorrington might want to speak a bit more about it, but our thinking in terms of making the election commitment really reflected the feedback that we had heard from GPs in things like the GP forum and in my meetings with them and with the AMA forums, which we all had the pleasure of attending, around things like supporting multidisciplinary care in their practices, having a social worker in the practice, having a psychologist in the practice, having access to pharmacy, medicine review and those kinds of things which are not well funded through the Medicare Benefits Schedule but that support multidisciplinary care and support GPs to do their job.

Those are the kinds of things, but there might be other capital things that people want to invest in, whether that is new equipment or adjustments to their facilities. So, really, our idea is to be quite flexible about the kinds of things that practices and GPs want to invest in—and also, of course, sitting alongside the investment that we are making in professional development and wellbeing. We are trying to be as holistic as we can about supporting practices in the ways that make the most sense for them.

MR RATTENBURY: How many additional bulk-billing visits do you estimate this pilot phase will deliver? Do you have an estimate?

Ms Stoddart: We do not have an estimate; it is about working with the practices and encouraging them.

MR RATTENBURY: Okay; thank you. One of the changes in this budget is to reduce the payroll tax threshold. We know this has been a contentious issue with GP clinics. How many GP clinics will be impacted by this reduction in the payroll tax threshold?

Ms Stephen-Smith: It would be a question for Treasury, not for officials in this portfolio—and they had a long time yesterday without any questions on payroll tax—

but I doubt that they would be able to give a concrete answer on that because, obviously, those practices are not currently required to register for payroll tax. It will also depend on the change in settings around payroll tax for practices—the change from the previous setting for the last financial year that exempted GP contract payments for GPs under eligible contracts for practices that bulk-billed 65 per cent or more of services, changing to exempting income from bulk-billed services right across the practice, no matter what proportion of services are bulk-billed. So, if they bulk-billed 30 per cent of services, all of that income is exempted from calculations of income for payroll tax purposes. That will actually change the dynamics a bit. There will be ons and offs in terms of that change that has come into effect this year with the change in the calculation of payroll tax for general practices and then the change that will come into effect next year in terms of the threshold.

MR RATTENBURY: Mr Emerson will be disappointed to hear your comment about a lack of payroll tax questions yesterday; he gave it a good run.

MR EMERSON: We learnt a lot.

Ms Stephen-Smith: Sorry; about GP payroll tax. Apologies.

MR EMERSON: I am going to keep my disappointment to myself.

THE CHAIR: Just a quick clarification: are you saying Health has not looked at all at the potential impact of the payroll tax changes on the primary care sector in the ACT?

Ms Stephen-Smith: That was not a specific consideration in relation to the payroll tax changes in this budget that will come into effect next year. What I did as health minister over the last two years was have long conversations with practice owners and GPs about the potential impact of payroll tax for them, recognising that it was not a change in policy, the early decision that we made to waive all back taxes and provide assurance about that and then, as other jurisdictions moved—the ACT was one of the first jurisdictions to have a concrete policy—talk to practices and—

THE CHAIR: I might not have been clear. I was very specifically talking about the new framework, the broadening of the base, in particular, of payroll tax. You have not done anything on that?

Ms Stephen-Smith: We did not look specifically at that—and it would be a hard thing to do. One of the things that has been challenging for the revenue office is trying to get a very clear picture from practices about their payroll. Compared to other jurisdictions and other primary health networks, there is probably a disproportionately high number of small family practices in the ACT rather than corporate practices. But there are also a range of corporate practices that would already have been well over the $2 million threshold for national wages.

THE CHAIR: Yes; which is why I asked about it.

Ms Stephen-Smith: Sorry. Mr Emerson; I did point this out yesterday in relation to one of your payroll tax questions. Compared to New South Wales, in particular, for those smaller businesses—the, up to, I think it is around $4 million of payroll—are still going

to be paying less payroll tax in the ACT than they will in New South Wales even after the change comes into effect. We reflected the feedback from practices that the arrangements that were being put in place in South Australia and Victoria, which we are now mirroring in relation to exemption for bulk-billing income, were a better arrangement than the arrangement we had in place, which has now been mirrored by New South Wales but with higher thresholds.

Dr Dorrington: An extra complexity in considering how many practices could possibly be affected is the fact that they are private businesses with their own structures and arrangements with their contracting GPs, and we do not know how many of those contracting GPs would be considered deemed employees to have their payroll considered within this, versus those that actually would not be considered deemed employees.

THE CHAIR: I know it is probably a very complex question to answer, but, at the upper end, the new top threshold that we are now seeing brought in, do we have any of those really large factors like primary health care, the big bulk providers, are likely to be impacted?

Ms Stephen-Smith: I think we will have to take that question on notice, Mr Cocks.

MR RATTENBURY: Do you mean they would be over the $150 million?

Ms Stephen-Smith: Over $150 million, yes. Just to clarify: over the $150 million national threshold?

THE CHAIR: Yes.

Ms Stephen-Smith: We will take that question on notice and see if Treasury has anything. To be honest, it is probably going to be a question of looking up the publicly available information about the large corporates that operate in the ACT. That is going to be the only way that we would know that.

THE CHAIR: I understand that, but any information you can give me.

Dr Dorrington: With any of them that are significantly bulk-billing, of course, the bulk billed services are not considered under payroll tax.

THE CHAIR: No; I understand.

MR RATTENBURY: Just quickly on the bulk-billing issues, you have also got $4.3 million in the budget which includes the patients under 16, but there are other elements of that funding. Can you just tell us briefly about what they are and how you would expect them to impact?

Dr Dorrington: Can I just confirm: is that the Professional Development and Wellbeing Fund elements of it?

MR RATTENBURY: Yes.

Dr Dorrington: This is mainly around supporting our workforce so that they can continue to deliver the services that they are delivering and take some of the pressures off, not just the individual GPs but the workforce in total. The Professional Development and Wellbeing Fund is not just for GPs; that is for the general practice workforce. Again, this is something that is going to be collaboration and codesign in terms of determining how that is delivered.

There are high levels of burnout. The RACGP's *Health of the nation* report from last year indicated that 69 per cent of GPs agreed or strongly agreed that they had experienced symptoms of burnout in the last 12 months and 32 per cent of GPs nationally indicated that they had an intention of ceasing practice in the next five years. We need to do what we can to support the workforce that we have so that we can continue to deliver the services that we are delivering and also to attract and retain new workforce as well. So it is about looking holistically at the system and supporting it where we can and trying to manage the aspects of the system that we can support, knowing that we cannot pay alongside a Medicare billed consultation. It is finding the areas in the system that we can support to try to maintain and build up the whole broader primary healthcare system.

Ms Stephen-Smith: I think, Mr Rattenbury, in terms of the overall package, it was probably a little confusing—and, as I said, I do not have my *Budget outlook*, which I managed to leave that in the office.

MR RATTENBURY: Hopefully, your office will take the hint the second time, Minister.

Ms Stephen-Smith: I have messaged them to do that. There are some ons and offs in terms of the $4.3 million. There is the bulk-billing for under 16s and the Professional Development and Wellbeing Fund and then there are also some specific strategies around bringing in additional trainee and GP registrars, including some funding to employ additional junior medical officers at Canberra Health Services to enable them to undertake a rotation into general practice.

You might be aware that the commonwealth has offered us the first—I think it is the first—metropolitan implementation of a single employer model. We are exploring that with the commonwealth. That enables GP registrars to be employed by Canberra Health Services or be employed by the ACT government and work in general practice full-time while they are doing their registrar training and not have to be reliant on that up-and-down billing income, be able to retain their leave, their maternity and access to parental leave et cetera. I do not know if you want to hear any more about that, but that is the other element of the overall GP funding package.

MR RATTENBURY: Thank you. That is useful information. I think the reflection I have on that is that those initiatives are some several millions. They are dwarfed by the $717 million that goes in over the next four years for increased demand and costs of acute care. So it does seem to be a disproportionate spend between acute demand and primary preventative demand.

Ms Stephen-Smith: In some ways, that is a fair point. In other ways, primary care is a commonwealth responsibility. It is not an ACT government responsibility, and we are

investing millions of dollars in something that is a commonwealth responsibility, alongside an additional millions of dollars that is being contributed by the commonwealth through a range of initiatives, including the triple bulk-billing incentives. We are working with the commonwealth in an area of their responsibility to try to boost primary care access in the ACT. But we have primary responsibility for the hospital and other supportive health systems. So it is unsurprising that that is where the majority of our funding goes.

MR EMERSON: On the GP registrar program, what is the expected uptake in terms of number?

Dr Dorrington: It is hard to say. We think that there will be a reasonable level of interest. In saying that, we can only have about 16 GP registrars. It may be less; I can take that on notice and let you know how many we get allocated. It does change each year. But we get allocated through the training program a certain number of registrar positions for the ACT. If we got half of those interested through this, it would be like eight places. These are not massive numbers that we can possibly offer. They are restricted by how many training places we have.

Having said that, there may be trainees further to the program that would be interested. We think that this is mostly going to be of interest to people leaving the hospital sector, where they have got their guaranteed income. It is about alleviating that fear of what does it mean to leave the security of income and go out into this billing world that you know nothing about. From the way that the single employee model has worked in other areas, we think that there will be a level of interest and that we will get people entering general practice in the ACT that may not have done it without this.

MR EMERSON: Okay; thank you.

MS CARRICK: On this topic of GPs, I want to ask about the urgent care clinic in Woden and where that will be. I have a few questions about that clinic. Do you know where it will be located yet?

Ms Stephen-Smith: That is a commonwealth initiative, Ms Carrick. We know that it will be located in Woden, and they have indicated that they will go through an appropriate procurement process for that.

MS CARRICK: It is not fifty-fifty funding?

Ms Stephen-Smith: No, it is a commonwealth initiative.

MS CARRICK: What involvement does the ACT government have?

Ms Stephen-Smith: We will engage with them collaboratively around how we ensure that that is part of an integrated health system, but it is up to them to undertake a procurement process around that.

MS CARRICK: Will it be delivered through the Capital Health Network?

Dr Dorrington: That is my understanding.

Ms Stoddart: That is our understanding, from our early conversations with the commonwealth.

MS CARRICK: What conversations have there been about where it might be located?

Ms Stoddart: There have not been any conversations about that. We have had broad conversations in terms of understanding their election commitments, and they have indicated that that urgent care clinic will be delivered through the Capital Health Network. They are working through their processes to fund the Capital Health Network and the process for what they would do to establish that clinic.

Ms Stephen-Smith: Based on what we have seen in other jurisdictions, it is often the case—and I am not saying that this will necessarily be the case—that they are procuring additional services from an existing practice in a location. It may be that it is an expansion of an existing practice, which is probably a more cost-effective way of delivering urgent care clinic services than establishing a whole new physical infrastructure.

MS CARRICK: Presumably, it will have GPs in it, or at least one?

Ms Stephen-Smith: Yes. The way that they have done this in other jurisdictions is that they have contracted with an existing general practice to deliver the urgent care clinic services, to deliver the out-of-hours services and some additional scope of practice to what GP clinics would normally offer, in terms of some additional equipment, and maybe additional funding. The funding provides for some additional nursing support et cetera—things that GPs would not normally do out of hours, and in terms of complexity and long appointments. Dr Dorrington can probably talk about the difference between what happens in an urgent care clinic and what a GP would normally see and do.

Dr Dorrington: My understanding of the difference, when GPs are doing this work, is that there is a higher level of government funding to provide this; therefore they can be provided free at the point of service, free at the point of care, and with the non-appointment based system. I think there are still some appointments, but it opens up the capacity for being seen at the time, as opposed to the way that general practice works, where people are booking in their appointments in advance, and it gets quite difficult, with regular follow-up and things, to see people urgently.

Also, if you are leaving appointments unbooked, there is a cost to unbooked appointments in a general practice, but in the urgent care centres it is being funded in a way that can provide for that variation and flux. That is my understanding of how they are generally working around the country.

Ms Hudson: I acknowledge the privilege statement. The commonwealth urgent care clinics have a very clear operational guidance document that is available in the public domain. That covers off the scope of practice and the way in which the operations are expected to run. All of the national urgent care centres that exist at the moment are largely aligned to delivery, and in concert with this particular guidance document.

MS CARRICK: Is there any assessment of how it might integrate into the services that

the ACT government delivers, how it adds to preventive health and the impact on acute health? Is there any assessment of how it might integrate with the ACT service or is it a purely standalone thing?

Ms Stephen-Smith: That is a good question, Ms Carrick. The conversation that we will be having with the commonwealth is about how we will ensure that it is integrated into a navigable system for Canberrans, who have become very well versed in walk-in centres and what the nurse-led walk-in centres offer, which has an almost identical scope of practice to an urgent care clinic. But urgent care clinics, for example, can see babies under one year old. That will be something that is added to the urgent care network outside hospitals in the ACT through the establishment of a GP-led urgent care clinic.

There are a couple of other things in the scope of urgent care clinics, which Ms Hudson referred to, that walk-in centres do not do. We have made that decision quite deliberately, in collaboration with the commonwealth, recognising that we have two emergency departments within a pretty close distance, and that it would not be effective for us to try to deliver those additional services, although we continue to look at expanding the scope of practice for our advanced practice nurses and nurse practitioners in walk-in centres. That is exactly the conversation we will have: how do we ensure that this is integrated and that Canberrans understand where to go and for what? Ultimately, it will be an additional port of call, which is a good thing, because our walk-in centres are now very busy.

MS CARRICK: Presumably, potentially it might be very popular, and it will pick up some of the demand around the area. Presumably, it will not be too far from the hospital, so it could pick up some of the demand from emergency.

Ms Stephen-Smith: Yes. That is the aim. That is the entire plan.

MR RATTENBURY: Will the urgent care clinic in the ACT have GPs or not?

Ms Stephen-Smith: It will be GP led, yes. The one in Woden, the new one that the commonwealth has committed to, will be GP led.

MS CARRICK: They will have a broader scope of work.

MS TOUGH: I am interested in the community health organisation side of things. What additional investment has the government provided to support community health organisations with cost pressures and increasing demand?

Ms Stephen-Smith: We made a commitment, which was actually using some funding that was available at the end of the last financial year through the then Health Directorate, to support our NGOs that we were already contracted with. I will ask Ms Jacobi to talk about it.

Ms Jacobi: In terms of our total funding for community organisations on the health side of the Community Services Directorate, around 11 July there was almost $83 million invested through over 80 community sector organisations. As the minister referenced, in mid-June, just before the end of the financial year, the ACT government

also committed to provide an additional $3.16 million in one-off funding to around 20 health and community organisations that were assessed as facing a challenging financial position due to increased costs and service demand. We managed to work with all of those organisations in terms of executing variations to contracts and pass additional funding to them.

MS TOUGH: What services are included in the 20 that got that additional funding?

Ms Jacobi: I do have a list. Do you want me to give you the list?

MS TOUGH: I do not need the full list of the 20, but the kind of things they cover. Is it perinatal mental health; is it arthritis—that kind of scope?

Ms Stephen-Smith: Arthritis ACT has an additional $100,000. You might recall that last year we did the same thing with Arthritis ACT to ensure that it could continue to provide hydrotherapy services on both the north and south side. It is a similar boost, while we work through the arrangements for the delivery of the new south-side hydrotherapy pool, which will open soon.

Another example is $77,000 in additional funding to support the Early Morning Centre. It is to ensure that they can bring primary care support through Directions, their partner, and deliver primary health services to clients of the Early Morning Centre.

There is quite a significant increase in funding for the Canberra After Hours Locum Medical Service. This is another example of where the ACT government steps into the space of general practice and primary care to ensure that after-hours locum primary care services are available through CALMS.

MS TOUGH: By how much has funding for community health organisations grown over the last four years? I am interested in the trajectory.

Ms Jacobi: I might need to take that on notice.

MS TOUGH: Yes, that is fine.

THE CHAIR: While you are looking at that, could we get the full list that you referred to, on notice?

Ms Jacobi: Yes, of course.

MR BRADDOCK: I have some questions about mental health services for multicultural communities.

Ms Stephen-Smith: I put out a media release on 20 June that had the full list of services for most of that funding. In the $3.16 million that Ms Jacobi mentioned, there are some additional services that we are still negotiating through the detailed arrangements, in terms of how they will spend that funding. Do you still want the full list on notice or are you happy to be referred to the media release?

THE CHAIR: Is that exactly the same list as was being referred to?

Ms Stephen-Smith: Yes.

THE CHAIR: If it is exactly the same list. For clarity, was it with amounts?

Ms Stephen-Smith: No, it does not have the exact amounts for each one, so we can provide that on notice.

MR BRADDOCK: I am interested in the level of services available for the multicultural community, noting that the Multicultural Hub is currently closed to new clients, in terms of their service. The only other service that I am aware of is Companion House, which provides a rather specific, niche service. What is currently in place that is serving the multicultural community in Canberra?

Ms Nagle: I have read and acknowledge the privilege statement. The ACT Health and Community Services Directorate is doing a strategic investment plan for commissioning of mental health services. While at the moment there are no funds committed exactly for the multicultural community, it has been identified as a priority group in the commissioning. The commissioning strategy will be launched this year. As part of the development of that and the development of grants, we will be looking at how commissioning can help to support this community.

MR BRADDOCK: Can you please elaborate on what you mean by "a priority group"? What will that translate into, as part of the commissioning process?

Ms Nagle: As part of the commissioning process, it has been identified that there are some needs in child and youth, particularly. As part of that, there is already significant investment in child and youth. As part of that, we are looking, in the development of those programs, at how we can specifically target the multicultural community in the children and young people area.

MR BRADDOCK: You have not yet started the commissioning process with NGOs and the community sector to identify what the services could be and design those?

Ms Nagle: At the moment some mapping has been done, and there has been some community consultation. The development of those programs and what we would be exactly looking for in the grants has not yet commenced.

Ms Stephen-Smith: Mr Braddock, I think your question was about health services broadly, not just mental health; is that correct?

MR BRADDOCK: It was mental health services.

Ms Stephen-Smith: Sorry, I missed that. I note that Companion House was one of the organisations that received some of that additional funding at the end of June.

MR BRADDOCK: Absolutely. It is just that they are a very specific niche, and it is about what is available for the ever-expanding multicultural community that we have in Canberra. We know that culturally appropriate care is more effective.

Ms Stephen-Smith: Yes, indeed.

MR EMERSON: I want to jump back to the GP registrar question. I was looking at some reporting from last December, where RACGP indicated that we had 17 unfilled GP registrar spots in the ACT at that time across 10 practices. This program will be for junior doctors going from the hospital into GP clinics; is that the idea?

Dr Dorrington: They will be accepted onto the registrar training program, yes.

MR EMERSON: Can you help me to understand, again, how many places we get in the ACT? More broadly, there are 20 registrars currently being trained. Are we intending to cover that whole gap that exists?

Dr Dorrington: The idea would be that, through various incentives, the single employer model being one of them, part of the collaboration co-design is to see what current registrars, prospective registrars and training practices are interested in, to try to bridge the gap and attract more GP registrars to the ACT, and attract more pre-vocational doctors—people who have not done training—into general practice through these incentives.

Ideally, yes, we would have all our training places fully allocated. There are various reasons why people take them up and do not take them up. We cannot change everything; but through the Professional Development and Wellbeing Fund, ideally, we will be able to make that more attractive. Also, the junior doctor placements in general practice are part of that workforce pipeline. We are hoping to get junior doctors more engaged in general practice and remind them about it when they get into the hospital system.

MR EMERSON: When that is rolled out, will private practices be paying Canberra Health Services for the GP registrars? How does it operate?

Dr Dorrington: There are a few models that are currently being used across the country. Within my office, the Office of General Practice and Primary Care, we have been looking at the way that it is delivered in the various locations at the moment. Currently, it is being delivered in areas where the GP registrars tend also to be employed in the hospital, in rural and regional areas. We will be the first urban location. It is a different model from what is being delivered elsewhere, in terms of what our public health system literally gets out of these registrars.

It has to align with what works not just for the government but for the training practices. We would not pay the practice; we would pay the registrar. The billings that the registrar makes in that practice would partially go to the practice, because that is how a general practice runs; it needs to earn money from the GPs working there. But other parts of that money would go back to the government, in terms of paying for the costs of that GP registrar. How that would work is not yet defined, because we need to go through these processes.

MR EMERSON: Does that mean that the funding in this budget is for figuring out how that would work, as opposed to actually funding it?

Dr Dorrington: No, it is for delivering it as well.

MR EMERSON: Is consideration being given to competitiveness? You mentioned we cannot be sure whether we will fill these training spots. What about competitiveness with other jurisdictions? Victoria and Queensland are offering $40,000 grants for GP registrars.

Dr Dorrington: They were not ongoing grants. My understanding—and I can take this on notice and double-check it—is that Victoria's were one-offs. Queensland's are only continuing for rural and regional areas, not for metro areas, for the financial incentives that they were offering. The federal government has announced some of their own incentives for GP registrars. As of January next year, there are $30,000 incentives to start on the GP training program from the federal government. They will have funding available for GP registrars to access payments equivalent to 20 weeks of paid parental leave and five days of study leave per year. There is extra federal funding that will also help, in terms of attracting GP registrars. The federal government, by taking those steps, have seen the impact and they are trying to level out the playing field.

THE CHAIR: Can I confirm: did you take it on notice to come back with some additional information?

Dr Dorrington: Information on the number of GP registrar places.

THE CHAIR: On the incentives available in other jurisdictions?

Dr Dorrington: Yes, I will check what continues to be available, as opposed to the one-off ones.

MR EMERSON: Do you mean where it is not a one-year, financial year—

Dr Dorrington: Yes.

THE CHAIR: Have you done any work generally comparing the competitive position of the ACT to each of the other jurisdictions?

Dr Dorrington: What do you mean by that?

THE CHAIR: In terms of incentives to come to the ACT—those incentives that we were just discussing?

Dr Dorrington: The incentives we were just discussing? Each area has their own pros and cons to go to any area.

THE CHAIR: I am interested in whether you have done any comparison between jurisdictions, so that you can look at whether what the ACT is offering will be successful in attracting people.

Dr Dorrington: We have not finalised what we will be offering at this point. That is part of the collaboration and co-design. Part of that will be looking at: is this actually going to achieve the outcome, and are we being competitive? It will be a part of that,

and it comes down to what continues to be offered and not offered in other locations.

Ms Rule: I have read and acknowledge the privilege statement. In relation to that request for information about other jurisdictions, I would suggest that we are not really in a position to answer that question. What we will have access to is publicly available information about what other jurisdictions are doing.

THE CHAIR: That is why I am asking whether you have done any analysis, in the process that you are working on.

Ms Rule: I appreciate that. I am referring to the earlier question, where you asked us to provide the committee with information on incentives offered by other jurisdictions. I would suggest that all we would have access to is already publicly available information in that regard; therefore it is probably not a question for us to take on notice.

THE CHAIR: Are you able to take on notice any analysis that you have taken into the competitive—

Ms Rule: I think Dr Dorrington has already answered that question, which is to say that we have not yet done that analysis.

MR RATTENBURY: I want to ask about the nurse-led walk-in centres that you spoke about earlier, Minister. Has there been a publicly available evaluation of the nurse-led walk-in centres?

Ms Stephen-Smith: No, that is not something that we have undertaken. We do regularly report on activity. Walk-in centre data is part of the health data dashboard, I believe. We have ongoing reporting to the commonwealth in relation to our agreement with them around it being part of the urgent care clinic network.

This has been an ongoing conversation around evaluation of the walk-in centres. We regularly look at the walk-in centres in terms of scope of practice and effectiveness. Obviously, Canberrans vote with their feet in terms of the increase in the number of presentations. I do not know whether Ms Zagari wants to say more about that. We also undergo hospital-wide accreditation on a regular basis. That happened in February this year. The walk-in centres were visited by the surveyors, and I think there was incredibly positive feedback. But whether they will go into any detail in any publicly available document, I do not know.

Ms Zagari: Thank you, Minister. No, there is not.

MR RATTENBURY: The tenor of my question is that they are a unique model for the ACT. I think their performance is excellent; I have no question about that. My question is about the model, and whether there have been any insights into whether this is the right model and whether it is delivering the expected outcomes.

Ms Stephen-Smith: It is an excellent question, because other jurisdictions have been very interested in the model.

Ms Zagari: Yes, I would agree with that. There is interest. It is a different model to

other jurisdictions. In terms of outcomes, we certainly look at the percentage of patients that need to be referred to another service, particularly the emergency department, or where we are unable to provide definitive care in the moment. We have not specifically compared the model to other jurisdictions, to understand differences in outcomes between them.

MR RATTENBURY: In terms of that, what is the number of people who are not able to be treated onsite?

Ms Stephen-Smith: I did know you were going to ask that!

Ms McKenzie: In the 2024-25 financial year, there were 10,388 patients who presented to a walk-in centre, out of 135,722, and they were referred to an emergency department. 8,819 of those patients then went on to present to the emergency department.

MR RATTENBURY: You are able to track that.

Ms McKenzie: Yes, and that percentage is consistent with the year before.

MR RATTENBURY: What happens to that other 2,000-odd? Do they just decide to go somewhere else, not seek treatment or whatever?

Ms McKenzie: Yes.

MR RATTENBURY: Do you know the updated cost for an episode of treatment in the walk-in centres?

Ms McKenzie: We do not have that immediately. We will see whether we can provide that before the end of the session.

MR RATTENBURY: Thank you; that would be helpful. The government has announced $27 million of investment for chronic disease management and prevention in the budget. I have not seen any specific details of what that will be used for. Are you able to outline for the committee what that will be used for?

Ms Stephen-Smith: One of the things we did in this budget, through a range of these measures, was to signal some of the things that we needed to do to ensure that we are achieving financial sustainability goals, while delivering quality of care. There was some sustainability work done between Canberra Health Services, the Health Directorate and Treasury in the lead-up to the budget, with some independent support from the chair of the Health System Council, Dr Nigel Lyons, a former deputy secretary in New South Wales.

One of the things that was identified—and it will come as no surprise to anyone—is better supporting people with chronic illness prevention and management to reduce their reliance on expensive acute hospital services. This is sending a signal around the effort that will continue to be made and that will be increasing in order to support people better in the community.

Ms Zagari: Indeed, it will include a range of things, such as increased access to

outpatient appointments for chronic disease management, so that we can address issues ahead of coming to an acute presentation and better support through that process. We are working, again, with the directorate and Treasury to ensure that there are some measures around those initiatives, and the effectiveness of those. The intention is to reduce the requirement for presentations to the emergency department with earlier interaction or earlier access to services for people with chronic disease.

MR RATTENBURY: Speaking of Treasury, I assume this business case would not have got through without some specificity. Is there actually an allocation to specific areas, or is this just a fund that you will work out as you go?

Ms Stephen-Smith: There was not a lot of specificity. There was a bit of working forwards and backwards in relation to what Canberra Health Services were going to need, in terms of a sustainable level of funding, and how we were going to direct that funding to some specific activities and say, "If we're going to be sustainable and continue to deliver quality care, these are the areas we are going to need to focus on." It was a matter of trying to be reasonable about what that quantum was and how it grew over time, or whether it was something that we really wanted to invest in up-front.

In terms of the structure of the funding, that is one that grows over time. The care of older people and long-stay patients is something that goes up and then it goes back down, in the hope that we better improve the care and the discharge processes. We spend a bit more money in the first couple of years; then, fingers crossed, we have fewer long-stay patients in those outyears because we have improved our processes, improved the care, and improved our capacity to transition people out. And, fingers crossed, the commonwealth government has also continued to invest in aged-care improvements that will support that.

As you can see from the round numbers, it is not a precise calculation. It is more a case of saying, "We're going to invest specifically in this area." It is a signal to CHS that, from a government perspective, we are saying, "We want you to invest specifically in this area, and we want you to report back on that." It is about saying, "Invest specifically in this area, and tell us what you are doing to achieve the outcome that we have set for you," rather than having a very detailed business case for each one of these initiatives, in the way that you would be used to in a separate business case, as Treasury—

MR RATTENBURY: It sounds like Treasury is getting soft, Minister!

Ms Stephen-Smith: I am not sure that that is how I would—

Ms Rule: I do not think officials would agree with that, Mr Rattenbury!

Ms Zagari: Chair, at an appropriate juncture, I can respond to your earlier question about emergency department activity.

THE CHAIR: That would be great. I might ask a couple of quick supplementaries on this line; then we will come to that. What metrics do you use to evaluate the success of individual walk-in centres?

Ms Stephen-Smith: As opposed to the walk-in centre network?

THE CHAIR: Yes.

Ms Stephen-Smith: In terms of comparing the walk-in centres to one another?

THE CHAIR: Not necessarily just in terms of comparing, but to make sure each one is achieving its objectives, making sure it is fit for purpose and the services it is delivering are fit for purpose for their community. In general, what do you look at when you are looking at whether each one is successful?

Ms Stephen-Smith: The ongoing feedback that we receive from staff and consumers, and the ongoing work to observe how the walk-in centres fit in with the rest of Canberra Health Services—

Ms Zagari: I might speak to this one, if that is all right.

Ms Stephen-Smith: Please do.

Ms Zagari: With the walk-in centres, it is a standardised model, a standardised approach. They are not particularly nuanced to the area that they are in, with the exception of having medical imaging, in particular at Weston Creek. The metrics that we look at are around numbers of presentations, and those presentations that are able to be managed to completion of care within the walk-in centre, where the referrals to emergency department come from. We do, of course, consider consumer feedback and monitor the level of compliments and concerns that come back, to ensure that they are not anomalous, and there is the standard suite of quality and safety indicators.

The more nuanced services, and ensuring that they meet the needs of the community, are really in our health centres, and that is where we would alter the service profile to better reflect the specificities of the community that they are servicing. The walk-in centres are a fairly standard model. People know that, if they go to a centre, they will get the same service as they will get at another centre.

THE CHAIR: Is there a complete list available of what those performance metrics are?

Ms Zagari: We could certainly provide the information. We will take that on notice.

MR RATTENBURY: Presumably, you monitor performance for each of the centres. Are you able to provide accurate—

Ms Stephen-Smith: Broken down by centre?

THE CHAIR: Yes. The current performance level against each of those metrics?

Ms Zagari: We can do that.

THE CHAIR: Thank you. Do you track patient outcomes by centre?

Ms Zagari: The outcomes that we track are around completion of care, referral and, as Ms McKenzie spoke to, the number of patients that actually go on to the emergency

department. We do not track, "This person attended with this position and ultimately the outcome was this," because it is short, sharp treatment. If clinical incidents are associated with the care—if, for example, somebody presented to their GP or an emergency department with an ongoing condition that had not been appropriately managed—it would cause there to be a clinical incident recorded. We would then follow up on the outcomes of that. But we do not ring patients and follow up on the outcome of their visit specifically.

THE CHAIR: Has there been any research or evaluation that looks into patient outcomes, those actual health outcomes, for walk-in centres?

Ms Zagari: Not that I am aware of. I will look to my colleague in the directorate, and to the minister—

Ms Hudson: Could I get some clarification of the question? They are largely nurse practitioner or advanced practice nurses, and there is lots of evidence about the quality of care delivered by that model. The fact that they are located in a walk-in centre does not refute any of the evidence that exists for the quality of care delivered by nurse practitioners, so I am not sure—

THE CHAIR: What I am asking is whether there has been any evaluation or research into the ACT's walk-in centres, to see—

Ms Hudson: The model of care that exists inside the walk-in centre is well evidenced. I am sure that our chief nurse would be able to—

THE CHAIR: If the answer is no, I am happy to hear that the answer is no.

Ms Hudson: Going to the answer before, the last evaluation was done in, I think, 2011, by ANU, when they first opened. There has not been a subsequent or specific evaluation in terms of the walk-in centres. However, the model of care is very well evidenced globally, in terms of nurse practitioners and advanced practice nurses being the first point of care in the ACT. They just happen to be located in a walk-in centre, as opposed to the outpatient acute facility in another institution around the world.

THE CHAIR: It sounds like the answer is: not since 2011?

Ms Hudson: In 2011, ANU did a review of the walk-in centres, and that is available, if you google it; it is in the public domain. That was in 2011.

THE CHAIR: With the metrics that you collect, in terms of outcomes and what I would tend to think of as the service outcome, how do you use that, in terms of the performance of specific walk-in centres? How does that feed back into performance improvement?

Ms Zagari: Within the divisional structure, there is an area within cancer and ambulatory services with accountability for delivery of services in the walk-in centres. Ultimately, that is within the general manager portfolio. Part of our monthly performance meetings includes review of performance within the area. If there were anomalous results in those metrics for a particular centre, that would form part of that conversation, and within the division that has responsibility. I know it sounds super

bureaucratic and hierarchical, but you have to organise yourself in some way when you have 10½ thousand people. Within the division, they would be working with the manager in charge of that to say, "What's going on here," and looking at rostering to ensure that the outcomes were consistent with what we are seeing across the network of centres.

THE CHAIR: Is it used for performance improvement—not just for comparison to other centres but in terms of: "Let's get things better anyway"?

Ms Zagari: The numbers specifically, no, but there is absolutely a focus on continuing quality improvement. That is one of the things that accreditation monitors: are we focused on how we do better? There is always a desire to do better; however, referring someone to an ED is not a failure of service. As long as the person should have gone to an ED because they have complexity of care, it is a good thing.

THE CHAIR: As long as it is the right outcome.

Ms Zagari: Correct. But, if we suddenly started to see one of the centres referring twice as many people, we would absolutely have concerns that maybe the full scope of the centre was not being achieved.

THE CHAIR: Are those outcome measures published anywhere?

Ms Zagari: They may be on the dashboard. Let me come back to you and confirm before the end of today.

Ms Hudson: The activity, the throughput, is on the data portal that is publicly available.

THE CHAIR: That is the activity. Where is the service outcome referred to?

Ms Zagari: That was going to be my question: is the destination—

Ms Hudson: No; there is—

Ms Zagari: Not at this stage.

THE CHAIR: Is there a reason that it is not or could not be?

Ms Hudson: The team in the directorate is working through making sure the data is solid and repeatable. We have to be very careful when we talk about data coming from CHS and the request for data coming from CHS, because it is not what we would call cleansed or clean data. When Ms Zagari is making a decision today or tomorrow about what is happening in her organisation, she can have a degree of error. When you start publishing stuff publicly and when you start submitting it to national bodies, you have to be very clear that it is slightly closer, in the same way as we make these decisions in our lives. It comes with a health warning perhaps—a limitation. Ms Zagari is referencing that it has an error margin that is not being corrected at that time.

Ms Zagari: What I would say, Mr Cocks, is that—

THE CHAIR: If we can quickly—

Ms Zagari: We could certainly ask the data area, in their consideration of what is going onto the dashboard, whether they have that validated data and they can consider whether it is included.

Ms Hudson: We are working towards that being included. Indeed, it is a request from the commonwealth in the context of UCC.

Ms Zagari: Thank you.

Ms Stephen-Smith: To go back to a question we took on notice earlier from Ms Tough in relation to NGO funding, I only have a topline number, but the information I have in front of me indicates that overall health program NGO funding has increased from around $47.3 million in 2019-20 to $72.3 million in 2025-26, which, by my calculation, is an increase of about 53 per cent. Mental health NGO funding has increased from around $14½ million in 2019-20 to $32.9 million in 2025-26, which is about a 127 per cent increase in funding. Obviously, given the previous underinvestment in mental health, we have been continuing to invest more in mental health compared to other NGOs. I only have those topline numbers; I do not have a lot of detail underneath that, so, if you want us to take on notice any further detail around that, Ms Tough, we are happy to do that.

MS TOUGH: I am happy with that level of detail. Thank you. Does anyone else on the committee want further detail?

THE CHAIR: That is all right. I probably have extra questions. We will see if we have time later.

MS CARRICK: I support nurse practitioners and appreciate the great work that they do. We were talking about referrals. Nurse practitioners have a scope of works. Do you have data on referrals to GPs as opposed to referrals to emergency?

Ms McKenzie: Ms Hudson is absolutely right. I should have said at the outset that it is drawn from operational data and may not align with published datasets. That was a health warning a little bit late. I do not have data on referrals at hand. We take that as part of our day-on-day review of operations of the whole health service. I do not have data on referrals to general practitioners.

MS CARRICK: At all?

Ms McKenzie: I can take on notice to clarify whether we are able to get that.

MS CARRICK: Yes—could you take that on notice for the sake of clarity: the referrals to GPs and the referrals to emergency and whether there are referrals elsewhere.

THE CHAIR: To be clear, could you take on notice anything that you can provide.

Ms Zagari: Yes. We cannot provide that specific metric because part of the walk-in-centre review is to encourage people to see their GP, particularly for ongoing care. One

of the things that is ticked in the DHR is: did you talk to the person about seeing their regular GP? The challenge is then reflecting what is a referral to a GP, because they require GP care as opposed to it being part of the routine practice at the walk-in-centre: "I have told this person they should see their GP in future." To your point, Mr Cocks—

THE CHAIR: That goes from that data—

Ms Stephen-Smith: Could I provide a specific anecdotal example that sort of reflects that. A friend went to the walk-in-centre because they had chest issues and was diagnosed as having pneumonia. They got a prescription and started antibiotics. They got a prescription from the nurse practitioner and started the antibiotics quickly after hours, but was also told, "You really should go and see your GP." They saw their GP and the GP confirmed the diagnosis and then provided ongoing treatment for the person. A referral to a GP does not mean that the individual has not received treatment at the walk-in-centre as well.

MS CARRICK: I suppose there is a variety of scenarios.

Ms Zagari: Yes.

MS CARRICK: I will keep on the data line. Looking at the RoGS data for mental health, there are a lot of gaps. I think this has been discussed before. There is no data for selected equity groups, the Indigenous category in mental health, restricted practices, self-harm in psychiatric care, patient discharge against medical advice, cost of care or mental health outcomes. My question is about mental health data. Where is it up to in providing it to the Productivity Commission?

Ms Hudson: This is part of the data remediation work that is underway. It is part of the machinery of government that some of our colleagues are no longer with us. They would have been able to answer this question in a slightly more refined way than I can. I see Ms Stoddart has come forward. It was well acknowledged in the submission that there are elements that we are unable to report on as a result of the digital remediation program. I believe mental health data is currently being worked through. Ms Stoddart has further information.

Ms Stoddart: Not a lot further. But the information that I do have, Ms Carrick, is that the data to support the three mental health submissions—this is ambulatory service contact, episode level care and phased care level—is currently under development. The data product itself is going through UAT testing at the moment and it is due to be delivered in late August 2025. Once that is delivered, we will be in a position to provide that data to national reporting going forward.

MS CARRICK: Were those mental health categories?

Ms Hudson: Those are for mental health.

Ms Stoddart: Mental health specifically.

MS CARRICK: Okay. Will the ones you mentioned cover all the gaps that are in the RoGS data?

Ms Stephen-Smith: Ms Carrick, I think it would be helpful to tell us explicitly what you are looking at. The other issue for the ACT in some of this national reporting is the small numbers. Sometimes numbers will not be reported for the ACT, not because we have not provided the numbers but because they meet the criteria for AIHW not reporting, because the numbers are so small that it is considered to be identifiable. Are you able to tell us exactly what you are asking about so that we can provide a clear answer on where we are on it?

MS CARRICK: There are a lot of gaps in the mental health data.

Ms Stephen-Smith: There is no doubt about that, and that is what we have been talking about in terms of data remediation.

MS CARRICK: I simply ask: when will that be rectified and when will we have ACT statistics in the RoGS data again?

Ms Nagle: It is a continuous improvement process with all of our data. Mental health is the current priority in that. As I said, the data product is currently going through its user acceptance testing to enable us to pull that data for the next reporting—

MS CARRICK: For RoGS.

THE CHAIR: Perhaps on notice, could you provide a list of any data that has been deemed to be so small that it is identifiable, so that we can understand where the balance is between what we are trying to catch up and when we just cannot get there.

Ms Rule: We may not know that. Until the data is available, we cannot know what data is small.

Ms Stephen-Smith: Once you start getting to things like seclusion and breaking it down by target populations, that is the point. More broadly, there is data remediation work to be done. All I was saying is that it does not necessarily mean that, when that data remediation work is done, every single data point will be reported for the ACT, because some will be subject to small numbers. I am not saying that is why it is not included now; I am just giving a note of caution that it also may not be included in the next one, for those that are broken down by target population and the numbers are small. As Ms Rule said, we do not know which ones that will apply to from year to year.

THE CHAIR: Will it be identifiable at that point whether that is the reason it is not included?

Ms Stephen-Smith: Yes; it will.

THE CHAIR: Thank you.

MS CARRICK: Who determines that the numbers are too small? Is that the ACT or is that the Productivity Commission?

Ms Stephen-Smith: It is AIHW and the Productivity Commission. It is basically a

standard counting rule. Usually less than five is not reported.

MS CARRICK: Thank you.

MS TOUGH: I am interested in changing tack a little bit to maternity health. How does investment in the baby bundles for vulnerable families in the ACT align with Maternity in Focus: the ACT Public Maternity System Plan 2022-2032?

Ms Stephen-Smith: You might need to repeat your question.

MS TOUGH: That is fine. I have a huge focus on maternity health. There is probably a shorter question.

Ms Buchanan-Grey: I have read and acknowledge the privilege statement. Thank you. The baby bundle and packaging partnership with Roundabout in Canberra will be delivered alongside Maternity in Focus. It is not part of that 10-year service plan that the ACT government have initiated, but it will seek to support first-time vulnerable families with a bundle that has elements in it that will support women and families in the Canberra community—things that they find hard to invest in themselves—to ensure that babies and families have the best start they can have. Could you repeat the additional part to your question, Ms Tough?

MS TOUGH: Yes. The first question was: how does it align with the plan? Following that, is the model consistent with any other jurisdictions in Australia or are we leading the way in providing these bundles?

Ms Buchanan-Grey: I cannot answer the jurisdictional analysis, but Roundabout have been running this model very successfully for quite some time. It would suggest that it is effective in meeting the need for Canberra families. This additional investment will help us to actually target vulnerable first-time families in a more specific way for the ACT.

Ms Stephen-Smith: There are probably two things. The overall baby bundle is rolled out in New South Wales to first-time parents. We have been working with New South Wales on what is in their baby bundle. They obviously have a lot more purchasing power than us. They have the logistics in place around delivering baby bundles to all first-time parents, which is our election commitment. We are starting with a smaller cohort for the baby bundle itself, but we are rolling that out to vulnerable families. We are rolling that out through Roundabout in part because we know that those are the families who are potentially also going to require the additional supports that Roundabout provides. It is a more holistic service for those vulnerable families. As I am sure you are aware, they access the Roundabout service through another service. Roundabout does not deal directly with parents and families. It might be that a social worker, a Child and Family Centre worker, a MACH nurse or a midwife picks up the bundle for the family.

Being able to provide that initial baby bundle and also anything else that they need from Roundabout—a pram, a car seat, additional nappies or whatever it might be—that material support, also helps to build trust with vulnerable families. We thought that integrated very well. Roundabout has indicated to us that, as we implement our election commitment to all first-time parents, it will probably be a separate initiative, but we are

still working through what that will look like. But New South Wales does it.

MS TOUGH: Are the vulnerable families identified through the health system as they present during a pregnancy stage or are they referred from other health providers? How are we making sure we are capturing vulnerable families and getting them the baby bundles and other services?

Ms Buchanan-Grey: It would be picked up as part of that referral process. There are specific demographics around Aboriginal and Torres Strait Islander identification, low socioeconomic status or they are possibly already known to be a vulnerable family in other parts of the sector. They would be identified in that way or, indeed, referred as you have already identified.

Ms Stephen-Smith: Going back to your original question about alignment with Maternity in Focus, the Maternity in Focus strategy has a specific focus on priority groups and those experiencing vulnerability. As Ms Buchanan-Grey said, it was not a specific action within Maternity in Focus initially, but it is very much aligned with that and our first 1,000 days strategy.

MS TOUGH: Thank you.

MR EMERSON: I have a justice health question. Output 1.2 in this area indicates the proportion of detainees at the AMC with a completed health assessment within 24 hours of detention. Last year, it was 97 per cent, and at Bimberi it was 95 per cent. Why are these figures below the targeted 100 per cent? Shouldn't everyone complete the full induction process?

Mr Aloisi: An assessment is offered upon induction to all detainees in AMC and young persons entering Bimberi. In some cases, though, we might have situations where the person might refuse or decline an assessment. That does occur on occasion. Particularly at Bimberi, where you have small client numbers, you generally tend to get larger fluctuations and do not meet that percentage. Sometimes we will make an assessment, and it might be in consultation with our colleagues in Corrective Services or youth justice services that it is not appropriate at that time to conduct the assessment, but we will come back to that person and conduct the assessment, even if it does not occur within that first period. Just because we do not complete the formal full health assessment does not mean that we also do not make an assessment of how they are doing. It might involve active monitoring. For example, if someone were in a highly agitated or unwell state, whilst we might not be able to have a face-to-face interview at that time, because it would not be appropriate and we obviously do not want to escalate their behaviour, we will take a monitoring approach to that person. That will dictate how we might manage that person within those facilities, again in consultation with our Corrective Services and Bimberi Youth Justice Centre colleagues.

MR EMERSON: Would you be able to provide, perhaps on notice, a breakdown of the kinds of reasons one was not undertaken in the first 24 hours? It might have happened within 48 hours or there might have been, as you just described, a refusal or otherwise.

Mr Aloisi: Yes. I can look into that if that would assist.

MR EMERSON: Thank you. And does that—

Ms Stephen-Smith: For the *Hansard*, that was a yes, we will take it on notice.

MR EMERSON: Thank you.

Ms Zagari: There will be the same caveat around small numbers. Where there are fewer than five, it might cause them to be identified. We could perhaps do a percentage breakdown.

MR EMERSON: It might be a proportion. That would be great.

Ms Zagari: Yes.

Mr Aloisi: We could most definitely find the common themes.

MR EMERSON: Thank you. And does that health assessment include a full mental health assessment?

Mr Aloisi: Yes. There are two parts to the assessment. There is a primary health assessment, and that is the one that is completed in that timeframe, and there is a mental health assessment conducted as well.

MR EMERSON: That does not have the same target of happening within 24 hours? Is that a separate assessment?

Mr Aloisi: That is. I confirm that there is a mental health element to the full assessment, and then a further mental health assessment might be warranted, depending on the outcome of that primary assessment.

MR EMERSON: The primary assessment contains a mental health assessment?

Mr Aloisi: Yes.

MR EMERSON: Does that cover conditions like ADHD, autism—

Mr Aloisi: It does not include specific screening around that, but, if the person has a history of mental illness and specifies that, whether it is autism or ADHD, that would be documented and captured as part of that assessment. It is not specifically a targeted assessment around specific conditions, because it is just the first screening interview. Once the person comes into custody, there are further opportunities in their engagement with both justice health services and our custodial mental health services if they require further assessments around specific mental health conditions.

MR EMERSON: Is there any later screening for every detainee? I can imagine that a lot of inmates have undiagnosed conditions, such as ADHD. Is there a later stage or is it under consideration to do, say, ADHD screening for all new detainees?

Mr Aloisi: Doing that would be very challenging from a resourcing perspective. You would potentially be doing that for a large range of conditions. We are guided by the

clinical information that is presented. Through the course of the detainee's contact with our health services, if we suspect it or they provide evidence or suggestions around a particular condition, whatever that might be, we can be engaged in further assessment and potentially interventions and treatment at that stage. But to potentially screen for a large variety of conditions, from a resource perspective it would be very challenging.

Ms Zagari: Mr Emerson, in recent months, I recall clearing a QoN or a QToN somewhere on this. We will provide the response that we had to you as well.

MR EMERSON: Thank you.

MR RATTENBURY: While Mr Aloisi is at the table and because of efficiency, do you know whether those assessments include FASD? Are any of those being taken through the AMC?

Mr Aloisi: I am not sure. I do not believe we conduct FASD assessments as a screening. Do you mean in terms of induction? No; we do not conduct FASD assessments. I am not sure whether Corrective Services might be doing anything in that space. They have their inductions.

MR RATTENBURY: Of course. I will ask them separately. I was interested whether Health was involved in that kind of screening at all.

Ms Stephen-Smith: One of the conversations that we have had in the past in relation to FASD, particularly in Bimberi, is that it is a quite complex diagnosis. The focus tends to be on the person's presentation—their presenting condition or presenting need for support rather than necessarily the underlying reasons for that presentation. That is, however, an ongoing conversation. One of the reflections that I had with one of my colleagues recently was the ongoing paucity of data around the number of detainees, both young people and detainees with a cognitive disability of any kind. As you know from the Disability Justice Strategy, the collection of data around people with disability is an ongoing challenge. FASD is only one of the many forms of cognitive disability or impairment that people in detention tend to have.

MR RATTENBURY: Those are good points. My particular interest is that this is a moment of intervention when we can identify folks who may be eligible for NDIS packages and the like once they leave custody. I am interested in where it sits between Health and Corrective Services. The Disability Justice Strategy seeks to implement it. I am interested in how that is progressing. I will come back to it later. I am conscious of the timing for the break.

THE CHAIR: Ms Zagari, you have something that you want to come back to?

Ms Zagari: I have the emergency department data that you asked about earlier.

THE CHAIR: I will come to you when we come back from the break.

Ms Zagari: Thank you.

Sitting suspended from 12.33 to 1.30 pm

THE CHAIR: We welcome back Ms Rachel Stephen-Smith MLA, Minister for Health and Minister for Mental Health. We also welcome back the officials in attendance. We will continue with questions. But, first off, Ms Zagari, I think you were going to provide an update on some information.

Ms Zagari: I was, thank you, Chair. You asked earlier about the activity through the emergency department and whether it was higher than we had anticipated and budgeted for. The year-on-year increase in the emergency department—with all of the caveats, and unvalidated data sources, and that we are only up to 23 July in the data—compared to the same time last year through the emergency department is around 14 per cent. However, July last year was before building 5 opened, so, in fact, the bulk of this represents the increase that we have seen since the opening of building 5, so it is consistent with where we have been at over the last several months. The bulk of the admissions coming through there are same-day admissions—so, discharged through the short stay units. What that means in terms of what we budgeted for, to get to the heart of your question instead of wandering around the place, is that it is managed within the existing emergency department staffing, so there is not an additional cost to it, and, therefore, it is currently factored into the budget. Those presentations are able to be accommodated within the existing staffing profile for the emergency department.

THE CHAIR: Okay, so they are able to be accommodated within the financials.

Ms Zagari: Correct.

THE CHAIR: But, in terms of those presentations, are they in line with what the budget had forecast?

Ms Zagari: The budget relates to the staffing and capacity of the emergency department, so this fits within that. So, yes, it is consistent with expectations for this time of year.

THE CHAIR: For the staffing?

Ms Zagari: Correct.

THE CHAIR: But presumably there would be forecasts around demand as well, which is what I was trying to understand—whether there was any deviation from those forecasts.

Ms Zagari: The forecasts, really, have been around budgeting. I will look to Ms Hughes about whether there are specific demand predictions. Fundamentally, it is around the budget and the capacity to accommodate that demand, and that is correct. It is where we had expected it to be at this time.

Ms Hughes: The budget is, as Janet said, based on capacity, and that is the capacity of the staffing models in the wards—the nursing models that cover ratios. The staffing capacity that has been budgeted—and as I said, over winter it is a higher number of staff—at the moment is within our costs based on our payroll costs, which would be the biggest determinant within what had been budgeted.

Ms Zagari: So we are within the capacity that we budgeted for.

THE CHAIR: Yes, so you are within the capacity. But, presumably, given the conversation that has been happening around the budget, that it is driven by increases in demand for health services, there are forecasts for the number of services you would expect to be providing and the amount of demand going through the emergency department.

There was a comment made that seemed to be suggesting that there is growth that is above what was expected, and I am just trying to find out, before whatever forecasts you have done around demand and service usage, if the numbers you are seeing are in line with that, because it would be very concerning if this early in the year we were already seeing them above—

Ms Hughes: They are. Although I started my role in November, last financial year the CHS opened more beds in both TCH and North Canberra Hospital than was built into the budget. This year the budget is based on the number of beds open. So, effectively, there has been 30 more at North Canberra over the last year than was actually put into that budget because that was an uplift to cover the activity that we were seeing—so you kind of get step-costs with health care.

THE CHAIR: Yes, but we are back to the discussion of costs.

Ms Hughes: Sorry.

THE CHAIR: Maybe to make things easy, would you be able to provide, on notice, perhaps, what you had forecast in terms of service levels for the first month and where we are at?

Ms Zagari: We can.

MR RATTENBURY: Ms Zagari, you talked about the increase being reflective of opening building 5. I do not quite understand the story there. Is it that more people are coming to building 5, or is it that there are more services being provided or some other—

Ms Zagari: Apologies, Mr Rattenbury, I was not very clear in what I said.

MR RATTENBURY: That is okay.

Ms Zagari: Since we have opened building 5, which does include additional capacity within the emergency department, the drivers are not clear cut, as the minister referred to earlier. Since the opening of building 5, we certainly have seen significant throughput increase.

MR RATTENBURY: In the emergency department?

Ms Zagari: In the emergency department. Last July, we were still in the old emergency department, and this amount of activity could not have fitted in there. The new building accommodates a larger volume of activity, and it means that July to July is not

comparable. We will be able to get better comparisons in forward months, once we are looking at the same amount of infrastructure sitting behind it. I certainly take Mr Cocks's point about activity, but one of the ways we measure and manage activity, obviously, is through beds or points of clinical service.

Ms Stephen-Smith: I would also say that it is a general observation that when new emergency department capacity opens, more people turn up. We have seen that in both of our previous emergency department expansions as well, with the ED at Canberra Hospital and the ED at what was then Calvary Public Hospital.

In both cases that saw an increase in presentations, and I think the increased improvement in performance also drives an increase in presentations. If people are confident that they will not have to wait as long, they are more likely to go to an emergency department, so both of those things have probably driven an increase in presentations as well.

MS CASTLEY: I was not here this morning, and I am happy to look back if I need to, but for the new ED, you said "beds and treatment spaces". Someone talked about Jason recliners. Can you explain what it looks like? How many beds are there? Do people get moved into a different section as they go through the process?

Ms Zagari: Yes, and what I will do is provide, on notice, the detail around what is in each pod of the emergency department. The emergency—

MS CASTLEY: The timeframes for staying in each section?

Ms Zagari: That is entirely dependent on the presentation. It depends on what you present with. You come to the emergency department and first of all you go to the triage at the front of the emergency and you talk about the reason you are presenting, and there is a clinical assessment about how urgently you need to be seen and how sick you are, which determines which part of the emergency department you go to. If you have come, for example, with a sporting injury, you will probably go through to the fast track where you will be seen and managed and treated. If you come in and you are critically unwell, we would put you into the resuscitation area. If you come in and you have got a child with you and the patient is a child, we would go through to the paediatric ED. The area of the ED that you go to depends on the condition that you are presenting with and how sick you are.

Moving to another area of the department might depend on what is happening in your treatment. Are you becoming more unwell? Are you becoming better? So, speaking about Jason recliners, there are areas in fast track, for example, where you will come through—and I am calling them Jason recliners, but they are not actually that brand—and there are treatment chairs which are capable of fully reclining, and we can actually perform resuscitation on a treatment chair if we need to, just for absolute clarity. For example, when my husband went to the emergency department with a minor injury, he went through and was treated on a recliner as was appropriate within the fast track area, whereas if you are unwell, you would go through to an area with beds.

MS CASTLEY: On the response times, so you leave ED and go to your "fast track"?

Ms Zagari: Fast Track is part of ED and so it counts in your ED time. All of that is in the need time. The only time that the clock stops is once you are admitted through to an admitted area like the short stay unit or into the hospital itself.

THE CHAIR: I am happy to pass my question to you, Ms Castley, as I know that you have a few.

MS CASTLEY: Thank you, Chair. I do have a number. Minister, today a *Canberra Times* article revealed that there are no senior cardiologists at North Canberra Hospital. Can you confirm that the reporting is correct?

Ms Stephen-Smith: I will hand to Ms Zagari on this.

Ms Zagari: Ms Castley, it is not correct. We have had two resignations at North Canberra Hospital. That is correct. I cannot comment on the individual employment matters that the *Canberra Times* article alluded to. As we said to the *Canberra Times*, it would be unfair to speak about specific individuals and their particular employment matters. But we have got coverage at North Canberra Hospital. Today, the coverage is being provided by a locum. Next week, for example, it will be provided by a senior cardiologist at Canberra Hospital. In future weeks thereafter, someone will come back from leave. So there is a combination of measures that we are using to ensure that there is continued coverage at North Canberra Hospital.

MS CASTLEY: The reporting also said that there were no permanent staff specialist cardiologists. Is that incorrect?

Ms Zagari: That is incorrect.

MS CASTLEY: Is it just one locum that we have that is available at the moment to cover the absences and vacancies that we have seen?

Ms Zagari: No is the short answer, but there is a locum who is covering today. At North Canberra Hospital, each day is covered by a cardiologist. Today, that happens to be a locum, and we have had locum coverage. So there is been a locum involved in the roster of cardiologists. With the recent resignations, we will add additional locums to that roster and they will go through a process to determine if they are appropriate to provide cover. That would be the case for covering leave anyway, potentially, because at the moment they are separate cardiology departments. But given the resignations, Canberra Hospital are assisting with coverage.

MS CASTLEY: The article claimed that no patients have been impacted. Can you confirm that no-one is been disadvantaged or adversely impacted by four of the cardiologists being out of action?

Ms Zagari: I can.

MS CASTLEY: I do feel it is a bit of a recurring theme. I do not understand why we have four highly qualified people. Do you have any idea why these senior cardiologists are resigning?

Ms Zagari: Next week, I am meeting with one of the two cardiologists that has resigned to work through the particular issues. There are some specific issues for him that would not be appropriate to discuss here that are not related to that employment, and we will work through that. We are working to understand exactly the concerns that they have, understanding that people resign for a range of reasons, which include personal circumstances, and are not necessarily driven by the work environment.

MS CASTLEY: Have any warnings been given in order to push these resignations? Have there been any concerns within the department at North Canberra?

Ms Zagari: Do you mean did people pre-emptively indicate that they were intending to resign?

MS CASTLEY: No, I am wondering if, from within Canberra Health Services, cardiologists been put on notice, or has there been an issue with any of the cardiologists, from your end?

Ms Zagari: So the question is about whether there are performance issues. I cannot comment on individual employment matters, because it would not be fair to individual cardiologists. We do not comment on individual employment matters.

MS CASTLEY: But, on a whole, you cannot comment as to whether or not anyone has been pulled aside and warned about—

Ms Zagari: No; I cannot comment on that.

Ms Stephen-Smith: I think the context being this is a very small group of people, and so any comment potentially might be identifiable.

MS CASTLEY: Sure. Over the course of the year, we have seen some pretty public resignations this year.

THE CHAIR: Minister, your official has made a claim of confidentiality. Parliamentary privilege overrides this claim. The Assembly has passed continuing resolution 8B that uses a public interest test. Minister, is it your view that it is in the public interest to withhold this information?

Ms Stephen-Smith: Yes.

THE CHAIR: Could you please specify the harm to the public interest that could result from the disclosure of the information publicly?

Ms Stephen-Smith: I think there are two harms. There is the harm to the individual, which is related to potential harm to individuals, which is related to the public interest. But there is also a harm to the confidence that our board and the clinical teams can have in the processes of Canberra Health Services if details of those kinds of personnel matters are made public.

That is a very challenging circumstance, and I am aware that this has explicitly been expressed by clinicians previously when a third party put in a freedom of information

request in relation to a culture review. That work, redacted, was released under freedom of information and a number of clinicians were extremely upset with the person who had put in the FOI request, with that information then becoming public. Obviously, that had the opportunity to be redacted, but it was still quite problematic in terms of the relationship between the leadership and the clinical group and another thing where trust needed to be rebuilt. I think in the context of the broader work to improve culture at Canberra Health Services, retaining and continuing to build trust between the executive and the clinical workforce is of vital public importance.

THE CHAIR: Could you also explain whether harm would accrue from providing the materials as confidential evidence?

Ms Stephen-Smith: Can I take that on notice, Mr Cocks? We can consider whether that information can be provided in confidence to the committee. I cannot give you an answer now, because I am obviously not privy to the detail of the information, either.

MS CASTLEY: And I am not asking for names. There are a number of cardiologists working in the hospital. Have any been warned or given a warning to change behaviour in any way.

Ms Stephen-Smith: I recognise that you are not asking for names, Ms Castley, but, with such a small team, it would be easily identifiable by other people, whatever was said, what was being talked about.

THE CHAIR: If you can take that away on notice, that would be very good.

Ms Stephen-Smith: Yes.

THE CHAIR: Thank you.

MS CASTLEY: I am concerned about the number of resignations across the board. You mentioned that there are exit interviews—and you have one next week. Does everybody get offered an exit interview and are they taking those up?

Ms Zagari: They do. Certainly, the cardiologist I have spoken to is taking it up, and we will work through whether we can actually resolve any matters that arise out of that. It may be possible, if there are issues that we could resolve, that people may make different decisions. That is part of the purpose of it, but also to understand whether there are workplace related drivers that have led people to make a decision on exiting.

MS CASTLEY: And that is with past resignations as well?

Ms Zagari: I would have to take that on notice. I have been in the position for—

MS CASTLEY: Yes; I understand.

Ms Zagari: But I will check.

MS CASTLEY: Do you do the exit interviews? Will that be your policy going forward? Who did it in the past?

Ms Zagari: I cannot answer on who did it in the past and, again, we will take on notice what the answer is on that, unless Mr White is able to respond on general practice.

Ms Stephen-Smith: My understanding—and, again, we can confirm this on notice and we will certainly provide a correction if I am incorrect—in terms of the recent resignations of orthopaedic surgeons that Mr Peffer made contact directly with each of those individuals and offered to sit down and talk with them. As you are aware, one of those resignations had been an expected retirement anyway that was brought forward. Of the other five, three have reversed their decision to resign. Mr Peffer took that responsibility very seriously as CEO.

MS CASTLEY: Okay.

Mr White: We have an overarching position on exit interviews. Every exiting employee gets the opportunity to participate in an exit survey, which is an online survey that staff complete which asks generic questions about their experience in the health service, the reasons for leaving—retirement, moving to another jurisdiction et cetera. Employers are also given the opportunity to have an exit interview as part of that process. Historically, that has been conducted through my branch in People and Culture. That has recently transferred to the Workforce Resolution and Support Services Branch, which sits under the CEE's office.

MS CASTLEY: Okay. Thank you. Is it possible to provide, possibly on notice, the list of concerns that have been raised across the two departments over the past 12 months?

Ms Stephen-Smith: Through exit interviews or—

MS CASTLEY: Yes; just a bit of high-level information about what their concerns have been.

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

MS CASTLEY: And is it something that you benchmark the turnover against interstate agencies? I imagine there is a lot of to and fro across all different jurisdictions. Do you do any sort of analysis on what the cost to Canberra Health Services is and what it looks like compared to other jurisdictions?

Mr White: The cost of resignations compared to other jurisdictions?

MS CASTLEY: Yes. It costs a lot to re-employ people and train them up.

Mr White: It is not something we have done historically, no.

Ms Zagari: We do measure turnover across the workforce.

Mr White: We do measure turnover. But, historically, I have not done a comparison on our separation rate compared to other health jurisdictions.

MS CASTLEY: Okay. They are specialised people. So there is no tracking of the cost

that it imposes on Canberra Health Services when we lose senior cardiologists or surgeons of any kind and how we better support them in order to not get to a resignation point?

Ms Zagari: We are certainly looking at ways to better support departments or to address issues that arise so that they do not get to resignation. That would always be our preferred circumstance—again, assuming that they are related to the workplace and not to individual circumstances. Dr Rady could speak to the work that has being undertaken in the medical staff wellbeing and retention space, if you would like, given that area of expertise. We do not specifically track the costs of an individual resignation, but there is good benchmark data around the cost for the turnover for a nurse, for example. There is an average cost estimate each time that happens.

MS CASTLEY: Right. There was some concern a while ago with regard to a few surgeries that had to be revisited. I am wondering how we are going with that. Has that continued? Has there been a pattern? Have there been more surgeries due to possible errors that have happened in the last 12 months?

Ms Stephen-Smith: I think you are talking about a very specific set of surgeries that were undertaken by a locum over a short period of time that were the subject of that conversation. More broadly, there is tracking of unanticipated return to theatre and hospital and that kind of thing, hospital-acquired complications, errors et cetera. That is part of quality assurance. In relation to that specific matter, I know that that reporting has been done. I am not sure how much Ms Zagari can say about it.

MS CASTLEY: Is that locum still working in the hospital?

Ms Zagari: No, that locum is not working in the hospital and has not worked in the hospital since the time that those concerns were raised. They were not working in theatre and was working in outpatient clinics and now is not employed by Canberra Health Services at all. Indeed, I understand they have retired.

MS CASTLEY: Okay. So just the three surgeries and nothing more?

Ms Zagari: The three surgeries, yes.

MR RATTENBURY: You spoke about locums filling the gap. I recognise it is a standard practice. Can you tell us the cost difference between, say, a day of a locum versus a day of a staff specialist in this sort of cardiology area?

Ms Zagari: I will take that on notice, Mr Rattenbury. There will be a variability between—

MR RATTENBURY: Of course, depending on the level.

Ms Zagari: if it is a VMO versus a locum versus a staff specialist. There is actually a range of employment arrangements, but we will take that on notice and come back with that.

MR RATTENBURY: I am happy for you to sort of judge the best information.

Ms Zagari: It might be a table.

MR RATTENBURY: Related to that, do the locums tend to come from the ACT or do they tend to come from somewhere where they have to travel in?

Ms Zagari: Often locums come from interstate. New South Wales would not be unusual. So somebody might come from Sydney and come for a period of time. It does depend, but often locums come from interstate.

MR RATTENBURY: Does the ACT pay their travel costs?

Ms Zagari: I will take that on notice.

MR RATTENBURY: Okay. Do we also pay them a travel allowance for meals and accommodation, in addition?

Ms Zagari: I will take that on notice. I will come back with the range of payments that might be made to a locum under various arrangements. I can keep it specifically to cardiology and the arrangements that are currently in place, or I can provide a broader, "These are the things that might be included in the cost of a locum."

MR RATTENBURY: Thank you. In that vein, can you tell me—I think this is the same area—what a section 245 payment is?

Mr White: Section 245 under the PSM Act is an additional payment. It is an incentive payment on top of base salary and wages.

MR RATTENBURY: Who would be entitled to a section 245 payment?

Mr White: It is an individual incentive arrangement which is paid, typically, to our clinical staff—in particular, our doctors.

MR RATTENBURY: The staff specialist doctors—or VMOs or locums?

Mr White: No, just to our existing staff. It is not for a contract; it is for existing staff arrangements.

MR RATTENBURY: Are there many of those?

Mr White: The section 245s, yes; I can actually answer that.

Ms Zagari: Should we take it on notice? Do you have a number?

Mr White: I do not have my folder. Apologies, I did not bring it.

MR RATTENBURY: No, that is okay. We can come back later, if you have it to hand.

Mr White: Okay.

MR RATTENBURY: While you are thinking about that, I am interested to understand what the scale of them is.

Mr White: In terms of dollar value?

MR RATTENBURY: Yes. I have no idea whether it is $5,000, $100,000 or—

Ms Stephen-Smith: I am learning something here. Does the section 245 cover ARIns or is that a different instrument?

MR RATTENBURY: No, I believe that is different.

Mr White: That is a different instrument.

Ms Stephen-Smith: A different arrangement.

Mr White: We have the group ARIn arrangement, which is based on a classification; then we have the section 245s, which is an individual arrangement. The individual arrangement would be different, according to the person.

MR RATTENBURY: Of course.

Mr White: The range would be different.

MR RATTENBURY: I am interested to understand how somebody applies or becomes eligible for a section 245 payment. If I can give you that bundle of questions, I do not know whether you can answer that straight up.

Mr White: I will come back to you on that.

MR RATTENBURY: Thank you.

MS CASTLEY: When we are looking at bringing in locums from New South Wales, or wherever they come from, is the skill set similar to the senior cardiologists that we are losing? They have not just finished all the levels of training?

Ms Zagari: No. The locum agency will provide details, for example, of available cardiologists, and there will be an assessment made, usually by the head of specialty or the executive director of medical services and the division to say, "Does this person have an appropriate level of skill to be able to provide the cover that is required?" North Canberra Hospital provides general cardiology services, at a general hospital level, not a tertiary hospital level, so they would make an assessment of whether they have the right skill set and whether they are appropriately registered as a cardiologist. There is then credentialing at a hospital level—a review of references, skills and experience—to make sure it is suitable to provide services.

MS CASTLEY: With the surgeons we have at Canberra Hospital, the tertiary, we have not lost any skill set? We can still—

Ms Zagari: With the cardiologists?

MS CASTLEY: Yes.

Ms Zagari: At Canberra Hospital itself? We have coverage of all the subspecialty areas within cardiology, yes.

MS CASTLEY: Currently?

Ms Zagari: Currently, yes.

MR EMERSON: Do you have on hand how many non-executives are currently on ARIns?

Mr White: I do have that in my folder. I will come back to that today.

MR EMERSON: Thank you. While you are providing that, how many might be on double ARIns and whether that number has gone up or down over the last five years.

Mr White: Double ARIn?

MR EMERSON: The additional that they are receiving—the incentives. Is that arrangement no longer in place?

Mr White: You are saying a group ARIn and an individual ARIn?

MR EMERSON: An individual, yes.

Mr White: I will take that on notice.

MR RATTENBURY: I would like to ask some mental health questions. Minister, I am keen to understand the status of the Office for Mental Health and Wellbeing. I have had a number of constituents raise questions about where it is at and its future.

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

Ms Rule: As part of the task force that looked at the machinery of government changes across the whole of government, there were some recommendations to look at the roles of coordinators-general and to think about the structure of those offices. We are currently in the process of thinking about that, doing some consultation with staff and with stakeholders, and we will form a position on that. Until then, the office continues in its current and previous form.

What we have essentially done is what we describe broadly as a lift and shift of the former health directorate, minus digital health, and the former community services directorate, minus some parts of housing, together into the new directorate. Most people in the directorate have stayed in their same jobs, working in the same way to the same structure, with the exception of deputies who now work to one D-G instead of two. In terms of the office itself, Dr Miller continues to be the Coordinator-General of the Office for Mental Health and Wellbeing, and the office continues to exist.

Ms Stephen-Smith: I have sought to reassure stakeholders that I have spoken to about this that the work is continuing. Particularly, explicitly in our response to the ACTPS task force report, we highlighted the work of continuing to develop and embed lived and living experience across the mental health system. The Office for Mental Health and Wellbeing has been leading that work. MDAS have been doing some great work in that space as well.

Between the Office for Mental Health and Wellbeing and mental health strategy and policy, in the first half of this year they have been undertaking some workload reduction activity, looking at priorities across the existing workload. That has been a collaborative exercise between the Office for Mental Health and Wellbeing and MHSP, which both report to Dr Miller.

MR RATTENBURY: Ms Rule, what is the timeline for that review process that you are currently undertaking?

Ms Rule: We are still working through what is a manageable timeframe for that. The first thing is to make sure that the basic structures of the directorate are correct. At the moment we are focusing on things like corporate services and how we bring those together, and the program areas like the Office for Mental Health and Wellbeing will follow secondly. We are working out what those timeframes look like now.

THE CHAIR: Is there a deadline by which time you want all of it to be completed?

Ms Rule: No, there is not. We are trying to work through it methodically, in a way that allows us to consult properly with staff, unions, stakeholders and all the other people who will have views on these things. As I said, our focus is on the establishment of the directorate. Shortly after, we will then move our attention to—

THE CHAIR: We could be back here asking the same question next year?

Ms Rule: I do not think so. But it may be a number of months before we are really at a decision point on some of those broader things.

THE CHAIR: That is what I am trying to understand—the scale.

Ms Rule: We are not quite there yet.

MR RATTENBURY: Can I ask for an update on the review of the Mental Health Act? I believe one is scheduled.

Ms Stephen-Smith: I will ask the Chief Psychiatrist to come to the table.

Prof Cidoni: I have read and acknowledge the privilege statement. We have a statutory review of the Mental Health Act which will begin between August this year and August next year. That is to review various provisions in the act, including all the various types of treatment orders and some other provisions, including the ability for the Chief Psychiatrist to produce guidelines. There are other factors, such as the ACAT processes associated with that as well.

We have committed to start that review early in that review period. We are already starting the process of the development of that review. We anticipate that we will be able to start in the first part of the year in which we have to start the review, because I think it is important that we press on and make sure that the changes that were made in the last Mental Health Act review are reviewed appropriately.

There are a number of other matters that we need to consider. There are the mutual recognition provisions that have been passed by the Health Ministers Meeting that will be in place from 1 January 2027. That will ensure that a mental health order is recognised in any jurisdiction in Australia. I am leading the process of implementation across jurisdictions to ensure that we have that implementation date, and we will need to have legislation put in place next year to enable that to start. That piece of work will go alongside the mandatory review elements of the act.

We also have the Chief Psychiatrist's report and the implementation of that, which will have some legislative changes as well, that we will be progressing. There are a number of things that are being worked through. There are also information-sharing provisions that are going through HMM at the moment, so we will need to look at those and make sure that we integrate any elements that need legislative change into our legislative reform.

Our proposal is that we will have an expert reference group that will have an external representative, a chief psychiatrist from another jurisdiction. The Health Services Commissioner will be part of that group as well. There will be those with lived experience—carer and consumer representation. There will also be representation of Canberra Health Services and there will be working groups that sit underneath the reference group.

We have worked through some of the details of the structure of the review. We will look at all the relevant provisions, then we will have public consultation, and we will bring that work back together to produce drafting instructions in terms of legislative changes. There will also be any clinical changes that are required, in terms of clinical practices or processes; that will be part of that review as well.

MR RATTENBURY: Thank you. You have very neatly anticipated my next couple of questions; I appreciate that. My last quick question in this mental health space for now is this: I have also heard that CAMHS, the Child and Adolescent Mental Health Service, will be moving from Bruce to Tuggeranong. Is that the case?

Ms Stephen-Smith: Do you mean the Cottage, not the whole Child and Adolescent Mental Health Service?

MR RATTENBURY: Yes.

Ms Stephen-Smith: The Cottage, as you know, has to move off the North Canberra Hospital campus for the development of the north-side hospital. The best location for that has been identified as being in Erindale, but it is a bit of a way away. We are conscious of—

MR RATTENBURY: Do you mean in terms of time or physical distance?

Ms Stephen-Smith: Both, but I meant in terms of time. Obviously, we need to refurbish a site in Erindale in order to be able to make that move. I am not sure whether Mr Aloisi can provide some further information about that. I will say up front that we recognise, in terms of distance as well, that it is a significant shift. It will be closer for young people in Tuggeranong and further away for young people in the north, and we are really conscious of that.

Mr Aloisi: The preliminary planning around the design for the facility has commenced, so there are working groups being structured, but we are at the very early stages, noting that we finalised the site just recently. That process is already underway.

MR RATTENBURY: I am conscious of that distance issue, with probably a preponderance of younger people in Gungahlin, particularly, and outer Belconnen. Having regard to the way the city is shaping at the moment, they are probably the growth areas. I am interested in what your thinking is on how to deal with that. I know Ms Carrick will be very pleased to see it go south of the lake.

MS CARRICK: Yes. I travel north a lot.

Ms Stephen-Smith: We are conscious of this. As you know, there has been a conversation for a while about child and adolescent mental health services, in Gungahlin in particular. I am not sure whether Mr Aloisi wants to add a bit more.

Mr Aloisi: Outside the Cottage and those specific programs, we do have a number of services that service the north side of Canberra as well, and a lot of our services are territory wide. In terms of the location at Erindale, as part of that review and the analysis in terms of the site selection, we did factor in things like public transport routes, and being accessible in those sorts of ways. The site does have a number of advantages with the scale of the site, in terms of the buildings that we can put on that site. It also has advantages in terms of access to parking and things like that. There are a number of benefits to that site, but we absolutely acknowledge that it is not as central as the current site.

Ms Stephen-Smith: Before Ms Carrick gets too excited, I should confess, because I am sure she will drag it out of me, that we had previously announced that the Cottage would relocate to Lyons, but when we did some further investigation of that site, it was not going to be large enough to accommodate the buildings, and it just did not quite work in terms of parking and the facilities onsite. I am sorry, Ms Carrick; we are moving to the south side, but not quite to Woden Valley.

MS CARRICK: That is all right. Erindale is good. I like all of the south—all of it.

Mr Aloisi: In terms of futureproofing, because of the size of the site, it gives us opportunities down the track, as we adjust for future demand. It does have that capability as well.

Ms Stephen-Smith: We are also considering child and youth mental health services in the context of the development of the new health centre in Casey, and how we then balance services across Gungahlin and north Gungahlin, recognising that the Gungahlin

health centre is easier to get to, from a public transport point of view—very close to the college et cetera. We have not made any firm decisions about service across those two sites yet, but that is part of our consideration.

MS CARRICK: I want to ask about the Safe Haven at the hospital. I know that it does not seem to be going ahead. We have the Safe Haven in Belconnen, with expanded hours to provide the services. Will we be getting one at the hospital or a more community-based one in the town centre? Where are we at with that?

Ms Stephen-Smith: We have not said we are not going ahead with the Safe Haven at the hospital. We have paused that project. The funding that was previously allocated to that project was ongoing, but the Belconnen community-based Safe Haven did not have ongoing funding, so we made the decision through this budget process to ensure that the community-based Safe Haven in Belconnen has ongoing funding, and we are exploring expanding hours of availability for that. It is a service that is appreciated by those who attend it. As Ms Lisa Kelly said in the hearings earlier in the week, people have to know it is there. As with many of these services, not many people know that it is there at this point. It is still very much a maturing service.

We wanted to know that that service had been evaluated and was representing a cost-effective response to distress, that it was doing the job it was intended to do or doing a different valuable job, and that it was a cost-effective service, before we committed to expansion.

With a community-based service, I know, Ms Carrick, that you were talking about a community-based one in Woden, and I did see Ms Kelly's evidence earlier in the week. I have had a couple of conversations with her and with other stakeholders. In fact, a group of the mental health peaks had a really good conversation about what is the intention of a Safe Haven in the hospital.

One of the things that I identified, coming into the role, was that people seemed to have quite different views about what it was supposed to be and how it was supposed to work. One of the things that has come out for me—again, Ms Kelly touched on this—is that, when people are in crisis and experiencing distress, they go to an emergency department, because that is a known place to go, but it is not the right environment for them. How do we ensure that there is genuine diversion? How do we ensure that if somebody just turns up to a Safe Haven in the hospital, there is an appropriate pathway for escalation?

That requires sufficient staffing, because people generally may or may not be able to be accompanied by one person. One of the things that the Belconnen Safe Haven team raised was that, if they need to accompany someone to the walk-in centre, for example, two people need to go with that person, for work health and safety reasons. They do not have the capacity for two people to leave the Safe Haven at the same time. Within a hospital, obviously, there would be other opportunities for wards people to escort, with a peer worker et cetera. That model of care still needs to be worked through.

With respect to the other thing that became clear to me in that conversation, part of what they were talking about was the value of mental health peer work within the hospital more broadly. I have asked the team to think about how we create a safe space for peer

workers, almost a bit analogous to the Aboriginal and Torres Strait Islander lounge and the veterans lounge. How do we create a space so that people in distress who know it is there will feel safe coming in, where care workers can be there, but where they can also do outreach to the rest of the hospital? It is so that outreach or the emergency department can identify people whose best solution would be that peer-led safe space, who otherwise might have ended up in the mental health short-stay unit, but they just need an opportunity to have their distress dealt with.

I will hand over to Ms Nagle to talk about that a little more, in terms of the evaluation of Belconnen Safe Haven.

MS CARRICK: There are a lot of different areas at the hospital. Now it is bigger; there is an area for children. When it was designed, there was not an area set aside for mental health patients?

Ms Stephen-Smith: There was an ongoing conversation during the design of building 5 around what we were going to do about mental health short-stay. There were competing views about whether there should be mental health short-stay in the emergency department, whether it was better located outside the emergency department, and what the model of care was going to be.

The end result was that there is not a short-stay. There is a behavioural assessment unit in the emergency department for people who are escalated in their behaviour, but the short-stay unit has stayed where it was, in the old emergency department, and it is used or not used as demand requires. Sometimes it is closed because there is no need for it; people can go straight into ward 12B or the Adult Mental Health Unit, as is appropriate for them. But sometimes it is open because it is required at that time, if there is someone in there. When I visited recently, there was one consumer in there, but they were going to be discharged fairly shortly, and the unit would close down for a period and the staff go and do other things.

The answer to your question, in terms of the future of Safe Haven, is that we do remain committed to a Safe Haven type model, a peer-led model, in the Canberra Hospital. We are continuing to look for the evaluation to understand the value of Safe Haven services and other distress intervention services in the community. I do not think that evaluation has been released.

MR RATTENBURY: Not the last time I looked.

Ms Nagle: No. As part of this budget item, there was $1.79 million to support the operation of the Belconnen Safe Haven, and $0.2 million of that is for an evaluation of the Safe Haven, because we will also be expanding the model—expanding the services at Belconnen. We have commenced conversations with Stride, who are the service provider, as to what an expansion of that service might look like. It might be an additional day; it might be an expansion of hours. It is about looking at the data. It is also about looking at emergency department presentation data for mental health, to see where the best evidence might be to increase the operational model. As part of that, we will do an evaluation, and that evaluation will be used to inform any future Safe Havens.

Ms Stephen-Smith: There was, though, a national evaluation of Safe Havens as well.

Ms Nagle: A national evaluation has been going on, done by ANU. That report is still confidential at the moment. We are expecting it to be released, hopefully, this month or next month. The ACT data is included in that.

MR RATTENBURY: Why is there funding for another evaluation, given the ANU one? I think I heard you say that there is $200,000 for another evaluation?

Ms Stephen-Smith: With the ANU one, I have been briefed by ANU on it. It does include the ACT, but it does not look at the ACT model in the level of detail we would want, because each model is slightly different.

MS CARRICK: I wanted to ask again about the mental health data. The emergency presentations that are seen within the recommended time is still below national average, and delays in seeing mental health professionals, due to cost, is still above the national average. What work is being done to improve those stats?

Ms Stephen-Smith: What data are you looking at?

MS CARRICK: *RoGS*.

Ms Stephen-Smith: *RoGS* from 2023-24? So it would be the *RoGS* that was recently released?

MS CARRICK: The latest release.

Ms Stephen-Smith: It would have data from 2023-24.

MS CARRICK: Yes, the latest release.

THE CHAIR: If we can just keep this part fairly tight, because there are still a lot of people waiting for questions.

MS CARRICK: Okay. It is just that there are still people not going because of cost.

Ms Stephen-Smith: To?

MS CARRICK: To seek mental health help.

Ms Stephen-Smith: They would be people not attending private mental health services—psychiatrists and psychologists—because of the cost. Are you saying there are more in the ACT than in other jurisdictions?

MS CARRICK: Yes; that is what the stats say, or that there are more delays in seeing them because of cost—people put it off.

Ms Stephen-Smith: Ms Zagari has helpfully pulled up the data while I was seeking clarity.

MS CARRICK: I think it is the third one in mental health.

Ms Stephen-Smith: I think that would be in line with a range of other private specialties in the ACT, where cost is higher than in other jurisdictions. We know that there is a shortage of psychiatrists nationally. There is a shortage of psychiatrists in the ACT, and costs are high. We have limited capacity to influence the private market.

MS CARRICK: Okay. So, with the public psychologists, are we increasing the numbers?

Ms Stephen-Smith: We do want to increase the number of public psychologists. We are short on psychologists at the moment, but there are public psychologists and psychiatrists, and maybe Mr Aloisi can talk about waiting times for public mental health services.

Mr Aloisi: Yes. In regard to your comment about the emergency department presentations, I do have some data that I can share. This is internal data which might, I think, provide a bit of a picture. Similar to the theme across general health services in terms of an increase in ED presentations, we have seen that for mental-health-specific presentations as well. If we look across the most recent financial year and the financial year previous to that—comparing 2023-24 and 2024-25—we have had about a 10 per cent increase in the amount of mental health presentations across our emergency departments.

But, at the same time, we have actually seen a reduction in the number of consumers who are in the emergency department for over a 24-hour period. We have also seen a seven per cent decrease in the amount of time that mental health consumers are waiting in the emergency department for an inpatient bed. Definitely we have seen a 10 per cent reduction in the amount of time that mental health consumers are waiting for care; that is from the point of arrival at the ED to the commencement of their clinical care. So despite the increase in activity, we have been able to manage that effectively.

As part of our ability to manage that there have been some systems and process change. Also, in terms of our ongoing recruitment in the Division of Mental Health, Justice Health, Alcohol & Drug Services, where our public psychologists, psychiatrists, social workers and nurses work, we have pretty much month-on-month grown that workforce. We have seen an increase in our workforce to meet that demand—to give you a bit of a pattern.

MS CARRICK: Okay, thank you.

THE CHAIR: Ms Tough, do you have a question?

MS TOUGH: Yes, thank you. I wanted to change tack to voluntary assisted dying. I will start with the first part of my question to you, minister. I am interested in an update on how implementation for voluntary assisted dying is going, given that it will commence later this year.

Ms Stephen-Smith: The team are doing a really great job, and I am getting incredibly positive feedback both from clinicians and from consumer organisations about the work the team is doing in engaging with the community and getting through the development

of all of the guidelines and training materials. Just fairly recently, applications opened for clinicians to register with various elements of voluntary assisted dying, and there has been a pretty good response to date. I will hand over to Ms Stoddart.

Ms Stoddart: As the minister indicated, we are working through all the necessary documentation to support implementation. That includes the development of the regulations that support the practical functioning of the scheme under the legislation. It is also building a specific ICT management system, and that will be used across the health sector to support the authorised practitioners to provide appropriate paperwork to support the clients and to keep the records of those going through the scheme.

We are also developing the authorised practitioner approval process. As the minister said, the workforce applications have opened, and we are going through the process now. We are getting a number of applications through. We are working through the approval process and then on to training to support them to be able to become authorised practitioners. We are working on the production of all the clinical guidelines and the standard operating procedures that will provide all the detail on how the scheme works day to day. We have also undertaken significant engagement across the sector, and more broadly, so that we have got that broader education and awareness and when we go live, on 3 November, we have got that strong understanding and awareness of how it works and how it integrates into the broader system.

MS TOUGH: Thank you. My next follow-up is going to be about education. On community day, one of the witnesses talked about the need for that broader education piece around practitioners for the entire community before it starts, but also for the general public to know what is actually available in the scheme, who can be part of it and how it will operate. Is that part of that broader education work?

Ms Stoddart: We have got some general awareness planned, but really our focus has been on educating the health workforce and the health services so that they are able to have that conversation at the appropriate time with a patient, with the appropriate information, to help them make the appropriate end-of-life decisions that they want. It is obviously quite a case-by-case, independent decision about accessing VAD, so it is about making sure that, across our health workforce and our health services, they understand what the eligibility is for VAD, when it is appropriate to talk to somebody about it, the information that they can provide the individual, and where to refer them to get them the process for the care navigation service, if that is the path that they want to follow.

MS TOUGH: Yes, that makes sense. That general education piece would be a bit of that myth busting of who is eligible and for the general population to know at the time, but the focus is more on practitioners who are actually working with patients.

Ms Stoddart: At that point, with a patient, when it is appropriate to have that conversation around the detail of it and broad general awareness that it is available and what it entails.

MS TOUGH: Thank you. The Independent VAD Oversight Board is an important mechanism to oversee the scheme. Is work underway to establish that board and where is that work up to?

Ms Stephen-Smith: Yes. We just recently got approval of the membership of that board from the relevant parliamentary committee—social services, I think. Is that what it is called?

MR EMERSON: Social policy.

Ms Stephen-Smith: The social policy committee. But I do not think we have announced that yet. I assume we have advised the people who are on it. I have certainly advised the chair that they were successful. We are probably in the process of me being about to write to people to let them know and to then announce the oversight board. It has been selected, so that is pretty close.

MS TOUGH: Wonderful. It is imminent. Thank you.

Ms Stoddart: "Imminent" is exactly the wording in my brief.

MS TOUGH: Wonderful.

Ms Stephen-Smith: Chair, I have been meaning to do this between questions; Ms Zagari has advised that she can talk about the personnel matters in-camera at some point, if you want to leave for five minutes.

THE CHAIR: Thank you. We will see when we can find the time to do that.

MS CASTLEY: I would like to chat about workforce. I am wondering if you can tell me what the expenditure on employee expenses for each of the forward estimate years is.

Ms Stephen-Smith: We will bring Ms Hughes and we will bring Mr White up in case you then have employment questions as well as employee finance questions.

MS CASTLEY: You pre-empted my—

Ms Stephen-Smith: The question was around the employee expenses over each of the forwards—

MS CASTLEY: Expenses for the forward estimate years, yes.

THE CHAIR: Do we need to move to something else while things are looked up?

Ms Zagari: I think that that would be helpful.

MS CASTLEY: All right. I would also like to know if you could tell us how much of the—has there been a change in employee—I feel like I need to be ready, because there is just a bunch of questions that follow on. But I can move to—

Ms Stephen-Smith: So has there been a change in employee expenses over the forwards?

MS CASTLEY: Yes. Well that and is it driven by—yes, that is right. So we will just go back to that track in a second. I would like to chat about—still on workforce, if we can just delve into a different section? Minister, Ms Zagari was appointed CEO of Canberra Health Services earlier this month and I am just wondering what was the recruitment process for the position?

Ms Stephen-Smith: Are you happy for me to talk about—

Ms Zagari: I am happy for you to talk about it.

Ms Stephen-Smith: As you are aware, Ms Castley, a number of Director-General positions were advertised recently. Mr Peffer obviously put his hat in the ring for one of those Director-General positions that was advertised, as did Ms Zagari. She was found suitable for the level of Director-General. When Mr Peffer was selected to be the new Director-General of the City and Environment Directorate, Ms Zagari, as having been found suitable and in fact in my view, highly suitable, for the level of Director-General, and there being a vacancy for the same level at Canberra Health Services, she was then slotted into that Director-General level position rather than another one.

MS CASTLEY: And it was publicly advertised? Yes?

Ms Stephen-Smith: So the Directors-General positions were yes, absolutely.

MS CASTLEY: Yes. Okay.

Ms Stephen-Smith: I mean—

THE CHAIR: Can I just clarify—

Ms Stephen-Smith: You would have had to be hiding under a rock to not know that we were employing—that we were doing the machinery of government changes and looking for Directors-General—

THE CHAIR: Sorry Minister, could I just confirm, was the specific role advertised or was that a broad approach?

Ms Stephen-Smith: The two specific roles—well we have also been recruiting to—recently we have recruited to a Director-General of Education and a Director-General of Justice and Community Safety, but the two roles that were specifically advertised and recruited for were City and Environment Directorate and Health and Community Services Directorate.

MS CASTLEY: And like, on SEEK? Like, where was this advertised?

Ms Rule: This process is the responsibility of the Head of Service—

Ms Stephen-Smith: Yes.

Ms Rule: —in the Chief Minister's Directorate, but they were publicised in national media. There was an executive search firm used. From memory, they were in the

Canberra Times. So they were in the kind of standard—it was an open recruitment process that went to market.

MS CASTLEY: Yes, and does that get handled internally or does the recruitment get handled—

Ms Rule: So there was a procurement process—again, these are—I will answer to the best I can—

MS CASTLEY: Thanks. I appreciate it.

Ms Rule: —but this was obviously the responsibility of Ms Leigh. The recruitment in all of these instances was supported by a recruitment agency and executive search firm. There were different ones for different positions. The panel was chaired by the Head of Service with an executive search firm to support the processes of advertising, short listing, all of those sorts of writing up reports, all those sorts of things.

MS CASTLEY: Do we know how many people applied, other than Ms Zagari?

Ms Stephen-Smith: That is absolutely not for this hearing—

Ms Rule: That is a question for—

Ms Stephen-Smith: —and is in the responsibilities of the Head of Service.

MS CASTLEY: Okay. So can we go back to finances now? The expenditure on employee expenses for each of the forward estimate years?

Ms Hughes: Yes. That is on page 92 of the budget statement B. It is for 2025-26, $1.621 billion, 2026-27 $1.585, 2027-28 $1.626 and 2028-29 $1.663.

MS CASTLEY: So how much of the change in employee expenses is driven by the number of employees? Could you also separately tell us how much of the change is due to change in wage levels?

Ms Hughes: We could probably bring back the percentages around those for you.

Ms Stephen-Smith: Yes. We will take that question on notice.

MS CASTLEY: Great. Thank you. I understand that the relevant enterprise agreements for CHS staff are due to expire in 2026. I am wondering what assumptions does this budget make around wage growth in the years after the agreements' expire?

Ms Stephen-Smith: The questions about assumptions on indexation matters like wage growth are questions appropriately directed to treasury.

MR RATTENBURY: The finance minister.

Ms Stephen-Smith: Well no. I mean, the Treasurer and the finance minister have different roles, and it is a question for treasury officials who are not here.

MS CASTLEY: But I am wondering if you can confirm whether there is an assumption about wage growth being greater than zero in the out years of—

Ms Stephen-Smith: Yes.

Ms Hughes: There is, yes.

MS CASTLEY: Yes. So there is wage growth factored into this budget? Yes?

Ms Stephen-Smith: Yes.

MS CASTLEY: Okay.

Ms Stephen-Smith: But I would also note, Ms Castley, that while there is some wage growth factored in, there is also—now that I said it is a question for treasury—there is a provision for enterprise bargaining. We actually, just this week, released the notices of the commencement of enterprise bargaining. We will be bargaining right across the service. So the actual wage growth for the next four years is not known at this point. There is another wage increase that is due in December, which is the last one under these agreements which expire in March.

MS CASTLEY: Yes.

Ms Stephen-Smith: So the actual wage growth under enterprise agreements beyond March next year is not a known quantity. There is currently a provision in the budget that sort of provides some of the funding that we expect will be required, or the funding that we project will be required, for the outcome of enterprise bargaining, but we do not know what that is 100 per cent yet. My hope is that we will get through bargaining fairly quickly and that the full impact of that will be reflected in the 2026-27 budget. This is my portfolio because I am responsible for enterprise bargaining.

MS CASTLEY: So just to clarify that, the budget assumes that there will be wage growth according to CPI? Are we willing to talk about that—go down that path, no?

Ms Stephen-Smith: Well no, not according to CPI. Again, for the detail of that I am afraid you will have to go to treasury.

MS CASTLEY: Okay.

Ms Stephen-Smith: What I can say is—

THE CHAIR: Sorry minister, to be clear, are you talking about the session with the Head of Service, is that—

MS CASTLEY: Treasury.

Ms Stephen-Smith: Well no. I mean, underlying assumptions that are built into indexation in the budget are really a matter for treasury.

THE CHAIR: Right, okay.

Ms Stephen-Smith: In terms of employee expenses more broadly, we obviously have an explicit budget measure that was part of our efficiency measures around employee expenses, but that explicitly does not apply to Canberra Health Services.

MS CASTLEY: Okay. I am just wondering, page 77 of the budget paper notes the increase of 449 FTE staff from 2024-25, the budget net estimated outcome, due to extra demand for services. Can you talk a bit about what the categories of these positions are, and if we can understand the proportion of the new roles, were they medical professionals or admin staff?

Ms Hughes: All of the new roles in the budget are clinical staff. They are either nurses or doctors. In fact, admin staff are currently fewer than they were 12 months ago. We have had a reduction in the number admin staff. So we can give specific numbers about how staffing has moved in the last 12 months, and the budget is based on those moves.

MS CASTLEY: Thank you. Can you also provide a breakdown by salary level with the—

Ms Hughes: Yes.

MS CASTLEY: —yes, thank you. There was also an increase of 98 staff from 2024-25, estimated outcome in the 2025-26 budget. Can you supply the same breakdown for those positions and salaries as well?

Ms Hughes: Yes.

MS CLAY: I would like to ask some questions about birth and midwifery.

Ms Rule: We will swap our—

Ms Stephen-Smith: I am shocked to hear it! Shocked to hear it, Ms Clay.

MS CLAY: Yes, do a team swap. You were expecting it. Minister, I reckon you will be able to help me out on the first one, so I might jump in. We are really pleased to see that that feasibility study has been done on the standalone birth centre. That was great to see. Will the recommendations be accepted or is that still a decision that you are in the process of making?

Ms Stephen-Smith: Yes. So, I cannot remember exactly what we said at the time of releasing it, but that is absolutely the intent that we are designing towards—the standalone birth centre on the North Canberra Hospital Campus, alongside the new Northside Hospital.

MS CLAY: Yes. We had a look at the budget and we were not sure, has the birth centre been funded in this budget? We could not see it in there.

Ms Stephen-Smith: Well, we are considering it as part of the broader development of the new Northside Hospital. We are still working through a final business case to fund

construction of the Northside Hospital. It has been through a number of iterations of funding, including funding specifically allocated out of its provision for the next stage of work in this budget. But given that the conclusion was a standalone centre on the Northside campus, we are wrapping that into the whole project and working with our very early contractor involvement partners, Multiplex, to ensure it is integrated into the broader project delivery. So we will be considering that in the context of the program for the new Northside Hospital and the business case and funding for the new Northside Hospital.

MS CLAY: Great. It sounds like the design is fully funded as part of the overall design. Have I heard that correctly?

Ms Stephen-Smith: So it will be incorporated as part the new Northside Hospital, yes.

MS CLAY: That is great. We have also—

THE CHAIR: Sorry, I just want to clarify on this point, so it will be in the budget or is it that it is already in the budget, the full design process for the Northside Hospital?

Ms Stephen-Smith: There is funding in the budget that has been—so there is a provision already spread over a number of years for the new Northside Hospital. That is a provision. Obviously, the final amount of funding that is required will depend on the final design that is chosen, the scope that is chosen and the costs that come back from Multiplex, or if we go back to market, you know, because we think that we need to. So I cannot say that all of the funding that is required for Northside Hospital is currently in the budget. What I can say is there is a very significant provision in the budget of more than $1 billion, and that the birth centre is now part of this project and will be considered as we go through the next stages of the process, from very early contractor involvement to early contractor involvement to construction partner.

THE CHAIR: So there is a provision that that may be adjusted over time?

Ms Stephen-Smith: Yes.

MS CLAY: It sounds like the government has committed to that standalone birth centre?

Ms Stephen-Smith: Yes, yes.

MS CLAY: Yes, that is great. Got it on record, that is great.

Ms Stephen-Smith: I do not know if that is new news.

MS CLAY: No, that is really great. I have some questions about midwifery continuity of care. We have the workforce report that was done under FOI. There were a few recommendations in that and there is a commitment to offer midwifery continuity of care to 50 per cent of women and birthing people by 2028. Have the recommendations in that workforce report been agreed to, to make sure that we will have the midwives that we need in this area?

Ms Stephen-Smith: Yes. I mean, it was likely internal sort of recommendations for Canberra Health Services. I do not know if Ms McKenzie wants to speak to that?

Ms McKenzie: It was an internal document.

MS CLAY: Yes.

Ms McKenzie: At the time of the FOI, it had not been finalised. The final step required is consultation. So we have not undertaken that as yet, and because it has not been consulted, we have not agreed to the recommendations.

MS CLAY: No, that is entirely understandable. We are adding up and it is looking, from all of this information, that we need about an extra 24 midwives?

Ms McKenzie: Yes, I am not entirely sure of the exact figure that it recommended, but it would require an uplift of midwifery positions into our continuity programs.

MS CLAY: Yes. We are a little concerned. If we have this target to meet by 2028, and we know we need 24 extra midwives by 2028, we are a bit concerned that running a two year trial that looks like it has fewer than 24 midwives—from our reading it looked like it has about nine midwives in it—it will then run out in about 2027 or early 2028. Can you give me a bit of reassurance about where the funding in this year's budget is and what the plan is to make sure that we have the 24 midwives that we will need?

Ms McKenzie: Sure. What trial are we talking about, Ms Clay?

MS CLAY: The report talks about running a two-year pilot.

Ms McKenzie: And because the report has not been finalised—

MS CLAY: It is internal. Yes, no. That is okay.

Ms McKenzie: Yes, yes.

MS CLAY: So let us not worry about that. Let us talk about how we are going to get to our offering 50 per cent by 2028. As I said, it is looking like we need an additional 24 midwives. Do we have additional midwives in this year's budget?

Ms McKenzie: No. There are no additional midwifery positions.

MS CLAY: Yes, okay.

Ms Stephen-Smith: No. But I think one of the challenges that we currently have is that we are continuing to use agency midwives, particularly at North Canberra Hospital, is my understanding. So we are sort of in an ongoing recruitment process for midwives. We obviously supported the commonwealth prac placement payments and we have supported, through the University of Canberra, midwifery students as well with practical incentives. In fact, I think, Mr Peffer has already written to all of the midwifery students who are finishing their midwifery studies this year offering them jobs at Canberra Health Services next year, through again the streamlined process that we used

for nurses and midwives to employ those that were graduating at the end of last year, to employ them this year.

MS CLAY: Great. It sounds like some great steps. Can I just check: how many midwives do we have practicing now? It sounds like we do not have any new positions funded in this year's budget. We are doing all the business-as-usual recruitment. But there is, I guess, no money—if you had twice as many putting up their hands for a job, you would not be able to hire them would you, because there is no funding in there for that?

Ms McKenzie: I think if we had twice as many putting up their hand we would be celebrating.

Ms Stephen-Smith: We would probably be finding the money.

Ms McKenzie: We would be finding the money, I feel confident. Although it is not for me to say, Minister, but I do feel that we would be doing that. So just to reiterate, we are intending to offer every graduating midwife a permanent position at Canberra Health Services. We are having to supplement some of our workforce at the moment with agency, and we continue to run standard recruitment processes locally, nationally and internationally.

MS CLAY: Sure. How many midwives do we have now in public employment?

Ms McKenzie: That figure I would have to take as a question on notice.

MS CLAY: That would be great. Thank you. For all of these positions, do they also practice in continuity of care midwifery or are they practicing in other types of midwifery?

Ms McKenzie: No, they practice in the multitude of models that we offer for women and birthing people.

MS CLAY: Are you able to tell me how many midwives we have now employed practicing in continuity of care?

Ms McKenzie: I can take that as a question on notice as well.

MS CLAY: Yes. Thank you. We might just wait until the information comes back. As I said, we are trying to work out how we are going to get from where we are to that really fantastic target without running along business as usual.

I was also interested in the perinatal Safe Haven initiative. We had a look in the budget and it looks like the perinatal mental health organisations are getting that funding. Is that for everyday operations for the perinatal mental health organisations or is that for a perinatal Safe Haven? I am trying to work out what that funding is for.

Ms Stephen-Smith: There are two lots of perinatal mental health funding in this budget. One of them is for the Perinatal Wellbeing Centre, so to continue their community-based work, and the other is to undertake some further feasibility work in

relation to a residential mother and baby unit, which is something that there was a scoping study previously in relation to that. The perinatal mental health Safe Haven work is around the wellbeing centre and the Perinatal Mental Health Alliance. To be honest, I am not quite sure why it is called—

MS CLAY: So there is no—

Ms Stephen-Smith: I think that may in fact be an error in the budget measure title.

MS CLAY: Sorry, Hansard cannot detect nods.

THE CHAIR: I note that there is nodding.

MS CLAY: Can we just confirm if there is a perinatal Safe Haven or not?

Ms Nagle: There is no perinatal Safe Haven. The title should be called Perinatal Safe Space.

MS CLAY: Right.

Ms Stephen-Smith: Yes.

MS CLAY: Okay. Thank you.

THE CHAIR: So Perinatal Safe Space.

Ms Stephen-Smith: Safe Space, yes.

Ms Nagle: Yes.

MS CLAY: That is why we could not find out much information about it. Thank you.

MS CASTLEY: I am just wondering, so there is no new funding for midwives, and to your point, Ms McKenzie, is that because there are just none? Even if we had money for new midwives, there are none applying for jobs?

Ms McKenzie: So our current models are funded and we are recruiting to the FTE in our current levels.

MS CASTLEY: To keep that level, yes.

Ms McKenzie: Yes. So the next step would be to determine where growth is needed to get us to the 2028, 50 per cent target. We will go through that process based on the work that has been done when we finalise that, and then we will move into a business case where we seek additional funding for the growth in models.

MS CASTLEY: Can I ask what the cost of an agency nurse over 12 months is, compared to a full-time employee—midwife?

Ms Zagari: So this was the comment I was about to make Ms Castley. Actually if we

found additional midwives and could directly employ them it would be more than covered by, offset by, a reduction in agency nurses. So we are absolutely recruiting as many midwives as possible. It is an area of workforce shortage and that is the challenge.

MS CASTLEY: Right. So if they come—

Ms Zagari: Correct.

MS CASTLEY: Right.

Ms McKenzie: Yes.

MS CASTLEY: And do you have those figures of what the cost difference is for an agency midwife a year?

Ms Zagari: We can provide it for you, but again it is a variable thing depending on the agency and because we employ our agency staff on long-term contracts, it does depend on the individual and the agency that they are employed through, but we can give you an average kind of cost.

MS CASTLEY: Yes, there must be—you must have some idea if you want—

Ms Zagari: Correct.

MS CASTLEY: Yes. Thanks.

Ms Stephen-Smith: My office has just reminded me that while there is no explicit funding for growth in midwives in this budget, growth in midwifery numbers was funded in the previous budget with the ratios funding. So we are implementing midwifery ratios, which will see an increase in midwives.

MS CASTLEY: I understand.

MS TOUGH: This might be something to take on notice as it might be too specific. With the continuity midwife program, are pregnant women and other pregnant people who are getting other treatments through the Canberra Hospital, say they are through the FMU or a different model of treatment service, able to access the continuity in the midwives as well, or is it a different model for their care?

Ms McKenzie: So FMU is a different model. Continuity is able to support women and birthing people of all risks and all needs. So having a higher acuity does not necessarily exclude you from a continuity program.

MS TOUGH: Yes. So someone in FMU could access the continuity?

Ms McKenzie: I am going to have to take that as a specific question on notice.

MS TOUGH: Yes, sorry. I knew it was going to be a bit specific.

MS CLAY: I might plant this for on notice. We have had a few things taken on notice.

I will note that at the moment we are offering continuity of care to 18 per cent and we are putting it to 50 per cent by 2028. I have heard that there is no new funding in this budget, but you would find it if you needed to. There was some previous funding. Is there any further information about what it is you are doing to get from that 18 per cent to that 50 per cent as is a pretty stiff recruitment.

Ms Stephen-Smith: I think it is also though that if more people are taking up continuity, then fewer people are participating in antenatal care through the other models of care. So part of the reflections that you would have seen in the report, Ms Clay, was around the current model of continuity requiring that significant amount of on-call, that 24/7 on-call for the continuity, all the way from antenatal through birthing to postnatal.

One of the things that is being consulted on—and obviously, there were mixed views about the different potential models—I am not going to get the name right Ms McKenzie—is the continuity through the antenatal period and postnatal period, but not necessarily then having to be on call and available for the birth. So making sure there is someone that you know, and a team of midwives operating as a team in continuity that someone will be there, but the same person does not have to be there the whole way through. So this is part of the consultation: what is continuity and how are we thinking about it. Some people really want to provide continuity as much as possible but also just cannot for their own reasons, or do not want to participate in that very heavy on-call load.

MS CLAY: I hear all that and that all sounds reasonable, but it does not sound like continuity of care. If you are offering prenatal and postnatal but not the bit in the middle, it is not actually continuity—like that is a different service.

Ms McKenzie: No I think—and that is referred to in the report that you received via FOI—the difference is between continuity and group practice. So group practice is absolutely intended as a continuity model. It just is not one midwife to one birthing person; it is a core group of midwives that that birthing person will have formed a relationship with throughout the period of their pregnancy. I also just want to pick up another point made by the minister to reinforce, the trajectory to 50 per cent continuity model also will see some shifting of resourcing in FTE from core maternity models into continuity models.

MS CLAY: Which is great.

Ms McKenzie: So some of it will require a small investment when we determine what the model is and some of it will be about a shifting, and we do believe that some form of group practice will be an incentive for midwives to want to work in those models.

MS CLAY: Okay. Thank you.

Ms Hudson: Is it worth enlightening just a final point? There is also inside of Maternity in Focus, a shared care model, which will also adjust the way in which we deliver care This is a shared care model between the hospital and primary care practices that is being led by Dr Dorrington who we have seen this morning as well. So there are many things at play that will change the way in which we currently deliver care for pregnant and birthing people.

MR EMERSON: I have some questions about strategic objective 11, which is: "A healthy community through collaborative leadership". The targets in the budget for very good and excellent health are 55 per cent, and for mental health they are 60 per cent. How are these targets set? They seem somewhat low to me. Do you think they are sufficiently ambitious?

Ms Stephen-Smith: Sorry—which page are you on, so I look at the same thing?

MR EMERSON: I am on pages 16 and 17.

Ms Stephen-Smith: When you look at the outcome, Mr Emerson, the objective is still higher than the outcome. I think we need to remember that it is about people who report their status as very good or excellent, not just good, and that is a high bar. I recognise we want more people in the community to have very good or excellent health and mental health, but, in terms of the health status of Canberrans, we also know that around 50 per cent of the adult population over a certain age—and I cannot remember what it is—live with at least one chronic illness. To the extent that has an impact on their life, they may not self-report their health status as very good or excellent. A lot of older people live with multiple chronic illnesses.

There is always a balance to be struck between the aspiration of what you would like to see and what a realistic target is. In relation to these strategic indicators, there is also a question, frankly—it is one of the things that we are looking at in relation to strategic objectives across the board, and we constantly have a conversation about it—about the extent to which the work of the ACT government or the work of the relevant directorate actually influences this outcome. Both of these outcomes, but particularly the mental wellbeing of Canberrans is going to be influenced by a multitude of factors. Similarly, health is going to be influenced by a multitude of factors, some the same and some different. I agree that, ultimately, we want people to have a higher level of very good and excellent health and mental health, but there would not be a lot of point in increasing the target if we are not even getting to it at this point.

MR EMERSON: I do not want to put words in your mouth, but is there a bit of a feeling that it was worth having the target? Is there behaviour change? If the target in the year just gone were 55 per cent and we got 46 per cent and in mental health the target was 60 per cent and only 49 per cent reached that target, is that actually changing behaviour in this budget? Is something being done differently because of that?

Ms Stephen-Smith: This goes to the ongoing question about the relationship between the indicators that we include in the Wellbeing Framework and the strategic indicators that we use for our directorates. As we establish new directorates, it is an opportunity to think about it. This is useful information to have. I am not saying that we should not collect this information or we should not have this information, but is it information that is telling us about the effectiveness of our programs and our directorates or is it broader information that should be included in the Wellbeing Framework that is telling us about the wellbeing of the community as a whole, which says that the mental wellbeing of the community as a whole is not where we would like it? And what role does everyone have to play to improve that? And then how do we measure the effectiveness of the things that we actually do? It is still a work in progress as to how

we bring together the Wellbeing Framework. I think we were the first jurisdiction in the country to establish a wellbeing budgeting process with how we measure the effectiveness of the things that we, as the ACT government, actually do and deliver.

MR EMERSON: Last August, a report was published on the analysis of unmet need for psychosocial supports. This came up earlier this week and also in annual reports earlier this year. It indicated that 4,000 Canberrans had severe unmet psychosocial needs and 4,000 had moderate unmet psychosocial needs. Lisa Kelly earlier this week indicated she did not see a change in behaviour to address those needs in this budget. What is your assessment? Is that report still being considered or is there anything new in this budget that will meet those needs?

Ms Stephen-Smith: That report is certainly still being considered. We recently had the second meeting in two years of joint health and mental health ministers. That was a topic of conversation, not just among ministers; we also had a panel of experts and people with lived experience present to us their reflections on that report into unmet psychosocial needs and what we should do about it. We also had a presentation from the Productivity Commission on their interim report, which is now being released—early thinking about their recommendations in this space.

As you would be aware, the psychosocial area is one of the areas identified for further investment through the foundational supports funding that was agreed through national cabinet at the end of 2023. Unfortunately, that work has not progressed as quickly as most of us would have liked. The early focus has been publicly indicated to be children aged zero to nine. Health ministers broadly are very keen to understand what of that $10 billion joint commonwealth, state and territory investment will be available to improve psychosocial supports and how we integrate that into our existing thinking about mental health and psychosocial wellbeing. It is a big piece of work. One of the things that we talked about was that we do not want to see another separate service system for psychosocial supports—separate from the community based mental health system, separate from the public mental health system, separate from primary care, and separate from the NDIS. We want to try to build a single navigable mental health system where there is no wrong door, because there is a capacity for people to understand and navigate the system and provide warm referrals across.

Of course, we recognise that the majority of actual mental health support, as opposed to psychosocial wellbeing support, is delivered in general practice. I saw Dr Dorrington sitting right behind you, so I was reminded to say that. Also, as Ms Kelly reflected on earlier in the week in terms of psychosocial wellbeing, it is a much broader suite of things that are going to improve people's connection to community and their psychological health and wellbeing, and that might be social prescribing. It might be about going out for a walk in the bush. That might be the thing that helps with their mental health. It is not just about clinical mental health services; it is really broad. Obviously, a lot of that is also about social connection.

One of the things that we lost in the establishment of the NDIS, which we talked about at the time and which we expected the NDIS to replace through tier 2 funding and ILC funding, was places where people could come together without having to use funding out of their package and without having to explicitly book in or pay a cost. That used to be run by our community services. I remember that, when I first became Minister for

Disability, Belconnen Community Services talked to me about some of the programs that they ran with the Belconnen Arts Centre that were drop-in, build a community, have somewhere to be, have somewhere to feel valued, and then get that warm connection to the next level of service if you actually needed some more support. Unfortunately, in the establishment of the NDIS, not just in the ACT but also in other jurisdictions, funding for some of those things was cashed out and was never replaced through the NDIS. We have now invested in some of those things over time and replaced some of that activity, but I think we all recognise that those gaps are still there.

MR EMERSON: There is the Age-Friendly City Plan. I know it is outside the portfolio, but one thing that was dropped off of the actions in that plan was nature prescribing. I am looking at the acute build-up at the end of the system and wondering how far back we are looking. Mr Rattenbury asked earlier about chronic disease prevention and management. How far back are we looking in this portfolio? I suppose that is the question I am getting at. On the same page, we have vegetable consumption. This might sound silly.

Ms Stephen-Smith: No; it is not.

MR EMERSON: Five per cent of adults and three per cent of children are meeting guidelines for daily serves of vegetables. In terms of funding which seems to be unallocated—$27 million—how far upstream are we considering using the productivities and prevention funding? We have $1.5 million in the budget for food relief, so I am trying to get a genuine sense of whether it is outside of the portfolio we are looking at for these issues.

Ms Stephen-Smith: We have a Preventive Health Plan. This is one of the things that we talk about. I do not know if it is—

Ms Zagari: Are you looking for Dr Coleman?

Ms Stephen-Smith: Maybe.

Ms Zagari: She is in the other room.

Ms Stephen-Smith: Maria might be able to help. We recently reviewed the effectiveness of the Healthy Canberra grants and looked at how we target funding to those types of things—how we most effectively target our funding to achieve prevention and early intervention support. It is really difficult. We have had some really effective Healthy Canberra Grants. Often they reach a quite small number of people but make a big difference to those people's lives, but how do we spread that? We have had some really successful ones. The Pregnant Pause campaign, to discourage pregnant people from drinking, has been picked up as a national initiative with commonwealth funding. That has been really effective use of ACT government funding—to pilot something and then see it go off without additional ACT funding being required. That is kind of what the Healthy Canberra Grants are supposed to do, but they do not all do that. Some of them just create pressure for additional funding for something that may or may not make a big difference.

THE CHAIR: Do we have something additional coming?

Ms Stephen-Smith: I have filibustered for long enough that they are no longer required!

MS CARRICK: A lot of us, including Ms Kelly, talk about connectivity, sense of belonging to community and building neighbourhoods. You mentioned the arts centre in Belconnen and that people can go there. You talked about how we spread out the grants. We have looked at the gaps and where the facilities are, where people come together—the basic stuff, like arts centres and indoor sports teams. I am going to preventative health. It is a no brainer. Why don't we have these facilities located across Canberra where people can get to them, build communities and get a sense of belonging?

Ms Stephen-Smith: Ms Carrick, we take your point, but the location of facilities is not really a matter for these officials; it is much more a matter for Planning and other directorates. As you know, we try to support facilities right across the ACT, and I know that you will continue to advocate for Woden.

MS CARRICK: You talk about preventative health. We have people who do not get involved in the community because we do not have facilities for them to get involved. They say it takes a village to raise children. Where do we go to do that—to the gaming clubs? It drives me nuts. We talk about this over and over, yet nobody will identify the gaps and fill them.

Ms Stephen-Smith: We have been doing some work on community facilities. There is a piece of work currently underway in the directorate around community health facilities. Again, that is around health, but it is based in the community. I note that we recently funded the Chifley gym to continue. Part of the feedback we had from the community there was that it was not just about the physical facilities at the Chifley Health and Wellbeing Hub; it was actually also about connection with community. That is why we saw it was so important to provide the additional funding to ensure that the gym could get back up and running as an affordable support for people, particularly in the Woden Valley—to come together to achieve physical goals, but also to have social connection.

THE CHAIR: Ms Carrick, to try to keep this tight, is your question about whether there is any geographic modelling—

MS CARRICK: How do you contribute to any strategic planning? That is all.

Ms Stephen-Smith: The whole of government contributes. Bringing health and community services together will really facilitate that in a more coordinated way.

MS CASTLEY: I am circling back to the Wellbeing Framework. We chatted about that. You mentioned that, I think, we were the first jurisdiction. I have just had a quick look at the website. I have brought this up before. The access to health page still has data from 2023. The overall health page has data from 2022—nothing newer: healthy lifestyle, 2021; life expectancy, 2021. For mental health, I think the most recent data we have is to 2022. Who is responsible for updating that, and can they do it?

Ms Stephen-Smith: The Chief Minister's directorate looks after the Wellbeing Framework data.

MS CASTLEY: From the health perspective, would you give him a push?

Ms Stephen-Smith: It is absolutely part of the challenge, Ms Castley, that some of these datasets that might appear to be the most suitable data against the outcome that we are looking at are not collected annually. They are sometimes collected through surveys that happen only every couple of years and then take some time to be processed. That is one of the challenges we and other jurisdictions face in doing this work.

THE CHAIR: It was good to hear you talking about No Wrong Door. It has been a particular passion of mine for the whole time. One of the big challenges over a long time has been the handling of the psychosocial area—whether it is handled within a health context or a disability context. How is the ACT approaching it? Is it sitting within community services? Is it within disability? Is it within health?

Ms Stephen-Smith: It is another of the advantages of bringing health and community services together, I think. There is a lot of crossover. One of the conversations around the psychosocial foundational supports piece is: "Who should, in fact, take the lead on this?" Having Minister Butler now as Minister for Health and Ageing, Disability and the NDIS helps to close some of those gaps. There is a reason that the psychosocial unmet needs report went to the mental health ministers, not the disability ministers. We have clearly been taking a lead in some of that work, recognising that it needs to connect with the NDIS, because people with severe psychosocial disability are also going to be NDIS participants.

Ms Rule: I think the answer to your question, Mr Cocks, is that it is all of those things. In a policy and program management sense, it all sits within the health and community services portfolios, but the areas of community services that were previously responsible for disability as a policy and program area and the negotiations with the commonwealth on foundational supports remain in the Health and Community Services Directorate. Once we establish foundational supports, I would expect that some of those services will be delivered by our colleagues in Canberra Health Services, in the health directorate, and in the non-government sector. It is multifaceted. The answer to your question is all of those things.

THE CHAIR: Thank you. We will move on to a new question. I will pass to Ms Castley.

MS CASTLEY: Thanks, Chair. I would like to chat about expenditure, the budget and some financial stuff. Table 4.2.6 on page 250 shows detailed functional expenditure. Specialised hospital services are declining by seven per cent over the forwards, from $22.3 million to $20.7 million in 2028-29. Why is that?

Ms Stephen-Smith: Sorry—could you give me the page—

MS CASTLEY: Page 250; table 4.2.6.

Ms Stephen-Smith: Ms Castley, what was the question?

MS CASTLEY: It shows the detailed functional expenditure. Specialised hospital services are declining by seven per cent over the forwards. There is $22.3 million this year and $20.7 million in 2028-29. I am wondering why there is a decline.

Ms Stephen-Smith: I see where you are looking. We may have to take that question on notice, unless Ms Hughes has the answer.

MS CASTLEY: If you adjust for inflation, it is actually a 15 per cent cut in real terms. I am wondering about the impact this will have on Canberra's waiting lists for specialists.

Ms Stephen-Smith: It is not a reflection of a reduction in access to specialist outpatient services, if that is what you are relating it to.

MS CASTLEY: Who is missing out, then—specialist hospital services, figure 2?

Ms Stephen-Smith: I am trying to find my way through this budget paper. It is now structured in a different way. Canberra Health Services is separate; it is not the health portfolio anymore. We will have to take that question on notice and come back to you about that, Ms Castley. It is a relatively small element of the overall health budget, but we will look.

MS CASTLEY: It may be, but, as I said, it is a 15 per cent cut in real terms, if you adjust for inflation. We have also seen no growth in general hospital services, which accounts for half of the total health expenditure. Given you talk about health and hospital pressures, I am wondering why we do not invest more in additional hospital capacity.

Ms Rule: Are you referring to the general hospital services line?

MS CASTLEY: This time. The initial question that you have taken on notice is about specialised hospital services, but, for general hospital services, it is half of what we are looking at here. I am wondering why there is not more investment in additional hospital capacity.

Ms Stephen-Smith: Hospital services are a growing line overall and general hospital services are a growing line overall. You can see the significant step up from the 2024-25 budget to the 2025-26 budget and ongoing growth in future years. We are clearly investing in additional hospital capacity.

MS CASTLEY: Okay. It is not significant growth, considering we have talked about additional services in the health space. That is why our budget has blown out. It does not seem like a huge amount of growth that we are budgeting for, looking at the forwards. We can move on. There is also—

Ms Stephen-Smith: If you take the hospital services line, that grows by $160 million between 2024-25 and 2025-26, and then, if you take the outpatient services line, that grows by about $95 million between 2024-25 and 2025-26—between the two of those—and outpatient services are usually delivered through a hospital or a hospital

related specialist. That is a really significant increase in funding.

MS CASTLEY: That is tracking based on the additional services that we saw last year?

Ms Stephen-Smith: Yes.

MS CASTLEY: I also note that there has been a cut in real terms to pharmaceutical spending. Are prices coming down? Does the government anticipate fewer prescriptions or will these be passed on to patients? This might not be on this table; this is just generally. I do not have the table in front of me.

Ms Stephen-Smith: The pharmaceutical products line increases from $47.8 million in the 2024-25 budget to $53.3 million.

MS CASTLEY: I am not referring to this table.

Ms Stephen-Smith: That is a fairly significant increase.

MS CASTLEY: I will have to get the table for you. I will come back to you on that one. Are we passing on pharmaceutical costs to patients? Does that happen?

Ms Stephen-Smith: No—on pharmaceuticals in hospitals. Obviously, if you get pharmaceuticals under the Pharmaceutical Benefits Scheme, there is a patient co-payment associated with that. One of the things that we are continually trying to negotiate with the commonwealth—and Ms Hudson might want to talk about this—is the Pharmaceutical Reform Agreement process, where you can get a longer amount of prescription drugs on discharge from hospital.

Ms Hudson: I do not have much more to add, Minister. We are continuing to seek an agreement through the commonwealth, captured through the NHRA negotiations.

MS CASTLEY: In the papers, there is a transformation program that you talked about. It has expenditure of $13 million over three years. Can you give us some details about what is involved with that program and how the money has been used?

Ms Stephen-Smith: Yes. In the lead-up to this budget, the health directorate, Canberra Health Services and the Treasury worked together with the chair of the Health System Council, Dr Nigel Lyons, to have an early look at what the evidence showed from other jurisdictions and what the evidence showed from previous reviews of financial sustainability of the ACT health system and other work that had been done around health services planning, to identify that we needed to look at improving efficiency. As we talked about this morning, some of those have been explicitly reflected in the allocated funding for things like better support for long-stay patients and helping to ensure that we can discharge long-stay patients, investment in implementing virtual care and care closer home, and improved chronic disease prevention and management.

We know that we will need a specific piece of work. I would maybe describe it as being analogous to the culture reform work that we did following the culture review in 2018, where we established the Culture Reform Oversight Group and had an allocated bucket of funding to drive particular pieces of work that were going to influence culture across

the whole ACT health system. That saw some really effective cultural change in terms of the wellbeing and safety of our staff at not just Canberra Health Services and Calvary and, subsequently, North Canberra Hospital but also the health directorate. Similarly, it will be about bringing people together to identify pieces of work that drive systemic change to improve the efficiency and productivity of Canberra Health Services while continuing to improve the quality and safety of care, built on an evidence base. In terms of the way that we intend to do that, we want to continue to work with the Health System Council.

One of the key pieces of work that the directorate is preparing for me is looking at how we establish a transformation program analogous to that culture reform piece, while also understanding the work that the Legislative Assembly has asked us to do in terms of inquiry work, making sure that there is not too much overlap between those. There is the work that the Auditor-General is doing: performance reviews of outpatient care and the Digital Health Record. It is about how we bring all of those pieces of work together, with this particular piece of work being focused on engaging clinicians and engaging consumers, carers and other stakeholders, like our non-government partners—to bring everybody's ideas to the table about how we continue to deliver excellent care for consumers in a more efficient and productive way.

MS CASTLEY: The budget papers say that the initiative will enable more revenue generation across the public health system. How will revenue be generated?

Ms Stephen-Smith: Both the Chief Minister and I have talked about this before. In the ACT, we see the highest rate of private health insurance membership in the country and among the lowest rates of private health insurance use in the country. In particular, Canberrans have never really been encouraged to use their private health insurance in the public hospital system. There was never really any incentive for Canberra Health Services, or previously ACT Health, to encourage that. Because of the way that Commonwealth funding worked and the way that ACT government funding worked with the health funding envelope, there was no need, from their perspective, to generate additional income.

MS CASTLEY: So we do not have a dollar amount? There is nothing in the budget that says how much we are expecting to earn in revenue from the $13 million we are spending?

Ms Stephen-Smith: No. It is not only about improved revenue generation; it is also about more efficient delivery of care. It is about sitting down—

MS CASTLEY: It says: "providing resourcing to support targeted interventions that enable more efficient delivery of care and improved revenue generation across the public health system".

Ms Stephen-Smith: Yes; that is what I just said. It is not just about improved revenue generation; it is also about efficient—

MS CASTLEY: But there is no line telling us how much revenue we are going to generate.

Ms Stephen-Smith: No. Funding for the transformation program has been allocated to do that work with clinicians. Those conversations have already started, with surgeons in particular, around how we ensure that our consumers understand the benefit to the whole ACT health system of using their private health insurance, and how we ensure that we can guarantee no gap when they do that. That is obviously a barrier to people using their private health insurance for public health care—if they think that they will have to pay a gap. That is part of, but not the main part of, the work that we will do with this $13 million. It really is about systemic transformation, and that requires a dedicated effort, which requires funding.

THE CHAIR: I want to ask for a quick clarification. Are there no assumptions of additional revenue coming from this work built into the budget now?

MS CASTLEY: No. There are no lines of revenue.

Ms Stephen-Smith: There is no specific line. Overall, I think—

THE CHAIR: The question is in general: is there an assumption built into the budget and a dollar amount somewhere in there?

Ms Stephen-Smith: No.

THE CHAIR: Also, for the cost reductions that you would expect to flow from this work, is there any assumption built into the budget around how much of a cost reduction we would get from this?

Ms Stephen-Smith: In the budget review, I think we talk about $27 million worth of efficiencies that we were working to achieve in 2024-25. As Ms Hughes said earlier, we came in meeting budget and achieved those efficiencies, and that flows into $74 million of efficiencies ongoing from those projects each year over the next four years. In addition—

THE CHAIR: That is the $7 million that we talked about earlier?

Ms Stephen-Smith: Then Ms Hughes talked about the 11 projects.

Ms Hughes: There are seven projects. There are other things that we are looking at too. In terms of the revenue opportunity that we are looking at, we believe that there is a revenue opportunity of $7 million to $10 million a year around revenue that we are not collecting for private patients, where we are not doing Medicare—having all the information in the system from practising clinicians that ensures that we all maximize our revenue. We are looking to improve by around $7 million to $10 million a year. But you need to put in place some systemic items to make sure that we do that, and also to ensure that we get the procurement savings we are putting in Procure to Pay. A range of system improvements need to be made that are one-off costs that you then get an ongoing return from.

THE CHAIR: When you say "private patients", do you mean people who are currently private patients that you are not collecting from or people who could become private patients in the future?

Ms Hughes: People who have private insurance and choose—

THE CHAIR: Who are not currently choosing to—

Ms Hughes: Who are not electing to use it. The ACT has the highest level of private cover and—

THE CHAIR: As the minister was saying. Are there are any other supplementaries?

Ms Stephen-Smith: But there are also things like, as Ms Hughes said, improving the way everything is itemised and billed to places like the Department of Veterans' Affairs, to ensure that we can actually generate that revenue.

Ms Hughes: Yes.

THE CHAIR: We will go to the scheduled break now, given we have held officials here for quite some time.

Short suspension.

THE CHAIR: We welcome back Ms Rachel Stephen-Smith MLA, the Minister for Health and Minister for Mental Health. We also welcome back the officials who are in attendance. Before we continue with questions, I want to clarify that the committee is not seeking an in-camera hearing on this discussion; rather, we would prefer that the question stand as being taken on notice. The committee will receive it and take it as a confidential response. We will go to Mr Rattenbury.

MR RATTENBURY: Minister, I want to ask whether you have seen the recent policy in the Tasmanian election from Tasmanian Labor called TassieDoc. Are you familiar with that?

Ms Stephen-Smith: You might have to give me a bit more information about it. I did pay some attention to the election policies in the Tasmanian election, but not necessarily their names.

MR RATTENBURY: The idea is that the state government would provide the clinic and consulting rooms for government-run GP clinics and health hubs around the state, as well as paying the nursing and admin staff.

Ms Stephen-Smith: It sounds familiar.

MR RATTENBURY: It does sound familiar. It was heartily endorsed by the Tasmanian Liberal Party, who vowed to match it. Has the ACT government seen this model and done any analysis of it?

Ms Stephen-Smith: No.

MR RATTENBURY: Are you intending to?

Ms Stephen-Smith: We have not discussed it at this point, but thank you very much for drawing it to my attention, Mr Rattenbury.

MR RATTENBURY: It is very familiar. It is obviously the policy that the ACT Greens took to the election.

Ms Stephen-Smith: It is very familiar. It will be interesting to see how that—

MR RATTENBURY: We were pleased to see the Tasmanian Labor and Liberal parties thoroughly endorse it. I also want to ask about co-payments for public dental care in the ACT. My understanding is that if somebody is receiving public dental care, there can be a maximum of $515 per course of treatment as a co-payment. Am I correct in understanding that?

Ms Stephen-Smith: There certainly can be a co-payment. I will hand over to CHS, if we have someone here who can answer that.

Ms Zagari: Give me one moment while I check that specific number. I will come back to you before the end of the session with the specific amount.

MR RATTENBURY: Thank you. As I read it—and I am happy to be corrected—that

has now increased to $550.30 per treatment plan, which is an increase of 6.8 per cent. In the way that government fees and charges are normally raised, this is above both CPI and WPI, so why was this amount increased by that much?

Ms Stephen-Smith: Do you have the instrument number?

MR RATTENBURY: I have not, to hand; I should.

Ms Stephen-Smith: That is okay. I can probably find it fairly readily.

MR RATTENBURY: I will double-check my source.

Ms Stephen-Smith: I will check, but it may be that there was a year when there was not an increase, so it might be a catch-up increase. I will double-check that.

MR RATTENBURY: Thank you. We heard from the Health Care Consumers Association during the community day that this co-payment could be a barrier to people seeking access to services. Why does the government have such a substantial co-payment on public dental care in the ACT?

Ms Stephen-Smith: It has been in place for a long time. I would probably have to take on notice, unless someone from the directorate is familiar with the dental funding model, the history of that.

Ms Zagari: If I can respond to the first question, $550.30 is the cap per treatment plan. The team will come back on the increase, and there is a targeted access program which supports vulnerable ACT residents who are referred by 16 partnered organisations. For people in that program, there is no fee for this program, including for the provision of dentures.

MR RATTENBURY: Thank you; that is reassuring to hear.

MS CARRICK: My question is about infrastructure investment in the health portfolio. In budget statements C, Starting at page 41, I note that, as you roll through it all—capital injections, at table 28—there is not a lot in the outyears. The first page has rollovers; there are budget policy decisions, and not much in the outyears. There are technical adjustments; that is not very exciting.

There is nothing in 2027-28 or 2028-29 for new works. The Asset Renewal Program is split across the years. With work in progress, presumably, all those projects finish up, but there is nothing in the outyears. With the new works on page 42, I would have thought there might have been something in the outyears, given new works presumably will go for longer.

If we move to page 87, this is another entity. We have moved to Canberra Health Services, and it is the same. You get the rollovers, nothing in the outyears, and budget adjustments. With capital injections, there is nothing much.

THE CHAIR: Could you come to the question now?

MS CARRICK: The question is: if you keep rolling past a couple of pages there, you will see that there is nothing much in the outyears for work in progress or for new works. What does all of that mean?

Ms Stephen-Smith: Probably, the short answer is that, other than some Canberra Health Services projects that they manage, which tend to be internal and relatively short-term projects, we have their Asset Renewal Program, which does have ongoing funding totalling nearly $43 million over the forward estimates, and their plant and equipment program, which does not have a number in 2028-29 but there is $25 million over the forward estimates. Anything that is in any way major capital infrastructure has been transferred to Infrastructure Canberra for delivery. That will not be retained within the Health and Community Services Directorate or within CHS as the funding line.

If you have questions about a specific capital project, you can ask who is managing it. If it is internal to CHS's facilities, they will be managing the project. With the Canberra Hospital master plan, we could probably talk about next steps, but if there are other projects, they will probably be the responsibility of Infrastructure Canberra.

MS CARRICK: I appreciate that the big ones will go to them. With these smaller ones, there are a lot of them, and I would have thought there would have been an ongoing program of investment. To me, it looks a bit odd that there is nothing much in the outyears. If there is an ongoing program of smaller investments, when will they come into the budget and what impact will that have on borrowings and interest?

Ms Stephen-Smith: The remit of Infrastructure Canberra has expanded. When it was originally established as Major Projects Canberra, it was only responsible for major projects. It is now responsible for a wider sweep of infrastructure delivery, with things like the new inner south health centre in Griffith, which is quite close to Woden—there is already a health centre in Phillip, just to be clear—and the north Gungahlin health centre, which were the responsibility of the health directorate; they are now the responsibility of Infrastructure Canberra.

MS CARRICK: It just looks odd; that is all I am saying. If smaller projects are embarked upon, there is the impact on borrowings, the debt and the interest payment. I highlight that issue; potentially, there is stuff missing there.

Ms Rule: Ms Carrick, if you refer to budget statements G, which reflects the money for Infrastructure Canberra, there are quite a few projects with a health bent to them that have money into the outyears. I refer to the inner south health centre construction, more parking at the Canberra Hospital and early works for a north-side hospital. All of those things feature money in the forward estimates under Infrastructure Canberra. That is just a snapshot.

I suggest that you look at budget statements G; then, if you have detailed questions, as the minister said, those will be for Infrastructure Canberra.

MS CARRICK: Thank you.

MS CASTLEY: Can we ask about the north-side hospital now? Can we ask about that in this session? Is it just about the project, or should that go to—

Ms Stephen-Smith: There is a session with Infrastructure Canberra. If it is about service planning, probably ask it here; otherwise ask Infrastructure Canberra, if it is about the project.

MS CASTLEY: What is the current estimate for the number of beds at the north-side hospital? Do we have that information?

Ms Stephen-Smith: We are still working through that, Ms Castley. As you would appreciate, there has been iterative planning around clinical services for the new north-side hospital, but that works alongside planning in relation to models of care, how we get care off hospital campuses, and how we do more virtual care and more hospital-in-the-home programs. Ms Zagari might want to talk about the clinical services planning for the north-side hospital, but that is still a work in progress, and it has not yet been agreed by government.

MS CASTLEY: Has there been an original business case that we are still fiddling around with?

Ms Stephen-Smith: Yes. While Ms Zagari is talking, I will look at the website and see whether I can find what is public around that. Ms Zagari can talk about where we are up to.

Ms Zagari: In terms of the clinical services planning, in partnership with the directorate and iCBR, we have looked at the known and projected population growth over the years until 2031 and then to 2041 to understand the expected demand associated with the area. We have done the mapping of how that should look across the territory—what should be provided on the north side and what tertiary services would remain at Canberra Hospital, to understand what the demand for services will be in the north of Canberra.

That is then pulled together into a clinical services plan that says, "Here is what we think will be needed to be delivered at the hospital," which will inform that design piece. It was informed; the directorate did some significant pieces of work in consultation with the community, and we are working with our clinicians at the moment.

There has been a lot of work undertaken with clinicians, which Ms McKenzie could speak to. We have been working with our clinical groups around what is important in order to provide the services that they need from the hospital—the things that they need to support that, so that it is encapsulated in that, and so that the bed numbers reflect what they see as key gaps as well.

MS CASTLEY: Is there a business case for the new north-side hospital?

Ms Stephen-Smith: I am just trying to think through the budget processes. A business case was developed to inform the original inclusion in the budget of the provision of more than a billion dollars. That was prior to the 2024 election. That would have been in the 2023-24 budget.

That was an early business case that effectively scoped the project. It also informed the approach to market for the very early contractor involvement. But this is an iterative process. There was a budget business case to release the funding. That was released in this budget for the early works, and for the very early contractor involvement. There will continue to be business cases to release the provisioned funding, and to determine what the final construction funding will be. Those will be of varying size and complexity, depending on what stage of the project we are at. Infrastructure Canberra will be able to talk more about that process.

MS CASTLEY: Do we know how big the ED will be? Do we have that information yet? Has it changed since the original business case, or is the business case basically saying, "We need a new north-side hospital," and it could look completely different from what we think now that it will look like? There does not seem to be much of a plan.

Ms Stephen-Smith: Obviously, there was quite substantial work done to inform the initial provision of funding for the more than a billion-dollar north-side hospital. There is more than a billion dollars provisioned in the budget.

MS CASTLEY: How much more?

Ms Stephen-Smith: Ms Castley, you know that we do not talk about specific numbers because we will be in ongoing contractual engagement with our partners in this project. That was based on the scope for the new north-side hospital which is outlined on the website—a state-of-the-art hospital, including new hospital inpatient services reflecting patient-centred and family-centred care, state-of-the-art facilities for medical practice, teaching, training and research, a new emergency department with improved access for patients, improved car parking, connections to help alleviate traffic pressure, and—

MS CASTLEY: I understand all of that. I get it.

Ms Stephen-Smith: But then there is the detail. Of course, we had an initial view about what that would look like, based on the modelling that the health directorate had done. The health directorate originally brought forward that business case, and Ms Hudson may be able to talk a bit more about that.

MS CASTLEY: Ms Hudson, has the scope changed dramatically from that original plan?

Ms Hudson: With the scope change, as I understand it—forgive me; it was not in my portfolio at the time, and all of this happened a number of years ago—there has been a revised piece of work that Ms McKenzie and Ms Jacobi may be able to talk about. As the minister was saying, the original planning work that was done was based on a series of assumptions, to work out the population and the population needs. There will be further refinement as we go through the process which will start to define when we engage with clinicians, community et cetera. My colleagues may be able to speak more about that.

Ms Stoddart: Adding to what you have said, Robyn, the directorate certainly led some modelling at a whole-of-ACT level. The refinement of the work has been led through

Infrastructure Canberra, with CHS and directorate inputs around building it up from a site level and understanding what the patient flows would be, and the model for the north Canberra campus.

MS CASTLEY: It seems that we decided we needed a new north Canberra hospital. We have a business case for what we thought that would look like and, at the moment, it is iterative. At the moment, we are saying that it is more than a billion, but it could go anywhere. Is there a plan, or do I need to talk to Infrastructure Canberra about that?

Ms Stephen-Smith: It is Infrastructure Canberra that you need to talk to, as I said at the beginning, when you started asking these questions about it. But it is iterative because, in an ideal world, if we were unconstrained by financial resources, we would deliver everything that every clinician and consumer wanted. But we are not unconstrained in terms of financial resources, so it is an iterative process of saying, "This is the budget allocation that we have at the moment, and this is our wish list."

Those two things do not quite marry up, so what is non-negotiable on the wish list? Where do we think we can stretch the budget? What arguments can I make about whether or not we need additional funding? That is the normal process of working through an infrastructure project from early concept to getting to the point of DA.

MS CASTLEY: In your original thoughts on what the cost would be, has the project cost significantly changed, regarding what we are hoping to have?

Ms Stephen-Smith: At this point the project cost has not significantly changed, but you would be aware that, over the last few years, there has been pressure on construction costs. I think we have done the right thing—and the Chief Minister talked about this yesterday—in terms of getting Multiplex involved early in the project, as a very early contractor engagement, in a period when there is a lot of demand on hospital building. We have picked a period between this peak and this peak, and we are able to engage a really good team from Multiplex to work with us to ensure that we are getting the best value in terms of constructability and deliverability on the site.

It is about looking at what the site complexities are. We have not had an opportunity until now to really explore the ground conditions on the site, to think about what can be retained from the previous facilities, and what are the cost benefits of retaining some parts of the previous facilities and what they are used for versus others. With respect to all of those things, Multiplex are helping us by bringing their expertise to the table, alongside the expertise that sits in Infrastructure Canberra, the expertise that sits in the health directorate around demand modelling, and the expertise that sits in CHS around service delivery, in this iterative process.

MS CASTLEY: But when you took over Calvary, you said there were other greenfield sites that you knew were good, bad or otherwise, and you have just said that it is good that we have Multiplex on board early so that they can finally review the site. Did we not know that? Was that incorrect information that I got before?

Ms Stephen-Smith: No. We did an assessment of whether we would build on the existing hospital site or on a greenfield site. There were pros and cons to both options. Ultimately, we determined that there was benefit in building on the existing hospital

site, including the co-location with Calvary Private Hospital, which would have been left isolated if we had built an entirely new public hospital on a new greenfield site and Calvary Public Hospital had been vacated.

With all of these pros and cons, building on the existing hospital site was seen to be the best thing, but we were not going in and digging down into the soil at that point. We have now had the opportunity to do those kinds of geo-technical assessments that require having a partner on board and having a commitment to the project before you go in and do that work.

MS TOUGH: One of the things I am often asked about in the community is cigarettes and vaping. What actions has the ACT government taken to regulate the sale of e-cigarettes and reduce the harms of vaping?

Ms Stephen-Smith: I will ask Dr Coleman and Ms Travers to come to the table. They are itching to answer this question!

Ms Travers: I have read and acknowledge the privilege statement. Can I confirm that the question was: what actions have we taken with regard to vaping?

MS TOUGH: Regulating the sales and reducing the harm.

Ms Travers: The commonwealth changes to the vaping regulations which came in on 1 July 2024 limited the supply of vaping products. This meant there were limited-strength vaping products available over the counter only at participating pharmacies to people over 18 years of age. Vaping products, both nicotine and those not containing nicotine, could only be sold legally to people under 18 years of age at pharmacies.

In April 2025, the first of the two planned legislative amendments occurred to the ACT tobacco legislation. They came into effect on 18 April. These changes aligned the local territory laws with the commonwealth laws. In the ACT, the sale of therapeutic and non-therapeutic vapes is now governed by the Medicines, Poisons and Therapeutic Goods Act, and the Tobacco and Other Smoking Products Act. At the moment we are also drafting a second tranche of amendments to the legislation which will focus on improving enforcement capability, and which will be better adapted to the new regulatory objectives.

MS TOUGH: What services are available to support people to cease smoking and vaping in the ACT?

Ms Travers: We have developed a range of campaigns, education and cessation services. To support teachers, particularly, of young people, we have developed two vaping use and health e-learning packages. These are accredited by the Teacher Quality Institute, and they are targeted at students in years 5 and 6, and 7 to 8. They have been very well received. They are self-paced, two-hour courses. To date, over 806 people have collectively accessed the courses. 164 teachers have received, as I said, Teacher Quality Institute hours. Importantly, in November 2023, we licensed these packages to the Tasmanian Department of Health; so they were leading packages at the time.

We offer cessation supports. Also, recently, we have awarded two non-government

organisations, through the Healthy Canberra Grants, with providing courses for young people on alcohol and the harms of vaping.

More recently, through a federation funding agreement, we have provided funding to Cancer Council Victoria to take on the new Quitline service for us, which, again, is targeted at young people. There are services other than a phone line—online, WhatsApp et cetera—that target those younger people.

MS TOUGH: You mentioned there are further amendments coming for enforcement.

Ms Travers: That is right.

MS TOUGH: Can you talk about what that is or is it still in the process of being developed?

Ms Travers: It is still in the process of being developed, but there is a National Vaping Enforcement Framework that will follow that. The commonwealth has provided some funding to states and territories to implement that. Certainly, we are working through an e-cigarette compliance and enforcement working group, and that is with other regulatory agencies across the territory.

MS TOUGH: In the budget, I think there was an increase to tobacco licensing fees. How does that support public health measures?

Ms Travers: Certainly, increases in the tobacco licensing fees can then be redirected back into health promotion and other health campaigns and health interventions that we can use to support people, to prevent them from taking up vaping and/or smoking in the first place.

MS TOUGH: How are lung cancer screening services—so the other end of the spectrum—being supported and delivered in the ACT, including in this budget?

Ms Travers: As many people would know, the National Lung Cancer Screening Program started on 1 July this year. We have been working very closely with our colleagues in Canberra Health Services to get that program up and running and implemented. The ACT is really well placed now to roll out that program. To date, we have 23 private imaging sites that have confirmed to offer the scanning that is required under this program. One of the confirmed sites is, of course, Canberra Health Services, who will be the preferred referral site for patients who have further scanning needs. We have also worked with the Capital Health Network on a local version of the National Health Pathway, again with input from Canberra Health Services. There was funding, as you would be aware, in the 2025-26 budget for Canberra Health Services—and they may want to speak further to that—for a new lung cancer clinic.

Ms Zagari: It does include funding for a new lung cancer clinic and new diagnostic services or an expansion of diagnostic services. We know that, when high-risk findings are identified on CT, one of the key contributors to a good outcome is then proceeding to appropriate diagnostics, which might include a bronchoscopy or an ultrasound-guided bronchoscopy, to support appropriate rapid diagnosis and then commencement of treatment within the desired timeframe. The funding allows us to expand the

availability of those services in light of the expected findings.

THE CHAIR: You made mention of enforcement and that there are going to be changes coming. One of the big concerns I hear very regularly from all sorts of areas in the community is about illegal vape sales and, indeed illegal tobacco sales. Are you currently monitoring the degree of the problem in the ACT? What is the current enforcement approach?

Ms Travers: In the Health and Community Services Directorate, we are responsible for vaping policy. But, with regard to enforcement, that would certainly be a question for our colleagues in ACT Policing, Access Canberra and the Australian government.

Ms Stephen-Smith: And the Health Protection Service.

Ms Travers: And the Health Protection Service—Dr Coleman.

Dr Coleman: In the ACT we regulate vaping through pharmaceutical services, which is a process that we have been doing through education and information to this point. Tobacco is managed through Access Canberra, and mostly that is done as part of their regular visits as well as when we receive complaints.

One of the biggest issues nationally that we have been talking about at our national meetings is the risk to our compliance and enforcement officers when they go out there and vapes are being supplied through illegal means. So there has been a big training program being run by the TGA. There have been two issues we have been trying to deal with. Because we are enforcing under the TGA legislation, we have actually had to learn what that means and how to do that. My staff have just recently completed that training with the TGA. One of the things that we are looking at doing is running a compliance and enforcement program in line with them.

Being a small jurisdiction, we really struggle to have the depth of resources and skills that bigger jurisdictions have to deal with these bigger issues. So we are going to work alongside the TGA in what we can do in that space. It is a really difficult space to actually work out what to do, because we are not interested in any compliance or enforcement with individuals who are using vapes; we are actually looking at the bigger supply pieces, and the majority of that comes from Australia into the borders or across borders.

THE CHAIR: In looking at the extent of the problems, clearly, across the ACT there are some places which are well known for supplying illegal vapes and illegal tobacco. The two seem to go hand in hand. Have you done any analysis of the extent of the problem and what the distribution networks look like in order to be able to work with your colleagues?

Dr Coleman: I think that would be a question for ACT Policing. This is illegal activity. When we receive complaints, we investigate those—and I must admit that we have not had too many complaints about vaping. So, if people are finding that, we would really encourage people to raise complaints and then we can actually refer those appropriately.

THE CHAIR: The reason I ask is that we periodically hear from people who are

struggling to find where to go.

MR RATTENBURY: I did hear the Chief Police Officer on the radio recently say that the police do not do this enforcement; that it is a job for public health services. So it does feel like it has fallen between the stools a little maybe.

Ms Stephen-Smith: The regulatory response is a response for public health services and Access Canberra, depending on whether it is vaping or tobacco. But, where there is significant illegal activity and related to potentially organised crime et cetera, that is where I think the conversation is about the role of policing. It obviously is illegal activity. The question is: is it a regulatory response or is it a legal response in a criminal sense? That is an ongoing conversation. A conversation with chief police officers around the country and between health and police ministers around the country for some time has been how you balance that regulatory response for businesses that do not know the rules or are standing on the edge of legality versus this being used as a revenue generator for serious organised crime, which I think is part of the issue around the safety of then public health officials going into that space.

MR RATTENBURY: Yes.

MS CASTLEY: I would like to talk about the operations centre. The contract was valued at $580,000, I believe—is that correct?—and finished in the middle of March this year. Has there been any review or analysis of its performance so far and whether it met the identified KPIs?

Ms Zagari: There has not been a formal assessment against the terms of the contract. There has been an ongoing assessment and iteration of the role of the operations centre within the hospital, as we update and make changes to implementation policies. The operations centre itself has been fully kitted out. The screens are in, all of the technology has been installed and the operations centre is running as intended, with some changes over time to policy in response to working with the clinical workforce. We have seen significant improvements in performance in areas that are related to the operations of the centre. I will take on notice the question about whether the specific contract KPIs have been assessed and a report produced. I will respond to that on notice.

MS CASTLEY: Thank you. Will there be a review in future? Do you have one planned?

Ms Stephen-Smith: Ms Castley, the inquiry that the Assembly called on the government to do included the integrated operations centre—so, yes.

MS CASTLEY: But, until that, if we had not have done that, you would not have had any kind of review?

Ms Stephen-Smith: I do not think that is a fair characterisation, because when we debated the—

MS CASTLEY: I am just asking the question, Minister.

Ms Stephen-Smith: Sorry; it sounded like you were making an assertion. When we

debated that, I talked about the fact that we were going to have to undertake continued sustainability work. I talked about the $13 million that was included in the budget for the CHS transformation program and that looking broadly at efficiency and productivity in CHS is directly related to the work of the integrated operations centre. So that was definitely going to always be part of this conversation about how it has contributed to improved flows and throughput productivity. The focus has primarily been on Canberra Hospital to date—so how do we ensure that this continues to be a territory-wide activity? One of the benefits of having North Canberra Hospital as part of the integrated hospital network is load sharing and ensuring that people are in the right place at the right time. So it was inevitably going to be part of that work, but now it is specifically part of the work that the Assembly has called on us to do.

MS CASTLEY: The contract to establish the centre, if I am correct—and I am happy to be corrected—was $580,000. What was the total cost? Is that the total cost of the operations centre and does this include staffing costs? I do not imagine it does.

Ms Stephen-Smith: No; I think that contract for the consultant—

Ms Zagari: Correct—the initiation and embedment of it. So it was solely that piece of work. The staffing of the ops centre itself, through bringing together different areas of the organisation, is separate to that.

MS CASTLEY: And screens and all of that—do we have an idea of what that cost is?

Ms Zagari: I will get that cost.

MS CASTLEY: Thank you.

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

Ms Zagari: Yes.

Ms Stephen-Smith: And there was some specific funding that was identified in the 2024-25 budget.

MS CASTLEY: The contract with Nassato for implementation support for the operations centre finishes in December this year. What is that for?

Ms Zagari: We would have to take that on notice, Ms Castley.

MS CASTLEY: Okay. There is another contract with the same company that established the operations centre. It was $314,00. It expires on 2 September. Could you provide details of what that contract covers as well?

Ms Zagari: Is that with Nassato again?

MS CASTLEY: Yes, the same company.

Ms Zagari: Okay.

MS CASTLEY: That would be great. Thank you.

MR RATTENBURY: Ms Castley, referred to the inquiry that the Assembly agreed to. Are we able to get an update on the resourcing for that and the timing of it?

Ms Stephen-Smith: That will be resourced within the $13 million that had already been allocated in the budget for the CHS transformation program, because it is very closely aligned with the work that we were going to do anyway. The Assembly resolution required that to be up and running in September. As I think I mentioned earlier, I am waiting for some written advice from the directorate around how all these pieces of work that we are currently undertaking align, making sure that we have a clear implementation timeline for all the difference pieces of work but also who is going to do them.

We have identified a shortlist of independent people, as the Assembly requested, to lead this work and are also making sure that that is done in partnership with the Health System Council and the chair of that, Nigel Lyons, who has been part of the sustainability work and brings real expertise to this conversation. We approved a shortlist—and I do not know if Ms Hudson can say any more than that about the process to get to who is going to lead the project.

Ms Hudson: I will borrow a word that was used before, it is "imminent". I think that is probably all I can say.

THE CHAIR: Miss Nuttall.

MISS NUTTALL: My questions are around the accessibility of LGBTQIA+ health services. I understand that you have been funded for a paediatric endocrinologist to support young trans and gender diverse folks, which is brilliant and a necessary part of health care. We have heard that it is difficult to find paediatric endocrinologists and have heard that we have not managed to find one in the ACT yet. Can you confirm that that is still true at this point in time?

Ms Zagari: We have recently employed a paediatric endocrinologist to support the work that is being done—

Ms Stoddart: And this is on top of the existing paediatric endocrinologist that we employ.

Ms Zagari: Correct. Somebody has recently started with us in paediatric endocrinology. I am sure I have advice somewhere.

Ms Stoddart: That is correct.

MISS NUTTALL: That is encouraging—fantastic; awesome. This changes a number of questions. Understanding that paediatric endocrinology is a very helpful part of helping trans and gender diverse young people but not the whole picture, I am interested in whether you have been providing funding to organisations to support specifically trans and gender diverse young people with gender affirming care?

Ms Stephen-Smith: The directorate might have some further information about this. But we have over time provided funding for A Gender Agenda, for example, to provide support to primary care in supporting gender diverse young people. But Ms Stoddart might have some more information about—

Ms Stoddart: I do not have much more information. As you say, we have funded A Gender Agenda to deal with the social and psychological gender affirming care for trans and gender diverse people. But I do not have the details on what that involves.

Ms Stephen-Smith: Can we take on notice, Miss Nuttall, to provide you with further details? I am sorry that we do not have those on us.

MISS NUTTALL: Yes; that is okay. I suspect this might be for on notice too: if you happen to know whether you have had these organisations or their clients indicate to you whether the level of funding is sufficient to meet the demand for this kind of service?

Ms Stephen-Smith: We will definitely take that on notice. One of the main pieces of feedback I have had from meeting A Gender Agenda is that they are really pleased to be engaged in the establishment of the service at Canberra Hospital. One of the issues that they are concerned about is the psychological impact on trans and gender diverse young people of some of the commentary, particularly the commentary that was coming out of Queensland earlier in the year. But they are supportive of the work that is now being done nationally with the National Health and Medical Research Council to develop a national guideline for care and treatment, in the sense that our services are already evidence based, but really reaffirming what that evidence base really looks like and the supportive language that Minister Butler has used in announcing that work.

MISS NUTTALL: Noting the challenges in general of finding professionals who specialise in LGBTQIA+ health services, are there any other funded positions that are currently sitting there or that we are having difficult filling, when it comes specifically to LGBTQIA+ health provision?

Ms Zagari: We have two vacant positions in our psychosocial unit to do with variation of sex characteristics. We are actively aiming to recruit to those.

MISS NUTTALL: With respect to access to services more broadly, I have heard from a lot of queer folk in my community that, when accessing non-LGBTQIA+ specific health services, sometimes they are turned away or referred elsewhere. They want to clarify that that is not always necessarily a clear-cut case of discrimination based on anti-LGBTQIA+ rhetoric; it is because a lot of medical professionals have indicated that they do not feel confident supporting clients who are part of the LGBTQIA+ community and who might have specific needs.

Obviously, queer folk deserve high-quality health care, too. I suspect we would see better health outcomes for this cohort if medical professionals felt confident supporting them across the board. What measures do you have in place to help medical professionals to upskill, in order to be confident in supporting LGBTQIA+ clients?

Ms Stephen-Smith: One of the things that we have funded in this budget is the

Professional Development and Wellbeing Fund for GPs. We know that GPs have expressed interest in upskilling in a range of areas, including mental health, including alcohol and other drugs. Better care for gender-diverse people is an area of interest, and LGBTQIA+ people more broadly is an interest for some GPs.

As in so many other things, GPs will tend to specialise in particular areas. One of the things that we will be doing, in co-designing the Professional Development and Wellbeing Fund, is identifying areas where we know that GPs are looking for additional professional development, at where it also aligns with the priorities of government, and at how we then support them to access that professional development with a bit more funding. Obviously, otherwise they are doing it out of their own pocket and in their own time.

Dr Dorrington might want to talk about the conversation within general practice about how this is supported, given GPs cannot know everything about everything.

Dr Dorrington: I think that is one of the biggest challenges, as you say, Minister. There is a lot to know about. Obviously, there are quite a few GPs out there that went through medical school some time ago—including me—where this was not part of the curriculum. There are many things that are now discussed in certain ways that were not the way that we were taught. It is about having capacity, on top of all the new medical breakthroughs, new drugs and everything else, to go and engage on these different topics. Sometimes it comes down to the cohort that start to see you, so you increase your skills.

Specifically, if we are talking about gender-affirming hormone treatment, which is not necessarily what everyone is looking for, there is a level of knowledge, training and competency that people generally feel that they need before they can start doing something like that with confidence. When it is not well known, it can be difficult to do as one person in a clinic. It is about having the ability to support some professional development, and the ability to build up communities of practice—and there are some really great ones out there. If we are talking about trans and gender-diverse health care, there is certainly a national body out there, but you pay to be a part of it. There is fantastic support, but there is a cost to a clinician to be a part of that.

This is one of many things, as the minister said, that we will be going to, with the co-design. It needs to be about what a clinician wants to do. But where are our gaps and how do we match these up, in developing a professional development support program so that we are not just supporting something that is already happening broadly but trying to fill the gaps and support the people that are supporting the more vulnerable in the community, from whatever standpoint from which they are vulnerable?

Ms Stephen-Smith: The other piece of that puzzle is working with Capital Health Network around health pathways to ensure that there is greater visibility of those GPs who do have a special interest, whether that is in gender-affirming care, more broadly in supporting the LGBTQIA+ community, or whether that is in menopause, mental health or whatever it might be. There needs to be some way of sharing that information across the community so that if a new GP who does not have those particular areas of interest sees a new patient, they can say, "I'm probably not the best person to provide this care for you, but I know that these other GPs in the ACT have this area of interest;

you might want to approach one of them." And that is hard to do, but—

Dr Dorrington: We do have that in health pathways as well. There is the GP colleague referral page for all those special interests, which is helpful.

THE CHAIR: One of the risks, when we talk about LGBTIQA+ health care, is that, with the individuals and the different groups within them—lesbian, gay, bi, transgender, intersex, queer—there is a whole spectrum of different needs within each of those groups of people. What are you doing to make sure that that is not missed? If you mix the whole rainbow flag together, you just get grey.

Dr Dorrington: Yes, because gender-affirming health care is not something that someone who identifies as cisgender but is same-sex attracted needs.

THE CHAIR: What are you doing to make sure that does not get lost?

Dr Dorrington: It is the different levers at different levels, isn't it?

Ms Stephen-Smith: Yes. I think it is well understood that gender-affirming care is a specific thing, and that people would identify their interest in that. Obviously, when you look at the work that Meridian does around supporting, in particular, men who have sex with men and sex workers, and a broader sweep of LGBTIQA+ people, there are some specific things that those particular cohorts might need in their health care.

There are some things where it is about everyone growing their knowledge and awareness to make general practice a safe space for a broad scope of people. You are exactly right, Mr Cocks, but I think GPs and other medical professionals understand those differences.

MISS NUTTALL: In terms of the professional development aspect, it sounds excellent. With the risk of it being entirely a matter of opting in, you might still not get a critical mass of practitioners that would opt in to provide support. From the perspective of someone who might be trans and gender-diverse, they are looking for there to be enough people they can see so that there is not a huge waiting list.

Through that process of co-designing the professional development, are you able essentially to check in with key groups that might be underserved by health services, as part of that, so that there is a strong incentive for GPs to take on more specialisation with LGBTQIA+ health?

Dr Dorrington: Directing people towards choosing to undertake this?

MISS NUTTALL: Yes; encouragement above and beyond. Essentially, it is to ensure that enough people are opting in so that there is a critical mass of professionals who are confident in supporting LGBTQIA+ folk.

Dr Dorrington: Certainly, there is no way we could guarantee there would be enough. Ideally, it would be everyone. That is the target. It is about the way we develop the system of how funding is provided for the professional development. Obviously, it is a collaboration and a co-design. I may have my wish list of what it might look like, but it

is not down to me; I do not get to choose. It is about having those collegiate networks. If you have one excellent person in a clinic, it brushes off on the people around them.

It is about building up knowledge in the community. We have a headcount of over 600 GPs in the ACT, but to some extent it is a small community as well. We do have a lot of crossover in relationships. That can be quite beneficial. It is the same as when we talk about getting opinions from non-GP specialists, and just checking in about something. It is often your personal network that can be helpful.

These things within general practice can be the same, so that you shoot a message to your colleague who you know has more expertise than you. You can check information and make sure you are delivering things right. It does not help within a consultation with delivering safe care, but delivering safe care for people in the LGBTQIA+ community should follow the same lines as delivering safe care for Aboriginal and Torres Islander people, other culturally and linguistically diverse people and people with disability. Hopefully, by delivering good patient-centred care, we can start overcoming some of that general stuff. With more exposure, there tends to be more education as well.

MISS NUTTALL: I am new to the concept of safe care—that sort of term. Is public health funding that you provide ever conditional on a service's ability to provide that safe care?

Dr Dorrington: There are very few services, clinical general practice level services, that we provide public funding to.

MISS NUTTALL: If I were a queer person who had been turned away from a service, where is the best place in government to go, to provide this feedback?

Ms Stephen-Smith: It depends on the service. If it was a service with Canberra Health Services, there is a feedback and complaints mechanism, and the team are very responsive. If it was a private practice and you did not feel comfortable escalating your complaint within that practice, you can seek advice from the Health Services Commissioner. That would probably be the first port of call.

MS CASTLEY: I would like to talk about culture. How much did the 2024 workplace culture pulse survey cost? We go out to tender on this one, don't we, for the pulse survey?

Ms Stephen-Smith: The Canberra Health Services survey?

MS CASTLEY: Yes.

Ms Stephen-Smith: Canberra Health Services have been using BPA for some years, to ensure a consistent survey over time. Canberra Health Services will be moving to the whole-of-government culture survey, but with some additional adjustments to make it as comparable as possible to BPA—

MS CASTLEY: There will not be a specific—

Ms Stephen-Smith: It will not have exactly the same specific questions. This is partly around the efficiency of the process, the cost effectiveness of it. Mr White might have an answer about how much it costs to secure BPA for this.

Mr White: Minister, you answered the part that I was going to answer. I will take the element of the cost on notice. I am pretty sure we can get that very quickly. I will try to get that this afternoon. As the minister mentioned, we have used BPA historically for the broader employee survey, as well as the interim pulse surveys. We are moving to the whole-of-government survey provider from September this year, in alignment with whole of government.

MS CASTLEY: Will Canberra Health Services be responsible for a part of the cost of the whole-of-government survey, or is it something that the whole of government do for the good of the—

Mr White: We would provide part of the overall cost, yes.

MS CASTLEY: The result for the history for type of culture worsened in 2024 compared to 2023 and 2022. Do you have any idea why that might have happened? The history for type of culture has worsened; there must have been a line. I do not have the survey with me.

Ms Stephen-Smith: In terms of being in culture consolidation, yes. I do not have it in front of me, but that measure has been fairly stable over the last couple of years, recognising that there has been quite a lot of disruption in Canberra Health Services over the last couple of years.

MS CASTLEY: If we go back to 2019, an independent review of the ACT public health services found overwhelming evidence of inappropriate behaviours, bullying and harassment, poor leadership management, and poor decision-making. The review found pride in working in the ACT public health system was low, bullying was common, and confidence in how the system resolved grievances was extremely low. There were 20 recommendations which were progressively implemented over a number of years. Minister, since it has been six years since that review, and with respect to the information that we received in the 2024 workplace culture survey, how do you feel things are going? If we are moving away from the pulse surveys and going to whole-of-government surveys, do you believe that is a good move, and that culture has improved significantly?

Ms Stephen-Smith: We have certainly seen over time since 2019, through the culture surveys, a very significant decrease in individuals having either been subject to or witnessing bullying and harassment, and an increase in people feeling confident to report bullying and harassment within Canberra Health Services. That was something that was called out not only in the culture review itself; unions and other professional organisations around the table in the culture review, and the culture reform oversight group, were particularly focused on this.

Obviously, there are some issues that have been talked about before in hearings around the broader culture of medicine and medical education. You might have seen that *Four Corners* this week touched on that, in another jurisdiction, in another hospital—some

of the enduring ways that medical culture has been challenging and needs to continue to improve. I am confident that that is happening. Ms Zagari has just pulled up "at a glance", which shows—

Ms Zagari: A slight reduction in "interculture of strengthening".

Ms Stephen-Smith: The name has changed over time.

Ms Zagari: Correct; the names have changed.

Ms Stephen-Smith: I think the "great place to work" results have improved since 2019.

MS CASTLEY: Is that the CHS survey or ACT Health?

Ms Stephen-Smith: Sixty per cent in that pulse survey said that CHS is a truly great place to work, which remained the same as the previous survey. For a health organisation, obviously, we want the figure to be better, but it is quite a good result.

MS CASTLEY: You are confident that the implementation of the review's recommendations has made real change for frontline workers? I know there was a bit of a difference between people in ACT Health and people in Canberra Health Services. There is trust back in the leadership team? That was quite a worrying—

Ms Stephen-Smith: I am confident that the implementation of the culture review recommendations and the ongoing work have made a difference, but we are also not complacent about this. We know that there is ongoing work that needs to be done. We said at the time that we were not going to turn around culture overnight, and it does require significant buy-in from our clinicians. We have some great clinical leaders. Dr Rady came to the table earlier. Dr Rady is the chief of medical wellness?

Dr Rady: Director of clinical training.

Ms Stephen-Smith: She can talk about the medical wellness work. This is quite a significant change in the way that our medical workforce is supported. Of course, we have also invested significantly in Towards a Safer Culture for our nurses and midwives, including the implementation of safe wards across 12 wards across our hospitals now. The Australian Nursing and Midwifery Federation feedback to me the other day was that this has driven not just a reduction in occupational violence and restrictive practice but it has changed culture on wards. From a medical perspective, Dr Rady?

Dr Rady: I have been in this role as director of clinical training for two years, since this role was created back in January 2024, working in the same office as the clinical medical wellness officer. We have seen significant improvement in culture for doctors in training. We can see that in terms of the national Medical Training Survey data that we use every year to look at the engagement of our medical officers.

Over the last two years, we have seen a significant increase in the number of doctors that engage in that survey. Last year, we had just over 500—528—junior doctors in Canberra, most of whom work in the health system. About 60 to 65 per cent of them

work in Canberra Health Services. It represents about 75 per cent of our junior doctor workforce, our doctor in training workforce. That is really good engagement. Eighty per cent of those doctors would recommend us as a place to work, as a training institution and as an organisation.

With respect to one of the really positive things that we pulled out of this, in terms of culture, particularly around the data for evidence of bullying, harassment and racism—sadly, there is still a lot of that within the medical workforce across Australia; we are on a par with that, which is a shame—our reporting behaviour is significantly better than other places, by about 10 per cent. Forty-three per cent of our trainees in the last year reported any incident that they experienced, and 38 per cent reported incidents that they witnessed. That is about 10 per cent higher than any other jurisdiction, which I think speaks highly of our own communication culture, and the engagement that we have with our doctors in training.

MS CASTLEY: I think you said 80 per cent of people would recommend—

Dr Rady: Yes.

MS CASTLEY: Is that data that we can see? Is there a report?

Dr Rady: Yes. If you go to the AHPRA website, you can look at the national medical training data. You can look at the ACT reports. Every year, it is all made public. Eighty-one per cent would strongly agree or agree that they would recommend their current training position; 78 per cent would strongly agree or agree that they would recommend their current workplace as a place to train. That is really great for us.

MS CASTLEY: What about surgeons? Do they feel the same way?

Dr Rady: This is doctors in training. This encompasses trainees across the workplace.

MS CASTLEY: I am not talking about trainees—staff specialists.

Dr Rady: In terms of that data, we would have to go back to the Canberra Health Services pulse survey and the culture survey.

MS CASTLEY: We are not asking them about current information?

Dr Rady: This data is only on doctors in training.

MS CASTLEY: We have no information about how happy our surgeons are?

Ms Stephen-Smith: That is reflected—

MS CASTLEY: Other than 2024?

Dr Rady: That is right. That is reflected in the broader survey data. A lot of our clinicians engage with the clinical medical wellness officer, and we are looking at the moment at a way to capture that data. There is an Epic proposal that is currently awaiting approval—hopefully, we will get approval for that in August—to look at

collecting Canberra Health Services data. Hopefully, we will have some of that more specific data for you in the future.

MS CASTLEY: Recommendation 19 of the review was for an annual independent external review on the implementation of the report's recommendations. I understand that continued for three years, with the most recent report being published in 2023. Why have they been removed?

Ms Stephen-Smith: Because all of those recommendations were complete or ongoing. There was a very specific government decision on receipt of the original report to invest funding over three years. I think it ended up being for four years. That was the implementation timeframe for the recommendations of that review and that annual reporting would occur. The last annual report was described as being the final annual report. It was a structured work program.

MS CASTLEY: It has been removed and we cannot see any history anymore?

Ms Stephen-Smith: It should not have been. It would all be available on the website. If it is not, let us know. It will all be on open access. In fact, Ms Castley—and some of this pre-dates your time in the Assembly—not only are all of those annual reviews available but we also published the minutes and papers from every meeting of the Cultural Review Oversight Group. We were incredibly transparent about this work. It resulted in a workforce data dashboard, which I understand is probably being maintained and shared.

I have not had a meeting with the unions for a little while, but we have an ongoing meeting with the industrial representatives that I go to with officials. Then officials leave the room and I have a frank conversation with industrial representatives about what they are seeing on the ground. One of the things that is shared with them regularly is a workforce data dashboard that addresses some of their concerns around the experience of their staff, including temporary and insecure work, as well as things like bullying, harassment and occupational violence.

MS CASTLEY: If things have improved so greatly, why have we seen the concerns with the surgeons in cardiology and orthopaedics? Granted, some orthopaedic surgeons have come back, but can you please explain why you think that everything is going okay when senior surgeons are prepared to leave? Why does it get to the point of having to resign or go to the paper to get any change in their work health situation?

Ms Stephen-Smith: Others have made the point, and I have said it previously in the Assembly, that there was quite a lot of commentary from some of those surgeons around the operations centre and the planned care process, but, in fact, orthopaedics was the first specialty, from my understanding, to engage in the planned care process and the work around scheduling theatres in advance. None of that was a concern until the conversation was raised about moving away from fee-for-service to sessional visiting medical officer contracts. At that point, all of the other concerns arose and escalated. That is not to say that they were not legitimate concerns. I have met with a number of surgeons, and certainly Mr Peffer met with the orthopaedic surgeons a number of times, to work through some very legitimate concerns about their contracting arrangements and decision-making in collaboration with the operations centre, about how data and

information about patient need and scheduling could be shared between those specialists and the operations centre to ensure everyone is on the same page. I reiterate my thanks to those surgeons for coming to the table and having those productive conversations.

The starting point for their concerns was a single email that was sent by the chief operating officer that was probably not as well worded as one would have hoped. It probably buried the lead about the visiting medical officer contract changes. It was not engaged with VMOs in the way that it should have been. In the meeting that I had with orthopaedic surgeons, the conversation from both sides was: "We've all probably not managed this as well as we should have. Let's start working together," and that is what happened.

Mr White: Chair, could I respond to Ms Castley's initial question of the cost. The pulse survey cost for 2024 was $22,805.

MS CASTLEY: Thank you.

THE CHAIR: I will try to get through the full round of questioning that we are currently on, but, out of consideration for all of the officials who have been here for quite some time, could we please try to keep questions and responses fairly direct. Mr Rattenbury.

MR RATTENBURY: Thank you. I want to ask about air quality from a population health perspective. There have been numerous reports and mentions in government documents in recent years about the limitations of our current air-quality monitoring. I understand we meet the minimum requirements for the number of monitors. That is the case, isn't it? I think the three stations we have—

Dr Coleman: For the NEPM requirements—absolutely. Yes.

MR RATTENBURY: Nonetheless, previous reports from the Commissioner for Sustainability and the Environment have highlighted that these are geographically dispersed and do not monitor diffuse air quality. Has the government done any work to investigate other options? I believe there are some low-cost air-quality monitors. Is there any consideration of expanding the network?

Dr Coleman: It is an interesting question, Mr Rattenbury. You may remember that we did some work on low-cost sensors. We found that they were not accurate enough to be useful for what we needed them for. They were particularly reactive to humidity, which caused a problem. It depends on what you want the air-quality data to be for. It may be to provide early indication to individuals about things in the air that they might need to be concerned about. If we are thinking about early bushfire warnings and the impact of smoke, one of the things we have invested in with New South Wales is looking at some forecasting ability. This bushfire season, if there is some risk associated with smoke coming over, we have been incorporated into the forecasting ability for New South Wales. I guess the question is: what do we want that data for? And then: what is the best way of delivering it? I do not know that there are some really good answers for that. There is some potential for medium-cost sensors in that space, but some further work still needs to be done.

MR RATTENBURY: Thank you. Aside from bushfire smoke, what does Health or the government consider to be the biggest air-quality risks for ACT residents?

Dr Coleman: Overall, at a population level, air quality in the ACT is very good. But, as everyone here knows, we have some areas of the ACT which experience some levels of poorer air quality during the winter season due to inversion, which I still do not really understand. That happens when it gets really cold.

MR RATTENBURY: You are a good scientist; you should be all right!

Dr Coleman: My expertise is elsewhere! When we have a lot of wood-fire smoke, it gets trapped. At an individual level, this can be a problem for some individuals. One of the things that we are trying to do is get messaging out about when you are able to see your doctor and make sure that all of the things that you can do in preparation are done in the best way you can.

MR RATTENBURY: Wood smoke and localised impact at schools are probably the two areas I receive feedback on. Has the government done any research on air-quality issues that arise from crematoria or incinerators?

Dr Coleman: No.

MR RATTENBURY: Is there any work that quantifies the cost and burden to the public health system of health impacts like respiratory problems caused by air quality in the ACT?

Dr Coleman: We have talked about a study. It was a desktop exercise that provided a mortality estimate that had a very large range. That had some quiet caveats associated with it, but in the ACT we have not done anything more specific.

Ms Stephen-Smith: Dr Coleman, I do not know whether you have anything on this, but I think it is really important to also recognise that, as well as outdoor environmental factors, indoor air quality is affected by a number of things,. Smoke might seep in. Indoor air quality is a quite significant contributor to health issues. It is not just about what is outside.

Dr Coleman: I was responding in terms of outdoor air quality.

MR RATTENBURY: Indoor air quality is a good point, Minister. I was particularly focused on outdoor air quality. But I agree with you.

Dr Coleman: There is increasing interest in indoor air quality, particularly coming out of COVID. It is interesting that microbiological and infectious diseases prompted us to think about indoor air quality and transmission risk, but it is landing on other particulate matters that can happen in that space. We do not have standards. We do not have things in place for indoor air quality from a general perspective, but there is definitely a national conversation happening in that space.

MR RATTENBURY: In response to my previous question, you referred to some

research work, desktop work, in the ACT. Is that publicly available?

Dr Coleman: Yes. It was not done by us; it was published—

Ms Stephen-Smith: I think it was from the ANU.

Dr Coleman: I think it was from the ANU. It was published several years ago and it spoke to a range of deaths that could be attributed to air quality in the ACT.

MS CARRICK: I want to ask about particulate matter that comes off roads and lands on people's verandas when they live next to big roads. Has that ever been looked at or considered?

Dr Coleman: In general, vehicle emissions are probably the second or third impact on external air quality, but, in terms of whether it is localised to particular roads that are under construction or things like that, we would not look at that specifically.

THE CHAIR: Ms Carrick, are you referring to large particulate matter?

MS CARRICK: Particulate matter from tyres and roads generally—a layer on people's verandas.

Dr Coleman: In general, we do not have NEPM exceedances associated with PM greater than 10, which would be large particulate matter in the ACT. At a population level, it does not seem to be a big issue, but I cannot speak to individual experiences of that.

MISS NUTTALL: You did a review of low-cost air-quality monitoring. Is that publicly available or something that you would be able to share with us?

Dr Coleman: Yes; I am sure we can.

MISS NUTTALL: Fantastic.

THE CHAIR: Is that something you are taking on notice?

Dr Coleman: Yes.

MISS NUTTALL: Thank you very much.

MS CARRICK: On Tuesday, community groups talked to us about the procurement of their services and going out to tender. They were concerned that there was no recognition of how long they had been doing it and the relationships that they have with people in the sector. When those procurements are done, is there any recognition of the knowledge that local people have and their built-up relationships?

Ms Stephen-Smith: I am very concerned about my capacity to give a short answer to this question, because, again, it is a big hobby horse of mine, Ms Carrick. Long story short, this is part of what we were trying to get to with the commissioning process—to really understand what service systems look like, who is embedded in those service

systems and what the social capital around that is, and to try to balance the need for ongoing certainty of service delivery and building on the existing social capital, with recognition that sometimes you need a service provider or a model that does not currently exist in the ACT, to enable a service delivery model that has been evidence based elsewhere. The work that the team did on out-of-home care procurement sought to balance those two things: known providers and organisations that could bring innovation to the system. Each of our commissioning processes has worked slightly differently. That is the exact conversation that I am currently having with the mental health sector about mental health commissioning.

The other piece of feedback that we have received—and it is in the opposite direction—is that some of our commissioning processes have gone through a really big co-design: how do we understand the sector; what do we want to do; do we want to do things differently? They ended up funding the same organisations to do the same thing. That is not the outcome we were aiming for either. This is an ongoing piece of work. I share that concern. I particularly share that concern in relation to commonwealth procurement, where they do a big national procurement that completely ignores local connection.

THE CHAIR: One of the things that came up in that discussion was that there seems to be a lot of confusion within those community groups over the range of ways that things are done and whether things are grant funding, commissioning of government services or procurement of government services. I intend to explore this a bit further when we get to our procurement section. However, from a health perspective, how do you go about making sure that delineation applies? I know Ms Rule is well across this from her time in the commonwealth. I am wondering how it applies in the ACT and specifically in Health.

Ms Stephen-Smith: We can have a further conversation about it in the procurement portfolio. Human services procurement is something that I have been banging on about for years. I am pleased to say that I recently met with the chair of the Procurement Board and there is a bit of alignment. But we have moved as part of the commissioning process, from procurement through to service funding agreements, through to the whole procurement process under the Procurement Act, towards a more grants process to enable some greater flexibility in the way that those conversations and funding arrangements are reached. It was on the advice of Procurement ACT that grants were appropriate for this process. But I have some ongoing concerns which I am happy to share publicly. I have shared them with everyone that I meet in the public service. It is not an ideal arrangement to use grants for a five- or seven-year funding agreement. We need to try to find a balance between our complicated, for good reason, procurement process and a grant process, which is not as well-defined, in order to find something that works for human services procurement.

THE CHAIR: The slight nuance in my question is about how you are defining a government service that you are providing through these community organisations versus a good thing that they want to do that you are providing a grant for. Is that work underway?

Ms Stephen-Smith: Yes. That is the advice that is sought from Procurement ACT on each one. That is a good point of delineation. Out-of-home care services are clearly

services that are government statutory responsibilities—services which we are procuring somebody else to deliver on our behalf—versus an organisation like Karralika, which is set up to deliver alcohol and other drug services. That is their mission, and we are funding them to deliver on their mission.

Ms Rule: But I think your point is well made, Mr Cocks: it is not as clear as we need it to be about what processes you use and when.

As we have mapped out the priorities for the new directorate, tackling this issue is one of the early priorities: bringing together what has been done in health and in community services. There are some pockets of good practice and there are some emerging good practices, but there are lots of issues that we are all well aware of that need to be addressed. So that is, absolutely, something we will do early on in the life of the new directorate: work through this process so that we are not in this position where we are using the wrong kinds of processes to get money out to the sector for a range of things.

THE CHAIR: We might explore it further in the procurement section.

Ms Stephen-Smith: I am happy to talk about it in the procurement part.

THE CHAIR: Thank you.

MS TOUGH: I will try to keep this very, very short, but it would be remiss of me not to ask about one of my favourite health things, our Tuggeranong health centre. I understand with the machinery-of-government change that the building itself now sits with Infrastructure Canberra. Are there are any updates on the services being planned and how they are going to operate?

Ms Stephen-Smith: Yes.

Ms McKenzie: Absolutely, I have that ready to go.

MS TOUGH: I drive past it every day!

Ms McKenzie: The South Tuggeranong Health Centre will be on the corner of Box Hill Avenue and Heidelberg Street in Conder. Consumers in the local community were consulted in late 2023. The concrete slab will be poured in stages over the next two to three weeks. It is always exciting when the concrete is down.

The services that are currently earmarked to go into that health centre—I know that is the crux of your question—are: pathology; chronic disease management; consult and treatment rooms; nursing; diabetes; paediatrics; paediatric neurodevelopmental; women, youth and child nutrition; ambulatory rehab services; and falls and fall injury prevention. There is also a virtual care interview room, because we know some people do not have infrastructure for virtual care in their own home environment, and there are various multidisciplinary group exercise and education programs.

MS TOUGH: Wonderful. Is the work underway to work out what will be based in the health centre and what will be satellite? How will that operate?

Ms McKenzie: There is a broader piece of work on where those services that I have just read through fit within the broader network of hub and spoke services, depending on the focus and where they are also delivered.

MS TOUGH: Wonderful. I know there is also the Inner South Health Centre, even though I do not drive past it every day! I know it is another important part of how the health system works. Is there an update on that?

Ms Stephen-Smith: Yes. I did get an early look at the design. In the process of major plan amendment, there is a major plan amendment that is currently out to effectively swap around some of the blocks, because the community facility zone block is on the roadside under a lot of trees and the other block that we want to build on is not community facility zoned. I am not sure what they have done with the major plan amendment, but they are effectively moving the community facility zone to where we want to build, and they have an early layout for that.

They are working towards development application, and we will be engaging with the community about that, but that is also informed by CHS's views about the services to go in it.

Ms McKenzie: There is no concrete in the inner south, so it is nowhere near as exciting! Sorry! But there are similar services to those earmarked for south Tuggeranong. Probably the key defining feature of the Inner South Health Centre is the inclusion of dental services. There are dental chairs, and, in particular, a special needs dental chair and a bariatric dental chair. This will be the first fit-for-purpose bariatric or special needs dental space in the territory. So that is going to be a really important development in what we offer.

MS TOUGH: That is really exciting to hear. Thank you. I look forward to seeing the concrete trucks in the next suburb!

MS CARRICK: I just wanted to clarify, was south Tuggeranong with Infrastructure Canberra or with the health portfolio?

Ms Stephen-Smith: The management of the construction is now with Infrastructure Canberra.

MS CARRICK: Can you take it on notice and just let me know what page the estimates are on, because I cannot see them.

Ms Stephen-Smith: The South Tuggeranong Health Centre was funded a couple of budgets ago. There was explicit funding in the budget a couple of budgets ago.

MS CARRICK: But if it is still under construction, would it not have been reprofiled forward to when it is getting spent?

Ms Stephen-Smith: I think it was reprofiled, but we will come back to that in Infrastructure Canberra. I am happy to take it on notice, Ms Carrick.

MS CARRICK: Thank you.

MS CASTLEY: So $103 million on 70,000 elective surgeries over four years. I am wondering how that is going to be delivered. Is it purely through CHS?

Ms Stephen-Smith: No. We have ongoing private partnerships to deliver a range of elective surgeries. That $103 million, just to be clear, is not the entire cost of delivering elective surgery. It is built on a base cost. It is about delivering additional. Obviously, the average to deliver 70,000 over the five years from this year is 17,500 a year. That was our target for last financial year. We did not quite get there, but we very much delivered a long way above what we have ever done before, and it really gives me confidence that we will meet that 70,000 target, all things being equal. We will do that largely through Canberra Health Services, but also through some private arrangements.

MS CASTLEY: Can you provide a breakdown of what surgeries? Do we have an idea of what they would look like year on year, or is it just 'as needed'?

Ms Zagari: Yes, it will depend on demand as it comes through.

MS CASTLEY: We had a policy similar to this, except Treasury costed our policy at $75 million. Why have you gone with a policy that is $28 million more expensive? How did you get to those figures?

Ms Stephen-Smith: Did Treasury cost your policy at $75 million, or did you submit a costing of $75 million and Treasury said those assumptions were reasonable?

MS CASTLEY: I think we went with $100 million, and they came back and said $75 million. That is my understanding. I could be wrong. But—

THE CHAIR: If I can interject, certainly Treasury came back and ticked off on the final costing.

MS CASTLEY: Yes.

Ms Stephen-Smith: I will take that question on notice.

MS CASTLEY: It is a significant number of extra surgeries we could be doing.

Ms Stephen-Smith: We previously expressed the view in relation to Liberal Party announcements on elective surgery that—in our view—they were under-costed. Treasury look at the assumptions that are made and determine the extent to which they are reasonable when they do their costings work. But I will have a look, and I will also have a look as well at what costing we did for ours.

MS CASTLEY: Thanks. I need another hour, but that is fine!

MISS NUTTALL: I am hoping to chat about neurodivergence and, in particular, the news that the ACT will begin trialling ADHD diagnosis through GPs, which is exciting. I understand, based on news reports, that you have not made the call yet on whether the cut-off age for this trial will be 18 or 26. Have you come to a decision on this yet? If

not, when might it be made?

Mr Cidoni: I think one of the challenges involves working with New South Wales, and also Western Australia, who are looking at these provisions. You will be aware from the Senate inquiry that the federal government wants to have standardised prescribing practice across the country if possible. So I think it is an ongoing conversation in terms of what we do in the first part of our trial. We are wanting to align with New South Wales as much as possible.

So the answer to your question is we have not landed on that at this point in time, but New South Wales have an age limit of 18 in the first phase of their pilot.

MISS NUTTALL: I understand this is a national conversation, but why has a cap been placed on the age of access, noting that there has been a significant increase in diagnosis of ADHD, particularly among older people and women?

Mr Cidoni: I cannot speak for New South Wales and their decision-making. I think it is based on the demand for paediatrics being their main source of pressure at this point in time. But we are aware that the transition made things very difficult in terms of trying to find an adult psychiatrist, so that is why we are looking at that broader age range. I think that is an ongoing conversation. But, given we sit within New South Wales, it makes sense to try and align as much as possible with their provisions.

I should also point out that we already have continuation prescribing. We have had that for a number of years. That is part of the reforms that they are making now, but we have had that in place for quite a while now. So ours is an extension of that.

MISS NUTTALL: I can also see that the government is continuing to provide free autism diagnosis for children 12 and under. I would be interested to understand why this access to diagnosis is limited only to this age range, and why it has not been expanded to—

Mr Cidoni: That sits within the community services directorate—the community services part of the combined directorate now. So I would not be able to speak to that particular issue.

Ms Rule: That sits within the Child Development Service. It has largely been about where the most acute demand is and matching the limited capacity of the Child Development Service to that demand at that earlier-stage range. So, really, as complicated as it is, it is a supply and demand equation.

MISS NUTTALL: Do we know whether there is substantial demand for autism diagnosis above the age of 12? I certainly know for myself, and the people I talk to, that that is an emerging cohort.

Ms Rule: Certainly in the Child Development Service there is demand above the age of 12.

MISS NUTTALL: Great to know. Thank you. As you would be aware, ACT Greens brought a plan for a co-designed neurodivergence model of care as an election policy.

That is also in our Supply and Confidence Agreement. How have the policy decisions around ADHD and autism diagnosis been made in co-design with neurodivergent Canberrans?

Mr Cidoni: In terms of where we are with our planning, we plan to develop the pilot proposal. That will be taken to public consultation, with direct engagement with our stakeholders.

MISS NUTTALL: So up until this point there has not necessarily been consultation with neurodivergent—

Mr Cidoni: We have had a number of discussions with our stakeholders along the way, but the formal consultation around that specific pilot program will occur. An important part of it is lived experience with carers and consumers.

MISS NUTTALL: When you refer to stakeholders, do you mind clarifying what that is?

Mr Cidoni: There is the College of Psychiatrists and the College of General Practitioners. We have Carers ACT, the consumer network, the community coalition, funder care services, Capital Health. We have a number of conversations—obviously it is a really important topic at the moment—but the formal consultation will occur around our specific pilot proposal.

MISS NUTTALL: Broadly, on neurodiversity, what progress has been made on the Neurodiversity Strategy and the co-design of the neurodivergence model of care? And will there be related—

Ms Rule: That is a question in the disability portfolio, which we have tomorrow, I think.

MISS NUTTALL: Fantastic. I will move it over in the sheet.

THE CHAIR: What is the reasoning behind handling neurodivergence and autism assessments within the disability and community services side of things rather than the health side of things? I can make a guess, but—

Ms Rule: I do not think there is any particular reason other than the fact that this work has been initiated through the advocacy of various disability stakeholders and agreed to by ministers for disability, but it will obviously need to be worked up in close conjunction with health colleagues.

Ms Stephen-Smith: I think I took on notice a question in relation to election costings. I have found the Canberra Liberals election costings. I feel like this is an obvious answer. The election costings started in 2024-25. The cost for that particular commitment started in 2025-26, and was $25 million a year for three years, which adds up to $75 million. But, if you add another year, it would be $100 million.

MR RATTENBURY: That is why you are the Minister for Finance!

THE CHAIR: Before we formally adjourn, I would like to express personal gratitude to all of the officials who have endured a lengthy session today. On behalf of the committee, I would like to thank our witnesses who have assisted the committee through their experience and knowledge. We also thank broadcasting and Hansard for their support.

If a member wishes to ask questions on notice, please upload them to the parliamentary portal as soon as possible and no later than five business days from today.

This meeting is now adjourned.

The committee adjourned at 5.28 pm.