LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

STANDING COMMITTEE ON SOCIAL POLICY

(Reference: Inquiry into Annual and Financial Reports 2023-24)

Members:

MR T EMERSON (Chair)
MS C BARRY (Deputy Chair)
MR J HANSON
MISS L NUTTALL
MS C TOUGH

TRANSCRIPT OF EVIDENCE

CANBERRA

THURSDAY, 20 FEBRUARY 2025

Secretary to the committee:
Ms K Langham (Ph: 620 75498)

By authority of the Legislative Assembly for the Australian Capital Territory

APPEARANCES

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Amended 20 May 2013

The committee met at 9.02 am.

Appearances:

Stephen-Smith, Ms Rachel, Minister for Health, Minister for Mental Health, Minister for Finance and Minister for the Public Service

Canberra Health Services
Howard, Dr Grant, Chief Operating Officer
Kaufmann, Mr Holger, Chief Information Officer, Digital Solutions Division
Lang, Ms Kellie, Executive Director, Nursing and Midwifery
Loft, Ms Catherine, Executive Group Manager, Infrastructure, Communications and Engagement Division
Nielsen, Mr Shane, Acting Executive Group Manager, Corporate and Governance Division
Peffer, Mr David, Chief Executive
Smallbane, Dr Suzanne, Executive Director, Medical Services
Zagari, Ms Janet, Deputy Chief Executive Officer

ACT Health Directorate
Cross, Ms Rebecca, Director-General

THE CHAIR: Good morning and welcome to this public hearing of the Standing Committee on Social Policy for its inquiry into annual and financial reports for 2023-24. This morning, the committee will hear from the Minister for Health.

The committee wishes to acknowledge the traditional custodians of the lands 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 this city and this region. We would also like to acknowledge and welcome any other Aboriginal and Torres Strait Islander people who may be attending today's hearing or are listening online.

Proceedings today are being recorded and transcribed by Hansard and will be published. Proceedings are also being broadcast and webstreamed live. When taking a question on notice, it would be useful if you used the words: "I will take that question on notice." That will help the committee and witnesses to confirm any questions taken on notice, from the transcript. I remind witnesses of the protections and obligations afforded by parliamentary privilege and draw your attention to the privilege statement. Witnesses must tell the truth. Giving false or misleading evidence will be treated as a serious matter and may be considered contempt of the Assembly. Please confirm that you understand the implications of the privilege statement and agree to comply with it.

As we are not inviting opening statements, we will go straight to questions. I have a question about aged-care assessment turnaround times. I understand ours are the worst in the country. What is the current average wait time for an aged-care assessment in the community, as opposed to in hospital, in the ACT?

Ms Zagari: I have read and acknowledge the privilege statement. I am waiting on that precise information. If I may, Chair, we will answer that before we finish the session today. I requested that this morning.

Ms Stephen-Smith: Nothing if not predictable, Mr Emerson.

THE CHAIR: What proportion of aged-care assessments are conducted in hospital in the ACT, and do we have an average wait time for those?

Ms Zagari: I will answer that at the same time, if that is all right, Chair.

THE CHAIR: Okay; we will come back to that. Perhaps you could give a qualitative response. I have seen data indicating that we carry out a larger proportion of assessments in hospital than any other state or territory—and we will find out if that is still the case—and that our turnaround time for those assessments is the second-longest in the country, after the Northern Territory. Why is it that so many of our assessments are happening in hospital rather than in the community? Anecdotally, we have heard that it has taken so long to get an assessment in the community that sometimes people are sustaining injuries, ending up in hospital and getting one there.

Ms Stephen-Smith: I acknowledge the privilege statement. Mr Emerson, there are probably a couple of issues there. Our catchment area for people who come to hospital is larger than our own population base. Presumably, New South Wales residents who are in our hospitals will also get their ACAT assessments in our hospitals. We try to ensure that people in hospital who require an ACAT assessment get that in a timely way so that they can be discharged in a timely way. The last time I saw the data, we had the highest proportion of long-stay older patients in our hospital system who were medically ready for discharge, and that is partly as a result of the challenges in aged care more broadly that are well-documented. In terms of having a higher proportion of people in hospital receiving an ACAT assessment, there are probably a number of factors. We try to prioritise and ensure that people can get their assessment in a timely way so that they can at least do the work to try to find an aged-care place.

THE CHAIR: Regarding people who are ready for discharge but are still in hospital, how many will already have had an assessment or are waiting on one?

Mr Peffer: We might have to take that on notice. That would be at a point in time. That number would change from time to time, depending on—

THE CHAIR: Would you mind acknowledging the privilege statement?

Mr Peffer: Sorry. I acknowledge I have read and understand the privilege statement. We can take that on notice and give you data for a point in time. That number will change through time as the number of medically-well patients fluctuates as well.

THE CHAIR: Thank you. My understanding is that these people get home-care packages, not just placements into the aged-care system. We have heard, in the last week especially, how much that is a federal responsibility, and we need people leaning on that funding.

Ms Stephen-Smith: Yes; that is exactly right. It is about home-care packages, as well as residential aged-care places. People cannot be discharged until they have those arrangements in place, whether it is at home or in hospital. There are also some

step-down arrangements that we have through the Transition Care Program, which is a partnership with the commonwealth. So interim steps can be taken with Canberra Health Services.

THE CHAIR: You mentioned assessments for New South Wales residents. Do we have that proportion—how many assessments are for New South Wales residents—and whether that proportion has been stable over the last few years? I understand the raw number might be increasing, but has the proportion been stable or increasing?

Mr Peffer: I do not think we have had any indication that the proportion is shifting. It generally tracks around one in four, so about 25 per cent of our occupied bed base is made up of New South Wales residents, and we see that is slightly higher in certain units. For example, ICU can get up to one in two at times.

THE CHAIR: Does the commonwealth pay the same rate for an ACAT for a New South Wales resident as it does for an ACT resident?

Mr Peffer: I will have to check that. I would presume so, but—

THE CHAIR: There is no differentiation?

Ms Stephen-Smith: From my understanding of the program—and I could be wrong about this, and someone in the directorate might be able to advise—is that it is a block-funded program for the ACT. We receive a certain amount of funding from the commonwealth to deliver the ACAT assessments. We have added resources on top of that funding and we have consistently advocated the commonwealth for more funding, please. My understanding is that it is a block-funded program, not a per-assessment funding arrangement.

THE CHAIR: Thank you. I am glad you raised the commonwealth funding. During a senate estimates hearing last year, you said the ACT had not been getting the funding it needed to provide ACATs. The Department of Health responded by saying that, in fact, we have been and that the ACT government had agreed to a remediation plan to increase its performance. What were the details of that remediation plan, and did it include hiring more staff?

Ms Zagari: Yes; we have hired additional staff, in order to address the wait time for ACATs. The ACT government has funded additional staff on top of the commonwealth contribution.

THE CHAIR: Do we have a sense of how long we basically did not have enough staff performing assessments?

Ms Stephen-Smith: There are two issues, Mr Emerson. The first is that, as I understand it, there were some vacancies in the ACAT team for a period. There is the period when there were some vacancies. When you say we did not have enough staff, the commonwealth does not fund enough staff for us to keep up with demand. We now have some additional ACT government-funded staff as well. We can take on notice the period during which there were vacancies and how many vacancies there were in the commonwealth-funded team.

THE CHAIR: Thank you. My understanding is that the ACT is the only place where the commonwealth contracts this work directly to the government. Is that still the case?

Ms Stephen-Smith: No. A few years ago, there was a conversation with the previous coalition government. They were going to take this program, which is delivered by states and territories across Australia, and outsource it to the private sector, and all of the states and territories said, "We absolutely do not agree with that approach," pushed back on that, and the commonwealth changed their position and decided to leave it with states and territories. My understanding is that it is delivered by states and territories across the board.

THE CHAIR: Everywhere?

Ms Stephen-Smith: Yes.

MS CASTLEY: Minister, I would like to ask some questions about the proposed surgeon staffing changes at the hospital. Is the government's intention to change the employment and payment structure for surgeons from a fee-for-service model to putting on full-time staff, and what is the reason?

Ms Stephen-Smith: Yes. What we have said is that we want to move towards the arrangements that exist in pretty much every other jurisdiction and every other major hospital network. They have moved away from fee-for-service models for engaging visiting medical officers. That is about two things: one is cost-effectiveness, and the other is engagement of those staff. Our preference, in a number of jurisdictions, is to have employed staff specialists who work on a full-time or part-time basis as part of the hospital team, but that is not the only option. We recognise that visiting medical officers are also a very important part of the workforce in every jurisdiction, and we have never said that we will stop having visiting medical officers as part of our workforce.

We have also never said that we will change the current contracts for any visiting medical officer. What we have said over time—and this has been clearly communicated to the visiting medical officer cohort—is that, as contracts come up, we want to move to a sessional-based contract rather than a fee-for-service arrangement. However, we know that there are some specialties in particular that are very committed to a fee-for-service model. Most of the VMOs, if not all, work on a fee-for-service basis. There are ongoing conversations with those craft groups about what this looks like. I want to be very clear in this hearing that we are not talking about changing any existing contracts, unless somebody comes to us and says, "I actually want to take up your offer and change from VMO to staff specialist," or "I want to take up your offer of changing from fee-for-service to a sessional arrangement."

Over time, we want to achieve the outcomes of reducing the costs of visiting medical officers, which are well above what other jurisdictions pay their visiting medical officer cohort, and ensure that our senior clinicians are well engaged in the business of the organisation, including training, research and management of the organisation as a whole, and other specific issues around availability for being on-call. All of those things are quite complex and will vary from craft group to craft group. Canberra Health Services senior executive and the leadership group are in conversations with individual

craft groups about what that looks like in their specialty.

MS CASTLEY: As contracts run out, is it your assumption that the cohort you have will be happy to change?

Ms Stephen-Smith: There will be conversations with each person. The other thing I should be really clear about is that—and I will hand over to Mr Peffer to talk about this—for anyone whose current contract is expiring within the next six months, there will be individual conversations with them. There is not an expectation that their arrangements would change overnight. I think there has been some misinformation circulating in the organisation—I do not think that has been provided by the leadership group—around this being some kind of sudden change or that we are asking people to upend their working arrangements overnight. That is absolutely not the case. I will hand over to Mr Peffer to talk about what we are doing for those whose contracts expire in the next six months.

MS CASTLEY: Also, please keep in mind that my question was: do you believe that, as their contracts run out, these people will be willing to change to the sessional arrangements or they will simply leave?

Mr Peffer: Ultimately, I think that is a decision for each individual. What we have said in engaging with the craft groups—and we have had some reasonably productive discussions over the last week or two with three of the craft groups to begin with—is that we are here to be flexible and to understand what matters to the individuals within the units and their working arrangements. Equally, we need to balance that with where we would like to take the organisation, the priorities and also the economic reality of the cost of some of these contracts. We have given a commitment to be very flexible and to work with individuals in the craft groups to resolve the differences as best we can and to try to land something that everyone can live with that satisfies the objectives that the minister has just outlined.

In terms of those who have a contract ceasing in the next six months, we provided an assurance, saying, "First of all, we will honour all the contracts." No contract has been changed at this point, and some of those contracts, in fairness, were settled in December and will come up for renewal in three years—some years into the future. For this workforce of roughly 70 medical officers, the renewal is roughly spread evenly across the three years—so you would imagine it is 20-something this year and 20-something next year, and 20 in the out year. But we have given a commitment that, where we have not provided adequate notice, we will look at providing a short-term contract extension so that people have the opportunity to engage with us to consider what that means for them, and, ideally, we will be able to resolve it.

MS CASTLEY: Have you fully costed the VMO model and the number of surgeries they can get through compared to sessional—the cost to the organisation; the output? Do you have that data to share with us?

Ms Stephen-Smith: On a practical basis, there should be no difference in the amount of surgery that people can get through purely as a result of the basis on which they are being paid.

MS CASTLEY: So you would have data to prove that and show that to me?

Ms Stephen-Smith: Any difference would be a choice that they would make, but there should be no actual difference in the amount of surgery they can do in a given amount of time.

MS CASTLEY: Can you show me the data where you have done that analysis?

Ms Stephen-Smith: It is obvious, Ms Castley.

MS CASTLEY: But it is not—

Ms Stephen-Smith: The amount of surgery you can do or the amount of surgery you can supervise is the amount of surgery you can safely do or the amount of surgery you can supervise in a given period of time. That is clearly not related to how much you are being paid to do that.

MS CASTLEY: But there are differences in the administration arrangements for someone who is a staff specialist or someone who comes in as a VMO. That is my understanding. My question was: have you done the cost analysis of the two different models or are you just telling me that it should be the same, so it is the same?

Ms Stephen-Smith: I do not really understand your question, Ms Castley, because, clearly, the amount of surgery you can get through in a particular period of time or the number of registrars undertaking surgery you can supervise over a particular period of time is unrelated to what you are being paid and how you are being paid to do that. Is the question that you are asking, "Have we modelled what the cost savings would be if everybody moved from fee-for-service to sessional and did the same amount of work"? Is that what you are asking?

MS CASTLEY: Yes; but my understanding is that it is not the same amount of work. There are other administrative arrangements that go on as a sessional surgeon. That is okay; you can go with that. I am wondering if—

Ms Stephen-Smith: Can you articulate what those might look like? I do not know whether Mr Peffer can enlighten us on this.

MS CASTLEY: People will have their appointments with the surgeon before they have surgery. My understanding is that is not charged by a VMO; that is just work that they do. But, if you bring people in as a staff specialist, all of that time will be charged, so the cost to the organisation could possibly be more. I am wondering whether you have looked at that and done an analysis. I am just asking the question.

Mr Peffer: Generally speaking, there are different aspects to the work that the surgical teams undertake. Some of it is undertaken in theatre. The constraints in theatre are really around clinical safety and theatre time, the workforce that supports anaesthetics and prognosis, and so forth. The vast majority of our workforce is already paid a sessional rate to undertake their clinics. For those outpatient visits, that is remunerated on a sessional basis.

THE CHAIR: I have a quick supplementary. Do you have a comparison of how many surgeries staff specialists actually carry out in comparison with VMOs on a fee-for-service arrangement? I think the idea is that, if you are being paid per surgery, you might do more surgeries than if you are being paid per hour.

Mr Peffer: What we find across our craft groups is that generally, perhaps with the exception of anaesthetics, we have a workforce of VMOs—for example, for orthopaedics or plastic surgery—or we have a workforce of staff specialists—for example, for neurosurgery. It is very challenging to line up procedures that are fundamentally quite different and say, "These guys have a faster throughput because of their contracting arrangements than a different craft group."

MS CASTLEY: I am worried about the impact. If these changes go through at the end of the contracts—I understand that is a long-term goal—what happens if the VMOs say, "No. We will not sign up for sessional arrangements. We will just go back to our private rooms"? Where does that leave ACT Health and Canberra Health Services? Are you confident that you can get people to move to Canberra?

Ms Stephen-Smith: It is a hypothetical. The reality is that we have seen some really successful recruitment. It used to be the case that an argument would be made in the ACT that anaesthetists would not work as staff specialists. We have recruited a very good head of anaesthetics as a staff specialist, and we have been successful in doing that because we have been able to demonstrate that Canberra Hospital and Canberra Health Services are good places for that individual to work, and they are very committed to working as a public hospital anaesthetist in that role. That is just one example of where recruitment has been successful. We have been successful in recruiting to backfill in cardiology. Five cardiologists left the organisation and people have moved around. So we have demonstrated that we are able to recruit.

However, our preference would obviously be that our existing surgeons, where they are not moving for other reasons, would stay. That is why the individual conversations with people are so important, to understand where they are at in their careers, what they want to achieve, and what is important to them about working in a public hospital service in delivering really critical surgeries for their community. That is part of the motivation for anybody who works in a public hospital.

We also know that, in pretty much every other jurisdiction in the country, this is the way that visiting medical officers are remunerated, so we are not trying to change to a different model from everyone else and pay our visiting medical officers less than everyone else around the country. We are actually trying to move to a model that is more consistent. And other jurisdictions do not face the challenge that you are talking about in terms of being able to get surgeons to do surgery.

MS CASTLEY: So you are confident that the financial decision you are making will not impact surgeries in the ACT, and we will be able to track that with data?

Ms Stephen-Smith: Ms Castley, it may be the case that an individual surgeon determines that they do not want to work under a new contract, and that will be worked through at the time. What I can say is that we are committed to ensuring that ACT patients get the care that they need. We have demonstrated a capacity to successfully

recruit to visiting medical officer positions and to staff specialist positions over time. We highly value our existing visiting medical officer workforce, and we will be working individually with each of those, as well as specifically with the craft group, to work through arrangements that are going to work for that service.

THE CHAIR: What level of consultation occurred with the existing VMOs prior to the announcement?

Ms Stephen-Smith: There have been some ongoing conversations in Canberra Health Services. I am not sure if Mr Peffer can speak to—

THE CHAIR: Were they aware of the announcement before it was made public?

Mr Peffer: They were, but the communication was provided a very short period before the announcement was made. We have been talking to the units about staff specialist recruitment. We recently recruited an ENT—ears, nose, throat staff specialist at the ENT unit, which has typically been solely VMOs. We created a desire to move or to look at staff specialist arrangements in that unit as part of that recruitment.

MS CARRICK: Minister, have you done a risk analysis on where your greatest risks will be if the VMOs do not move to the sessional arrangements? You have just mentioned ENTs. Where would be the greatest risks? I imagine there are not a lot of each type of specialist.

Ms Stephen-Smith: Do you mean the risk in terms of specialty?

MS CARRICK: Yes.

Ms Stephen-Smith: I think the largest VMO craft group is probably in orthopaedics. Obviously, there is a reasonable trauma load in orthopaedics. Risks are different across different craft groups and different outcomes, but that is why we recognise that continuing to provide this service is critical. We also know that our VMOs and specialists recognise that continuing to provide this service is critical to the community.

That is why we are working with each of them to ensure that this is done in a measured way, and why we have consistently sought to reinforce the message that this is not something that is going to happen overnight. We are not trying to change people's current contracts. We are not asking people to change their arrangements tomorrow. We are going to work with people over time, and that will enable us to manage any risks associated, as Ms Castley said. If we have a new standard contract, for example—we do not have one at the moment; I want to be clear about that—and somebody decides that they are not willing to work under those arrangements, we have the conversation early enough that we are understanding the decisions that those people are making and we can put other measures in place.

THE CHAIR: On that question, which surgical units are currently on the risk register?

Ms Stephen-Smith: I would not describe it as a risk register. I do not think that is an accurate interpretation.

THE CHAIR: Are there units where, if we lost one or two staff members, that unit would be untenable? Which are those units?

Ms Stephen-Smith: There are units with a relatively small number of visiting medical officers. So plastics and vascular are probably the units that are largely visiting medical officer run and have a relatively small number of specialists.

THE CHAIR: If there is not a risk register—

Ms Stephen-Smith: But, again, I am not sure that this is an accurate way to describe it. There are locums out there. We can often get locums at very short notice across a range of specialties, and they are usually paid on sessional rates. Most locum contracts are actually sessional, not fee-for-service, is my understanding. I am not sure that the way that you are characterising the risk is an accurate way to think about it.

THE CHAIR: I thought there was a risk register. I thought that was internal language from within CHS. Is that not the case?

Mr Peffer: Mr Emerson, we do have many risk registers across our organisation that relate to the operations within divisions. We also have a risk framework that talks about how, where we have got risks that exist across multiple departments or services, it can roll up into an enterprise-level risk.

THE CHAIR: Which of the surgical units are currently on the risk register? Is it plastics and vascular?

Mr Peffer: We do not have those two units specifically identified on the risk register, but we do have an enterprise-level risk about workforce. This has been a risk that has existed for some time. It is not specific to individual surgical specialties. It relates to a range of skills across the organisation—midwifery and certain nursing areas—where we have experienced critical shortages, and we are in the process of rebuilding skills. We accept that workforce remains an ongoing risk for the entity. We are a people business. We run on our people. So that is something we maintain a continued focus on.

MS CLAY: Minister, you have indicated in the press that VMOs are a cost and that you are going to reduce them. But I think in earlier questioning, when Ms Castley asked for the cost-benefit analysis, it did not sound as if there had been one. Is there a cost-benefit analysis on this of the two different models?

Ms Stephen-Smith: We do have an identified savings target in association with this, but nothing is locked in concrete. We understand what it would look like to change these arrangements over time. So, yes, we have done that work.

MS CLAY: I do not mean the target; I mean the cost-benefit analysis—the economic modelling that shows that you will save money through this. I do not mean the target of the dollars that you wish to save.

Ms Stephen-Smith: Sorry; the target is based on our understanding of what this change would deliver. We do not just randomly pick the number out of the air to create a target.

We have actually worked out what the saving would be if we went down this route.

MS CLAY: Can you provide that modelling on notice, please?

Ms Stephen-Smith: I do not know if I would describe it as "modelling". I think that is a little bit—

THE CHAIR: What is the number of the target?

MS CASTLEY: What is the number? Is there—

Mr Peffer: It might be of use to the committee if I ask Dr Howard to come and talk to the parallel arrangements of what a fee-for-service looks like and how the billing works for that versus a sessional and why there is a differential.

MS CASTLEY: We understand that.

MS CLAY: I do not need that. I was just wondering if you can provide on notice the modelling, the cost-benefit analysis or the methodology behind the target that you set, and the chair has also asked for the target. Is that information you can provide on notice?

THE CHAIR: Or now?

Ms Stephen-Smith: I think your characterisation of how this type of thing works, Ms Clay, is just incorrect. We cannot provide a cost-benefit analysis, because that is not the kind of work that you would do to make this decision.

MS CASTLEY: Sorry, but you must be able to have a cost-benefit analysis of why the VMOs and not locums. There must be some way that you have come to this decision.

Ms Stephen-Smith: Yes. We have looked at the types of arrangements that other jurisdictions use to pay their visiting medical officers to achieve the exact same outcome in clinical throughput and patient care, and said—

MS CASTLEY: So, because others do it, it is going to work for Canberra?

Ms Stephen-Smith: "Other jurisdictions are paying significantly less overtime"—

MS CASTLEY: What is the output? Where is that cost-benefit analysis?

Ms Stephen-Smith: But it is not a cost-benefit analysis because—

MS CASTLEY: It must be.

Ms Stephen-Smith: What you are talking about is delivering the exact same thing for a lower cost.

THE CHAIR: So what is the lower cost?

MS CARRICK: What is the costing?

Ms Stephen-Smith: Undertaking a cost-benefit analysis assumes that you have two options that you are looking at that are—

MS CASTLEY: But you do.

THE CHAIR: So maybe just the costings.

Ms Stephen-Smith: It is just—

MS CASTLEY: What is the cost? Can you give us the cost?

Ms Stephen-Smith: Yes; we can provide that.

Mr Peffer: We can provide that comparison on notice.

THE CHAIR: Thank you.

MS CARRICK: I have one more on this. Will the target that you are talking about for the savings become an indicator in your budget papers that are coming up, so that it can be tracked—so we have a budget indicator and then we have an actual at the end of the year to see how you have progressed over time with this target?

Ms Stephen-Smith: That is actually a really useful question, Ms Carrick, because it enables me to go back and say that, in working through the midyear review process with CHS, we looked at what the cost pressure is for CHS, which is in the realm of $240 million for this financial year, and looked at where efficiencies could be delivered, which is in the realm of $27 million—those numbers do not add up—and then worked through the additional funding that would be required.

Sorry; there are some cost pressures of around $240 million and then there is some expected revenue reduction. So, overall, it is about $250 million. We worked through what efficiencies we would be able to achieve and then determined what additional funding would be provided to CHS to ensure that it could continue to deliver both the necessary emergency demand-driven services—like the emergency department, intensive care and ward-based services—and also continue to deliver things like elective surgery and procedures. The alternative would have been to pull back on those.

The ultimate decision that the Expenditure Review Committee made was the additional $227 million in funding for CHS, recognising that CHS had identified, with the agreement of ERC, that it could deliver about $27 million in efficiencies. But that was a ground-up exercise in looking at what efficiencies we could deliver over this period of time to come to that figure, to result in the additional funding CHS is receiving. It is not a requirement of CHS that each one of those ground-up estimates is delivered exactly as was estimated. The requirement of CHS now is that, within this financial year, it is living within its means of the new increased budget. Obviously, any of these things are estimates over time.

So the answer to your question, really, Ms Carrick, is: what is going to determine whether or not CHS delivers on these is whether it lives within its budget for the year.

The performance indicator is you live within the updated budget for the financial year.

MS CARRICK: I thought that, by moving from VMOs to sessional staff—doctors and surgeons—there would be a saving. I thought that was the target you were talking about, the VMO target, and the savings from moving the salary arrangements. That is the target I am talking about. Will there be an indicator so that we can see whether the move from VMOs to sessional arrangements actually saves money?

Ms Stephen-Smith: There will not be a budget indicator in the budget papers associated with that. We do have a target that was built from the ground up on the basis of what we understand this change could potentially deliver. It is not a high target in this financial year. It is a very low target in this financial year, for the very reasons that we have been talking about. In terms of anyone with an existing contract, we are not intending to change their contract. So, by definition, we are not going to achieve very many savings in this financial year, because we have given people six months to talk about those changes.

This particular element of the overall package is actually talking about how we build in efficiencies for the long term, recognising that, while there has been an unexpected, significant increase in presentations this financial year, which has created a cost pressure in this financial year, there is a long-term cost pressure on the health system, and we need long-term efficiencies. This is one of the medium- to longer-term, measures that we are taking, but it is part of a broader set of measures. So we would not have an independent, individual indicator in the budget papers on this particular measure.

MS CARRICK: Can you provide the targets to us on notice for this—

Ms Stephen-Smith: Yes; we have already printed it up.

MS TOUGH: Minister, last week in the mental health session we talked about mental health emergency department presentations. I am interested in a further overview of, more broadly, the types of presentations we are seeing in the emergency departments.

Mr Peffer: I might ask Dr Smallbane.

Dr Smallbane: I have read and acknowledge the privilege statement. I work in medical administration mainly, but I do work in the emergency department. The types of presentations are unchanged. The volume of presentations increases, but the spread of the types of presentations coming to the emergency department is unchanged over many years.

MS TOUGH: So that includes accidents, emergencies, sickness or trauma?

Dr Smallbane: Trauma, mental illness and paediatrics presentations are all increasing. But the types of presentations stay the same; it is just the increasing numbers, as opposed to different categories.

MS TOUGH: Fair enough. Can you provide an update on how the Acute Medical Unit will help support the emergency department with dealing with presentations?

Mr Peffer: I might get Dr Howard.

Dr Howard: I am the Chief Operating Officer. The official title, I think, is Group Director, Clinical Operations. I have read and acknowledge the privilege statement. If I could just summarise briefly, was the question about the benefits in having an acute medical unit?

MS TOUGH: Yes.

Dr Howard: For some time—and certainly for the better part of three decades—people have understood that the emergency targets as they exist, in terms of how long it takes for someone to be seen and either go home or get admitted, is a reflection on the whole system from front door to back door. So, in order to make the whole system work better, you need to decrease the amount of gatekeeping and increase the amount of flow through the system.

The Acute Medical Unit provides an opportunity for patients who are going to be admitted, even if it is only a short period of time, to get the attention they need and move from the emergency department—decrease the congestion in the emergency department and just improve the flow and the timeliness of care for everyone. It has been a tremendous success over the past 12 months to 18 months.

MS TOUGH: That is good to hear. Building on that, we have had the new Critical Services Building open with the new emergency department at Canberra Hospital. How are the changes made to the design of that, with this new emergency department, supporting people as they present—building that with the Acute Medical Unit, how is that all working together to have the emergency department working efficiently?

Dr Howard: Thank you for the question. It has been great. I am not sure how many of you would have gone to the previous emergency department, particularly on a Friday afternoon. It looked more like a rugby match than an emergency department. The extra space and the better flow through the departments has been fantastic. We have not commissioned all of the emergency department footprints. So it is not simply that we have gone from this many to that many and so it has diluted the numbers throughout. We have seen an uptick in people presenting. So build it and they will come—it looks nice and they get treated faster. So it is more attractive.

There are huge opportunities in the emergency department new build that we moved into and are exploiting in a good way—for example, fast track, the ability to separate out better, and looking after children from the main adult emergency department. There is also space for us to move and to refine that flow better.

Certainly, before we moved into building five, Canberra Hospital and CHS as a whole, the National Emergency Access Target has gone from being possibly the worst performing jurisdiction for some time; whereas, both those hospitals, in the last release of information from AIHW, were leading Australia in their categories. I think Mr Peffer did a calculation on the back of an envelope of how many Canberrans we are seeing on time relative to previously, or at least faster. Some people have said, "Well, those are just numbers," but, fundamentally, each number represents a person who got better care

faster.

MS TOUGH: Wonderful. Have you had a positive response to separating the paediatric emergency from the rest of the emergency? Touch wood, I have not had to go to the new paediatric emergency yet, but I have spent many a time in the old emergency with a child.

Dr Howard: There has been good feedback from staff and patients. That is partly reflective of the additional number of people that are turning up, happily. We still have a little way to go in terms of fully implementing the paediatric model of care in ED, including a short stay unit. That will form part of our winter planning for this year—rather than moving everyone from ED to a ward somewhere, when in fact they just need a little bit of extra care closer to the front door and faster, that is where we will be aiming to go; and broadening the idea of a paediatric emergency department, a paediatric department or a whatever to, actually: what does the territory-wide service for children look like and is it integrated and joined up in the way we want it to be? That is a journey we have been on for probably two years now.

MS TOUGH: Wonderful. Thank you.

MS CLAY: It was good to hear earlier in answer to that question that we are recording why people are reporting to ER. We heard that the categories are about the same; it is just the overall number has increased. Are you able to provide, each year for the past three years, the data on the number of presentations by category?

Dr Howard: Absolutely.

MS CLAY: That would be great on those. Can we also have an indication of how many of those might have been dealt with by preventive? I think we are already reporting against dental, but there might be other preventative things. Is that part of the categorisation?

Dr Howard: I think it is very difficult to report on who did not turn up and why. I think there are so—

MS CLAY: Not who did not turn up; the people who are turning up with things that could have been dealt with preventatively. Dental is a good one, and there will be other examples.

Dr Howard: I think for specific and individual clinical issues like the dental one you have mentioned, we can certainly provide and interrogate the data. But, in terms of a more sweeping catch-all of things that could have been seen or done somewhere else or prevented earlier, I think that is quite a hard thing to—

MS CLAY: All right. We will start with what we get. Thank you.

Mr Peffer: I might just add, if I could Ms Clay, that there is an indicator that gets released by the Productivity Commission each year as part of their publication, their report on government services, which tracks potentially preventable hospitalisations. It essentially measures those who are presenting to hospital who otherwise may have been

able to be treated in the community or through some other means. I think the territory is one of the top performers—if not the top—nationally on that indicator.

MS CLAY: Thank you.

MR RATTENBURY: Minister, I want to ask about the increase in demand that you have publicly described. You talked about an extra 85,000 presentations. I did ask about this in the Assembly, but I am keen to understand in more detail where those 85,000 presentations were and in what category. For example, in the media there was a report of 6,000 more emergency department visits and 6,600 more overnight hospital admissions. What are the rest of the 85,000?

Ms Stephen-Smith: I will hand over to Mr Peffer.

Mr Peffer: Thank you for the question. That relates to point-in-time data, Mr Rattenbury. That was the current data as at November, which was informing us as a health service and considerations around our trajectory in terms of activity. At this point in time, it has well and truly exceeded 100,000 additional patient episodes compared to the prior year. I can read out a long list of breaking that down across acute care, rehab, pal care and other things, but it might be more useful if we provide a table across the various categories.

MR RATTENBURY: Yes, that would be helpful. Thank you. On that basis, I am then keen to understand the impact that has on the budget request that has been made. You talked about a figure of $227 million, and there has been a public discussion. In the budget papers there is a range of figures. The first is $80,000 for the ACT Health Directorate. Perhaps this might be a question for Ms Cross. I am keen to understand what that is going to, given that the stated public reason is the increase in demand, and the Health Directorate tends to provide policy response.

Ms Stephen-Smith: That is in relation to a write down over expected income under the National Health Reform Agreement. I think Tasmania has had the same experience. At the end of last financial year, when we were putting the budget together for this financial year, there was an understanding that New South Wales was in a recruitment freeze and Victoria was significantly pulling back on things like elective surgery because of their financial challenges. As you would be aware, Mr Rattenbury, the larger jurisdictions drive the overall numbers in the National Health Reform Agreement. There is a 6.5 per cent cap in increasing commonwealth funding nationally. That is applied as a soft cap across jurisdictions. So, if the 6.5 per cent cap nationally is not reached, other individual jurisdictions can go above that cap and share the additional.

We had, from all of the projections that were available to us at the time, thought that potentially New South Wales and Victoria would not reach their 6.5 per cent and that there would be available headroom under the National Health Reform Agreement for the ACT to go above 6.5 per cent. Unfortunately, probably in part due to significant cost escalation, as well as an inability to pull back on some activity in New South Wales and Victoria for specific decisions and also the demand pressures that we have experienced, we now do not believe that there will be headroom under the cap for the ACT to go above 6.5 per cent growth in funding under the NHRA. So this is essentially a technical revision of our estimates of what we are going to achieve from the

commonwealth.

MR RATTENBURY: Minister, then there is a separate line item of a further commonwealth National Health Reform Agreement revenue shortfall of $105 million. Is that the same issue?

Ms Stephen-Smith: Sorry; that is probably the issue I am talking about. Which page are you on?

MR RATTENBURY: I am on page 9 of the appropriation bill.

Ms Stephen-Smith: I do not have a copy of the appropriation bill in front of me.

MR RATTENBURY: That is all right. There is a figure of $80 million allocated to Canberra Health Services. I am keen to understand what that is for.

Ms Cross: To Canberra Health Services, or to the—

MR RATTENBURY: Sorry, my mistake, Ms Cross—the ACT Health Directorate. My apologies.

Ms Cross: I have read and acknowledge the privilege statement. I will just see whether our CFO has that paper with those numbers.

THE CHAIR: While you are doing that, might I just ask a question about the table? Are you tabling the table or are you taking that on notice?

Ms Stephen-Smith: We will just take it on notice and then come back after the first break.

Mr Peffer: Yes, we will take it on notice.

THE CHAIR: Thank you.

Ms Cross: Mr Rattenbury, can I check which document you are looking at?

MR RATTENBURY: I am looking at the budget 2024-25, supplementary budget paper, page 9, table 1, the impact of additional appropriations for 2024-25. There is an $80 million allocation to the ACT Health Directorate.

Ms Stephen-Smith: Sorry; I was looking at the wrong one. Yes; page 9.

MR RATTENBURY: At the top of table 1: ACT Health Directorate, $80 million. Investing in public health care and delivering sustainable health services is the descriptor.

Ms Stephen-Smith: If you add up the $80 million there and the $147 million in the next line of the LHN, you get to the $227 million. So I think it is related to how that funding is being distributed.

MR RATTENBURY: Thank you. That is the core of my question: what is the ACT Health Directorate doing that needs $80 million to meet that increase in demand?

Ms Cross: The ACT Health Directorate is also the Local Hospital Network. We are the LHN. The funding that is provided to CHS comes to the directorate and then flows through to Canberra Health Services. I do not have—

Ms Stephen-Smith: I think what is happening, Mr Rattenbury, is that, in order to manage cashflow issues, the ACT Health Directorate is effectively contributing $80 million to the Local Hospital Network in the short-term and then is being reimbursed for that $80 million through the appropriation as a result of this. It is really a pass through the Health Directorate to manage the short-flow cash into the Local Hospital Network while the Assembly considers the appropriation bill.

MR RATTENBURY: Thank you. That makes sense. Minister, I then take it that, in your earlier answer when I asked the question—where I think we just miscommunicated—you were referring to the $105 million.

Ms Stephen-Smith: I was referring to the $105 million. I apologise; I was not looking at the page.

MR RATTENBURY: That is okay. So you were essentially saying—and I am not trying to be pejorative here—that it is a technical adjustment to reflect a missed measurement of what we thought we would get from the commonwealth?

Ms Stephen-Smith: Yes.

Ms Cross: We gave our best estimate at the time. Then, when New South Wales and Victoria did not underachieve on their target, we have had to make that adjustment.

MR RATTENBURY: So that is also an additional cost, on top of the $227 million, that the ACT has to bear on a health budget?

Ms Cross: Yes.

MR RATTENBURY: Right. While I am in this bit of the budget, just for my own clarity, the line above, is $11 million in Canberra Health Services own source revenue unrealised.

Ms Stephen-Smith: That is when earlier I was talking about the $227 million and the $27 million, and I said it did not add up to $240 million—which is the cost pressure, because there is also an own source revenue shortfall estimated for Canberra Health Services for this year. So, overall, the $227 million additional investment, which is the $80 million plus $147 million plus the $11.3 million, will go to Canberra Health Services to make up for both the demand pressure and the own source revenue unrealised. That takes into account the Canberra Health Services target of achieving $27 million worth of efficiencies. Otherwise, it would have been an additional $27 million they would have required.

MR RATTENBURY: So, if I am correct, the actual overall increase in funding

injection is in fact, $332 million, because you have got to pick up that $105 million for the commonwealth.

Ms Stephen-Smith: Yes, and I think that is what is reflected in the appropriation bill.

MR RATTENBURY: Thank you.

MS CLAY: Minister, I am interested in all this explanation. We have got a bill before parliament at the moment and the explanatory statement is about a page, and we have not had any of that explanation. Do you imagine at some point you might be providing a bit more written explanation about what that appropriation bill is by line?

Ms Stephen-Smith: That would be a matter for the Treasurer. He is responsible for the appropriation bill. I cannot answer on his behalf.

MS CLAY: We did try asking the Treasurer about this bill, and he said it was a matter for you.

Ms Stephen-Smith: No; I watched some of that hearing. People were specifically asking about the 85,000 additional patient encounters and what that meant et cetera, and he said that that was a matter for us—where that demand was coming from.

MS CLAY: So questions on the bill are for the Treasurer. That is fine.

A lot of jurisdictions have tried activity-based funding, and it has been criticised pretty widely as driving lots of activity but not driving positive health outcomes. We have heard that about Singapore's public health system and about NHS in England, and I think a lot of jurisdictions have pulled back from that. We have introduced activity-based funding here. Do you think that has had any impact on what we are seeing in our health outcomes and the cost of our health outcomes?

Ms Stephen-Smith: I will hand over to Ms Cross in just a moment, but I think there are a couple of things. Other jurisdictions in Australia have not pulled back from activity-based funding. It is the basis for the National Health Reform Agreement, and the ACT is an outlier in not having had an activity-based management system in place to this point. Secondly, we have not actually implemented our activity-based management or activity-based funding yet. Thirdly, there is no way that a funding system like activity-based management could drive presentations to the emergency department or the intensive care unit.

I think some of the criticism that you were talking about, Ms Clay, may be related to very early iterations of activity-based funding models. A lot of lessons have been learnt in the 20-odd years that activity-based funding has been used in Australia and certainly since the implementation of the first National Health Reform Agreement in 2012. But Ms Cross can provide an update on where we are up to on the project.

MS CLAY: A brief update on where we are up to on the implementation of it would be great—but just quickly.

Ms Cross: We have actually been doing a shadow budget using activity-based funding.

That means that we are not using it in the actual budget, but we are monitoring what it would look like if we were. Some of the benefits of looking at activity-based funding is it gives you a much more granular understanding of what is happening in the hospital. So you can identify areas where there is low-value care, and you can identify if you have got hospital-acquired complications and what the cost of that is.

It is not a tool to just link activity to funding and encourage more activity. It is actually a tool to better understand what is happening in different parts of the hospital system, and it is a tool for CHS to then manage that. If you just have block funding, each year you just look at the block funding amount and increase it by two per cent or whatever you do. With activity-based funding, you can look specifically at where you want the increases and where you think that something is low value and you may cease to fund it. It should lead to improvements in management of the hospital budget and activity.

MS CASTLEY: Back on the appropriation, which has not yet been agreed by the Assembly: what is the latest date that the appropriation would need to be agreed to avoid adverse impacts in the—

Ms Stephen-Smith: The appropriation bill covers the whole of government, and there are cash management strategies across government. The date that the appropriation bill needs to be considered by the Assembly is really a matter for the Treasurer, because it is a whole-of-government question in relation to management of the budget across the whole of government.

MS CASTLEY: At what point would a decision need to be made about changes to services if the proposed appropriation is not agreed?

Ms Stephen-Smith: If the proposed appropriation is not agreed, there would be some very significant service impacts. We would have to make a decision immediately to cease providing pretty much all of the elective and non-emergent, non-demand driven services that Canberra Health Services provides.

MS CASTLEY: How close to that point are we?

Ms Stephen-Smith: Obviously, we are not going to make that decision. That is why we have put in the additional funding. But even then, Ms Castley, as Mr Peffer said earlier, most of our services are delivered by staff who are permanent staff who need to get paid, whether they are delivering services or not. So the costs avoided would largely not be in the staffing, because we would still have to pay people or we would have to make them redundant, which comes with a very significant cost, and we could not do that.

MS CASTLEY: I understand the impact; I am wondering at what point you would need to have to make those decisions.

Ms Stephen-Smith: If the Assembly voted against the appropriation bill, we would have to make that decision that day. But, at this point, we are confident in our agreement with the Greens and Mr Emerson in relation to supply and confident that they are not going to take a drastic decision that will result in us having to shut down significant health services.

MS CASTLEY: Great. What is the current level of cash reserves held within the portfolio and what amount of cash reserves would be accessible through Treasury or other parts of government?

Mr Peffer: I think we would have to take that question on notice, Ms Castley.

MS CASTLEY: Thanks. Who decides the level of reserves that you hold? Is this your decision as minister or is it made by the Treasurer? Or are there fiscal rules which you are required to abide by?

Ms Stephen-Smith: It is not my decision. It would be, I think, part of the responsibilities of directors-general and the CEO to make those decisions but, presumably, in partnership with Treasury. But, again, that is a whole-of-government question that you are asking. That is really more appropriately directed to the Treasurer than to me as health minister.

MS CASTLEY: A large slice of this is for Health, but given the—

Ms Stephen-Smith: That may be the case, Ms Castley, but I am not the Treasurer.

MS CASTLEY: Given the appropriations that have been agreed, not including the appropriation currently before the Assembly, how many days of spending can be sustained at the current rate before you run out of money?

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

MS CASTLEY: Okay. Are you confident that prudent levels of reserves are held within the portfolio, or are we really down to the wire?

Ms Stephen-Smith: We are down to the wire, Ms Castley. That is why we have introduced an appropriation bill seeking a significant amount of additional funding, because the current appropriation—

MS CASTLEY: But is it not prudent to have an amount of reserves to get you out of trouble?

Ms Stephen-Smith: The current appropriation and cash reserves that exist for this financial year are not sufficient to get us to the end of the financial year. That is why we have introduced an appropriation bill that seeks the Assembly's agreement to a significant additional appropriation across the ACT government.

MS CASTLEY: Who is responsible for managing that and understanding at what point we are going to run out?

Mr Peffer: Ms Castley, there is a set of rules in a framework that is applied. It is a Treasury framework. This is what gives rise to Treasury performing that sort of typical Treasury function that you would see in a corporate or large company. Those rules are applied to all of the bank accounts held within directorates. It sets the terms of how much funding is left in those bank accounts and at what rate the funding is flowing to

those individual accounts to support fortnightly wage runs and the payment of invoices and other things. So it is a Treasury governed and a sort of Treasury managed process across the whole public service.

MS CASTLEY: Thanks. Could you take on notice to advise the committee the latest date which the appropriation bill would need to be agreed, to avoid further adverse impacts to the portfolio?

Ms Stephen-Smith: Can you put that question on notice to the Treasurer, Ms Castley? As I have said, that is not a question for the Health portfolio. That is a question—

MS CASTLEY: Do you not have any interest or concern for your portfolio about when that might be, though?

Ms Stephen-Smith: Ms Castley, I have significant interest and concern for my portfolio and in my role as Minister for Finance, through which I sit on the Expenditure Review Committee, but I am not here in that capacity, and that is a question for the Treasurer. Please put it on notice for him.

MS CLAY: The Financial Management Act, section 31, says:

> (1) The responsible director-general of a directorate is accountable to the responsible Minister of the directorate for the efficient and effective financial management of the public resources for which the directorate is responsible.
>
> (2) The responsible director-general of a directorate must manage the directorate in a way that—
>
> …
>
> (b) promotes the financial sustainability of the directorate; and

Has that been happening with Health?

Ms Stephen-Smith: Yes. We have been through some timelines a couple of times. In the 2024-25 budget itself, there was an understanding that we had seen significant increased demand on Canberra Health Services in 2023-24 and there was quite substantial additional funding provided—at least a six per cent increase in Canberra Health Services funding year on year—to account for both cost pressures and demand pressures in the system. When I looked at the 2024-25 budget papers, I added up about $100 million of additional funding just for the 2024-25 year in areas like funding additional paediatric beds, funding the expansion of the Acute Medical Unit, funding additional beds at University of Canberra Hospital and other things that reflected what we knew about the increase in demand.

There was a long conversation through the 2024-25 budget process—which Mr Rattenbury might remember—about how we manage our funding for the health system. That was clearly reflected in the 2024-25 budget, which also reflected in its statement of risks that there was an ongoing risk in relation to Health. In the statement of risks at the back of the 2024-25 budget, you will find some commentary about that. Then we had budget estimates and we passed the budget. We went pretty much straight into caretaker at that point.

At that point, we were still in winter. For July and August, we are still in a busy winter season. It is quite hard to project from winter a straight line trajectory for the rest of the year. We went into caretaker, I think, on 13 September. So we did not even have full first quarter numbers for even operational data around activity, let alone cleansed data around weighted activity, what the complexity of that activity looked like and what it would actually cost.

Early in October, Mr Peffer provided some advice to my office that we were looking like we were running above budget. There was not anything we could actually do with that advice at that point, because we were in the middle of an election. We were less than three weeks before an election. But Mr Peffer provided advice to me through my office as caretaker minister that this risk was eventuating. As soon as I came back in as health minister and the Treasurer was sworn in as Treasurer, we were advised what that risk was looking like.

So Canberra Health Services advised us, when they had information available to them, that this was a risk. At that point, I have to say—before the next inevitable question—that both in October and in November, it still was not clear whether or not that risk could be pulled back and managed. That was the work that was done between early November and January, when the Expenditure Review Committee made the final decision about the additional funding for CHS, to understand how much we were continuing to see that demand pressure on the system and how much we could potentially pull back, and some decisions to be made.

It is not for CHS to make unilateral decisions about reducing activity to address that demand. That was a decision that needed to be made through ERC, and it was open to us to make some decisions about pulling back on activity, rather than increasing funding as much as we have decided to do. So I do think that Canberra Health Services has kept me informed as minister.

MS CLAY: Minister, you mentioned that CHS briefed you during caretaker. I believe caretaker conventions would mean that the Leader of the Opposition and possibly the leader of the Greens should also be briefed when that is happening during caretaker. Is that the usual caretaker convention and, if so, is that what happened?

Ms Stephen-Smith: My understanding is that it was a brief phone call to my chief of staff. I can hand over to Mr Peffer to talk about that.

Mr Peffer: At no point did we seek a decision. If we were seeking a major decision about the rationing of services, a significant reduction or a redefining of what the Health Services would do, that would constitute something quite different. My understanding, and I guess it is a question for the Chief Minister's directorate, is that the minister remains the minister through caretaker, and advice can still be provided to a minister during that period, provided it is factual advice and not seeking a decision.

Ms Stephen-Smith: My understanding of the caretaker conventions, as to when the opposition, and others, potentially, may need to be briefed, is when a decision is being taken that will have a material impact post the election.

MS CASTLEY: Minister, could you table any briefings that you received in that period?

Ms Stephen-Smith: I did not receive any briefings. As I indicated, it was a phone call from Mr Peffer to my chief of staff, who then informed me that the phone call had been made. On this matter, I do not think I received any written briefing.

Mr Peffer: No. I provided raw activity numbers, so they were not cleansed and converted into weighted activity units.

MR HANSON: Minister, when you received that notification, did you then alert the Treasurer or the Chief Minister?

Ms Stephen-Smith: I did not. I will take the question on notice as to whether my office did. Again, there was no action that could be taken at that point. It was merely a heads up: "We're busy, and we're seeing additional activity."

MS CARRICK: My question is about the Treasurer's advance of $79 million.

THE CHAIR: Is this a supplementary?

MS CARRICK: It is about the same thing; it is about the appropriation. Yes. It is a supplementary.

Ms Stephen-Smith: I am sorry to interrupt, but my chief of staff has advised that, to the best of his recollection, he does not think that he advised the Chief Minister's office at the time.

MR HANSON: Could he confirm that for us, please?

Ms Stephen-Smith: He has messaged me to say—

MR HANSON: Yes, but he said to the best of his recollection. Perhaps he could check his records, phone records or whatever it may be.

Ms Stephen-Smith: Yes, we will take that on notice.

THE CHAIR: That is taken on notice; thank you. Ms Carrick?

MS CARRICK: Going back to the appropriation, the $79 million Treasurer's advance, was that used for Health?

Ms Stephen-Smith: Yes, it has been used to support the budget broadly, and I think that has been—

MS CASTLEY: Do you think or do you know?

MS CARRICK: When was that drawn? When was the request made to the Treasurer to allocate the Treasurer's Advance to Health?

Ms Stephen-Smith: You are right; the way that the Treasurer's Advance normally works is that there is a request from the minister at the end of financial years to say, "My directorate needs some additional funding." That was not the process this time. The whole process of how the whole of government was going to manage this pressure was managed through the Expenditure Review Committee and by Treasury. I do not know whether Mr Peffer or Ms Cross have any additional information to add; overall, again, that is a question for the Treasurer as to how that Treasurer's Advance is—

MS CARRICK: My question is: when was the decision made? Whether you requested it or whether, sitting in the ERC, a decision was made, when was that decision made to allocate the $79 million Treasurer's Advance to Health?

Ms Stephen-Smith: There were decisions made through the Expenditure Review Committee process, and officials were tasked out of Expenditure Review Committee to understand how best to manage the financial pressure until such time as an appropriation bill could be passed. With those decisions, any further detail on that, Ms Carrick, needs to be directed to the Treasurer to discuss the detail of the Treasurer's Advance.

MS CARRICK: Was it in 2025 or 2024? Has it been spent?

Ms Stephen-Smith: Again, that is a question for the Treasurer. The Expenditure Review Committee met late in 2024 and in January 2025. The final decisions in relation to the budget review were taken in January 2025.

MS CARRICK: I am not sure what the $79 million has to do with the budget review. It is a part of the 2024-25 appropriation.

Ms Stephen-Smith: That conversation was about how much we need to include in the appropriation bill and how we manage the pressures on the overall ACT government budget between the beginning of 2025 and when the appropriation bill passes. Part of that conversation was about the recruitment pause that all directorates have been engaged in, and the Treasurer wrote to all directors-general to provide advice in relation to ensuring that they live within their own existing appropriation, as well as some measures such as the recruitment pause that needed to be taken. Again, this was a whole-of-government decision through the Expenditure Review Committee and at officials level.

MS CARRICK: Thank you, Minister, but I still do not know when the $79 million was—

Ms Stephen-Smith: Again, that is not a question for me to answer.

THE CHAIR: I asked the Treasurer this question and he took it on notice, so we will get an answer. It is time for a short break. We will now suspend the proceedings and reconvene at 10.30 am with the Minister for Health and officials.

Hearing suspended from 10.16 to 10.30 am.

THE CHAIR: Welcome back to the public hearing of the Standing Committee on Social Policy for its inquiry into annual and financial reports 2023-24. The committee will now continue to hear from the Minister for Health.

Ms Stephen-Smith: Chair, can we respond to a couple of things from the last part of the hearing?

THE CHAIR: Yes, of course.

Ms Stephen-Smith: I will hand over to Ms Zagari in a moment to talk about ACAT. The advice that came from Mr Peffer to my office was on 4 October; it was an email, not a phone call. It went to two of my staff. My chief of staff has confirmed that it was not passed on or advised to the Chief Minister's office. My chief of staff verbally told me that he had received this advice that Health Services was busy. We both thought, "It's 4 October, there's not a lot that we can do about that. It'll be a problem we have to deal with after the election, if we are re-elected, but we're in the middle of a campaign." I have asked my office to print out a copy of the email and attachment and bring it down to be tabled; otherwise there will inevitably be an FOI, so I might as well table it now.

MS CASTLEY: That is right.

MR RATTENBURY: Well played, Minister!

Ms Stephen-Smith: It will confirm the way that we characterised it earlier. Did I say that my chief of staff confirmed that he did not advise the CMO?

THE CHAIR: Yes, thank you, Minister.

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

Ms Zagari: Thanks, Minister. I will return to the chair's questions at the start of the last session. I have the majority of answers that you requested, Chair. Within the ACAT team, there are a total of 12.8 FTE that are funded by the commonwealth, and we have increased it by a further three FTE funded by the ACT.

There has been a focus on the timeliness of community assessments, understanding that we had significant delays. The last data available to us from the commonwealth is from November 2024, which saw the number of long waits in the community—which is classified as anyone who has waited more than 75 days for a community assessment—is now less than half what it was in January 2024. It changed from 640 to 303. We expect that next time we get data back, that will have improved further, given the significant focus on it.

In terms of hospital assessments, we are meeting the KPI for in-hospital assessments, where we are conducting over 90 per cent of in-hospital assessments within the allocated timeframe. Currently, our ACAT team see all hospital assessments within 48 hours of referral. That goes to your question about people who were waiting for ACATs in hospital.

I know that we currently have 69 patients who have been ACAT-ed and are waiting for a place in a residential aged-care facility. What I do not have, but the team are working to tell me if we can have it, is the number of patients who are waiting for other things like a home-care package. There are 69 waiting for residential aged care. If we can provide the other number, I will either provide it by the end of the session or take it on notice. I am not certain whether or not that is possible, so we will come back.

The remediation plan that was developed last year in collaboration with the commonwealth included those strategies around streamlining administrative practices; making it easier for the assessment team so that they could undertake more assessments, which they are; supporting the assessors to meet their weekly assessment KPIs; offering some additional overtime for existing assessors and casual contracts; and the surge workforce that has been funded by the ACT to contribute to managing the workloads.

The way we have approached it is to look at those people that have been waiting the longest, and looking at that long tail, to bring those down. As new assessments come in, we go to the high priority first, while concurrently working on the significant delay in the community.

THE CHAIR: Thank you very much for all of that information. Correct me if I am wrong, but there are outstanding queries around the proportion that are conducted in hospital compared to in community?

Ms Stephen-Smith: Yes.

THE CHAIR: And the median and average wait times for those that are undertaken in the community; I think you have answered that for in-hospital. They are all being seen within 48 hours. All assessments are being carried out within 48 hours. That is a huge improvement.

Ms Stephen-Smith: In relation to the visiting medical officers, I can advise that, with the initial target out of the $27 million for this whole program of work, which is not only about changing people's contracts, which we have already talked about—not immediate changes—the overall amount was $5 million. Dr Howard can talk a bit more about this. But I do need to be clear, again, as I said previously, that what really interested us was the overall target of $27 million, and that there was flexibility within that for some to be over-achieved and some to be underachieved. My understanding is we are over-achieving at the moment in relation to reducing agency nursing costs. There is also significant activity on procurement activities and overall FTE management.

I would not want that $5 million to be set in concrete in relation to VMO contracts, because that would not be an accurate reflection of where we sit at this point. It was a piece of work that was done to inform the overall additional funding that would be allocated to CHS through the appropriation bill. If you want Dr Howard to talk about this anymore, or if you want Mr Peffer to talk about the broader objectives around agency nursing procurement, surgeries and FTE management, we can do that.

Ms Zagari: Chair, could I come back to ACAT for a moment? I have some additional information. There was a question asked about the mechanism for funding. The minister was correct; it was block funded. However, from December 2024 it has moved to fee-

for-service funding. The positions under that system, therefore, are now all funded by the commonwealth. The FTE has moved to 16.97 FTE. We undertake New South Wales assessments that are in-hospital assessments for New South Wales patients, not community assessments. Those are funded under the same mechanism.

THE CHAIR: You said before there were 12.8 FTE funded by the commonwealth and three funded by the ACT; what is the 16.97?

Ms Zagari: That is new FTE that has been moved to from December. Under the fee-for-service arrangement, it is therefore funded by the commonwealth because it is no longer block funding that has been topped up—

THE CHAIR: That is all funded by the commonwealth?

Ms Zagari: Correct.

THE CHAIR: Now the ACT no longer needs to fund—

Ms Zagari: Correct.

MS CLAY: Minister, the Auditor-General warned that MyDHR is $160 million over budget. Given that HRIMS wasted almost $80 million in public funding and was subject to investigation by the Auditor-General, can you tell me what processes you have put in place to ensure that MyDHR took lessons from those previous findings?

Ms Stephen-Smith: I will hand over to Ms Cross and get her to talk about the DHR—it is DHR, not MyDHR—system. I do not think we needed the Auditor-General to tell us that the overall project was under budgetary pressure. The Health Directorate identified this. It was raised through budget processes. The Auditor-General's findings more broadly on DHR have largely confirmed things that the Health Directorate had already identified through internal audits and reviews. That is probably point number one.

Point number two would be that the DHR project was occurring concurrently with HRIMS. There was no opportunity through the DHR project to learn lessons from HRIMS because the DHR project was happening at the same time. There were, however, significant governance arrangements in place for the DHR project and it successfully delivered a whole-of-ACT public health system electronic medical record system. It is up and running and it is making a difference, both to clinical service delivery every day and to the amount of activity that we are able to capture in our system.

It has successfully delivered a project. It has been under financial pressure. With that, I will hand over to Ms Cross and Mr Kaufmann to talk about what that looks like and what is being done about it.

MS CLAY: I might reframe my question, based on that information. It is great that you knew what went wrong before the Auditor-General told you. On that, Ms Cross, maybe you can let us know how you applied the lessons that you already knew from your internal reviews to both of those systems while you were doing that?

Ms Cross: The first thing that I would like to do is clarify the figure of $160 million. The directorate supports over 100 IT systems. The Digital Health Record is just one of them. In our budget, post COVID, we have seen cost increases across all of those systems. In some cases, because of supply chain issues brought on by COVID, the cost of things went up. The cost of licences for a number of systems went up. The cost of contracts, when we renegotiated them, often went up by five or six per cent, whereas our indexation is only 2.5 per cent.

As we moved from paper-based systems to having everything online, we needed to provide 24-7 support for a whole range of IT systems, not just the DHR. The commonwealth changed a number of security requirements, through the critical services infrastructure bill, so we had to increase security for a number of the systems.

Another factor for all of those systems is that the number of licences you need increases as you have more staff. As you have increased demand in the hospital, you have more staff, and you also need to store more records. The figure of $160 million is not just costs associated with the DHR; it is the culmination of all of those factors across over 100 systems that the directorate supports.

MS CLAY: Are you able to tell me what the estimated budget increase is for DHR?

Ms Cross: Yes, we could give you a breakdown of that. But a number of—

MS CLAY: Can you do that now?

Ms Cross: I cannot break the $160 million down now.

MS CLAY: Okay.

Ms Cross: I want to make the point that a lot of—

THE CHAIR: You will do so on notice?

Ms Cross: Yes, I will take that on notice. I want to make the point that a lot of those costs are not actually the Digital Health Record; it is the totality of the IT system that we support.

MS CLAY: Can you tell me what the main elements of the increase are?

Ms Cross: Yes. With the increases, as I said, a lot of it relates to increased demand in the hospital system, which means we have employed more staff, we are storing more records and we have more licences. A lot of it relates to factors outside our control, such as contractors increasing their rates. We think we have negotiated very well with a number of those contractors to reduce the increase to five or six per cent, according to what they had originally asked. That is still more than the indexation that we receive. We can give you a complete breakdown. But many of these are not specific to the DHR, and they are experienced by any organisation that is dealing with IT systems.

MS CLAY: It sounds like most of the things you have mentioned are outside your

control. What confidence do you have that DHR, and any other digital system or digital project that you are managing, will be delivered on budget, given that these budget blowouts are quite large, and they seem to be outside your control?

Ms Cross: We have a much more sophisticated way of managing and projecting the costs of all these systems now. Every time we renew a contract, if the renewal is more than the 2.5 per cent indexation, we advise Treasury. We will often be able to absorb that by finding efficiencies in other areas. We do keep Treasury closely informed, because this is a structural budget issue, and you have it in any area that is running IT.

We have far more sophisticated ways of projecting forward what the likely increases are. We have far more sophisticated ways of managing those system costs, looking at what we can reduce, looking at what we can turn off. That is an ongoing process of work that is led by Mr Kaufmann. This year, having carefully managed the budget, we are slightly underspent, but with a number of cost pressures which we will use that underspend to cover.

The other point I would make is that this was the biggest ICT project the territory had ever undertaken. It was delivered during COVID. The same team that was delivering the DHR was also often offline setting up vaccination centres, vaccination hotlines, testing stations and the quarantine arrangements. They set up the Check In CBR app. This same team, while they were delivering the biggest ICT project, were also doing a lot to save lives in the ACT community. What we have learnt is that, when you are under that much pressure, sometimes some of the processes fall down, in terms of projecting forward and managing that budget.

MS CLAY: I am new to health. I have run ICT projects before, and typically businesses do not create or procure custom built systems unless they need to. Typically what people do is they buy an off-the-shelf product because it is tested, it is cheaper and it comes with support. I have had a number of people, who are in health, suggest other systems—New South Wales have digital health records. Before this project began, did you consider purchasing somebody else's and using an existing—

Ms Cross: So the—

Ms Stephen-Smith: Can I? Sorry.

Ms Cross: I think we all want to answer that question!

Ms Stephen-Smith: You go, Rebecca.

Ms Cross: I was just going to say the system that we have chosen, Epic, which is the heart of the digital health record, is a product that is used in a number of other hospital systems around the world. It was already in use in Victoria in Parkville, and currently the New South Wales government is now looking to introduce it for their health system. So it was a product that was off-the-shelf, well tested, and then just brought in and set up to support the ACT health system.

Ms Stephen-Smith: It is fair to say, in the context of Epic, that we implemented more of the elements of Epic in the ACT than they had in Parkville. So there has been some

new to Australia implementation of Epic in the ACT, but not new to the world. The Epic team was absolutely integral to the delivery of the project, as were the clinicians. As Ms Cross said, we are looking forward to New South Wales implementing Epic across their system as well.

MS CLAY: Have we got any examples in government right now of projects greater than $10 million that were managed on time and on budget—ICT projects? At the moment, have we got any that we did manage really well?

Ms Stephen-Smith: In health?

MS CLAY: ACT government probably, or in health. I do not know. Are there any examples where we are doing it well?

Ms Stephen-Smith: I do not think in this particular hearing we are in a position to comment across government. I have already appeared in my role as the Minister for the Public Service, but the Digital Data—

Mr Kaufmann: DDTS.

Ms Stephen-Smith: DDTS, and the ACT Chief Information Officer, Bettina Konti, could answer if you want to put some questions on notice about that. But Rebecca wants to answer a question on the health side.

Ms Cross: I will pass to Holger, but, as I said, we have over 100 systems, and the vast bulk of them would have been delivered within budget. The one I am currently aware of is the IT system that we are developing for the voluntary assisted dying scheme, which we are actually anticipating will come in under budget. So that does happen if we carefully manage IT projects. I will ask Mr Kaufmann if there are any other examples he would like to add?

Mr Kaufmann: I acknowledge that I have read and understood the privilege statement and agree to it. I wanted to make a clarifying point about the HR project. I think it is really important to recognise that the project phase is finished. We have implemented the system successfully, clinically safe, within the timeframes that were planned and roughly within the budget as well. The cost pressures that we are seeing arising are operational costs of this system, for maintaining it, together with about 130 other systems that we maintain in the system. There are mainly three reasons for that. One is to do with assumptions that we had in the business case, back in 2018. There were probably some optimistic assumptions about cost savings that we were not able to realise. The second thing is that the system that we are supporting is significantly larger than the baseline that was in the business case. So just looking at the NWAUs, they grew about 25 per cent in that timeframe—

Ms Stephen-Smith: That is National Weighted Activity Units, the measure of activity in the hospital.

Mr Kaufmann: Sorry, yes. With activities, for instance, our licensing costs, IT licensing—higher activity means higher licensing costs; it means more beds, more users and more facilities that we are supporting. So the baseline has changed. As we discussed

earlier today, activities have gone up overall in the health system, which creates cost pressures, and that includes costs pressures in ICT. That is the second really important factor to keep in mind. The third one is we had a pandemic and the pandemic has created, especially in ICT, a significant inflationary pressure on all of our services and service costs. We could not get labour from overseas and our supply chains were disrupted. For instance, last year, we saw a 15 per cent price increase on Microsoft licenses for the new enterprise agreement. So those cost pressures have also affected the price of services that we provide. These are the cost pressures that we are talking about when we are talking about the DHR overspend. It is not the delivery of the project by itself.

THE CHAIR: I have spoken with a midwife who has a concern about the DHR and that she does not have internet access when she goes to someone's home, which obviously midwives do a lot, is there a—I am not saying that you need to fill the black spots in the ACT, although that would be great and I am sure it is in a different portfolio—but is there a plan to address that gap, given we have just heard that the project is complete?

Ms Stephen-Smith: I would be happy to take that up if you want to provide some further information to me or to my office, about the specific circumstances of that. More broadly, I know that the transition to the digital health record was a challenging one for many of the midwives, who had not operated on an electronic medical record system previously, but I think there are some potential real benefits in relation to being able to remotely access the system. If there are concerns about that accessibility, we are happy to—it is probably not appropriate to take it on notice, but if you want to let my office know the details, I am happy to follow it up.

THE CHAIR: Yes, she reported on a bad day she could spend 30 per cent of her time transcribing notes into the DHR, and that many of the senior midwives left as a consequence of its introduction. Is that something that people reported directly to CHS?

Mr Peffer: That is not my understanding. The problem of connectivity with a business system like this is not limited just to our midwives. We have a lot of teams that operate out in the community, with more than 1,000 team members that are not based on our hospital campuses. Many of them deliver care in people's homes. It has been a challenge, but it is not a challenge that did not exist previously. So previously we still had issues with connectivity with business systems with people out in people's homes. We had situations where different community teams would be doing exactly the same, they would be handwriting notes to come back to transcribe them into a business system. I think it has certainly improved productivity, but we acknowledge that it is an ongoing challenge for us in terms of connectivity across the city.

THE CHAIR: The other concern she raised was that their training on the system had been undertaken before the system was ready. So she reported that it was a hypothetical "When the system is ready it will look like this," and then they did, I think, one or two full days of training. Is that the case, and is that common practice?

Mr Peffer: So that is the case. That is how the training was structured. However, since that time we have been engaging with Epic, where we have had teams fly out from health services around the globe. As the minister mentioned, Epic is not just in place in

our hospital system, it is right around the globe. More than 400 health services, many much, much larger than ours, use this system. So we have teams that come in and then experience the system at the elbow with each of our teams; different specialties, departments, clinics, services and wards. They talk to the teams about what they are struggling with, and ask "What is creating the headaches?" They look at the typical experience for a midwife, or a nurse, or a doctor; how many clicks is it taking you—this is a sort of measure of productivity—how many clicks does it take you to get something done that you want to get done. That provided a range of either on the spot, or post that engagement, options, many of which they built in a reasonably quick time to be able to speed up people's experience and resolve some of those issues. Holger, did you want to mention anything further on that train?

Mr Kaufmann: Yes, I just wanted to add on the connectivity issues. We are aware of connectivity issues for many of our community nurses and midwives. We are currently looking at a device refresh, moving some of the devices from 4G to 5G, and we are hoping to provide better connectivity for nurses in the community, going forward. On the training, we train about 2,000 staff a year on Epic. During the actual roll out, so before the system went live, there was no other option than to train people on the system, which was still in train; but now we have training environments that are very, very close to the actual environment.

THE CHAIR: The other struggle I heard from another midwife was that there was a system for logging concerns with the glitches and bugs, and that sort of thing, but it had become so backlogged that they just wiped all of the logged jobs and started afresh. I found that pretty remarkable to hear. I do not think she has a reason to lie to me, though. So, did that happen?

Mr Kaufmann: Yes, we did a refresh of our ticketing system. That was a review that we did together with CHS. The reason why we did that is because during the go-live phase, and shortly after, we got a large number of requests, which over the course of time were addressed by other changes we made. So we did a bit of a clean-up. We did make sure that as part of the clean-up we did not delete anything that was an imminent and urgent requirement. Together with CHS we introduced a new prioritisation process to raise issues, non-standard issues I should say, which could then be prioritised by the CHS executive leadership in the way it is most important that they be addressed for the system.

THE CHAIR: I see why you would take that approach. But my concern would be, on the other end of that, you have staff who are overworked, they are already struggling to manage a new system and then they are just going to throw their hands up in the air and say, "Well even our concerns are not being—well they are being wiped."

MS CASTLEY: I am worried that DHR has been in for a while—I have heard this midwife story from a number of people as well—and you said that there is about to be a refresh or something—an upgrade, to fix their concerns. Is it appropriate that they have had to wait this long when they are out in the field? How do you prioritise that? I think you said that the executive has looked at the complaints that were lodged and then wiped, and then you prioritised what you thought needed to happen. Did any consultation occur with frontline people about their need?

Mr Kaufmann: Yes, interaction with frontline people happens all the time. We do not just have the ticketing system; we have field support and we have the Chief Nursing and Midwifery Information Officer and other staff that constantly interact with our clinical staff to analyse and try to understand their needs and prioritise the work that we do to address that need. I should probably point out that in a resource and funding constrained environment we have to make priority calls, which we are trying to make in alignment with the strategic and tactical needs of the health system and our hospitals. That is how we prioritise our work.

MS CASTLEY: But you yourself have said that there were assumptions in the business case; that it was larger than the baseline in the business case. These were the reasons for the extra cost, and obviously licenses. I understand that. But surely this is—it is called scope creep—so who was looking at the business case and managing the project in order to say, "No hang on, that is not what we have paid for." Then to the licensing; I understand, yes, licenses cost more with more staff. Was there no planning or understanding from the project's perspective of, in a year we will have this many staff? In a year we are going to roll this bit out and it is going to go to this many staff. Was there no understanding or calculation of that?

Ms Cross: I think there were some fairly sensible assumptions made at the time the business case was put forward, based on the activity at that time and the historical growth in activity. They did not know there was a pandemic coming, so some of the cost increases were unexpected. And since that time, we have seen rapid escalation in activity at the Canberra Health Services, which we have been talking about earlier today. So the assumptions in the business case, when they were made, I think the assumptions on growth and activity were entirely reasonable. As Mr Kaufmann said, there were some optimistic assumptions about how many savings we would make once the new systems were in place because we were replacing 40 systems with one new one. So we assumed that there would be fewer staff needed to manage it, and we also assumed that we could turn off a number of the legacy systems. As it has turned out, we have not been able to turn all of them off yet. We have been gradually turning them off, there are four left—

MS CASTLEY: Do you know how many? Four.

Ms Cross: There are four left, I think, and we are in the process. For some of them, to turn them off it would be a huge cost to transfer all of the data into the digital health record.

MS CASTLEY: Was that not advised during the business case on the pre-project that—

Ms Cross: Some of this—

MS CASTLEY: Data storage is one of the hugest costs.

Ms Cross: Yes, yes, but what we have actually found is that it will be cheaper to pay a very small amount of money to have the records available in the old system. So some of those assumptions—they were the best assumptions at the time in advance of introducing a system which we have never used before. The ones which were possibly optimistic where that we would have significant staff savings because we were getting

rid of 40 systems and replacing it with one, and that we would be able to turn all of the systems off immediately, which did not happen, but at the time they were quite sensible assumptions. It is just as we knew more about Epic and as we got further through the project, we learnt more, and also the pandemic was completely unforeseen and that has had an impact on a number of the costs.

Ms Stephen-Smith: Can I just interrupt, Chair? I am not sure if this has already been provided for you but I will table the email and attachments that I was referring to earlier.

THE CHAIR: Thank you, Minister.

MR RATTENBURY: On page 28 of the CHS annual report, strategic indicator 6.1 measures the proportion of patients presenting to emergency department or walk-in centres who have a primary healthcare provider recorded. The target is 100 per cent. In 2023-24 we had 90 per cent of patients recorded with a primary care provider, which is down from 99 per cent in 2021-22. I could not find a figure recorded for 2022-23. Can you outline your understanding of why that figure has declined and what impact it has, because people are unlikely to be able to continue their healthcare recovery if they do not have a primary healthcare provider.

Ms Stephen-Smith: I will hand over to Mr Peffer.

Mr Peffer: So Mr Rattenbury, my expectation is that we have not seen a sudden drop off in the number of patients who have a general practitioner or primary carer. The difference we are seeing here relates to our ability to extract that specific indicator in a neat fashion from the digital health record. That has been part of one of the build improvement processes we have commissioned in that system, as we have gone through a couple of years of refining it and building the reporting capability, so I expect we will see a significant increase in that number in the years ahead.

MR RATTENBURY: Minister, in the Assembly in the last sitting week, when you were asked about bulk-billing rates you made reference to ACT Labor's election commitment to improve bulk billing in the ACT. My reading of that is that this funding focuses on an $11 million infrastructure investment. Can you explain to me—and if I misunderstand it, this is why I am asking you the question—how is this investment actually proposing to increase bulk-billing rates?

Ms Stephen-Smith: Well, it is not solely infrastructure, but you might be aware, Mr Rattenbury, that previously the ACT government has partnered with providers to invest in infrastructure like the opening of the Interchange Health Co-op in Tuggeranong. That was an infrastructure investment that significantly increased the availability of bulk billing in Tuggeranong through the Interchange Health Co-op. So infrastructure investment co-funding capital can make a difference, and in that partnership we require a commitment to a level of bulk billing.

What we said in relation to this $11 million fund is that we will work with Capital Health Network and general practice providers to co-design that, so there will likely be an element of infrastructure or capital funding, but we may also be looking to invest in other things that result in an increase in bulk billing. An example of something that Capital Health Network has done is partner with practices to fund social workers in

primary care. So we might say well, we will fund you to have a social worker in primary care and the quid pro quo is that you will commit to bulk billing a certain cohort of people. We obviously have a focus on children in our election commitment and alignment with the Albanese Labor government's tripling of the bulk billing incentive to back that in. You would also be aware that there are limits on how you can co-fund to support bulk billing. You cannot just say we are going to close the gap in funding on a per patient level. So you have to find other ways to support practices that themselves have a commitment to bulk billing, and even within that, that is hard because practices will tell you they cannot require the individual GPs to bulk bill, but it is clear that some practices have more of a commitment to bulk billing and seek to attract GPs that share that philosophy, while other practices do not. So there will be a range of initiatives but capital investment in the past has seen significant increases in the bulk bulling rate in the ACT.

MR RATTENBURY: I love a good co-design process as much as anybody, but given that process is still to come, how did you decide $11 million was the appropriate investment given there is not actually a plan behind it?

Ms Stephen-Smith: Well, like everyone in making election commitments, you balance the availability of funding that you think is going to be reasonable across the forward estimates with the kinds of investments that you think you might want to make and come up with a figure. Certainly in relation to both that $11 million and the $4 million investment in professional development and wellbeing across primary care, both of those were really thinking about what we think is reasonable for the ACT government to invest, in an area that is not an ACT government responsibility but is really important to our community, in the context of all of the other investments that we also have to make.

MR RATTENBURY: In the context of the pressures on bulk billing, and then the pressures on the hospital system, have either the Director or the Canberra Health Services done any modelling to understand that this will in fact provide more community-based healthcare to, I guess, stem the flow of people then needing to come to the emergency department because they are unable to access primary healthcare. Do you have any cost benefit analysis or modelling of the better way to spend our health budget?

Ms Cross: So I think as a general point we always look at prevention and early intervention as being the nirvana of healthcare and so where we can, providing care in the community, closer to home, earlier on, for people is obviously what we are aiming for. I think we have seen in the ACT a steady reduction in presentations at emergency departments of people who could have seen GPs. I am happy for Mr Peffer to talk about the walk-in centre program and the expansion to urgent care centres and how that has actually contributed to more people being seen outside of the emergency department and outside of the hospital.

We have not done a specific cost benefit analysis, but I could find multiple ones on early intervention that show that for every dollar you spend on early intervention and prevention, you save money in the long run. I think you would see, particularly in the mental health area, there has been substantial increases in funding to community-based organisations, Step Up Step Down, and a whole range of things like that, which has

actually, as I understand it, eased pressure on mental health beds in the hospital system, but Mr Peffer may want to say more about the walk-in centres or any of those things.

Mr Peffer: So our walk-in centres is an area where we have seen significant—

MR RATTENBURY: Yes. Actually, I think we all understand the walk-in centre model, so I was unsure whether to interrupt or not.

Minister, in the last sitting period, both you and Mr Barr claimed that the freezing of Medicare rebates was initiated by the federal coalition government which has subsequently led to the crisis we are now seeing in the availability of bulk bill GP access in Canberra. However, the Medicare rebate freeze was initiated by the Gillard Labor government in May 2013. Is that your understanding as well?

Ms Stephen-Smith: That decision by the Gillard Labor government in 2013 was specifically about realigning timing. So there was a decision to defer the increase to the second half of the year to align with timing of—and I do not have the detail in front of me, but it was a specific six month delay. Then there was a change of government and that freeze was in place for six years. So the decision to maintain a freeze for six years was clearly a decision of the coalition Liberal National government. The decision that was made by the Gillard government was a realignment in timing that they effectively paused an increase for six months.

MR RATTENBURY: No, it was actually an eight month—it was indexed from—

Ms Stephen-Smith: Eight—well, whatever, you know the time realignment was less than a year.

THE CHAIR: At the risk of this becoming question time, do you have any questions—

MR HANSON: Who started the freeze, Minister?

MR RATTENBURY: Just to be clear, though, the alignment was from 1 November to 1 July, and it identified a saving of $664 million over four years.

Ms Stephen-Smith: Okay, yes, but it was from 1 November to 1 July, and it was going to end on 1 July, but when the Liberal National government was elected, they froze for six years. So the freeze under the Liberal National government is clearly a freeze under the Liberal National government, that was not intended to be in place under the previous government.

MS CLAY: Budgeted for four years?

MR RATTENBURY: Yes; it was budgeted for four years.

Ms Stephen-Smith: Mr Rattenbury, that delayed increase of eight months would have compounded in future years and resulted in savings over 50 years. That is how compounding indexation works.

THE CHAIR: Ms Clay?

MS CASTLEY: And they would not have gone ahead with that, of course.

MS CLAY: Mr Peffer, I may have—

Ms Stephen-Smith: That is not what was in the budget.

THE CHAIR: Ms Clay.

MS CLAY: I have the talking stick. Mr Peffer, I may have misunderstood your first answer so I just want to check that I understand. Going to the original question, back in 2021-22, 99 per cent of people who showed up at a walk-in centre or ER had a health provider, had a GP, and, in 2023-24, the record shows that only 90 per cent of people had a GP. I think you indicated that was something to do with DHR.

Mr Peffer: My apologies. Sorry, I have looked at the wrong table. I have answered that question incorrectly. I thought we were talking about goals of care.

MS CLAY: No. We do not have records for the year between. We could not find them in the annual report. In 2021-22, 90 per cent of people who showed up at the ER or a walk-in centre had a primary healthcare practitioner; they had a GP. In 2023-24 only 90 per cent of the people showing up at a walk-in centre or ER had a GP. This is going in the wrong direction and interesting. Do you have anything to tell us about why that has dropped so significantly?

Mr Peffer: No, other than to say we capture the data at the point that someone presents it. It is one of the questions that our teams ask about a person's primary care provider. If that number is trending down, that is not something that we can control, other than to capture that as part of someone's healthcare journey.

MS CLAY: So the only thing we have learned from this is that presentations at ER and walk-in centres are increasing and costing a lot, and fewer people have access to a GP. This is probably the only conclusion we can draw.

Ms Stephen-Smith: Ms Clay, we are in furious agreement that access to GPs in the community and access to bulk-billing is a problem and it is creating pressure on our tertiary system. I am not sure that you could take this indicator as proof positive for that proposition, because the fact that people cannot name a GP does not mean they do not have a practice. They may have simply made a choice not to record who their GP is. There might be reasons people do not do that. More people are probably attending practices or going to multiple GPs to try to find somewhere where they can get a bulk-billed appointment and are not necessarily accessing the continuity of care in primary care that we all would hope they would be accessing. I understand the point you are making. We all can agree that access to general practice and bulk-billing is really problematic in our community. This may be an indicator that that is the case, but I think that taking it as a definitive would be a stretch.

MS CLAY: Perhaps on notice you might provide what Canberra Health Services did or what you did when you saw those two figures. What action did you take to find out what was going on? I am happy for that to be on notice, because we have had a long—

Ms Stephen-Smith: I certainly did not take any action when I saw that figure. As Mr Peffer said, that is a self-reported thing that is collected on presentation. I am already aware that people do not have sufficient access to general practice in our community, and we are taking action constantly to seek to address that issue. This is not an indicator that I would use that would result in further action on top of what we are already doing to address a known issue.

THE CHAIR: Perhaps you could take on notice the 2022-23 figure that is not in the annual report. I think we had 2021-22, and we want 2023-24.

Ms Stephen-Smith: That is probably something that was unable to be reported as a result of the implementation of the Digital Health Record in November 2022. There would have been a break in the capacity to collect that data.

THE CHAIR: Would you mind confirming that on notice?

Ms Stephen-Smith: That is fine. We will take that on notice.

THE CHAIR: Thank you.

MS CASTLEY: Minister, following answers from earlier, I want to ask you about the application of the caretaker conventions. Section 3(f) of the 2024 convention states:

> Directorates and agencies should generally not be asked to provide policy advice during the caretaker period. There might, however, be circumstances where urgent issues arise that clearly require advice to be given to ministers in order to allow responsible agency administration or to enable the government to protect the public interest.
>
> To avoid controversy and claimed breaches of the apolitical and impartial nature of the ACTPS, it may be appropriate to also brief the opposition and crossbench or to decline a request for assistance if it requires the use of significant resources. If in doubt, advice should be sought from relevant officials within the directorates.

Minister, did your office seek this information or was it provided on the initiative of an official?

Ms Stephen-Smith: I certainly did not seek the information; it was provided on the initiative of an official.

MS CASTLEY: Do you accept that the circumstances around this money was an urgent issue that clearly required advice to be given to you?

Ms Stephen-Smith: You are talking about a part of the caretaker conventions that relate to seeking advice. We did not seek advice.

MS CASTLEY: Do you accept that the circumstance was actually an urgent issue that clearly required advice to be given to you?

Ms Stephen-Smith: We did not seek advice.

MS CASTLEY: You just had a quick phone call—

MR HANSON: You provided it.

Ms Stephen-Smith: We did not seek advice.

MR HANSON: You provided it.

Ms Stephen-Smith: We did not seek that advice and so that—

MR HANSON: It does not matter.

Ms Stephen-Smith: That part of the caretaker convention is irrelevant because—

MS CASTLEY: No; it is not. It was an urgent issue.

Ms Stephen-Smith: No. The provision of advice was in relation to an urgent issue. We never sought the advice.

MR HANSON: Yes, but you provided it because it was an urgent issue.

Ms Stephen-Smith: It was some factual information that was provided to my office, and Mr Peffer can speak to that.

MR HANSON: It does not matter whether you asked for it or not, Minister.

Ms Stephen-Smith: Well, it does. That is exactly where that provision of the—

THE CHAIR: A supplementary, Ms Barry.

MS BARRY: I guess the question is whether the advice you were providing to the minister was to be provided to the opposition as well. Did you seek that advice?

Mr Peffer: I did not seek that advice.

MS CASTLEY: Why not? It is clearly an urgent issue. It clearly required advice.

Ms Stephen-Smith: I am not sure that is true, but go on.

Ms Cross: Perhaps I can make just a general observation. It is not unusual for us to provide factual information to a minister during the course of the caretaker convention period. As long as it is flat factual information, that is not unusual. Advice is something different. Advice is when, on top of flat factual information, you then offer an opinion or advice on what might be done. Very early in the year, because of the way health activity data works and because of the lag in getting accurate data, as the minister said earlier, we did not have a full quarter of data. For me in the directorate, if you provide some flat factual information, I do not think we were at the point of providing advice on it. It was more just an update on what the numbers were showing. When we then cleanse the data and when we look at it against the trends in previous years—when we

do all that—that is advice. That is different. It is not unusual to provide flat factual information, and, in fact, that is something we would be expected to do because the minister is still the minister.

Ms Stephen-Smith: Could I just clarify, Ms Castley: were you referring to part 3(f) of the caretaker guidance?

MS CASTLEY: Yes; I believe so.

Ms Stephen-Smith: The heading of that, for Mr Hanson's information, is: "Requests by Ministers of directorates and agencies". Then it says:

> Ministers may seek factual information and information relating to day-to-day business of government from senior executive officials during the caretaker period.

If I had sought that factual information in relation to the day-to-day business of government, that would have been perfectly legitimate. I did not seek that information and my office did not seek that information, but, if we had, that would have been a perfectly legitimate thing to do as the caretaker minister.

MS CASTLEY: But, if I understood Ms Cross correctly, she said it was factual information that you provided the minister's office.

Ms Cross: I was talking in general. This is the information provided by Mr Peffer. I was just saying it is not unusual to provide flat factual information to an office during the caretaker period.

MS CASTLEY: But there was no discussion, Minister, with yourself or others in your office about whether to inform other members of government, given that this was an urgent issue?

Ms Stephen-Smith: No. As I said, Ms Castley, my chief of staff and one of my other advisers received the information, and the email has been tabled. That information was not solicited by me or requested by me or my office, and, when it was received, it was noted. My chief of staff advised me verbally of the receipt of the information. It was just over two weeks to the election, and our response was: "Cool. There is nothing we can do with this information now. We will get back to the campaign."

MS CASTLEY: Except transparency for the community.

Ms Stephen-Smith: Ms Castley, I have already said many times publicly that it was clear, through the 2024-25 budget process, and with the opening of the Critical Services Building, that Canberra Health Services was busy. We responded to the significant increase in activity that we had witnessed in 2023-24, through the 2024-25 budget. You had lots of opportunity to ask, in the 2024-25 budget estimates period, what our projections were. To the best of my recollection, you asked no questions in relation to this type of matter or activity.

MS CASTLEY: But this took you by surprise. You would not have known.

THE CHAIR: We are going to move on. I do not think it is—

Ms Stephen-Smith: This information was, as you will see from the email that has been tabled, very early preliminary information on which no action could possibly have been taken at that time.

THE CHAIR: Ms Carrick, a new substantive.

MS CARRICK: Thank you. My line of questioning is around Burrangiri. I understand from a previous conversation that we have 69 people in hospital with ACAT assessments waiting for residential aged-care beds. Is that right?

Ms Stephen-Smith: Yes.

MS CARRICK: Moving to the respite side of aged care, because a lot of the respite beds are in aged care, how many respite aged-care beds do we have in Canberra?

Ms Stephen-Smith: That is probably not a question that we can answer, because it is a commonwealth responsibility, but Ms Cross might have some more information.

Ms Cross: Yes. Generally, respite places are made available in residential aged-care facilities on a short-term basis. I understand that, in the ACT, there is not a huge supply of them. We have Leo's Place, which provides respite as well.

Ms Stephen-Smith: For palliative care.

Ms Cross: For palliative care. But most of the places in respite are provided by the commonwealth through the residential aged-care facilities, and they would track availability and numbers. We have the additional facility at Burrangiri, which is still open but will be closing on 30 June.

MS CARRICK: How much does the ACT government pay the Salvation Army to operate Burrangiri?

Ms Cross: I will ask Chloe to come to the table. It is around $1.1 or $1.2 million.

Ms Stephen-Smith: It was $1.72 million in 2024-25, according to the advice that I have. That does not include GST or indexation.

Ms Cross: There you go. That is the correct answer, then.

MS CARRICK: Thank you. How much does the ACT government pay for Burrangiri as a whole, in addition to Salvation Army operating costs?

Ms Stephen-Smith: The service funding would be what we fund the Salvation Army, and then there would be any maintenance costs for the facility itself.

MS CARRICK: Exactly. You own the land and the building, so there are, presumably, costs in addition to the Salvation Army operating costs.

Ms Loft: Good morning. I acknowledge that I have read and understood the privilege statement. Thanks for the question. Over the past three years in annual reactive maintenance, on average we have spent $99,000 a year on maintenance, and, in addition, we have another $37,000 scheduled for this year.

MS CARRICK: Primarily, what activities would they be? It looks to be in good nick. It looks like the painting has been done recently.

Ms Loft: It is basic maintenance to keep the condition, which is different to a functional requirement for the service. We have an asset management plan and all maintenance is scheduled according to risk. We have replaced vinyl floors and have done the painting and roof replacement—basic maintenance to keep the building safe.

MS CARRICK: What are the deficiencies in the Burrangiri building with respect to the provision of respite care?

Ms Loft: While it is currently safe, we do not believe that the building is meeting the current standards for respite care. Some of that is centred around the number of toilets and showers. They are insufficient for the number of residents. The building cannot be refurbished cost-effectively because of the structure. It was built in 1989. For example, it has solid concrete walls. That makes it really difficult to retrofit for the higher levels for disability that we are seeing today—for bariatric in particular, to retrofit hoists and widen doorways. These are some of the issues. The room sizes are below current standards, so that makes it really complicated for manual handling of clients.

MS CARRICK: How many respite beds in the ACT do not have their own ensuite?

Ms Cross: Again, because most of them are in aged-care facilities, we would need to check that with the commonwealth. I think most new aged-care facilities are built with ensuites, but some of the older ones occasionally have shared bathrooms. We would have to check with the commonwealth. Certainly, if we were creating a new respite centre, we would not be looking at one bathroom between six bedrooms. That is a quite old ratio.

MS CARRICK: It was reported that there were two, but there are actually four bathrooms between 15 rooms.

Ms Cross: That is correct.

MS CARRICK: There was a review into the building to make this decision. Are you able to provide the review?

Ms Loft: Yes. There were several reviews. The building was built, as I said, in 1989, and that was a result of a review undertaken by the federal government in 1986 into rehabilitation and geriatric services of the ACT. Then, in 2020, the infrastructure division contracted SAFM Solutions to undertake a review of the then 2017 asset management plans, and that was to look at updating the plans and the asset priority index ratings for all health infrastructure, with the view to then updating building asset management plans. We commenced consultation in 2020 for that review, with the

output to produce an updated building and asset management plan, and also to assess the functionality assessment, but that was placed on hold due to COVID. Legislative changes meant that we could not access aged care, so we could not conduct a technical condition assessment because there was no access to the building. By 2023, the asset management plan was updated. We can give you a copy of that, if that is what you would like. That outlines maintenance requirements for the short and long term of the building.

MS CARRICK: That would be good. Thank you. It is a very popular service. We have had a lot of representations about its closure. People in the community are quite upset about the fact that it is going to close, because it is not easy to access respite beds. What is the concern about closing these 15 beds? Presumably, it will make a significant impact in the ability for people to access respite care, given we do not even know how many beds we have in the ACT. On what basis is the decision made when we do not know how many beds we have and what the impact of this will be to the community?

Ms Stephen-Smith: Primarily, the decision was made on the basis of the advice I received about the facility itself. As Ms Loft has said, it is not just about refurbishing; it is about significant renovation of the facility to make it fit for purpose. Primarily, the timing of the decision and the driver for the decision was about the facility itself and the need to substantially renovate the facility to make it fit for purpose for future use, and that was starting to become urgent. Having met with the Salvation Army provider, they understand those issues around the facility. The decision to close the facility is related to that infrastructure need. Then the decision will be: do we try to somehow replace that service somewhere else? The decision that I have taken is for the Health Directorate not to try to establish a separate ad hoc service, having given consideration to some of the issues around the availability of services, but also consideration of the fact that Canberra Health Services already runs the Transition Care Program and Short-Term Restorative Care, which supports people to step down out of hospital and partners with residential aged care to provide short-term placements for people who are transitioning home. We also fund the CAPS program, which supports in-home care for people who are transitioning out of hospital.

Given the existing programs that were in place, the decision was not to establish another separate ad hoc program and arrangement around respite care funded by the ACT government when aged-care respite care is absolutely a commonwealth responsibility. To be absolutely clear: the timing decision around this was driven by the infrastructure recommendation that the directorate made to me that we needed to close this facility in order to refurbish it for future use of some kind. Coincident with that, the Salvation Army's current service contract was coming to an end, and in fact has been extended to deliver the service up to the end of June 2025.

Ms Cross: The only other two things I would add are that, firstly, we are aware of a number of new aged-care providers coming to the ACT, so we expect there will be an increase in aged-care places and therefore respite places in those facilities; and, secondly, we fund Carers ACT to support people to find those places, so there is a service out there that people will be able to access to have support in finding places. I know the Salvation Army itself will be looking at what they can do within their existing facilities as well.

MS CARRICK: I think Carers ACT have a four- or six-month waitlist to try to get into respite care. Sometimes you just cannot wait for that long. Given that not one person has complained about the building, they like the service, and there is not one person that we have come across that is unhappy about the building, can we keep the building open until we are sure that people have access to respite? This is about people, not a building. The people should come first, and they should have access to this service until we know that there is some alternative in place that people can access.

Ms Stephen-Smith: I will take that as a comment from you, Ms Carrick. I have explained why I have taken the decision that I have. I have no intention of changing that decision. It was not an easy decision and I understand that people will be upset about it. I also understand that much of the feedback that has been received from people about the service is from people who have previously used the service.

We will continue to monitor the situation, but, as I said, I received pretty clear advice from the Health Directorate about the condition of the building and the need to address that, as well as the fact that the current service contract was coming to an end. This was a decision point where, if a decision was made to continue the service, to be in line with our procurement rules, we would potentially have to go to market for that service, because the current service agreement with the Salvation Army had an expiry date, and we have procurement rules around this.

There were a number of things that came together in relation to the timing, but, from my perspective, it is not an easy decision, but a decision has been made.

THE CHAIR: Mr Rattenbury, do you have a supplementary?

MR RATTENBURY: No. I think Ms Carrick has covered everything. If I am correct, the conclusion is that, because the building does not meet current standards, you are going to close it, but there is no alternative service in place.

Ms Stephen-Smith: As Ms Cross said, we are seeing additional investment coming into aged care with the aged-care reforms having been made, and there is a new facility currently being built in—I do not know whether it is actually in Curtin. We are starting to see some of that coming online. We have also committed to working with Carers ACT to support them to establish a respite facility and service, which they are absolutely confident could be funded from other funding sources that would not require ongoing ACT government funding to run, recognising that aged care is not an area of ACT government responsibility.

Given all of the budget challenges that we have been discussing in the first part of this hearing, I have said we have to take some difficult decisions. This is one of those difficult decisions.

MS CARRICK: This is a casualty of the budget blowout?

Ms Stephen-Smith: No. The timing, Ms Carrick, is in relation to the building and the service funding contract coming to an end. The decision then was: do we try to find an alternative way of trying to deliver this service? My decision is that, no, we are not going to do that at this point. That is partly related to the budget pressures that we face,

and the difficult decisions we have to make in every single budget.

MS CLAY: I have had constituents whose family members have been in hospital for 31-day stays whilst waiting for nursing care or respite care. I wonder whether you have—and you can take it on notice—done any thinking about what happens to our ACT-funded hospital system when these in-community services are not available. You are welcome to take that on notice.

Ms Cross: The point I would like to make is that almost every one of those people in hospital are unable to be looked at in this respite facility because the facility does not meet the standards for things like bariatric care. We have very few, if any, people from Canberra Hospital able to go into Burrangiri because it is not meeting the standards. As has been suggested, it does not have wheelchair access, so—

THE CHAIR: Are you talking about the specific facility or across the system?

MS CLAY: You have misunderstood my question. I have had constituents who have had family members admitted into hospital and who stayed there for stays of 31 days because there is no nursing residential care facility available—respite care. They do not need the hospital care. That is the bed that they are put in because they do not have access to the respite care or the residential nursing care.

It is not about access to the facility; it is about not having these community respite and residential care facilities. Do you know what impact that is having on the hospital system? I am very happy for you to take that on notice.

Ms Cross: We do know there are a number of long-stay patients in the hospital—

MS CLAY: That is what I am getting to, yes.

Ms Cross: who are just waiting there, and we cannot put them in Burrangiri because Burrangiri does not meet the standards.

MS CARRICK: You cannot put them anywhere.

THE CHAIR: Do we have numbers for how many—

MS CLAY: Yes, could you take on notice how many patients you have who are long-stay patients in hospital at the moment? Can we get that on notice?

Ms Stephen-Smith: Mr Peffer talked about that earlier, and Ms Zagari can—

Ms Zagari: I might add to that, Ms Clay. The team have advised me during this session that only five per cent of hospital referrals to Burrangiri specifically are suitable for that facility. We spoke earlier about the number of 69 patients who have had an ACAT and are waiting for an aged-care facility placement.

MS CLAY: Sixty-nine?

Ms Zagari: Sixty-nine, yes.

Ms Stephen-Smith: One of the points that is sometimes made about Burrangiri is that you do not need an ACAT assessment to use the facility there, and that is true, but my understanding from the 2023-24 data is that only about one in five of the Burrangiri clients did not have an ACAT assessment. The vast majority did have an ACAT assessment and would have been eligible for commonwealth-funded respite care.

MS CARRICK: On notice, can you provide a breakdown of the upgrades that are needed for specific sorts of health issues? It might be that 90 per cent of health issues require a very small upgrade and 10 per cent require a lot. What upgrades are needed for specific sorts of health issues?

Ms Cross: We have pretty good information on what we need to keep the facility at an appropriate standard for health and safety. We have just engaged a design consultant to look at what further upgrades would be needed to get it to a point of general amenity for the sort of facility that you would want to run. We will certainly be able to give you a breakdown of the $900,000, which is just basic maintenance, and we will see what we can provide in terms of the other broader upgrades.

THE CHAIR: I have a question about recruitment. I have heard that 385 grad nurses have just been hired by CHS in one intake. Is that number accurate?

Mr Peffer: I think that is correct. I will ask Ms Lang to confirm that.

Ms Lang: What number did you—

THE CHAIR: 385 is the number of grad nurses that I have heard about.

Ms Stephen-Smith: The intake of grad nurses for this intake was just over 290, from my recollection. There is a further intake that will occur in the middle of the year.

THE CHAIR: Midyear; okay.

Ms Stephen-Smith: Yes. The full number has been provided for the—

THE CHAIR: Okay.

Ms Stephen-Smith: There may be a follow-up.

THE CHAIR: With the full number, there are potentially another 95 midyear. How does that compare with prior intakes?

Ms Lang: I have read and acknowledge the privilege statement. The intake this year is greater than in previous years. We have been increasing, over the last probably four years, gradually each year. That is based on the fact that we have a growing demand across the organisation as well.

THE CHAIR: What would it have been last year, even if it is a ballpark figure?

Ms Lang: It was approximately 200.

THE CHAIR: In total across the year; okay. Have you observed any anxiety in the workforce about the plan for training these nurses—trying to work within a safe scope of practice and maintaining a high standard of care? That is a huge intake of new grads at once. Is that a concern, and how is it being addressed if it is?

Ms Lang: We have a transition-to-practice program that we run at Canberra Hospital—also, North Canberra have a new graduate program—where we provide support to the new graduates for a 12-month program. During that time we provide various education supports through a team of staff running that program. At the same time we have clinical development nurses attached to each of the clinical spaces. They provide additional support. The new graduates are also aligned with a preceptor, who is like a buddy within the ward system. They have a period of time when they are supernumerary, when they are still learning, and that is probably about the first four to five days that they are in the clinical space.

THE CHAIR: With those teams that are training the new grads, because this is almost a doubling of the intake, has there been a doubling of the size of those teams, or is it a doubling of the responsibilities within the existing—

Ms Lang: It is probably because they are more spread out, so we have them on much greater shifts. We have some doing night duty; and they spread through the whole health system. It is providing additional placements across the organisation.

THE CHAIR: Was there an interview process? 385 interviews would be a lot of interviews.

Ms Lang: No, there was not. We did two different processes this year for the new graduates. One process was that we sent out letters to all of the third-year undergraduate students last year at UC and ACU—local universities—offering them a permanent position straight up; they did not have to apply. There was paperwork that they had to fill out, giving particular details. Provided they completed their program and were registered, they were given a position. We had about a 65 per cent uptake of that. At the same time, though, we did run a recruitment exercise externally to the ACT new graduates. They did undergo an interview process, which is generally providing a video.

THE CHAIR: I do not think you answered my question before about whether there is anxiety. This is flooding the system with a whole bunch of nurses that will need quite a lot of support to upskill, I assume. Is there any anxiety within the existing workforce about managing that, given the level of demand on the system?

Ms Lang: There probably was, to a certain degree, but I know that the directors of nursing at each of the organisations spent a lot of time with the managers, helping them and providing them with additional supports in relation to additional resources and things like that—teaching resources and things like that to help them.

THE CHAIR: I saw some media about this general recruitment earlier this week, I think.

Ms Lang: Yes.

THE CHAIR: Were nurses or other CHS staff given scripts, talking points or any media training ahead of that announcement?

Ms Lang: Not that I am aware of.

Mr Peffer: Mr Emerson, are you talking about anyone who provided comment on—

THE CHAIR: Yes.

Ms Stephen-Smith: In the press conference, we had a medical intern speak, an allied health professional, a nurse, and there was a midwife there as well. They spoke from their experience; that is my understanding.

THE CHAIR: Is it common practice, when doing that sort of thing, to provide media prep of any kind?

Mr Peffer: No. Generally, if we have clinicians of any kind—nursing, midwifery, medical and so forth—who offer commentary in the public domain, we do not provide scripts. It is usually on the basis of their experience and expertise.

THE CHAIR: Would you mind taking that on notice? I know you said that it was your understanding.

Ms Stephen-Smith: Yes.

THE CHAIR: Could you check and see whether that was the case in this instance?

Ms Stephen-Smith: Yes. We can take it on notice.

MS CASTLEY: Minister, given you have asked the taxpayer to fork out $227 million or $33 million—a figure we got to earlier—to pay for this blowout, how were these health workers funded from your health budget? Were they funded before you asked for the money or after?

Ms Stephen-Smith: Part of the health system is demand-driven. If you want to describe it as a "blowout", that is your lookout. I would describe it as just continuing to provide vital health services for Canberrans—and ACT Labor will always prioritise the delivery of public health services for Canberrans.

MS CASTLEY: Of course. I am just wondering in what part of the budget cycle you prepared for this—before or after?

Ms Stephen-Smith: We have seen a significant increase in demand for those health services, which we have committed to meeting through this budget review process. I will hand to Mr Peffer to talk about the—

MS CASTLEY: And when was the decision made?

Mr Peffer: In terms of what happens with the workforce, typically, from 1 January,

what we will see in the size of our workforce for nursing, leaving aside new graduates, is that people may start to retire, move interstate or they will pick up other roles. So you have this ever-growing need to refresh and replenish your workforce as people retire and finish up. With our graduates, we have two opportunities to try to map out and figure out how many nurses we will need to respond to the reduction in the workforce and the overall growth in the service responding to demand, as the minister has said. That is no different for any other workforce.

In years gone past, we have come up short. So we have gone out with offers to a set number of nurses that would fill the vacancies that were available, but the conversion rate would fall short. We would then need to make up the difference with more expensive agency, contracted arrangements, which was what we had been doing for some years. This time around, there are the partnerships that we have with the universities to actually ride out and get ahead of recruitment rounds that happen nationwide and say, "We will guarantee a permanent job." To be fair, these are nurses doing placements in our hospitals, and so they are known to us.

MS CASTLEY: I think it is great that we went direct and said, "Here is a job for you; we really want you." That is not the problem. I am just wondering when the decision was made. Was it before caretaker started on 13 September or was it after 6 November?

Mr Peffer: We can confirm this, but I think we wrote out in around May or June last year.

THE CHAIR: Those letters that you referred to?

Ms Stephen-Smith: Yes, we talked publicly about it, and—

Mr Peffer: Correct. It would have been in the first half of the year that the decision was made.

MS CASTLEY: And that was when the costings were worked out—how much it would cost and how many we actually needed?

Mr Peffer: Correct.

MS CASTLEY: Great. Thank you. I would like to talk about staff morale. I know there is often culture surveys. I am wondering where the most recent one is at with regard to Canberra Health staff—what they think about the workplace, how they are treated by superiors and all that sort of stuff. Where are we at with the most recent one?

Mr Peffer: We undertake a culture survey every two years. Then, in the year in between, we do a sort of short fire pulse survey, which does not have the depth of questioning and that sort of thing; it is really just to check in to see how people are going. The survey result landed in December last year. It showed our engagement rating dropped one per cent. The headline question about, "Does CHS provide a great place to work," remains static. So that is still at 60 per cent saying yes and 40 per cent saying no. For us, that still says we have got a lot of work to do. We would love that number to be a lot higher. That was the pulse survey. We released the results of that survey to all of our workforce. That is up on our intranet, so that they can access the results for

their division and see how they are trending.

MS CASTLEY: Would I be able to see that as well? Can I access the intranet?

Mr Peffer: I am not sure if you would have access to the intranet, but we could take it on notice and provide the survey results.

Ms Stephen-Smith: I am amazed you have not got it already, Ms Castley, but we will be happy to table it.

MS CASTLEY: Me, too. From the survey, staff morale is at 60 per cent. Are there any other concerns that you are taking action on now?

Mr Peffer: The example that people use is that culture is a little bit like your garden—you cannot sort of set and forget and hope that it will end up being a great garden; you have to continually work at it. What we observed from survey to survey is that some teams will improve in terms of their culture, some will remain static and some will take a step backwards. Those results go out to all of the managers and are shared with all of the teams. We make sure that they understand exactly how they are tracking and what has come back. Where there are actionable issues that are raised, the managers will look at that, talk to their teams and see what can be done. That will differ between every team. So I cannot say, "Here are the thousand things that we are doing."

MS CASTLEY: So there is nothing glaringly obvious that you are concerned about? I know I will get the results, but I am just wondering if there is one? When I get the results, is there something that you are particularly concerned about that has gotten worse?

Ms Stephen-Smith: One of the things that Canberra Health Services and I are concerned about—and I do not think this was in the pulse; this was in the previous survey—was in relation to the confidence and trust in the senior exec. There have been some changes in the structure and the work of executives to respond to that and ensure that people are closer to the front line. You might want to just touch on that.

Mr Peffer: That has certainly been an expectation change in terms of having executive coverage across our facilities seven days a week. We have executives on site at hospitals. We know that our workforce is a 24/7 workforce, and so our expectation around how the leadership team functions—where we are, the visibility and the access to us—has changed as well. The team is notably smaller than it was, say, two years ago, in the number of SES contracts that we have in place. The concern that was expressed by the workforce of any disconnect between the executive remains a focus for us, and we work very hard to close that.

Ms Castley, in terms of picking up on other things, there are a few things that are always cause for concern. These are headed in the right direction, but they remain a focus for us: occupational violence, discrimination, racism and bullying and harassment. Those indicators have been trending in the right direction now for a number of years, but they are still too high that we would accept that we have resolved those issues.

THE CHAIR: Ms Tough?

Mr Peffer: I am sorry, but could I just respond to the question before about whether the spokespeople were provided a script? They were not. They were not coached in any way. All they had seen was a copy of the media release, which was put out associated with the announcement.

THE CHAIR: Thank you.

MS TOUGH: I have picked my shortest question in the interest of time. Minister, I saw this morning that a lead contractor has been procured for the South Tuggeranong Health Centre that is going to be built in Conder. Could you provide an update on where the project is up to and what the next steps are from here?

Ms Stephen-Smith: The project has received conditional DA approval—and Ms Loft can speak to what that means. It is exciting to see it taking the next step—and, alongside that, yes, we have a contractor in place.

Ms Loft: We have received conditional approval for the DA and we have engaged a head contractor, Shape, and we expect building to commence in April this year.

MS TOUGH: Do we have a rough timeframe of when that will be completed and potentially open to the public?

Ms Loft: Twelve months.

MS TOUGH: Perfect. We are really excited.

MISS NUTTALL: I am interested to know about the workforce reduction task force, which was established in December 2024. Could you tell us a little bit more about that task force and what it does and what its terms of reference might be?

Ms Cross: Interestingly, when we do our staff feedback surveys, the most common issue that comes up is workload for staff. They feel that they have got too much work and too many competing priorities. So we have set up a task force to do two basic things. The first piece of work is to look at all of our processes and systems to see where we can become more efficient—get rid of levels of approval, use the IT systems more appropriately and basically seek ideas from staff on ways that we can actually reduce workload and reduce the noise and hard work about doing their day-to-day business.

The second half of the task force is to look through all of the possible work that could be undertaken over the next four years of government and work with the office to prioritise that so that we have a very clear set of priorities that we are working through, and we are allocating the resources to those priorities and doing them well, rather than trying to do multiple things and spreading ourselves too thin. That is a problem that most directorates face—that there are multiple things; not all of which will add the same value and have the same impact.

With the new government coming in and with the new election commitments, we are really keen to work through what the highest priorities are and make sure that we deliver them well. That should reduce the workload for some teams who are actually trying to

do multiple things simultaneously—and then we may just agree that some of those are lower priority.

They are the two streams of work. The task force reports to Shane, who is the Head of Corporate, and they have already identified that, across the directorate, we are using the Objective filing system differently and, if we could get consistency in every part of the directorate, we will come up with a much better way of managing paper flows.

MISS NUTTALL: Awesome; thank you. I am interested to know what work that the task force does sits outside of, for example, the senior executive's regular remit?

Ms Cross: All of the proposals that they come up with will be socialised with Shane, who will have a first look at them, and then come to our executive board. They brought their first paper to the executive board, which proposed these changes to the way we manage paper flow through Objective so that we could all save time. The executive is part of that Objective workflow. So some of what they are doing will impact us, but all of it will come to the executive board for sign-off before it is implemented.

MISS NUTTALL: What is the total cost of running the workforce?

Ms Cross: The total cost of?

MISS NUTTALL: Sorry; of running the task force.

Ms Cross: The task force has been set up for six months. I might see if Shane can give the rough estimate of the cost.

Mr Nielsen: I will have to take the value on notice.

THE CHAIR: Would you mind acknowledging the privilege statement?

Mr Nielsen: I am sorry; I have read and acknowledge the privilege statement. I apologise.

THE CHAIR: Thank you.

Mr Nielsen: I will have to take the value on notice. Originally, the team consisted of four staff. Unfortunately, the team is currently acting with two, just with some other acting opportunities. The intent is to have through to 30 June either two or three people within there at the SOG B or SOG C level. But I will take on notice the actual value of that.

Ms Cross: Can I just make sure that I have correctly named it as the Workload Reduction Taskforce? Occasionally, "workforce" slips out, but it is definitely the Workload Reduction Taskforce.

MR RATTENBURY: An important distinction.

THE CHAIR: Yes; I was wondering about that. Do you have something to add, Mr Peffer?

Mr Peffer: I was just going to confirm that the letters were sent to undergraduate students on 14 June last year.

THE CHAIR: Is there anything else to add before we wrap up?

Ms Stephen-Smith: I have one thing, if I may, Chair. The additional information you requested around ACAT wait times is not currently available because the commonwealth is currently rebuilding the health data portal, which is the assessment data system, due to be available to us from April of this year.

THE CHAIR: Thank you. On behalf of the committee, I thank you all 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*.

Hearing suspended from 12.00 pm to 4.05 pm.

Appearances:

Barr, Mr Andrew, Chief Minister, Minister for Economic Development and Minister for Tourism and Trade

Chief Minister, Treasury and Economic Development Directorate
Mehrton, Mr Andrew, Executive Branch Manager, Social Policy and Office for LGBTIQ+ Affairs, Policy and Cabinet Division

THE CHAIR: Welcome back to this public hearing of the Standing Committee on Social Policy for its inquiry into annual and financial reports for 2023-24. The proceedings today are being recorded and transcribed by Hansard and will be published. The proceedings are also being broadcast and webstreamed live. The committee will now hear from the Chief Minister and officials in relation to LGBTIQ+ affairs, policy and services. When taking a question on notice, it would be useful if witnesses use the words: "I will take that question on notice." That will help the committee and witnesses to confirm questions taken on notice from the transcript.

We welcome Mr Andrew Barr MLA, the Chief Minister, and officials. I remind witnesses of the protections and obligations afforded by parliamentary privilege and draw your attention to the privilege statement. Witnesses must tell the truth. Giving false or misleading evidence will be treated as a serious matter and may be considered contempt of the Assembly. Would you please each confirm that you understand the implications of the privilege statement and agree to comply with it?

Mr Barr: I understand the privilege statement.

Mr Mehrton: I have read and acknowledge the privilege statement.

THE CHAIR: Thank you very much. As we are not inviting opening statements, we will proceed directly to questions. I have a question about the Capital of Equality Strategy from, I think, May 2023. The strategy lays out progress towards the government's goal for Canberra to become the most welcoming and inclusive city for LGBTIQ+ people in the country. It had a number of findings that the office found important to address. In particular, at the time, more than half of the respondents of the survey were not aware of the existence of your office and its role. I would like to understand what efforts have been undertaken to spread awareness of the role and functions of your office since then.

Mr Mehrton: Sure. The office undertakes a number of engagements with the community and promotions as well. That is often done in partnership with our ministerial advisory council, who are members chosen from the community to make representations to the government on behalf of community members. We have presence at major events, like SpringOUT and Fair Day, where the office will have stalls, sometimes with the ministerial advisory council. We have newsletters that we put out that people can subscribe to. We work through key stakeholders in the community, like Meridian and A Gender Agenda, to promote the office's awareness. Those are the main strategies. We also hold events like flag raising on IDAHOBIT, and certain other events that are specifically around different points in the calendar to raise awareness. But it is definitely a challenge to reach out to the community and get word out about the office's

existence.

THE CHAIR: Have you done any work to measure whether that has led to an increase in awareness of the office or is it something that you are prioritising without tracking per se?

Mr Mehrton: It is not one of our key metrics that we target, but we do measure it through the community surveys and the evaluation of the Capital of Equality plan. The measurements that you are referring to are our efforts to try to track that over time. The Capital of Equality plan is now in a second strategy—it started in 2019—so we do not have a particularly long-term trend that we can measure, but it is something that we are trying to track now in the community research that we do.

THE CHAIR: I have one more on this before I go to Ms Barry. Some respondents in that survey felt unsafe in the community, in public settings and in accessing services, which was before the really disgusting homophobic violence that we saw in the middle of last year. What measures and programs have the ACT government introduced to address the safety concerns of LGBTIQA+ people?

Mr Mehrton: That happens in a range of ways. You would need to look into what individual directorates do, but we have measures such as the Safe and Inclusive Schools Initiative in public schools. We are currently preparing to run an awareness campaign later in the year, which was one of the initiatives under Capital of Equality, about discrimination and vilification. Legislation has passed. There are some significant pieces that the ACT has led on banning conversion practices, as well as putting in place protections for people with variations in sex characteristics in medical settings. There is a range of legislative reforms, but there is also cultural reform work that we are doing through directorates and support of community organisations like Meridian, who offer training to organisations and NGOs, as well as ACT government directorates, to try to improve understanding of the issues. Then there is confidence in directorates and other agencies to address those issues.

MS BARRY: I have a few supplementaries on the grant. I note that the applications for stream 2, the partnership and capacity-building grants, have identified some vulnerable groups: First Nations, disability communities, trans communities, intersex communities and different age groups. I want to understand how this works in practice. What would that involve? How would you implement this in practice?

Mr Mehrton: The way the office works, generally speaking, is to try to take an intersectional approach to all of our work. The grants are one example, but we understand that the needs for each of those cohorts will be quite different. The needs of an LGBTIQA+ young person will be quite different to the needs of an older person. We do not have direct criteria that we assess—whether it ticks boxes—but we tend to try to have a diverse panel when we assess those grants. We have the approach of trying to prioritise applications that come through that directly address one or more of those groups. That is not to say that each of those priority groups will get funding in every round, but, for someone that comes through and says, "We have a program that will support people on temporary visas that are LGBTIQ+," that is more likely to get support in addressing a specific need in the community than someone who might just be proposing to run an open community event, where there is more capacity to do that and

maybe less need than some of the targeted cohorts.

MS BARRY: For the obviously targeted cohorts where, for example, they do not get a grant in stage 2, is there a process to follow up? Obviously there is limited funding and you cannot give all of the community groups a grant.

Mr Mehrton: Yes; absolutely.

MS BARRY: Is there a follow-on process to identify who has missed out and where there probably is need?

Mr Mehrton: Yes. We run at least one grant round each year. They are recurring grants. For some of them, though, we run multiple grant rounds per year. I do not think we do that for stream 2, but for a couple of the others we will. We also have a pretty proactive approach in how we work with potential applicants to the grants, before and after the program. We will have information sessions where people who are interested can speak to the office about what they are thinking about and how to shape a grant, and also how to put in an application, so that there are fewer barriers to apply for the funding in the first place. Through that process, we get a sense of what some people in the community are saying there is a need for. That is not to say that they then go on a merit list and can receive funding the next time around, but at least there will be a better understanding in the office of what that need is. It is also an opportunity to engage with the applicants and maybe provide some feedback on how their application might have been improved or other organisations they could partner with to deliver a stronger application.

MS BARRY: There is obviously a balance so that a section is not getting more than another section, whilst there is a need. You would balance it so at least there is a cross-section.

Mr Mehrton: Yes. We do not try to define a percentage that each part of the community will get in a given round. If there is a really strong application that is delivering something for people with disability, we would not deliver 10 other grants that are also supporting people with disability, because we want to make sure that the breadth of need in the community is being addressed.

MS BARRY: Thank you. That is useful to know. In terms of stream 3, the LGBTIQA+ leadership funding amount, how is that determined and what is the quantum?

Mr Mehrton: That is a relatively small part of the stream. That has ranged from about $20,000 to $25,000 per year. That is one that we tend to run a couple of times. It is about supporting upcoming leaders in the LGBTIQA+ community, typically around supporting their engagement in training or professional conferences and that kind of thing. It is one of the much smaller schemes where we tend to provide a couple of thousand dollars per applicant that might support them to register for major conferences and training events, and a bit of travel support sometimes as well.

MS BARRY: That covers travel as well. That was my next question. You will probably need to take this on notice. Can you provide a table showing how the values of these grants have changed over the past five years? Would that be information you would capture?

Mr Mehrton: Yes; that is fine. I can take that on notice.

MS BARRY: Excellent. Thank you very much.

MISS NUTTALL: I am happy to continue the trend and ask about the Capital of Equality Grants Program. The CMTEDD annual report—I think it is on page 202, in the pink highlighted section—states that 21 per cent of all awarded projects under the Capital of Equality Grants Program are either led by or benefit Aboriginal and Torres Strait Islander LGBTIQA+ people. Could you please explain how "benefit" is defined for this purpose?

Mr Mehrton: I can take on notice some of the detail, but I think "benefit" in the context of that annual report means that the grant is either led by or for Aboriginal and Torres Strait Islander people specifically.

MISS NUTTALL: Do you have a breakdown of how many of these projects were, in fact, led by Aboriginal or Torres Strait Islander people?

Mr Mehrton: I do not have that at hand, but I am happy to take that on notice.

MISS NUTTALL: That is very kind. Thank you. Can we chat about ABS statistics and the census? Could you please provide an update on the ACT whole-of-government's data collection framework for sex, gender, sexual orientation and sex characteristics?

Mr Mehrton: Sure; I can provide that update. That was a data standard that we delivered under the last Capital of Equality Strategy. It is essentially an implementation of the ABS's data standards, or it adheres as closely as we can to the ABS's data standards for sexual orientation, gender identity and sex characteristics but in the ACT government context. It sets out the way we would like directorates to capture variables about sexual orientation, gender identity and sex characteristics in our administrative data. That is not always possible. It is going to be a progressively phased in standard because, obviously, you have legacy business systems that cannot necessarily capture free text, for example, where they were set up to capture a binary [*interruption in sound*] originally.

Under the second Capital of Equality Strategy, we are working with a number of directorates to try to pilot some improvements in, in particular, business systems to enhance that data. Housing ACT is one of those. That work is taking place slowly. It is obviously a complex system, but it is one of the areas that we have identified. Having better information about the LGBTIQA+ status of people that need housing or homelessness services would be of great value to us, but the data standard is there for anyone across government who might be working on a business system. It not only provides technical guidance about how they capture the data but also helps people understand the differences between gender and sex characteristics, for example.

MISS NUTTALL: Thank you. How has the data helped so far with the ACT government supporting the LGBTIQA+ community?

Mr Mehrton: At the moment, we are not drawing on large amounts of our

administrative data. As I alluded to, a lot of the systems we have were not originally set up to capture that data, which is why we have needed to do the work of defining what it is and the need for collecting it. The work that we have been doing to try to build our evidence and data that we use in the office is probably twofold. One has been some primary data collection through the survey that we were talking about earlier. That involves going out to the community, giving them surveys and asking them to fill them in. The other is that, where we can, we partner with academics and other researchers to piggyback on work that they might be doing nationally. The *Writing themselves in* report is a good example where we were able to provide a small financial contribution to Latrobe University, which undertook that research. They were then able to collect some really valuable data about the experiences of young people in the ACT, which we would not have been able to undertake ourselves without their work. It tries to support [*interruption in sound*] elections, which is why the work and engagement with the census process is also so valuable to us.

MISS NUTTALL: Beautiful. I am curious as to when you do partner. This is a bit of a tangent, but I heard that there was research coming out around working at a Gender Euphoria Scale. Is that something that has come across your desk at all or that you have engaged with?

Mr Mehrton: Not me personally. I have not heard of that work specifically, but if it is occurring, it would be in probably CHS or the health directorate.

MISS NUTTALL: Yes.

Mr Mehrton: Certainly the health directorate in particular is very closely engaged [*interruption in sound*].

MISS NUTTALL: Yes, excellent. Just on that compatibility work that you are doing with data systems, do you have kind of indicative timeline for that work? When will you know it has progressed? Do you have a completion point in mind?

Mr Mehrton: No, that is fairly exploratory at the moment. We have got a commitment to work on a particular system, but we do not have a detailed project plan that is going to hold the directorate to revising their business systems by the end of next year. We will do progress reporting on the Capital of Equality Strategy and action plan, we expect, later in this year. It is the first progress report, so we will provide some updates at that point on what we can.

MISS NUTTALL: Awesome; fantastic. In December 2024, ABS made its first estimate of the proportion of Australians who are, in this instance, LGBTI+. Is there any way that this data has informed and assisted the ACT government in setting and achieving goals around LGBTIQA+ policy?

Mr Mehrton: I think it is too soon to say that that data, in particular, has directly influenced any policy decisions, but we were certainly very excited to see that validation of the data, which confirmed the proportions that there are in the community of people who have variations in sex characteristics or gender identity and sexual orientation. That is the first time that we have ever had that data with that level of confidence in what the population estimates are, so that will certainly now be the

benchmark each time we need to try to assess the macro need in community, going forward.

MISS NUTTALL: Are there any particular data points that currently are not in the census that you think might be useful to the ACT government?

Mr Mehrton: In the census—from the next one or from the current census? There will be new variables that are included in the next one. They will capture sexual orientation and gender identity, but only for people over 16 years of age. They will not capture data on variations in sex characteristics, which we would have found very valuable, given the work that the ACT has already done on the medical protections I spoke about earlier.

We would have liked to have seen that included, but having access to sexual orientation and gender identity, and being able to cross-tabulate that with all the other variables under the census, is going to be amazing.

MISS NUTTALL: Thank you. I am very excited to see where it goes to from here.

THE CHAIR: You mentioned a progress report for later this year, but are you able to give an indication of, at this point in time, how many of the 37 actions within the first action plan have been completed?

Mr Mehrton: I will take that on notice. There are a handful that I think are completed, but I better take that on notice

THE CHAIR: Okay, no worries.

MS BARRY: Just a few questions around staffing. I can see that it is only you here. In previous hearings, we had a room full of people. Can you advise of the total staffing budget for LGBTIQA+ affairs, policy, services and give a breakdown of staffing numbers by qualification?

Mr Mehrton: Sure. The office itself is three FTE: there is a senior officer grade B and two senior officer grade Cs.

MS BARRY: Right. That is it?

Mr Mehrton: That is it, yes.

MS BARRY: Alright, okay. And is there a total budget?

Mr Mehrton: The total budget is $1.34 million in 2023-24, and of that there is $477,000 which is for staff—

MS BARRY: Staff and then?

Mr Mehrton: and the remainder is for the grants and service contracts and some for services and supplies.

MS BARRY: Thank you. You mentioned that the data work that you are currently

doing is still in its exploratory stage. Is there anything you are doing to ensure that, whilst you are still undertaking that data work, some of the lessons you have learned or the conversations you have had in the community is reflected through policy? Are you doing any work around that whilst we wait for, obviously, a more accurate point of reference?

Mr Mehrton: Yes, certainly. I mean the data standard that was developed, which we undertook with the Digital, Data and Technology Services part of CMTEDD, was promoted across the whole of government through our data governance group. We have done a fairly wide promotion of that data standard and made it known to business areas so that that can be adopted.

We are doing some more work around an inclusive language guide as well, which is another action under the current action plan, which then provides a bit more guidance and context around the different languages used, which is a bit more useful when talking with community and other people, rather than just the pure data side of things. I think that will be an equally useful product for directorates to use in informing themselves and their work.

We also have an inter-directorate committee that meets quarterly that oversees the Capital of Equality Strategy. That is an opportunity for directorates to provide some ad hoc reports on the work that they are doing but also to hear from what is almost like a community of practice about how other directorates are delivering the strategy and the other initiatives they are doing to support LGBTIQA+ people. There is a kind of general network that is disseminating information, and then we have got a couple of specific projects that we are trying to drive a bit more actively ourselves.

MS BARRY: Thank you. That is useful to know.

MISS NUTTALL: On the inclusion of variations in sex characteristics in the census and other useful data points, have you made any representations to your federal counterparts on the use for that data?

Mr Barr: There was an engagement process the ABS undertook. We participated in that.

Mr Mehrton: Yes. Certainly, at an officials-level, we are very closely engaged. There is a process the ABS goes through to work with state and territory governments on the census broadly, to which we provide submissions at a whole-of-government level, but the Office of LGBTIQA+ is also on a reference group, or an advisory body, for those sexual orientation, gender identity and sex characteristics variables as well. We have certainly been very actively engaged at the officials-level in advocating for those variables to be included and in how they should be defined and shaped.

MISS NUTTALL: Great to hear, thank you. The latest action plan for the Capital of Equality Strategy includes a focus area on collaborating with ACT Policing to enhance relationships with LGBTIQA+ communities. ACT Policing did not reference this relationship in their 2023-24 annual report; though, when my colleague Mr Rattenbury asked about this, they did acknowledge that there was work to do, particularly relating to the organisation's recent dis-invitation from SpringOUT. Have you spoken to ACT

Policing about them addressing this relationship?

Mr Barr: Yes. They held an alternative event. Rather than the stall at SpringOUT, they held their own community engagement event subsequent to SpringOUT Fair Day.

MISS NUTTALL: Beautiful. Did you, as part of the Office of LGBTIQA+ Affairs, have conversations with ACT Policing following SpringOUT in that event?

Mr Mehrton: Yes. We have met with the new LGBTIQA+ liaison officer that ACT Policing have employed, who attended the event at SpringOUT that you mentioned. I went along to that event. I think a couple of members of our advisory council also attended. We have had some meetings with that new liaison officer, who has only been in the role for a couple of months, or a few months, now. From the office's perspective, we are actively engaged with them in building that relationship and some specific initiatives that we might be able to do [*interruption in sound*].

MISS NUTTALL: That is awesome. Have you jointly identified, or have they identified any sorts of actions that they are hoping to take, or engagement or things like that?

Mr Mehrton: I do not think we are at that stage just yet. I think my understanding is that they, with the role being fairly new, are also establishing themselves in community and their relationships with stakeholders, so we will try and facilitate that. I think that will be the jumping-off point for some more specific pieces of work that we might be able to do together.

MISS NUTTALL: Beautiful. Thank you so much. I am curious: what mechanisms does the Office of LGBTIQA+ Affairs, or government more broadly, have to ensure that policing and other government agencies follow through on the goals of the strategy?

Mr Mehrton: That goes back to the inter-directorate committee that I spoke about, but also the progress reporting that we do. We have relationships at an informal level between the office and all the people across government that are working on actions under the action plan. We meet with them quarterly, as a group, to talk through what is happening. All of the actions will get reported on annually as what we have committed to, so it will progress [*interruption in sound*] in that way. Then we will periodically follow up with them, or they will reach out to us as they need to on specific bits of work.

MISS NUTTALL: Thank you.

THE CHAIR: I have a question about policing and interaction with health services. Looking at the action plan, some of the statistics are concerning around access to GPs, access to specialists, access to psychologists and so on. What is the level of engagement with Health? And I acknowledge that it is a tricky area, because I feel that if I asked Health, they might say, "Well, some of those are federal issues." How do you navigate where there is a crossover, like with GPs, or what is happening in that space?

Mr Mehrton: I think that would need to be put to Health officials. We work with the health directorate in particular on the policy aspects of access to health services

generally. From the office's perspective, we are not in the kind of day-to-day of accessing individual or particular services. We try to support the health directorate to progress that work themselves, but I do not have a great deal of advice more broadly than probably what the health directorate would tell you on how they are progressing access to GPs and other services.

THE CHAIR: So that might be provided through this progress report later in the year, I think you mentioned earlier.

Mr Mehrton: Certainly, for the actions that are included in the action plan, we will release some updates on what work has been done, but it is just not something that I can speak to in detail myself.

THE CHAIR: Thank you.

MISS NUTTALL: Obviously, with things going on in the US, it is a pretty tough time for trans people to see their rights dialled back in real time. There has been a really vocal presence here in Canberra and strong support for trans people within the community. Have you had an opportunity to meet with Trans Justice Canberra or those organising bodies or done any work to see what you can do to provide reassurance to trans folks here in the ACT?

Mr Barr: I guess the obvious point is that Australia is not the United States, and we are very thankful for that in light of recent events. Undoubtedly, some of the issues in US politics and the US government at the moment will inevitably find their way into Australian political discourse, not necessarily always by people wishing to follow the United States, but as in the way you framed the question, with people seeking to get ahead of any thought that that might be a direction of public policy in Australia.

I think one of the challenges we face is, perhaps, more broadly a lack of understanding in the community about the fact that President Trump's executive orders do not have an impact in Australia. They will receive and be bombarded with more news and information about what is happening in the United States than they would about what is happening in Australia or in Canberra, even in our own media. There has been more coverage of those matters in the US than anything in the ACT, by a massive factor.

One of our challenges is around reassurance, but I am also of the view that endeavouring to respond every single day to every single utterance from the United States is not a particularly productive use of anyone's time and really only goes to elevate the level of hate and the level of concern, potentially, around these issues. The approach that we have been adopting is to be very clear that none of the agendas that are being pursued in the US are being pursued in the ACT, and, to the best of my knowledge, they are not being pursued at a national level, at least by any mainstream political party, although I do note the return of Mr Palmer

THE CHAIR: Mr Palmer aside; yes, exactly.

Mr Barr: Indeed, so I imagine that would be a risk point in the forthcoming federal campaign.

MISS NUTTALL: Yes. I think one of the concerns, especially from a lot of folks that I have chatted to, is what is happening in Queensland with the freeze on puberty blockers, despite medical expert advice to the contrary.

Mr Barr: I can be absolutely clear that there is no such policy intent in the ACT, and regrettably, the new Queensland government has gone down that path. Queensland does not have the greatest human rights record in the states' history, it would be fair to say.

MISS NUTTALL: Thank you. I am reassured to hear that that is not happening in the ACT context, and it sounds like there is willingness to engage with the trans community on this, which is great.

THE CHAIR: We are all out of time, so on behalf of the committee, I thank you for your attendance today. If you have taken questions on notice, please provide your answers to the committee secretary within five business days of receiving the uncorrected proof of *Hansard*. I would like to thank our witnesses who have assisted the committee through their experience and knowledge today. We also thank broadcasting and Hansard for their support, and the secretariat as well. If anyone wants 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.

The committee adjourned at 4.37 pm.