LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

STANDING COMMITTEE ON SOCIAL POLICY

(Reference: Inquiry into Annual and Financial Reports 2024-25)

Members:

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

TRANSCRIPT OF EVIDENCE

CANBERRA

TUESDAY, 11 NOVEMBER 2025

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

By authority of the Legislative Assembly for the Australian Capital Territory

APPEARANCES

Privilege statement

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

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

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

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

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

Amended 20 May 2013

The committee met at 9.01 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
Zagari, Ms Janet, Chief Executive Officer
Lopa, Ms Liz, Deputy Chief Executive Officer
Hughes, Ms Rosalie, Chief Financial Officer
White, Mr Andrew, Executive Branch Manager, People and Culture
Aloisi, Mr Bruno, General Manager, Mental Health, Justice Health Alcohol and Drug Services
Wakefield, Ms Katherine, Executive Director, Women, Youth and Children

Health and Community Services Directorate
Arthy, Ms Kareena, Acting Director-General
Hudson, Ms Robyn, Deputy Director-General, Policy and Transformation
Coleman, Ms Kerryn, Chief Health Officer, Population Health Division
Travers, Ms Maria, Acting Executive Group Manager, Population Health Division
Jacobi, Ms Skye, Executive Group Manager, Health System Innovation and Performance
Hayward, Mr Lewis, Chief Finance Officer, Finance and Assurance
Stoddart, Ms Chloe, Executive Group Manager, Policy, Partnerships and Programs Division
Keene, Mr Toby, Acting Executive Branch Manager, Ageing and End of Life Branch, Policy, Partnerships and Programs Division
Bladin, Ms Caitlin, Executive Branch Manager, Strategic Infrastructure, Health System Innovation and Performance

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 2024-2025.

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

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

We welcome Ms Rachel Stephen-Smith MLA, Minister for Health and Minister for Mental Health, and officials. We have many witnesses for this session. As we are not inviting opening statements, we will now proceed to questions. I have a question about elective surgeries. The number of surgeries performed is below the target, by 100-odd, and also the recommended number of elective surgeries performed within the clinic. The number of patients waiting longer than the recommended timeframes for elective surgeries is quite a lot larger than the target. What is the core driver of this?

Ms Stephen-Smith: Probably two things, in terms of the number of people waiting. Chair, thank you for the question. You would be aware, and we have discussed this in the chamber before, that the combination of COVID-19 slowdowns and the theatre fire at Calvary public hospital significantly impacted the number of elective surgeries that were able to be done in 2022-23. That has had a flow-on impact in terms of the number of people waiting. The team has done a really great job in 2024-25 in getting through an absolute record number of elective surgeries and we are starting to see that waitlist come down, and the number of long waits is coming down as well. At more than 16½ thousand elective surgeries completed in the 2024-25 year, it is 1,200 more than the next highest number in any previous financial year, which was in 2021. It is a significant uplift in the number of elective surgeries. It is a bit short of the target that we had set. I will hand over to Ms Zagari to talk about why we did not reach the target of, I think, 17½ thousand.

Ms Zagari: Thank you, Minister. Thank you, Chair. I have read and acknowledge the privilege statement. As you are aware, in August 2024 we opened the Critical Services Building, and in the lead-up to that we needed to make some reductions in the throughput of elective surgery to allow time for staff training and familiarisation with the building. There was a reduction through those months in the number of elective surgeries that went through and that had some impact on the overall target. I am really pleased to say, however, that we have seen an acceleration this year in the delivery of a number of cases to ensure that we can meet the target. We are on track at this stage to again perform the most surgeries ever in the coming year. Ms McKenzie can provide additional detail on that, if that is of use.

The other thing in terms of the number of patients who were waiting longer than clinically recommended timeframes is that there was a very conscious effort to deal with some of the longest waits that had been on the waitlist for an extended period of time. When that happens, because the counting is done at the point that the operation happens, you will see that the number of people having surgery done who have waited longer than clinically recommended looks like more, as we target the people who have waited for a very long time, to ensure that they receive their surgery.

THE CHAIR: If you are targeting those people, does it mean you are targeting category 3 surgeries as a priority?

Ms Zagari: We are targeting within each category. Absolutely, for category 1s and category 2s, we are still targeting within clinically recommended timeframes. But, if we are going to do a category 3 surgery, it is absolutely the longest wait, and we make sure that there is access to category 3 surgeries whilst prioritising category 1s and clinically urgent surgeries. It is a fine balancing act that the team have been very nuanced in their approach to.

THE CHAIR: You might be able to answer this. Obviously, the government has election commitments in relation to the number of elective surgeries performed through the term. Will this year be a catch-up year on top of what was already intended?

Ms McKenzie: In the year to date, as at 31 October, we have delivered 6,000 surgeries. In the same period last year, it was 5,500, so there were nearly 500 more in the first four months. It is a continual process of trying to get through the waitlist and deal with those. As Ms Zagari said, in a nuanced way we have to deal with those who are clinically urgent and long waits at the same time. We are on track to make some significant inroads into that this financial year.

THE CHAIR: Is it the intention for those almost thousand surgeries that you fell short by last financial year to count for this year or will there be an extra 350 this year and 350 next year? How is that working over time?

Ms McKenzie: It is not that we will take this amount off this list and that amount off that list; it is a continual process that requires clinical judgment versus long wait or need versus wait. We look at that, list by list, as we do on a week-by-week basis to plan our operating theatres.

Ms Zagari: Chair, I think your question was whether, in addition to the 17½ thousand that were intended, we would do the extra number we were short by last year. We are certainly on track to do a significant proportion of those. We have not set out to specifically do that number. It is about being able to get through as many surgeries as possible within the funded and allocated time that we have, but we would expect that, over the course of the next several years, we will make up that gap from last year.

THE CHAIR: You mentioned the new building being a factor responsible. Of course, multiple surgeons resigned and some returned over the last year. What impact did that have? I assume the resignation of surgeons has an impact on the number of surgeries completed within a month.

Ms Zagari: Absolutely, the resignation of surgeons has an impact. However, we have been successful in our recruitment across multiple specialities. Ms McKenzie might have detail on any specific specialties where surgeon availability is problematic, but, if we think about orthopaedics as an example, we have been able to retain a number of those surgeons and attract additional surgeons to undertake the surgeries that we need to.

Ms McKenzie: I can speak to orthopaedics specifically, if that is what you want information on. I note that, as you can see, we are a very big organisation, and we have attrition from all professional groups throughout the year, as any organisation would. The primary way of dealing with that is recruitment. I think everybody would be aware that medical recruitment is a very long process. The very first thing we do is aim to re-allocate lists or work within our existing department. When it comes to orthopaedics, that is exactly how we have been able to maintain our activity this year in the space of two resignations: we re-allocate to our existing surgeons. That is the most effective way of dealing with resignations. Generally, people will not even know that a surgeon has resigned as they would be allocated to an appropriately skilled surgeon at the time that

they were due to have their surgery.

Ms Stephen-Smith: To reinforce that, it is important to recognise the contribution that the orthopaedic surgeons have made to working with CHS leadership to re-organise those lists. They have been very committed to ensuring that is the case, and the result is that there were more orthopaedic surgeries performed in the first quarter of 2025-26 than there were in the first quarter of 2024-25—slightly more, but they are definitely on the same track.

THE CHAIR: Regarding the surgeons who resigned temporarily and returned, for how many was it a condition of returning that they retained control of their waitlists?

Ms Zagari: If you do not have the information, we will take it on notice.

Ms McKenzie: I am not aware it was a condition of anybody's return that they have control. There are various systems, and surgeon control is one of them. They have to be supported through other surgical booking processes. All our surgeons work through those processes and it is absolutely collaborative. It is done by senior nursing staff. I think it would be fair to say that the elective surgical liaison nurse, which is their title, and the surgeon work hand in hand to determine those lists. That is a process that is in place for all our surgeons, including orthopaedic surgeons.

THE CHAIR: Perhaps I will reframe the question. Was it a condition for any of those surgeons that they were not moved to pooled waiting lists?

Ms McKenzie: A pooled waiting list is a different concept.

Ms Zagari: I will speak broadly to the concept, if that is all right, Chair. At the time, I am sure you will recall that there were tensions around, in particular, the interface with planned care or the ops centre and there was a sense that the ability to direct care had been removed from the surgeon. We have worked really closely with our surgeons, including the orthopaedic surgeons, to ensure that they are able to make the clinical decisions that drive waiting lists. Dr Gert Frahm-Jensen, who is the head of the division of surgery, is the person who ultimately supports the decision-making in that space. If the surgeon feels that a decision has been overruled, they have an escalation point, if required, but it is actually a much more collaborative relationship.

The move to pooled waiting lists is specialty dependent and subspecialty dependent, because it really depends on the level of expertise that is required. It is suitable for certain cases and not for others, depending on the nature of the surgery. Where appropriate, there is a pooled waiting list methodology where patients may move between lists. That tends to be for less complex surgery. The more complicated surgeries or more specialised surgeries stay with the named surgeon.

Ms Stephen-Smith: To clarify for the committee, that is not a particular issue that has been raised in the conversations I have had about this whole process. The concern that was raised with me and publicly was not about people on the elective surgery waiting list and how they were being allocated by the operation centre; it was actually about people who had come in for urgent surgery but did not need to be admitted through the emergency department and stay in hospital until their surgery occurred. It was about

the kind of in-between people who were identified as needing urgent surgery but were able to go home and come back. The orthopaedic surgeons felt they were not being supported through the processes that were in place. They were effectively managing that process themselves and calling people back to have their surgery at an allocated time. I think that is the difference in understanding that had arisen with the operations centre—about where those people were slotted in. That was the main issue in terms of the public conversation: who was making decisions about who was getting their surgery and when.

THE CHAIR: They have come back. That tension has essentially been resolved.

MS CASTLEY: Chair, while we are on staffing, how are things going with the cardiologists at the moment, staffing-wise, happiness-wise and their general wellbeing?

Ms Zagari: We are working with Cardiology across the breadth of CHS to look at what a networked cardiology service should look like to deliver the care needs for the territory. They have engaged in that process to understand what they should do, where and at what point we should move to that to ensure that we have a sustainable service. We are staffed. Do we have any vacancy in Cardiology?

Ms McKenzie: We are mid-recruitment at the moment. I would not be able to say what our exact vacancy situation is, because we are in the process of allocating people who are suitable. We had a small amount of vacancy that I anticipate will be all but filled with the recent recruitment.

Ms Zagari: We have interviewed and are in the middle of the process of appointment.

MS CASTLEY: Has anybody been put on leave without pay? Are there any kinds of issues like that at the moment? Is that what you are recruiting to fill? Have people completely resigned?

Ms McKenzie: We had pre-existing vacancy at North Canberra Hospital. That is a vacancy that has existed for a number of years. One recruitment is to attempt to fill that vacancy in a stable way. I think that was the primary reason behind the recruitment.

Ms Stephen-Smith: It is probably no secret within the medical profession or within Canberra Health Services that there is some instability within Cardiology generally. Again, the team has done an incredible job in bringing down the cardiology waiting list over the last 18 months or so. It was really significant between April 2024 and June 2025, with a 49 per cent reduction in the overall elective waitlist for the Cardiac Catheter Lab at Canberra Hospital. They have made some huge progress in reorganising the way that they work, but there is also recognition that there are some tensions within Cardiology. Again, I want to acknowledge everybody involved for the fact that they have come to the table to have really productive conversations with CHS leadership about how to resolve some of the tensions. It is important that the process plays out. I also recognise that the Australian Medical Association's ACT branch has been supportive of those conversations.

MR RATTENBURY: What is the current status of the head of the Cardiology Unit?

Ms Zagari: Currently, there is an interim leadership structure in place within Cardiology. Dr Bani-Yaseen, who is our Clinical Director of the Division of Medicine, has stepped into a leadership role in Cardiology, supported by four technical leads in each of the subspeciality areas, while we work towards the right leadership structure and the right structure for Cardiology in the longer term, acknowledging the work that was done by Dr Scott in that head of Cardiology role and the significant inroads that the minister has spoken about into those waitlists. We are looking at what is the right structure going forward and will recruit to the structure once it has been determined.

MR RATTENBURY: Thank you. What is the status of Dr Scott?

Ms Zagari: Dr Scott remains employed by Canberra Health Services.

MS CASTLEY: I have questions about the ACT Government Analytical Laboratory.

Ms Stephen-Smith: Yay! No-one ever asks about that. Dr Coleman is making her way to the table.

MS CASTLEY: I am just happy to be pleasing somebody this week! It is the primary public health multidisciplinary scientific testing laboratory comprising of four functional units that undertake a variety of activity to support the health of the ACT community—just in case we were not informed. The units are Forensic Chemistry, Forensic Toxicology, Microbiology and Environmental Chemistry. Minister, the Analytical Laboratory has responsibility for the testing of illicit drugs. I assume that is included. Given the recent figures showing greater use of illicit drugs in the ACT, is the office experiencing extra demand for its services?

Ms Stephen-Smith: I think the last time I visited that particular area in ACTGAL was prior to the changes to the drugs of dependence law coming to effect. At that time, the team was experiencing some quite significant pressure, particularly around some of the cannabinoids that were being detected in the community. That pressure was around testing, and that included testing for synthetic cannabinoids and the different types of things that were in the community, as well as storage space for the amount of cannabis and synthetic cannabinoids that were detected. I am very happy to hand over to Dr Coleman to talk about what has happened in relation to those pressures over time, and other drugs as well.

Dr Coleman: I have read and acknowledge the privilege statement. It has been a journey for ACTGAL. A range of pressures have increased the number of illicit drug samples that have come through the lab. Police seizures come through. We store those and we test those. We also get a variety of samples through the implementation of drug testing, through the new policies—through police testing and those kinds of things. One of the things that is important to realise is that it takes about three years to qualify a scientist to be competent in testing as well as reporting on that. Once we see an increase coming up, it takes three years to try to build sustainability. We recently got some additional resources through the most recent budget. That is going a really long way to support our enhanced capacity in responding to the increase in illicit drug samples.

MS CASTLEY: That was my next question—the need for extra employment of staff because of the demand. What activities does the office undertake to support harm

minimisation, if anything, strategy-wise?

Dr Coleman: ACTGAL itself?

MS CASTLEY: Yes.

Dr Coleman: ACTGAL is our source of drug expertise. They provide input to policy. They work very closely with the ATOD team, the alcohol, tobacco and other drugs team, as well as JACS in terms of policy development in this space. They are also heavily involved in our pill testing response. One of the things that we do when we have a level alert through pill testing is convene a small group that includes our expertise from ACTGAL to provide us with advice on what to do and where to go. There are a number of other ways in which ACTGAL contribute to whole-of-government functions.

MS CASTLEY: You talked about policy. Does the office provide advice as to how to prevent increased use of drugs?

Ms Coleman: They have the scientific expertise in what drugs are made of, how you detect them, and those kinds of things. They are not the experts in harm minimisation policies themselves.

MS CASTLEY: The office also looks at air and water testing. Minister, can you detail any of the activities undertaken with regard to water testing—frequency, reporting, solutions to contaminated water et cetera?

Ms Stephen-Smith: I will hand over to Dr Coleman.

Dr Coleman: Regarding water testing, if my memory serves me correctly, during the recreational water season, we provide weekly water sample testing, where we test for microbiological products. That is mostly around the E. coli contamination that you can see following drought periods or significantly elevated rain periods. We also provide advice around the E. coli measures and what that means for the risk of people swimming.

MS CASTLEY: Is Lake Ginninderra part of that?

Ms Coleman: Yes.

MS CASTLEY: From memory, I do not think Yerrabi Pond is, but I imagine there would be a list that I could get and look at.

Ms Stephen-Smith: I think Yerrabi Pond is not considered a recreational—

MS CASTLEY: It is a sediment pond. I want to talk about the dog that died. With regard to reporting timeframes, how did it get to the point where a few dogs were sick? If you have weekly data in a period of time, is that enough? And is the reporting going to get any better?

Ms Stephen-Smith: There are two things on that. Firstly, that overall process is not the

responsibility of either ACTGAL or the Health and Community Services Directorate, which is why Ms Cheyne has been primarily taking questions on this matter. From the public statements that have been made about it, the particular substance that the dogs are presumed to have ingested—and our hearts go out to the dog owners—was not the type of substance that Dr Coleman is talking about. Regarding that particular substance, the water right next to it can be uncontaminated. It is a solid substance that can come up from the bottom of the lake and sit around the edge of the lake or on the surface of the lake. It can move or appear from one day to the next, so it is not the kind of thing that necessarily weekly testing is going to pick up, which is why Ms Cheyne has talked about the visual inspection by City Services, but also encourages people to undertake their own visual inspection of beaches and water before letting their dogs play in the water.

MS CASTLEY: Thank you.

MS TOUGH: I want to talk about voluntary assisted dying. The old Health Directorate's annual report provided some information about how the community was engaged during the implementation of voluntary assisted dying. I am interested in how that came about. Did the Health Directorate engage with particular groups or cohorts to inform implementation, such as people with disability and multicultural groups? How did it go before implementation day came about?

Ms Stephen-Smith: There was strong engagement with all the stakeholder groups that had expressed an interest.

Mr Keene: I have read and acknowledge the privilege statement. Thank you for the question. In order to ensure broad consultation with appropriate groups for voluntary assisted dying, we formed a group called the voluntary assisted dying Community and Consumer Consultation Group, which abbreviates to an extraordinary number of Cs: the CCCG. It comprised representatives from the disability community, the multicultural community, youth representatives, older persons, health consumers, carers, and Aboriginal and Torres Strait Islanders, as well as advocacy groups, such as Dying with Dignity and Palliative Care ACT. That group has met monthly for about the last 12 months and has worked through a range of public-facing and internal documents to support the voluntary assisted dying suite of documents. It includes everything that is public-facing, everything that is on our website, plus all the clinical guidelines and pharmacy guidelines that the authorised practitioners use to ensure they are all fit for purpose.

MS TOUGH: Thank you. On the last point, how are clinicians who will be part of voluntary assisted dying engaged through the process and supported to make sure that they know how to help people and tell people where to go?

Mr Keene: We recognise that, across Australia, engaging, sustaining and retaining a workforce for voluntary assisted dying is a real challenge. So, from the beginning, we have been very keen to have an integrated strategy. That strategy comprises a number of elements. There is the eligibility to become a voluntary assisted dying practitioner. You would be aware that, in the ACT, we are unique in that nurse practitioners can perform voluntary assisted dying assessments, which has been of great assistance. We have also worked up a number of remuneration strategies to ensure practitioners are

appropriately remunerated for their time, and we have established a community of practice. That community of practice has had several meetings and is a very active source of support for practitioners, even though we have only been going for a short period of time.

MS TOUGH: Thank you. Regarding the independent Voluntary Assisted Dying Oversight Board, what was the role for the oversight board in the lead-up to implementation? And what will its role be going forward?

Mr Keene: The oversight board was established with seven members, including a chair. Its role under the legislation is to provide general oversight, review and advice to the minister about the scheme. In the ACT, it does not have a prospective permit role, such as occurs in other states, so it does not have power to overrule a practitioner's decision, but can retrospectively review it. In the lead-up to the scheme commencing on 3 November, the board met three times, even though it was not legally established at that point, to undergo training and start to understand the scheme. They went through a version of voluntary assisted dying practitioner training so they could understand how practitioners are trained. They have also been provided with all relevant documentation and have been inducted into our information management system and reporting framework.

MS TOUGH: Thank you for your work on it.

MS BARRY: You say you consulted with the multicultural community. Could you expand on that for me, please? Who was on the list? How did you approach the community? I am asking about the general work you did on that.

Mr Keene: The multicultural community was engaged through that voluntary assisted dying Community and Consumer Consultation Group. It had representatives from the ACT government, the Office for Multicultural Affairs, and the representatives went out more broadly to the multicultural community. I would have to take on notice exactly who they consulted with through that.

MS BARRY: That would be great. Thank you.

Ms Stephen-Smith: I want to acknowledge that Ms Barry has raised this issue with my office and there has been some engagement on it. I emphasise that the engagement does not stop now. This is an ongoing process of consumer and clinician engagement and education as the scheme is now in place.

MS BARRY: Thank you.

MISS NUTTALL: Obviously, you set up a process specifically for VAD, but also for any number of the small but worthy reforms that come through Health. Do you have a similar approach to consulting with various multicultural communities as well?

Ms Stephen-Smith: It depends on the circumstance. This is an issue about which we certainly get some feedback. Sometimes it is from the multicultural community about specific issues and access to services. There has been some recent media commentary about the availability of interpreters as well. I do not know whether anyone from the

directorate wants to talk about engagement with the multicultural community and policy. We will take on notice some detail about how that process generally works.

MISS NUTTALL: If that is okay, that would be wonderful. My next question is specifically about the Local Hospital Network costs. For reference, this is on page 367 of the Health Directorate's annual report. It notes that the Local Hospital Network's net cost of services is $163.8 million, or 14.2 per cent more than budgeted. With that in mind, what actions are you taking to reduce projected hospital demand in the future? And what analysis are you doing over the medium term to analyse how investment in preventative and population health strategies might slow the rate of increase in the demand for hospital services?

Ms Stephen-Smith: Thank you, Miss Nuttall. There are probably two separate questions there, in some ways. The funding for the Local Hospital Network is primarily about Canberra Health Services. The increase in funding is what we talked about through the budget review process and the additional $227 million for Canberra Health Services that was reflected in the midyear review. Obviously, there is a piece of work around sustainability of the Canberra Health Services' budget that CHS can primarily speak to. And your broader question around investment in preventive health, primary health care and health promotion is something that the directorate would be better placed to speak to. Which one would you like first? We could speak under wet cement about both of those things. Maybe we could touch briefly on the sustainability work. Ms Zagari can talk about that. The CHS CFO is coming to the table as well, and then we can talk about preventive health.

Ms Zagari: The minister is right: we can talk under wet cement on the sustainability work that is to be done. In a moment, I will hand to Ms Lopa, who is the deputy CEO, and to Ms Hughes, as the CFO. Between them they will answer the questions that you have. There is a considered body of work underway, led from the top but also in partnership with our clinicians, looking at the opportunities to make the health service more efficient—to bring down our cost of delivery of health care per plated activity unit, to start to increase efficiency and therefore address the budgetary issues. Ms Lopa will speak to the program of work going forward, which is in partnership with LHN oversight, and then Ms Hughes will talk about our progress to date, if that is helpful.

Ms Lopa: I have read the privilege statement. We are working in collaboration with the Health and Community Services Directorate and Treasury to look at our costs as a health service and making our service more sustainable. The focus of this work is twofold. There are the immediate things that we are putting in place right now, and Ms Hughes will talk to the impact that they are already having on expenditure in the health service. There is some more medium to long-term work happening around longer term reform that will bring in longer term sustainability. It is about how we do our services, how we can reform how we do our service delivery, to make us more sustainable over time, not necessarily to save money today, but looking at how we do things longer term.

We have an LHN assurance committee, which comprises Canberra Health Services, the Health and Community Services Directorate and the Under Treasurer, chaired by Nigel Lyons, who is an independent chair that we report to about these activities. The CFO and her team are working on the shorter term initiatives that are bringing savings right

now, which she can speak to. In my bailiwick at the moment, there is that longer term sustainability work.

We are looking at doing some work looking at our admin staffing model, looking at our nursing positions, all those things, which will inform, longer term, how we benchmark against other states and territories with respect to our levels of staffing.

When I say "levels", I do not mean numbers; I mean looking at whether we are top heavy, whether we are seeing an issue with middle-level nursing. It is about looking at how we run our business and all our staffing. That is not with an aim of reducing staffing. That is actually so that we can know what we have and what our levels are.

We are looking at things like virtual care. Where could virtual care play a role in how we deliver our services? We are looking at things like long-term patients. We are working with the Health and Community Services Directorate on those patients that are in our hospital who probably should be in residential aged care, rather than in the hospital. We are working with the Health and Community Services Directorate and the commonwealth on what we might do around getting those patients into the appropriate place for them to be living, which is definitely not a hospital.

We are doing engagement across the service. We are going out to our doctors through our general managers, through our COO, to say to doctors and nurses, "If you have been in your role and you think, 'Why do we do it this way?' or 'It would be more effective if we did it this way,' we want to hear about it." We want to be having those conversations. I think the success of programs led when they come down on people are not nearly as successful as when people come forward with their ideas. They are the people that are working in our hospitals and in our community services every day.

That is some of the longer term work that we are doing. We will look at outpatients—how we run it, whether it is efficient and effective. All those things will inform future reform or changes, knowing that we might do that work and find that it is the most efficient and effective way to run it. It is about having a really good look at how we run our service. Ms Hughes can talk about the short-term gains that you are seeing.

Ms Hughes: I have read and acknowledge the privilege statement. We have a short-term savings program—we call it financial sustainability, actually, because it also includes some revenue initiatives—with a target of $74 million in savings in the 2025-26 year. As you will notice, the budget uplift, from what was actually paid with the second tranche of funding through the budget process last year, is not as significant as it was in the 2024-25 year, with that extra supplementary increase. We are relying on $74 million in savings. After the first quarter, we are on track.

The largest part of those is in reducing agency nursing and bringing nurses in-house. That is $41 million. We are actually ahead of that target. I think that is a double good news story, because we have brought the cost down and we have put on a whole lot more graduate nurses, and nurses, over the period. That is a double good news story, because we have more staff and we also have lower costs.

We are working around how much work we outsource versus done in-house. We are looking at how we can improve the efficiency of our throughput. That is showing some

gains, but it is in its beginning stage. We have had some good procurement savings, which is about standardising products, using appropriate products for a clinical situation. We might be using the most expensive product all the time, when we could have some variation.

We have also tightened up our budget controls, and set a budget based on the correct safe staffing levels for nursing and adhering to those. We are working heavily on revenue optimisation. We are seeing some good gains there. That is about claiming for all the things we can claim for, making sure that we do not have billing errors and data errors, and making sure our price lists are up to date.

We are on track with those initiatives, but we totally acknowledge that the longer term changes in how health care is delivered are what is required for sustainability, with the ageing population and growing demand.

MISS NUTTALL: On page 54 of the Canberra Health Services annual report, it says that while employee expenses are seven per cent ahead of the original budget, supplies and services are up 27 per cent, or $171 million. What proportion of that was VMO costs?

Ms Hughes: I would have to do the maths offline to get the VMO costs for you. VMO costs themselves were up. I can get the exact number for you. I think it was about $11 million over the previous year in 2024-25. The really big increase at the beginning of 2024-25 was in agency nursing, and that has been significantly reduced.

THE CHAIR: Are you taking that question on notice?

Ms Hughes: Yes, we can get the details.

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

MS BARRY: I did not hear the last thing you said. What was the biggest increase?

Ms Stephen-Smith: Agency nursing costs.

Ms Hughes: The biggest single increase at the beginning of 2024-25, and in the first six months, was the agency nursing costs.

MISS NUTTALL: Have you done the modelling of that alternative cost if those human resources were employed directly by CHS?

Ms Hughes: Yes, we have for nursing. We are working through that a little bit for medical staffing. But we are more focused on what is the correct medical staffing plan to deliver our volumes, rather than the types of staff.

MISS NUTTALL: What was the modelling for nursing, when you did it?

Ms Hughes: We can share that with you, in terms of the NIMS templates.

Ms Zagari: We will take that question on notice and provide that detail.

MR RATTENBURY: I have a question on costings. I noticed on page 367 the issue of cross-border payments due to the ACT still to be reconciled was $27.1 million, against $2 million projected. Can you explain to us why there is so much variation in these figures?

Ms Hughes: That would be a question for the directorate—cross-border payments.

Ms Stephen-Smith: Mr Rattenbury, can you repeat the question?

MR RATTENBURY: Sure. It is on page 367, Minister. Cross-border payments due to the ACT still to be reconciled were $27.1 million. The projected budget was $2 million. I am interested in understanding the significant variation.

Ms Hudson. have read and acknowledge the privilege statement. I will not be able to answer your question in full. My understanding around cross-border is that there is a pre-payment model that is done; then there is a reconciliation that occurs at the end of the financial year. The creation of the tables for us will always be out of sync with the reconciliation.

We can answer the question in detail around the numbers. I would need the CFO's support. Given the changes that have occurred recently, I am not sure whether we are in a position to answer the question. Largely, it is because of the flow and the way in which the MOU arrangement is with New South Wales, principally.

Mr Hayward: I think it largely due to the increase in cross-border payments. As we see more cross-border payments flowing towards the ACT, we will also see more cross-border payment liabilities, because we expect more payments in the future.

MR RATTENBURY: In your view, are New South Wales residents being treated in the ACT covering the cost of the capital and equipment needed to cover their treatment? Are we getting a fair deal out of New South Wales?

Ms Stephen-Smith: Those are two separate questions, in some ways. The answer is no, they are not covering the cost of capital, because the cost of capital investment is not included in the national efficient price. The national efficient price reflects the cost of delivering services once you have built the hospital or whatever facility it is. That is a conversation at the national level.

The national efficient price is intended to reflect the cost of service delivery, though, and New South Wales does pay us at the national efficient price for all New South Wales residents that are treated in the ACT. They would argue that they are indeed paying their fair share.

We would make two points about that. We have made, in the context of the National Health Reform Agreement negotiations, the point that it is almost impossible for small jurisdictions to deliver at national efficient price. The reality is that we do end up cross-subsidising New South Wales patients. That is not necessarily the fault of New South Wales itself. It is as a result of the way the national efficient price is calculated.

I would also make the point that we have, under our current cross-border agreement with New South Wales, seen a significant improvement to what used to be the case, prior to, I think, 2022-23, when we renegotiated the cross-border agreement with the former New South Wales health minister. New South Wales had a cap on the year-to-year increase in funding from New South Wales to the ACT. They would only increase funding by two per cent a year, from memory. Now they pay for all the activity that is undertaken in relation to New South Wales patients. As a result of that, that is what has seen the really significant increase in cross-border flow.

Ms Hudson: To take it one step further, they also contribute to what is called the teacher training and research contribution, which I think is what you are meaning. They pay a percentage of that, which is not part of the national efficient price.

MR RATTENBURY: There was a motion passed in the Assembly in September that noted, because the ACT was not achieving a national efficient price, if we had been able to do that, our budget would be $473 million better off. As part of that motion, the Assembly agreed that the government would employ a new health analyst in Treasury to assist the health directorate to achieve the national efficient price, or the small jurisdiction equivalent. Has the health analyst been employed yet?

Ms Stephen-Smith: I do not have the exact language of the motion in front of me. Ms Lopa talked about the LHN oversight committee. Is it called the oversight committee?

Ms Lopa: It is called the assurance committee.

Ms Stephen-Smith: The assurance committee. Treasury is a member of the assurance committee, so we do have Treasury expertise and input. It is not necessarily so much a question of Treasury having the expertise to help the health service to deliver at the national efficient price. All the work that Ms Zagari, Ms Lopa and Ms Hughes talked about earlier in the sustainability piece is in fact about helping us become more efficient. There is health service expertise that will inform that as much as there is external expertise.

In addition, with the work that we have commissioned Michael Walsh to do, as part of that inquiry, the directorate have recently finalised the procurement for the independent consultants who will support him. A group from KPMG has been brought on board as the independent consultants to support Mr Walsh with that work. They will have expertise in health system efficiency as well. That is how we have addressed that piece of work. I am looking forward to getting his recommendations about the other things we can do.

Ms Hudson: It is also worth noting that there is expertise sitting in Ms Jacobi's team—health economics et cetera. Indeed, they are leading the small states efficient price component, together with Tasmania and Northern Territory. Perhaps the health directorate brings some of the expertise alongside the service expertise that sits with our hospital colleagues, and through that LHN assurance committee, which is chaired by the directorate D-G. There is expertise drawn together in that conversation. Beneath it there are also senior officer groups working together to work through what part is a smaller state contribution to our price; also, where the efficiency finding is, which is

that sustainability piece.

MS BARRY: You talked about cross-border payments corresponding with cross-border liability. What does that mean?

Mr Hayward: Essentially, we usually have that "true-up" model, for want of a better word, where we do a reconciliation at the end of the year. We might get additional payments to ourselves, or in some cases we might have additional payments to other states or territories. What we often do at the end of the year is recognise what we think is the flow either way, if it has not been settled at the end of the year but it relates to that year's activities.

Ms Hudson: There are important components to that. For instance, there is an arrangement with Westmead, if I have that correctly, because we do not have all the skills required in the ACT to deliver very precise and very expert pieces. We do have flow that goes out for that expertise. I think it is worth recognising that, when we consider New South Wales.

MS CASTLEY: I would like to talk about staff in the ACT health directorate report. On page 25, in the organisational chart, Minister, I note that there are 38 specific roles that are held by individuals, and 12 of them are acting positions. Is it normal to have 12 people acting in these roles?

Ms Hudson: I think that is a contextual component, given the machinery of government occurring. There was a decision taken to support flexibility at that time. There are a number of acting positions, and we were aware of the machinery of government, obviously, well before the completion of the financial year.

MS CASTLEY: On page 62, it talks about being a high-performing organisation. Strategic indicator 4.1 is about the directorate being a great place to work. Table 8 is about staff engagement and strengthening organisational culture. Both indicators, for staff engagement and strengthening culture, are far behind the 2024 target. Do we know why that is the case?

Ms Hudson: You are referring to the 64 per cent relative to the target of 75 per cent?

MS CASTLEY: Yes.

Ms Hudson: I cannot answer specifically as to why. I agree that it is a very key component of staff morale et cetera. There was significant work undertaken in the directorate at the time because the other component was high workloads, which was driving some of the staff engagement components, if you listen to the way in which they unpack. Staff engagement is the reflection of all the other component parts that they measure in the survey. At the end of last year, there was the commencement of the work, a prioritisation piece, which was addressing that. That progressed over the year. Indeed, it is coming to fruition this financial year.

MS CASTLEY: Have the figures been improving or are they getting worse, say, over the last—

Ms Hudson: We do not have the outcome of the most recent staff survey.

Ms Stephen-Smith: The most recent staff survey was undertaken in August-September this year, so that should be out fairly soon.

Ms Hudson: Yes, it should be out by the end of this year, I believe.

MS CASTLEY: Do you have any indicator of whether it is better than last year or the year before?

Ms Hudson: It is difficult to say because we are brought together with community services, and I do not have the Health and Community Services outcome.

MS CASTLEY: On page 74, it talks about the northside hospital transition. The claims for compensation were extended until 2 July 2025. The territory received 32 claims for compensation since 3 July 2023. Can you detail who made these claims, not individually, as in names, but was it staff or was that from Calvary itself?

Ms Stephen-Smith: That is Calvary.

MS CASTLEY: With each individual claim, what was the average cost of those individual claims? Do you have that detail?

Ms Stephen-Smith: I am not sure whether we are able to provide the detail. There are some claims that are relatively small, and other claims, obviously, were quite significant. The claims range from the acquisition of the land and the termination of the Calvary network agreement through to some specific costs associated with the process itself, which would be quite small. Ms Bladin can provide some further detail.

Ms Bladin: I have read and acknowledge the privilege statement. We have previously provided a list of the number of claims received. As the minister has correctly said, there was a vast difference and range of value of those claims. As the minister said, a lot were associated with transition costs—the costs that Calvary incurred in undertaking work associated with the transition, right through to, as the minister said, the more significant claims, claims of higher magnitude, associated with the acquisition of the land. There were claims associated with the payment of redundancies and a range of other claims that were considered through the process, not all of which were accepted, as at the date of settlement.

MR RATTENBURY: I want to ask about the directorate's CO2 emissions on page 62 of the annual report. As someone who knows about these things, I am struggling to understand what the table means. Table 5 talks about the reduction in CO2 emissions; it has a 2024-25 target of 308 kilotons, CO2 equivalent, and the actuals are 355. Does that mean that is what your actual emissions were or is that what the reductions were? I cannot tell.

Ms Stephen-Smith: That is an excellent question, Mr Rattenbury. I am sure there is someone here who can answer it.

Ms Bladin: I am actually not sure. I did not clock what it was measuring. I do know

that we did not meet our target. We did not exceed our target for the last financial year. I am not sure whether it is emissions or reductions, but we emitted more than we had targeted to emit.

MR RATTENBURY: I think it probably means that emissions were 355.

Ms Bladin: Yes, I would say that is what that means.

MR RATTENBURY: Perhaps for next year that might be—

Ms Bladin: Clarified.

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

MR RATTENBURY: What is the reason that the directorate did not meet its target? What is being done to ensure that the target is met next year, or in the current year?

Ms Bladin: We have been working closely with our colleagues in the City and Environment Directorate who undertake these measurements and assist in the reporting of them. We do not have a significant number of levers. We are in a commercial lease arrangement on Bowes Street. Bowes Street is still reliant on gas. Holder is our other significant emitter. With the two office blocks, we own Holder and we lease Bowes.

We are making gradual changes through gradual infrastructure works that are trying to shift us away from a higher dependency on non-renewables. As I said, in Bowes Street, that is very difficult. We are also going through a process of overhauling our fleet and, where possible, moving those to electric vehicles. But we do not have a huge number of levers with that.

MR RATTENBURY: There is obviously a bit of a gap between the target and the actuals. I appreciate that the target was ambitious, but why didn't you get there? What were the barriers that came up during the year, given that, clearly, there was an intent to get to a better number?

Ms Bladin: Yes. I think we have communicated that we were not 100 per cent sure that that target was achievable for us, when the targets were set. We have been trying to work with, as I said, City and Environment to revise some of the targets so that they might be more achievable, given the trajectory of works that we have planned and, as I said, the long-term nature of the leasing arrangement in Bowes Street.

Ms Stephen-Smith: More broadly, obviously, we will have to redo all of our annual report structures, in response to the machinery-of-government changes. In addition to clarifying this target, this is probably an opportunity also to consider how we better articulate who is responsible for what. I certainly note that, in relation to some of the activities that the health directorate has identified, the ownership of the infrastructure sits with either Canberra Health Services or Infrastructure Canberra now—places and spaces. We will probably have to go through a whole process of working out who reports what and where, in terms of the infrastructure impact, including some of the leasing arrangements where the health directorate is not actually the leaseholder; it is Infrastructure Canberra that is the leaseholder.

MR RATTENBURY: Does the government have data on the number of bulk-billed appointments in the ACT each year?

Ms Stephen-Smith: That data would not come to the ACT government. We would potentially have access to commonwealth data, but that data is generally Medicare benefits data that is publicly reported, I think, through the Institute of Health and Welfare. We would not collect our own data because that is not something that we would have any control over or any reporting mechanism to us.

MR RATTENBURY: Is that AIHW data broken down by jurisdiction?

Ms Stephen-Smith: Yes. There is a range of primary healthcare data that is publicly available that is broken down by jurisdiction and, indeed, by primary health network, and the ACT is a single primary health network.

MR RATTENBURY: In our supply and confidence agreement, we have an aim for an extra 160,000 bulk-billed appointments each year. Do you know if we are on track to achieve that?

Ms Stephen-Smith: Certainly, in terms of the most recent reporting, it probably would not show a change at this point, in terms of a really substantial change—the impact of some of the measures that we will take, and some of the measures that the commonwealth government has taken. I will hand over to Ms Hudson to talk about the measures we are about to implement in relation to primary care.

Obviously, from 1 November, the commonwealth government tripled the bulk-billing incentive for all patients and added the incentive to become a fully bulk-billing practice. We have seen five additional practices in the ACT become fully bulk-billing as a result of that, in addition to the six that were already fully bulk-billing. The commonwealth has also committed to the establishment of three additional fully bulk-billed clinics in the ACT.

We are investing in a $1½ million initiative to support and incentivise practices to fully bulk-bill all children and young people under the age of 16, and to support general practice professional development and wellbeing, to take some of the financial pressure off GPs and to support more GPs staying in the profession, and the recruitment and retention of junior doctors into general practice as well. Both initiatives are currently subject to co-design with GPs, practice owners and our colleagues in the RACGP and AMA. I will hand over to Ms Hudson, to talk about that.

Ms Hudson: Of course, we know that, here in Canberra, we have a very low base on which to grow from, with 90.6 FTE per 100,000, which is less than the national average. We know that we have a small number of GPs, and it is really important that we provide the best context in which they can operate, maintain that group of people and, indeed, grow further.

As the minister said, there are a number of initiatives underway at the moment, and very heavily, in trying to understand what the best direction of travel would be. There is $4 million being placed towards professional development and wellbeing funding,

including $400,000 for Drs4Drs.

In terms of the professional development and wellbeing piece, there is some very key engagement occurring over the next two months to ensure that we are in a position early next year to go out with some opportunities. That includes specifically with registrars in training, as well as through the AMA and, as the minister mentioned, the Royal College of GPs.

MR RATTENBURY: I am aware of the government's initiatives. I want to understand whether there is any indication of movement in the data.

Ms Stephen-Smith: As I indicated, I do not think we will necessarily see that in a nationally comparable sense at this point. I do note that the AIHW Medicare bulk-billing and out-of-pocket costs of GP attendances over time was last updated in December 2024. If it is on an annual cycle, you would expect that there will be some further information coming out towards the end of this year around 2024-25 from AIHW.

MR RATTENBURY: So the ACT does not have any data—

Ms Stephen-Smith: Ms Zagari is currently looking at some—

Ms Zagari: There is a dashboard on Medicare statistics which has year to date.

Ms Hudson: Correct.

Ms Zagari: There is 20 24-25 data there. All the underlying data tables are available there as well.

MR RATTENBURY: So that is how the ACT government is able to track our progress?

Ms Stephen-Smith: Yes.

MS CASTLEY: Minister, on page 95, at table 48, it says there are still 13 internal combustion engine vehicles. I am wondering why we have not increased the number of EVs in the fleet, and why the amount of petrol use increased so hugely.

MR RATTENBURY: An excellent question, Ms Castley.

MS CASTLEY: Thank you, Mr Rattenbury.

Ms Stephen-Smith: I will invite Ms Bladin to talk about that.

Ms Bladin: Can you repeat the question?

MS CASTLEY: I am wondering about the electric vehicles and why we do not have more of them. We still have 13 internal combustion engine vehicles, and the fuel bill looks to have skyrocketed.

Ms Bladin: I will have to take the exact details on notice, but I do know that they run petrol vehicles at the Ngunnawal Bush Healing Farm, so that would explain a portion of it. I will take the exact numbers on notice.

MS CASTLEY: Could you provide, on notice if necessary, the breakdown of the number of kilometres that each vehicle and their category type has done over the last two years?

Ms Bladin: Yes.

MS CASTLEY: Also, I am interested in whether there are enough charging ports for the existing vehicles that need to be charged. I believe there are some plug-in hybrids; are they able to be charged, or are they just being run as petrol vehicles?

Ms Bladin: I will take all of that on notice.

THE CHAIR: I have a question about the ACT Aboriginal and Torres Strait Islander Agreement. Page 51 of the CHS annual report identifies that the action under that agreement to ensure reasonable adjustments are provided to Aboriginal and Torres Strait Islander people with disability, as part of the Canberra Health Services disability action and inclusion plan, is delayed. Can I understand what caused that delay?

Ms Zagari: The delay relates to a build happening within the DHR. In order to capture people as having a disability and requiring adjustment, there are changes that are required in the DHR for that to happen. As part of the prioritisation work across DHR, this is one of the pieces of work in that prioritisation mix. We are delayed pending that. At the moment there is not a mechanism for staff to see within DHR that this person requires an adjustment for disability and specifically what that adjustment might be. As a result, the ability to (a) enact this on anything more than an ad hoc basis and then (b) report against it is delayed.

THE CHAIR: That gap in the DHR was not understood at the time the action plan was created?

Ms Zagari: That is correct.

THE CHAIR: When do you expect this to be implemented?

Ms Zagari: I will have to take that on notice. I know we have a session on digital coming up, but I will take that question on notice and work with colleagues in Digital Canberra—I was going to point to the directorate but it is not the right place—to be able to respond to that and understand whether there is a timeframe for it.

THE CHAIR: You are taking it on notice?

Ms Zagari: I will take it on notice.

THE CHAIR: Is that a phase 2 action under the ACT Aboriginal and Torres Strait Islander Agreement?

Ms Zagari: We will also take that on notice.

Ms Hudson: We will look it up.

THE CHAIR: While you are doing that, perhaps you can let us know if that will be rolled into phase 3, if that is the intention, phase 2 having concluded in June, according to the annual report. I want to ask about reconciliation action plans or similar documents. According to the ACT's whole-of-government 2024 annual report on the National Agreement on Closing the Gap, tabled in the Assembly in June, a key measure of identifying and addressing systemic racism, discrimination and unconscious bias under the national agreement is the number of directorates with a reconciliation action plan in place.

That report also indicates that CSD had a reconciliation commitment developed in 2018 and embedded within the strategic plan for 2018-28, and that the health directorate had committed to developing and implementing a cultural integrity plan. Which of these two approaches has been adopted by HCSD?

Ms Arthy: I think it is a bit too early for me to commit to which way we are going to be doing it as a joint directorate. The directorate has only recently come together and, as yet, we have not met to talk about how we will approach reconciliation action planning as a combined directorate, but that is certainly a priority.

THE CHAIR: During estimates hearings in July, the former director-general indicated that there is a cultural integrity statement. I have been trying to find that document. I think it is also mentioned in the ACT Health annual report.

Ms Arthy: We commenced work towards a cultural integrity plan. That may well be the reference point. I believe it was led by one of our directorate executives. It included Aboriginal and Torres Strait Islander and non-Indigenous representatives across the directorate. It is fully articulated on page 171 of the annual report, if that is what you are referencing.

THE CHAIR: This is on page 167. It says: "The group developed an ACT Health Cultural Integrity Commitment Statement."

Ms Arthy: That was the work of the Cultural Integrity Reference Group that came together.

THE CHAIR: I am assuming the plan will be built on the basis of this statement, but that is just an assumption.

Ms Hudson: That is a reasonable assumption to have, but, as Ms Arthy just said, because we are now a combined directorate, we are waiting to have a singular step forward rather than continuing to offer it through Health and Community Services. We will try to learn from each other's various strengths.

THE CHAIR: Is that Cultural Integrity Commitment Statement that has been prepared available somewhere or could that be provided to the committee on notice?

Ms Hudson: We can take that on notice.

THE CHAIR: Thank you. In relation to the machinery of government changes, what happens to the Community Services Directorate's strategic plan in that annual report I was referring to—that is, the National Agreement on Closing the Gap annual report? It described it as a 2018-2028 plan. I just jumped on the website and there is a 2023-25 plan. I do not know whether that is a subplan or an action plan—something like that. Where is all of that up to? And will that continue or will it be redeveloped?

Ms Arthy: Mr Emerson, I will have to take that back to the team. This is my second day on the job, so I am not across all the detail. I can go to the general approach. The broad approach for the new directorate is to have one approach to how we deal with Aboriginal and Torres Strait Islander matters and reconciliation planning. As I mentioned before, we are still in the very early days of working through that. There is a specific element of that in terms of the CSD component. I can get the team to come back on notice with an answer to that specific question. As Ms Hudson said, we want to learn from the best and the worst of both previous directorates and come up with a way forward that works for the entire new directorate.

Ms Stephen-Smith: Could you repeat your question, Mr Emerson?

THE CHAIR: The question is about the fate, I suppose, of the Community Services Directorate Strategic Plan 2018-2028 that was referenced in the 2024 annual report on the National Agreement on Closing the Gap. That report indicates that the reconciliation commitment, which was developed in 2018 by CSD, is embedded within Strategic Plan 2018-2028. I am not sure where that plan is, if it still exists.

Ms Stephen-Smith: If it is an internal Community Services Directorate strategic plan, that will be part of the updating, and bringing those things together will be part of the work of the implementation of the machinery of government changes.

Ms Arthy: That is right. One of the things that we need to do is map out all the different plans and agreements that exist, because there are a lot. Part of the job is to streamline and develop one approach for how we deal with this. In terms of that specific document, as I said, I can go back to the team and ask that very specific question. The goal is to have one set of documents that covers both—the new directorate.

Ms Stephen-Smith: Could I go back to a question that you asked in relation to the Disability Action and Inclusion Plan and the Aboriginal and Torres Strait Islander Agreement? Priority action 8 under the phase 2 implementation plan, for the strategic priority area, is ensure reasonable adjustments are provided to Aboriginal and Torres Strait Islander peoples with disability as part of the Canberra Health Services Disability Action and Inclusion Plan. It is a phase 2 action, and my expectation would absolutely be that, given the delays in implementation, it would be rolled over to phase 3.

Ms Zagari: The team is confirming for me that it has happened, and I will let you know before the end of the session.

THE CHAIR: Whether it is rolled into phase 3, or it might happen regardless.

Ms Zagari: Correct.

Ms Stephen-Smith: Yes. It will continue to be implemented, whether it is articulated in writing in phase 3 or not.

MS BARRY: You mentioned that you have not met yet since the departments were merged. Is that right?

Ms Arthy: I cannot talk to that because, as I said, this is day 2 in the job, in an acting role. What I said was that we have not formalised the processes to bring together the reconciliation action planning or anything to do with this, as far as I am aware, but that is certainly one thing that we need to do fairly urgently.

MS BARRY: Could you please confirm, or take on notice, whether you have met in the six months that the department has been merged?

Ms Stephen-Smith: I am not quite clear on what you mean by "met".

MS BARRY: She mentioned—that was the evidence—that there has not been a meeting to—

Ms Arthy: I am not aware that I said "meeting". I said that there was not any work done on bringing the documents together yet. It was not about meeting around—

Ms Hudson: There is the commencement of an internal subcommittee to the executive board to focus on Aboriginal and Torres Strait Islander affairs, to make sure that we, as executives, are held to account for what we say we will do in phase 2 and phase 3. That work has commenced. I am sure that, if you want to know more detail, Daniel may know, but we are working through the terms of reference at the moment in partnership with our Aboriginal and Torres Strait Islander leaders within the directorate, and, indeed, all staff who are Aboriginal or Torres Strait Islander.

MS BARRY: Thank you.

THE CHAIR: You are talking about the meeting of the reference group.

MS BARRY: The reference group.

Ms Hudson: There is a subcommittee of the executive board, as required by government, being developed.

MISS NUTTALL: Going back to reasonable accommodations, if they currently cannot be accessed or read through the DHR, what does that look like for an Aboriginal or Torres Strait Islander person with a disability when they are trying to access services?

Ms Zagari: The change in the DHR will not be limited to just Aboriginal and Torres Strait Islander people. It is actually to reflect adjustments made or required by any person with a disability. Depending on the nature of the disability, some will already be reflected in the DHR. To use the example of somebody with particular mobility requirements or need for support services to deliver care to them, they will be reflected

in the plan of care for them. It is about some of the more nuanced support—for somebody who is neurodivergent and comes to an outpatient clinic, for example. They might need an adjustment to the space so there is less sensory overload. That is not currently reflected. It means that individuals need to talk to people when they come to the clinic. They need to say, "This is what I need." It may be difficult for someone with a disability to do, so we intend to create a mechanism for that to be captured one time and then have it flowing through. Particularly in the neurodivergent space, people may find it very difficult to articulate a need to a person at the end of a phone or in front of them in a clinic or in a moment when they are quite overwhelmed by the noise and bustle of a hospital.

We acknowledge that there is work to do, which is the intent of this action—to do better with it. Obviously, we have clinicians who are really committed to doing the right thing by every patient, but we are looking for a mechanism to make it easier for patients to identify the support that they need and not have to say it every time. We hear clearly from people with disability that having to ask for things every time or repeating it can be disempowering for them. I speak from experience. My husband has a disability. Needing to state that can be confronting for people. We would like to make it possible for people to declare it once and then receive the care they need every time, with the adjustment built in. At the moment, it is dependent on individual conversations.

MISS NUTTALL: Thank you. That answered all my questions.

MS BARRY: There was reference to a disability access audit in 2023-24, but I cannot see it in the current budget. Has that happened?

Ms Zagari: Correct. There was an access audit undertaken. I will take on notice to come back with the detail around that.

MS BARRY: Thank you. I want to know what it found and what work has been to implement it.

Ms Zagari: Thank you.

MS BARRY: Minister, did you commission a Russell Bayliss report on cardiology? Was that a report you commissioned?

Ms Stephen-Smith: No. I do not commission those kinds of reports. I will hand over to Ms Zagari to talk about that.

Ms Zagari: There is not a Russell Bayliss report. Mr Bayliss undertook a piece of work for us in relation to some industrial matters.

MS BARRY: Can you tell us what those were?

Ms Zagari: I would need to discuss that with the minister. They relate to individual employment matters.

Ms Stephen-Smith: We know that previously, when reviews into employment matters and concerns about the culture of a particular area have been reported and were subject

to freedom of information, it has been quite damaging for the staff in those particular areas. So we would need to take some advice, particularly if there is not a single written report that could be easily redacted to protect privacy and respect the industrial processes involved. We would have to take on notice whether there is anything that we could provide in relation to the outcome of that matter.

MS BARRY: That would be really useful. Thank you, Minister.

Ms Stephen-Smith: No worries.

MS TOUGH: The directorate is working with CHS to implement activity based funding for hospital services to help us understand the cost of services. The annual report says it is to inform commissioning of future hospital services. Could you explain what this involves and what the benefits are?

Ms Jacobi: I have read and acknowledge the privilege statement. Activity based funding was introduced in the ACT on 1 July as the basis through which we are commissioning Canberra Health Services for the delivery of public hospital services. Compared to what has previously occurred, where there was a block grant, activity based funding now involves funding based on the activity that Canberra Health Services undertakes according to a price. It also provides the ability for us to have greater visibility in the system, in terms of how things are tracking, and a more transparent way in which activities are funded.

MS TOUGH: Thank you. Does that make it easier to understand where there is demand in certain areas of care?

Ms Jacobi: It enables us to fund according to the demand that we can see. It provides a level of transparency for CHS based on previous years and what we are projecting. It is much more in kind with what is actually done and it enables the territory to make commissioning decisions as well, in line with the ACT's health system priorities.

MS TOUGH: Thank you. I understand the commonwealth's funding for public hospitals has been going backwards as a percentage of costs over the last several years. What is driving this? And is it unique to the ACT?

Ms Jacobi: We are currently in negotiations with the commonwealth around a National Health Reform Agreement addendum. That is proposed to be from the middle of 2026 to 2031. It has continued to be pushed out. The commonwealth, through those negotiations, has made a commitment for a particular level of growth that it would commit to. Because of the increased growth in the cost of public hospital services, the commonwealth's contributions towards public hospital services, while they have been increasing, have been falling behind.

Ms Stephen-Smith: The percentage is estimated. Without the additional $50 million that the commonwealth has committed this financial year as part of the extension of the current addendum, I think the contribution rate was estimated to fall from about 37 per cent to about 33 per cent. With the $50 million, I think we are estimating it is 35.6 per cent for this financial year. It is a long way from the ambition of 45 per cent by 2035, which is the challenge that we have in our negotiations. To answer the first

part of your question, we are not unique in this regard. All jurisdictions are experiencing this.

MS TOUGH: Thank you.

THE CHAIR: We will now suspend proceedings for a short break.

Ms Stephen-Smith: Before we have a break, very quickly for Mr Rattenbury: my office has advised that, regarding the use of the same dataset that we use to base our agreement on in relation to the 160,000 extra bulk-billing appointments, the most recent dataset for 2024-25 reflected just over an additional 23,700 bulk-billed appointments.

MR RATTENBURY: Thank you.

Ms Stephen-Smith: No worries.

Short suspension.

THE CHAIR: Welcome back to the public hearings of the Standing Committee on Social Policy for its inquiry into annual and financial reports for 2024-25. The committee will now continue to hear from the Minister for Health and Minister for Mental Health. I believe Ms Zagari has some information for us.

Ms Zagari: I can confirm that the action in relation to reasonable adjustment is in our phase 3 agreement actions; also, that it is intended that the changes to the DHR will be completed by the end of quarter 3, so by March 2026.

MISS NUTTALL: My question is about CAMHS and their referral policy for children and young people who are thinking about their gender, who think they might be trans or gender diverse. What is the CAMHS policy for supporting children and young people who express that they are thinking about their gender, that they might be trans or gender diverse and would like support transitioning, whether that is socially, legally or medically?

Ms Wakefield: I acknowledge the privilege statement. We provide a paediatric gender service at Canberra Hospital. Would you mind repeating the question?

MISS NUTTALL: What is the CAMHS policy for supporting children and young people who are thinking about their gender and thinking they might be trans or gender diverse?

Ms Wakefield: I cannot speak for the CAMHS side of things, but we have services open to people who would like to be referred to our service. We have psychology, we have social work, we have a nurse coordinator and a doctor, including a GP, that support children and young people who might want to talk about gender.

MISS NUTTALL: I am interested in that specific link—that referral link. For example, with CAMHS, do you have a specific policy, if young people come to you and they are thinking about their gender, that you would refer them through to the gender clinic?

Mr Aloisi: I have read and acknowledge the privilege statement. Yes, effectively, that is what would happen. If we had someone who required that service, we would refer through to the paediatric service that Ms Wakefield spoke about.

MISS NUTTALL: Do they also continue to get support from CAMHS in the process?

Mr Aloisi: Absolutely. If the person is an existing client of CAMHS, they would continue to receive ongoing services, so it would depend on the particular individual and what services they were already receiving, if they were already a client. If there was someone who was not known to the CAMHS service and who was referred through our intake process, it might mean that we just make the referral to the paediatric service, and that might be the extent of our involvement. It would depend on what the individual has presented with. If they have a comorbid mental health issue that needed treatment, we would also support them with that.

MISS NUTTALL: Do referrals also go to community organisations like A Gender Agenda, Meridian and organisations like that?

Mr Aloisi: Yes, absolutely. With our referral process, we have an understanding of what services exist, in both the government and non-government sectors. Our referral process would generally cover a range of services that are available, and it is not always an internal referral to another mental health service, for example. We absolutely value and rely on community organisations who provide a number of significant support services within the ACT.

MISS NUTTALL: Do you have a breakdown of how many referrals tend to go through to the gender clinic as opposed to community organisations? Do you track that information?

Mr Aloisi: We can take the question on notice. My understanding is that we do not have that level of specificity in terms of where our referrals go. We would definitely be able to track those referrals which come internally, but in terms of how we record things in the digital health record, it does not capture that level of specificity. As you can imagine, there are a range of services out there, so trying to capture each single service, in terms of being able to extract data, would be very challenging. Within clinical records, you would definitely be able to find reference to which particular services that person has been referred to.

MISS NUTTALL: If you have a young person thinking about their gender, at the same time they might turn up to CAMHS experiencing a moderate to severe mental health crisis. Do you take into account whether community services are funded to support people with that level of need around the mental health space when you refer them out?

Mr Aloisi: Our fundamental decision would be around the level of acuity, at the tertiary end of the mental health service. That would be our fundamental involvement. If the person can get that mental health support in more appropriate or more accessible ways, or in other ways, we will also explore that. An individual might be referred through to us or might call our intake line, and we might refer them back to, say, a general practice; they might have a private psychologist involved, or a community organisation might be able to provide them with support. We will make our assessment based on the level of

acuity. Often, as part of that assessment, we are also taking into consideration things like risk, which obviously factors very highly in our decision-making.

MISS NUTTALL: When you refer young people through to the gender clinic specifically, what do those referrals tend to look like? Do you look at things like gender dysphoria and things like that?

Mr Aloisi: Yes, absolutely. Again, we rely on the expertise of the service to do a lot of the diagnostic work and the work-up, in that sense. We will obviously share our impressions, our clinical judgements, around what we think might be happening for that particular person. The important thing is that we will continue to work with the service as well—the paediatric service. That is very important; we see ourselves as part of that treating team. Whilst the expertise might lie in the paediatric service in terms of the gender-related matters, our actual involvement might still be continued in terms of other things for which we might be providing support.

Ms Wakefield: Psychiatry.

MISS NUTTALL: Does the paediatric gender clinic work with CAMHS as well to understand this from a practitioner's perspective and language—gender-affirming language to use for young people and the right terminology if someone is thinking about their gender, in that initial, more clinical intake, so that they are still feeling safe in the process?

Ms Wakefield: Part of the paediatric gender service is working with other care providers for that young person, particularly around some of that language and supporting them not only with health care, but also in other elements, like schools, for example.

MISS NUTTALL: Do you provide much support in school settings for trans and gender-diverse young people?

Ms Wakefield: I believe it is more with the young person and how they would like us to support them with their social and education environment.

MISS NUTTALL: Do you have the pathways within Education to chat to teachers and admin staff?

Ms Wakefield: I would have to take that specific detail on notice. That is part of our model of care, whether it is working outside, just with the young person, their family and their circle, or health care.

MS CASTLEY: I would like to talk about the ACT Health Directorate strategic objectives. At pages 47 and 48, under "a healthy community through collaborative leadership", table 2 shows the percentage of ACT adults who self-report their health as very good or excellent. Minister, you have a target of greater than 55 per cent for that, yet, after all the initiatives, we are still 10 points below the target. Can you talk about that?

Ms Stephen-Smith: I am conscious that we did not really get to the heart of

Miss Nuttall's question earlier in relation to health prevention and promotion, and primary care. Obviously, people's health and self-reported health status is related to a combination of types of health care. It is one of those areas where, while we have a target and part of our overall aim is to support the health and wellbeing of the ACT community, it is not something that is entirely in the control of the ACT government, but it might be an opportunity to talk about the work that we do around health promotion, preventive health and community wellbeing.

One of the things that we have been doing, in terms of our investment in health centres across the community, is trying to get health closer to home for people, supporting their access to primary care, in terms of our GP initiatives that we talked about earlier. We are trying to take a more holistic approach to meet people where they are at, with their health care. Ms Travers might like to talk about that particular indicator.

MS CASTLEY: I understand that there are all of the initiatives, but my question is: why do you have a target of 55 per cent? Even after the initiatives, we are still below; if it has remained stable since 2018, other than 2020, why do you keep setting the target at 55 per cent?

Ms Stephen-Smith: That is an excellent question. One of the things that we will be doing, in the context of the machinery-of-government changes and redoing the annual reports, is looking at our targets. Obviously, there is a relationship between the wellbeing framework and individual directorates' accountability indicators. One of the things that I have talked to directorates about over time is that we need to have a closer look at what is reflected in the wellbeing framework that we report on regularly, and what is reflected in terms of our own strategic and accountability indicators that we have a more direct influence over, so that we can be clearer with the community about where we are influencing, and where we are measuring, the overall wellbeing of the community. It is a really good question as to why we choose these particular indicators, which Ms Travers may be able to touch on.

THE CHAIR: I am conscious that we are approaching the 11th hour of the 11th day of the 11th month, so we might observe a minute's silence, if people are happy to stand. Thank you, members, the minister and officials, for taking a moment to remember those who have fallen in the line of duty. Ms Castley?

MS CASTLEY: I have specific questions about the general health survey. Is it weighted to represent the population? Where do our participants come from, and what is the sample size?

Ms Stoddart: I will have to take the question on notice. I do not have the details here.

MS CASTLEY: Thank you. Moving to objective 1.2, "improving the mental wellbeing of Canberrans", at page 51, table 3 gives the percentage of ACT adults who report their mental health status as very good or excellent. Again, Minister, we are setting targets, especially for mental health, that we just are not achieving. Why are we doing that?

Ms Stephen-Smith: At a high level, the answer would be the same—that we need to look at what fits in the reporting against the wellbeing framework versus what fits in the reporting around strategic and accountability indicators for our own directorates and

agencies.

Obviously, in terms of our broader focus on wellbeing and the wellbeing framework that informs the budget, the fact is that the proportion of adults who have rated their mental health as very good or excellent has decreased. When you say we are setting the target at 60 per cent, in 2018, as the report indicates, it was 56 per cent. It was much closer, then it has decreased and remained stable. The annual report provides some reasons why that might be the case. Going to your broader point about why we are picking the particular indicators, this is an ongoing conversation around the most appropriate place to report different types of indicators.

MS CASTLEY: Lastly, strategic objective No 3, "trusted, transparent and accountable", on page 59, strategic indicator 3.1 is "community engagement". Minister, I note that, in the activities that support strategic indicator 3.1, the Health Services Data Dashboard was published. How did you report the health data before this?

Ms Stephen-Smith: Effectively, this is a replacement for the quarterly performance report, the QPR.

MS CASTLEY: The data is delayed by three months from when it has been published on the dashboard. Why is that?

Ms Stephen-Smith: That is to ensure that the data is appropriately cleansed. Ms Hudson might want to expand on that.

Ms Hudson: Exactly, Minister. It is so that we are really clear. Previously, we have had questions about the difference between the nationally reported figure and those in the dashboard, so we are trying to make sure that we have congruence between those two numbers.

MS CASTLEY: Queensland Health publish their health data more quickly. Is it possible to get it?

Ms Hudson: It is a maturity question. The EMR here is still in—

Ms Stephen-Smith: The electronic medical record.

Ms Hudson: The electronic medical record of the DHR is still being worked through. We have heard today about certain metrics that are being delivered around Aboriginal and Torres Strait Islander people. We are not in a position where we are as mature as the Queensland system.

MS CASTLEY: Are there plans to publish separate health data for First Nations people? Again, looking at how Queensland Health do that, they carve out those figures and report separately, which I think gives a better understanding of how we can help our Aboriginal and Torres Strait Islander community. Do we have plans for that?

Ms Stephen-Smith: We are working through a range of improvements in relation to the data dashboard. One of the things that we have been talking about for quite some time is reporting of outpatient data, including outpatient waiting times, so that has been

a priority. There is also mental health data that gets reported. That is definitely something that we would want to start reporting on, as the maturity of the system improves.

Certainly, I have been pleased to see, where we do have the data being reported, that the gap has largely closed between Aboriginal and Torres Strait Islander "did not waits" in the emergency department. Safety of the emergency department for Aboriginal and Torres Strait Islander people, and whether or not you waited for treatment, is a well-recognised indicator of how people are experiencing that. Effectively, that gap has now closed between Aboriginal and Torres Strait Islander consumers and non-Indigenous consumers, which is really good. We would certainly like to be able to report that information publicly, but the priority at the moment is making sure that we can report on our patients.

Ms Hudson: There are really important concepts around Aboriginal and Torres Strait Islander data, and that is in priority reform 4. There is significant work underway around Indigenous data sovereignty and data governance projects, which are articulated in the annual report. We have to remember that it is important for us to know, but there is a whole other process that is much more important, where an Aboriginal or Torres Strait Islander is having control of their data.

MS CASTLEY: On the wellbeing framework, if you look at the statistics, we are still reporting nothing further from 2022. Is there a reason why we cannot have up-to-date figures on the ACT wellbeing framework?

Ms Stephen-Smith: I am not responsible for the wellbeing framework, so we do not have the right officials in the room. Which indicator are you referring to?

MS CASTLEY: Overall health and health status.

Ms Hudson: The health stats webpage; is that where you are at?

MS CASTLEY: Yes.

Ms Stephen-Smith: No, in the wellbeing indicator.

Ms Hudson: The wellbeing framework.

MS CASTLEY: ACT wellbeing framework. In Health, it does not matter whether you look at mental health; the statistics are just—

Ms Stephen-Smith: I do not know. You will have to ask the Chief Minister's directorate why they have not updated the dashboard in relation to the proportion of Canberrans who self-rated their health as excellent or very good, and if more recent data is available.

MS CASTLEY: As the Minister for Health, would you not have an interest in following it up, to make sure your portfolio is accurately represented?

Ms Stephen-Smith: I am happy to do that, but I cannot answer the question—if that

data has not been updated, why that is the case.

MR RATTENBURY: I would like to ask a couple of questions about alcohol and other drugs. In the health directorate annual report, at page 90, there is a reference to the government response to establishing a northside opioid maintenance treatment clinic. Has that been done? I understand that it has not, and I want to ask whether that has been followed though.

Ms Stephen-Smith: There was a northside opioid treatment clinic that was established, and it was subsequently closed, I think, in the early days of the COVID-19 pandemic, and it has not been reopened because of some changes, particularly around opioid treatment, which Mr Aloisi can speak to, in relation to the move from methadone to long-acting buprenorphine.

Mr Aloisi: I think you have pretty much answered the question, Minister. That is the primary reason. In terms of the demand for that service on the north side, with the change in the prescribing practice, with buprenorphine becoming the more preferred method in terms of OMT, we have seen that shift. The requirement for northside dosing around methadone is becoming less and less needed, so there has been a shift there. Obviously, if that situation changes, in terms of demand, we could reassess that, but that is effectively—

MR RATTENBURY: For people who are still on methadone—I assume there is still a cohort?

Mr Aloisi: Yes.

MR RATTENBURY: Are there dosing options on the north side, or do they have to go over to Canberra Hospital?

Mr Aloisi: There are dosing options. It is a tiered approach in terms of opioid maintenance therapy. People can access methadone through pharmacies; there is that option. There are various models of prescription and administration that are in operation, depending on the person's tier. For some people, because of the nature of that person's circumstances, they might need to be seen through the opioid maintenance treatment program run at the Canberra Hospital, due to the environment or some potential challenges in terms of administering for that person. That service only exists at the Canberra Hospital. For a number of other people, they will access through a pharmacy.

MR RATTENBURY: On the Watson health precinct, it is obviously a very welcome investment, and it is great to see it progressing out there, steadily. I want to ask whether there is a commitment or whether it has been put in place—the staffing capability to go with that. Do we only have infrastructure at the moment?

Ms Stephen-Smith: In relation to the Aboriginal and Torres Strait Islander AOD facility in particular?

MR RATTENBURY: Yes.

Ms Stephen-Smith: The other two are replacement facilities.

MR RATTENBURY: Yes.

Ms Stephen-Smith: Yes, there was some funding in the budget, I recall, for Winnunga. We are starting that process, and Maria might have some more information.

Ms Travers: Absolutely; there was some funding in last year's budget for Winnunga. That was certainly around developing a model of care and supporting the staff out there to become experts in delivering the care that is needed. Yes, there is funding for the model of care and for staff.

Ms Stephen-Smith: We understand that, once it opens, there will be a need for additional funding to support the ongoing operation. It is also part of our conversation with the commonwealth government around responsibility for Aboriginal and Torres Strait Islander health. I do not hold out a lot of hope for commonwealth funding, but we will continue the conversation.

MR RATTENBURY: Just to clarify, money has been allocated for the set-up phase; but, at this point, there is not clarity on the delivery phase or the ongoing operations phase?

Ms Travers: There is certainly funding for the outyears, over the four years of the budget measure.

MR RATTENBURY: There is?

Ms Travers: There is, absolutely. It is funded through the four years.

Ms Stephen-Smith: Sorry; that was misleading of me.

MR RATTENBURY: That is all right. We have had it clarified.

THE CHAIR: What is the barrier to establishing a safe consumption room in the ACT?

Ms Stephen-Smith: It is about priority, the model of care and the feasibility of where you deliver it. There is certainly no in-principle disagreement around the benefits of a supervised consumption facility, but what we saw in the report on harm reduction measures is a finding—which is consistent with our view—that a peer- or nurse-led model would be a more cost-effective approach to delivering that service in the ACT. My understanding is that that is not the way the legislation is set up. It is certainly not the way that either Melbourne or Sydney's supervised injecting rooms are set up. They are very much a medical model of service, not a peer-led model. Establishing a model of care for a peer-led service would be unique in Australia.

When I was on holiday in Amsterdam, I visited a peer-led service, which is a very different model of care. I have been to both facilities in Sydney and Melbourne. It is a very different type of model. There are questions around how you would establish that model of care from a legal and a clinical governance perspective, there are questions about where you would put it, and there are questions about whether it is the best use

of limited resources, in terms of cost-effectiveness. What the report on harm reduction clearly identified was that expanding some of our existing programs, like naloxone availability and treatment services such as opioid maintenance therapy and drug-checking, could potentially be a more cost-effective intervention than supervised consumption. We are certainly very much working with the sector to understand what a supervised consumption model would look like as part of an integrated approach.

For me, it is about creating a safe space where people would not only have access to a supervised consumption room but would also have access to a range of other services facilitated onsite or with warm connection. It is about being a safe space for people to access a range of services. Again, that is not really the way that the models have operated in Sydney or Melbourne, although there are some service connections.

THE CHAIR: It is my understanding that the costing in that report was based on a multisite model. I think there was still a 2.1 to 2.9 benefit-to-cost ratio, which is pretty good, compared to 10 or whatever else you were seeing with other interventions. Is that your understanding? Do you think it is worth revisiting the costing once the model is established? I imagine we will have one site in the ACT if Melbourne and Sydney have only one site.

Ms Stephen-Smith: I think we would at least start with one site!

THE CHAIR: That would be a significant change—right! Do you know what informed the decision to do a multisite costing? Was it because that would have been the ideal?

Ms Stephen-Smith: I imagine that was informed by the findings of the Burnet Institute's scoping study. I think that is what it was. It identified that there was not an obvious single place. In both Sydney and Melbourne, where supervised injecting rooms have been established, it has been very location-specific, where they have seen a significant amount of public drug use. It has been about addressing that issue as well as the safety issue. They were seeing people using drugs in public and overdosing in public. So it is about addressing that as much as it is about harm reduction for the people who use drugs. The challenges that we face in the ACT are quite different. The Burnet Institute's conclusion was that there was no obvious single location. Clearly, the city is the most obvious location. I think that is what drove it.

THE CHAIR: The existing act says:

> the facility must contain, or provide satisfactory access to—
>
> (i) primary health care services …

and so on. To me, it looks like it could suit a nurse-led model if clear referrals were provided to those sorts of services. I do not know that it requires that a GP be onsite. I understand a range of work needs to happen.

Ms Stephen-Smith: The question is about looking at the broad legislation versus what a model would look like—and I have not done that work myself. We do not have a model of care proposed yet. I know the sector is working on that. Also, to your point around the rate of return and cost-effectiveness, we could make lots of investments in the health space that would find a rate of return of 2.9 or more. We cannot do all of

them, so we have to choose where we invest our resources, and that is the ongoing conversation with the alcohol and other drug sector.

THE CHAIR: Going to procurement of equipment within CHS. I understand that, in June 2023, the Newborn Intensive Care Foundation approved $117,000 in funding to purchase an AngelEye camera system, and it still has not been procured by CHS. I was told that this follows other similar occasions where the cost of equipment has escalated from an agreed funding amount during the time it has taken to carry out the procurement process. It has made the fundraising activities effectively redundant. Are you able to walk me through why this is the case?

Ms Wakefield: For AngelEye, Digital Canberra are leading the procurement. We have some clinicians from the Neonatal Intensive Care Unit involved in that. I cannot speak to the specific delays, except that we are working with them to continue that procurement and deliver that for us.

THE CHAIR: Are you aware of this having been an issue in other situations, where third-party funding is received to procure a particular piece of equipment and then the procurement process takes such a long time that the funding is not sufficient?

Ms Wakefield: Not specifically.

Ms Zagari: I am not aware of circumstances that specifically relate to equipment. There has been an instance where funding has been raised in the capital space and the time taken and/or the total cost of the project has become more sizeable than was originally projected. We had to seek additional funding either from government or from donors. But I am not aware of that happening in the equipment space, with the exception of this one, where the complexity of the digital integration has driven it. We will get a timeframe update from Digital Canberra as required.

Mr Rattenbury: Are you are able to provide that on notice?

Ms Zagari: I will take it on notice.

Mr Rattenbury: Might you also look at whether there are any other instances of this sort of thing happening in the last five years? It could be interesting.

Ms Zagari: For donor funds for equipment, specifically where the equipment being purchased has increased in price because of lag time?

Mr Rattenbury: Yes, and what was done as a consequence of that. Was more funding sought, did CHS cover the spread or was the item not procured and the funds were returned, or something to that effect?

Ms Zagari: We will endeavour to find out.

Mr Rattenbury: That would be great. Thank you.

MS BARRY: Minister, I want to go back to the $11 million for VMOs—I think in response to the question about whether part of that money was for nursing agency cost.

In March this year, there was a change to English requirements. How has that affected your ability to recruit nurses who are from a non-English-speaking background? This goes English-language proficiency.

Ms Zagari: Understood. CHS have not seen a direct impact from the changes to the English-language requirements. We certainly are continuing to recruit nurses from non-English-speaking backgrounds. Ms Lang will provide some additional detail to that. We have seen some very successful international recruitment, ongoing.

Ms Lang: I have read and acknowledge the privilege statement. We have not seen an impact. We did a significant international bulk recruitment last year, at the beginning of 2024, for building 5, and some of them were still arriving in early January and February. Since then, we have had very small numbers coming internationally. We have not seen an actual increase or decrease. It has not affected us.

MS BARRY: What I understand from several reports I have received is that, if you are from a non-English-speaking background—for example, from Nigeria—and you studied in Australia, you are still required to undertake the IELTS. That is not your understanding? That is not what is happening?

Ms Lang: I am not aware of it. I would need to find out.

Ms Hudson: Perhaps I can answer some of this. This is a recommendation from the Kruk review. It is a national thing. It was approved by health ministers that the change would go from either 6.5 to 7 or the other way around. My recollection is that we are the same as New Zealand now. The change reflects that. It made differences to some countries and not others, but we are aligned with New Zealand.

MS BARRY: Then the question is: as a result of that, have you seen any reduction in your ability to recruit?

Ms Zagari: We have not seen a reduction in our ability to recruit, and we have not had any reports of that as a barrier from people applying to us. There is no impact at a workforce level that we are aware of to date.

Ms Stephen-Smith: It is important to emphasise that the major international recruitment effort that we undertook was prior to the changes that were made at the national level.

Ms Hudson: But it made it easier to pass, as opposed to harder to pass.

Ms Stephen-Smith: Yes.

MS BARRY: Thank you.

MS TOUGH: I want to talk about occupational violence within CHS. Occupational violence in health care is happening across Australia; it is not unique to the ACT. Strategic indicator 4.1 relates to occasions of staff absences caused by occupational violence. Last financial year, CHS missed the target. What steps are being taken to reduce the rate of occupational violence for the CHS workforce?

Ms Zagari: Thank you. Before I throw to colleagues, I want to take a moment to acknowledge the increasing incidence of occupational violence. Whilst we have worked hard to increase the reporting of it, it is evident that our staff are facing occupational violence on a more frequent basis. While significant work has been undertaken, this is a key focus for us in the coming year. It is not my expectation that any of our staff should be exposed to occupational violence. A change is required with our response, but it is actually much broader than that, in terms of societal expectations and norms. I will pass to a combination of Mr Aloisi, to talk specifically in relation to mental health, justice, health, and alcohol and other drugs, and Mr White, as our head of People and Culture, to talk about some of the strategies that have been implemented in the organisation.

Mr Aloisi: I will start by acknowledging and echoing the point: one of the by-products of having a positive reporting culture is that more incidents are reported. We do not minimise that. When we look at the data—I can speak for, in particular, mental health, justice or the alcohol and drug services, where unfortunately a lot of that occupational violence and aggression incidents occur—we are primarily seeing greater reporting of verbal aggression. That is a large contributor, and that is a positive thing, because, in years gone by, you would not have staff speaking to verbal aggression. It was almost seen as part of the job that you experienced it. So it is positive that staff are reporting it. Obviously, it is not positive that staff are experiencing it. We acknowledge that.

Over the last 12 months, in terms of the occupational violence space, a number of major projects have arisen. First of all, an occupational violence action plan has been developed. That speaks to a lot of the actions that are required to continue to work on this issue. They range from things around understanding people's vulnerabilities—what makes a person more predisposed to behave in a way that might display as aggression or violence in a health setting—to understanding the individual, which is a huge part of it. As part of that action plan, one of the key actions is to educate our staff around trauma-informed responses. I think that is important. Often a lot of occupational violence arises from people's previous experience of the rest of the world and how that translates to them when they are placed in certain environments or they attend certain environments.

We have done further work on our home-visit risk assessment. As most people would be aware, we had notifications from WorkSafe around that, so there has been a strong focus on how we make sure that we protect our staff when they are visiting people in the community. That has been a big element of our work.

Safewards is something that we have rolled out across a number of our inpatient settings. They are very well-established within mental health settings. The fundamental elements of Safewards are about the relational security aspect, such as how we maintain the relationship between staff and patients to minimise the possibility of aggression and violence. As well, we look at other things, such as our processes—for example, how we might assess a person who might be at risk of becoming heightened in their emotional state. It is about making sure that we have some ongoing assessment through various tools that we use across our settings.

It is definitely about support and ensuring more continuous engagement between staff

and our patients. We have heard patients say that they do not find that they get that sort of engagement on the floor. The more you engage with the person on the floor the more likely you will minimise any possibility of aggression or violence happening, when you have established a relationship with the individual. That is a huge element. Specific training is something that we maintain a focus on for our staff—as I said, not just in the trauma-informed care response but also in how we respond to and mitigate aggressive behaviours. That is a fundamental part of our processes.

From an infrastructure and physical security presence perspective, it is about the way we design our facilities and the way we operate our facilities. We seek to minimise. It might be things like making sure our interview rooms have dual egress, for example. That is so that the individual who might be assessed has a safe exit, but it is also for our staff in case things get heightened.

That is the flavour of things. We have the action plan, which obviously goes into a lot more detail, but those are a few of the key measures.

MS TOUGH: Thank you.

Mr White: I have read and acknowledge the privilege statement. Mr Aloisi has done a fantastic job of summarising my talking points. The only thing I would mention in addition to that is that we have used the word "maturity" here a few times this morning. I would suggest that, from an occupational violence perspective, the systems, processes and governance measures that Mr Aloisi mentioned are things that we continue to mature. We know from our data that a large portion of incidents relate to repeat offenders. So it is about how we integrate the use of our DHR, the Digital Health Record, for patient safety management plans, early intervention, strategies and risk assessments we use. We continue to mature through those processes to improve that metric you were talking about.

MS TOUGH: Wonderful. Do you have things in place for staff who have to take time off in response, to help support them and return to work?

Mr Aloisi: We do. We have a leave entitlement for occupational violence.

MS TOUGH: Wonderful.

Mr Aloisi: Other than that, it is also about ensuring that they are connected with the relevant areas, in terms of rehabilitation and having ongoing contact with their managers, for example, just to check in and make sure, particularly after a significant incident, that they are okay. There are those checks.

MS TOUGH: Wonderful. Thank you.

MS CASTLEY: Do you advise people to take time off work after an occupational violence incident?

Ms Zagari: It depends on the nature of the incident.

Mr Aloisi: It depends on the nature of it. Some people are unaware, so we will

absolutely, in our discussions with that individual, see whether they need to know that a provision is available for them in terms of leave. It is an individual discussion, but we would definitely promote the availability of that leave to our staff, particularly when they have been involved in an incident.

MS CASTLEY: Do you agree that staff absence due to occupational violence is a flawed metric for the assessment of whether occupational violence incidents are on the rise?

Ms Zagari: It is not solely a metric for that. It is true that, similar to workers comp, you look at lost-time indicators as a representative indicator of severity of incident. That is nuanced by the fact that we now offer OV leave. It was not previously offered. Regarding the piece of work that the minister referred to around strategic and accountability indicators, whether we need to change what we are measuring into total numbers is part of consideration this year: is it the right indicator?

MS CASTLEY: Do we know the absolute number of occupational violence incidents recorded in RiskMan since the pandemic? Do we track that?

Mr White: Since the pandemic?

MS CASTLEY: Yes—per year.

Mr White: Yes. If we are going back since the pandemic, I would need to take that on notice.

MS CASTLEY: Great. Thank you. Do we know which clinical area most of the incidents occur?

Mr Aloisi: They occur within mental health services.

MS CASTLEY: How many occupational violence incidents involve patients with known drug or alcohol addiction or presentation?

Mr Aloisi: I do not think that is necessarily extracted in the reporting. It does not go down to that level of granularity.

Ms Zagari: I do not think we will be able to provide that.

Mr Aloisi: It would require visual inspection of a number of records to determine that.

MS CASTLEY: Thank you.

Mr Aloisi: In terms of one of the previous questions we took on notice—around the number of referrals to external agencies—I have confirmed that we are not able to extract that data.

MISS NUTTALL: I am keen to ask about your crisis mental health services. There is Access Mental Health, and I believe HAART is also related. Is it true that Access Mental Health is the ACT's only dedicated mental health crisis line?

Mr Aloisi: It depends on how you define a crisis line. We have things like Lifeline, for example, which some people might classify as a crisis line. If you are talking about a crisis line where you want to activate or form a response that might result in emergency mental health care—for example, having someone come and visit you at home or come to hospital—that is the primary line. Lifeline performs a bit of a different function, in terms of supporting an individual who might be experiencing a crisis of some sort. For the ACT, it is the publicly available crisis line for people who need urgent mental health support.

MISS NUTTALL: That actually initiates the emergency response?

Mr Aloisi: Yes.

MISS NUTTALL: I have heard that Lifeline will sometimes refer to Access.

Mr Aloisi: That is correct.

MISS NUTTALL: What is the Access Mental Health unit's target timeframes for follow-ups, for the various categories, after patients have been triaged?

Mr Aloisi: They vary. I will go through the triage categories for you. They start from an emergency response. That would be when we get a call and the person is at risk of an immediate life-threatening situation. That is a triple-zero call. That is right at the top; that is category A. Then we have category B, which is still high risk, where we would activate a response within four hours. A category C response is within 24 hours, and then there is category D, which is within 72 hours. Category E is within four weeks. That is generally a non-urgent type referral. Then we have referrals that do not require our assessments. They are the ones we typically refer to other agencies.

MISS NUTTALL: There is obviously a differentiation between category D and category E. What is the differentiating factor, if you do not mind me asking?

Mr Aloisi: It is based on a risk assessment. The timeframes are meant to align with that. For category D, which has a 72-hour response, you might expect that the person would be relatively safe, from a risk point of view, to, for example, maintain themselves in their home until they were seen within the three-day period. It is that sort of risk. You are looking at things like: is there a chance that person's mental state might deteriorate rapidly over the three-day period? When you start moving out to category E, they are the ones where the risk profile is obviously much lower. You would feel very comfortable, in the sense that the person could be seen within a two-week period. It really depends on the presentation. There is no general rule, whether a person presents with depression or a person presents with psychosis. There is no general rule; it is based on the clinical features that are assessed.

MISS NUTTALL: Do you track how often Access Mental Health meets its target follow-up timeframes across those categories?

Mr Aloisi: No. It is something that we are absolutely focused on doing. We do not have that data at the moment. We are very keen to extract and work out whether we are

meeting our timeframes. We can do it on a manual audit basis, but we would like that to be a more automated function.

MISS NUTTALL: There is no current way of collecting or understanding whether people are actually followed up within that timeframe? I cannot help imagining that someone's risk profile might change, especially if there has been a commitment to have a call-back and, for whatever reason, that does not happen; someone's risk profile might actually—

Mr Aloisi: Yes, that is right. We are not extracting that data from DHR at the moment, in terms of meeting the triage categories, but it is absolutely something that we are intending to do, moving forward.

MISS NUTTALL: When will that happen by?

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

MISS NUTTALL: Thank you. Just on that, what is the current breakdown of staffing within Access Mental Health and within the HAART team? How many people do you expect to have on shift at once?

Mr Aloisi: It would vary, on shift. I will see whether I can find it.

Ms Zagari: While Mr Aloisi looks for that, I have an answer to an earlier question of Miss Nuttall's.

MISS NUTTALL: Yes, please.

Ms Zagari: You asked about the interface between Paediatric Gender Service and Education. The response is that there is not a formal arrangement with Education, but if a young person requests and consents to the clinicians within the Paediatric Gender Service supporting them in talking to their education providers—teachers, teaching assistants and so on at the school—they do that.

MISS NUTTALL: Thank you very much.

Ms Hudson: While we are in that vein, Ms Travers said four years of funding was available, and the 2025-26 budget provided $5.2 million over three years for a grant to Winnunga Nimmityjah Aboriginal Health and Community Services to operate the alcohol and other drug residential rehabilitation services for First Nations people. So it is three years, not four.

Mr Aloisi: It might be easier to take that question on notice and provide the exact breakdown, because it varies across shift, and there are different components of the team. I think it would be much simpler to put it all down on paper.

MISS NUTTALL: This one might have to be taken on notice as well. How often in the past year have either of these units had to rely on covers or overtime? How often have there been gaps in shifts that have needed to be filled?

Mr Aloisi: It would have to be very regular. We will take it—

Ms Zagari: I do not think we can provide that because that would require a manual review of rosters, so the time required would not be possible.

MISS NUTTALL: Okay.

Mr Aloisi: I think we can say it would be a regular occurrence, because we do have people on personal leave, for example. It is a regular occurrence that we have to backfill a shift. Across both Access and HAART, it would be a regular occurrence.

MISS NUTTALL: What pressure does that put on the team in the meantime? I am mindful that you have an intake line. If you have a couple of people supporting category A or B patients, that does not leave many people to do the follow-up work.

Mr Aloisi: I am sorry; I thought you were asking how many times we would need to do it. We are able to fill those shifts fairly consistently. It is not as common that we are left a shift short, but it does happen; we would have to acknowledge that. When you are reducing the amount of people, for example, responding to phones, if that reduces from four to three people, or three to two, that does create extra demand on those particular clinicians, in terms of response.

As much as possible, we will explore every avenue, when we do have a shift that is short, particularly when we already have a good sense of the workload demands for that day. Often, it is quite visible to us early in that shift or before the vacancy appears, so we will endeavour to fill that shift, however we can. There is definitely no reluctance on behalf of the service to backfill those vacant shifts. But if they are a person down, it creates extra demand on those existing clinicians.

MISS NUTTALL: I have referred to follow-ups, but what are the metrics that you use within Access to determine whether we are meeting the needs of people that are ringing in?

Mr Aloisi: We track our demand. We track the number of calls that come through to our service; that is one element, in order to get a sense of demand. We track things like call waiting times and call abandonment rates. There are the standard call centre type metrics that are used to look at how effectively we are providing that service, and the accessibility of the service.

MISS NUTTALL: Do you think that the current staffing numbers are sufficient for staff to be able to reach out to everyone who is experiencing a mental health crisis, especially before their risk profile escalates, if they are not followed up on?

Mr Aloisi: There are not many people who would not argue for more resources, of course. In terms of the demand that we have seen, we believe that we have a reasonable response to that. We have not seen, for example, in the Access space, similar growth that we have seen through presentations to the emergency department. We have not seen that level of growth. I would say that, for the most part, our staffing is able to manage the demand that we have. That is probably a general statement.

MS CASTLEY: Minister, I would like to ask a couple of questions about the inquest into the death of Rozalia Spadafora, which is referred to on page 30. Can you explain to the committee: what does "paediatric specialist input" mean?

Ms Stephen-Smith: On page 30 of the CHS annual report?

MS CASTLEY: Yes. It is where the inquest is reported. Could you explain what "paediatric specialist input" means?

Ms Zagari: It means that, with every child that is admitted to the intensive care unit, a paediatrician has to be involved in the care of that child, so that they are not solely under the remit of intensive care. When patients are admitted to ICU, they are under the care of the intensivists. For children, in every instance, the paediatrician also needs to be part of that care team.

MS CASTLEY: What staffing changes in the emergency department were implemented to ensure paediatric specialist input?

Ms Stephen-Smith: It is important to recognise that the emergency department at Canberra Hospital has changed considerably since the very tragic death of Rozalia Spadafora. We now have a separate paediatric stream, a separate paediatric waiting area, a much higher level of specialist paediatrics in the emergency department—a much higher level of paediatric emergency department specialisation across both medical and nursing in the Canberra Hospital emergency department—than was the case at the time.

MS CASTLEY: What is the expertise of the staff in emergency?

Ms Zagari: I can be more specific than that, if it is helpful.

MS CASTLEY: Are they trained paediatric emergency positions?

Ms Zagari: Yes, they are. There is quite a lot of detail in my statement to the Coroner which was published at our request, which talks about the changes that have been made in the emergency department expertise and staffing in response to the tragic loss of Rozalia. They are either emergency specialists who have additional paediatric training or paediatric specialists who become emergency physicians. There is a breadth of paediatric-specific skills now employed directly in the emergency department.

In addition there is a registrar allocated to the paediatric ED. There is a paediatric registrar rotation through emergency department, and additional training for non-paediatric specialists in the care of sick children. There are changes to staffing rostering. Rather than being rostered to the paediatric area on a relatively ad hoc basis, people undertake blocks of allocation to that, to ensure that they can develop and maintain a sufficient skill set. There is an opportunity, where staff want to rotate through the ICU, to rotate into paediatrics, depending on their particular needs.

MS CASTLEY: Are these people that we are focusing on trained paediatric emergency physicians, as in Westmead or Randwick, or are they adult-trained emergency physicians with an interest in paediatrics?

Ms Zagari: There is a combination of those things. We have trained specialist paediatric emergency physicians. I cannot promise you which hospital they come from, although I have read their CVs; there are people who were originally trained adult ED specialists who then gained additional skills in paediatrics.

MS CASTLEY: How many intensive care physicians does CHS employ that are capable of managing a paediatric case in intensive care whilst awaiting a transfer to Sydney?

Ms Zagari: We will have to take that on notice. I do not think we have the specific answer in the room today.

MS CASTLEY: Okay. Who have you employed at CHS to assure Canberra's parents that there is more than one, or however many you have—that that is adequate to look after a critically ill child?

Ms Zagari: Can I clarify the question? Are you asking for how many specific doctors we employ or—

MS CASTLEY: You have taken that on notice; is it one person or is it five? What have you done whilst employing them?

Ms Stephen-Smith: Can I clarify, though, that Canberra Hospital looks after critically ill children all the time on a regular basis.

MS CASTLEY: That is why I am asking how many are adequately trained.

Ms Stephen-Smith: The implication of your question is that critically ill children are not safe at Canberra Hospital, and I want to emphasise that it is a part of Canberra Hospital's job to look after critically ill children.

MS CASTLEY: Okay. I have one last question, while we are talking about emergency, because a constituent raised this with me on radio. Can you get a cup of water when you are in the emergency department, or do you have to be sent out to buy your own water from a vending machine?

Ms Zagari: You can get water in the emergency department. Ms Ogilvie can talk to the specifics of that, but you can get water in our emergency department.

MS CASTLEY: So the reports have been wrong?

Ms Stephen-Smith: I can assure you that you can get water across Canberra Hospital.

Ms McKenzie: I do not have anything more to add than what Ms Zagari said. You can get water in the emergency department. There is always a clinical judgement about whether you are allowed to have water—for example, if you are fasting. But if you are allowed to have water and you are a patient in the emergency department, we can give you water, and we do give water.

MS CASTLEY: Interesting. Okay; thanks.

MS BARRY: I have a follow-up on that. You give the water; the water is not located where someone can just go and grab the water?

Ms McKenzie: No, we give water. We do not say, "Please go and buy your own water."

Ms Zagari: I think the question is: is there a water fountain?

MS BARRY: That is correct—a fountain or something where you could get water if you need water.

Ms McKenzie: No, we would have bottled water or cups of water available.

MS BARRY: Interesting.

MR RATTENBURY: I want to ask about discharge from hospital and the respite care that goes with that. In the past financial year, how many bed nights have been occupied by patients declared fit for discharge but they could not be discharged because there was nowhere for them to go?

Ms Stephen-Smith: We may have the number of patients.

Ms Hudson: I can probably answer that, because it is subject to the commonwealth negotiations. We would say that, on average, in Canberra Health Services it is just over a hundred on any one day. I cannot answer about the bed days aspect, but it is around a hundred, and around 70 fit into the aged-care cohort. There is probably plus or minus there, but that would be the way in which we are operating.

Ms Zagari: I have bed days for maintenance care patients. However, that would be broader than just aged care; it is also patients waiting for NDIS care.

MR RATTENBURY: I am interested generally.

Ms Zagari: The overnight bed days for maintenance care for 2024-25 amounted to 44,260 days.

MR RATTENBURY: Is there a figure for an average cost of a bed night in that context?

Ms Stephen-Smith: My recollection of the figure that we are using is $1,300. If that is incorrect, we will come back and correct it.

MR RATTENBURY: Thank you. In terms of exiting people from hospital, is there a scenario in which people are exited into a hotel or temporary accommodation? The reason I am asking is that I have had concerns raised with me that people are being discharged, not into homelessness, but they framed it as someone will be sent to temporary accommodation, with nowhere more permanent to go.

Ms Zagari: There are circumstances in which somebody might be discharged to

temporary accommodation. It comes down to individual circumstance. There are times when we would support somebody to access temporary accommodation.

Ms Hudson: Nationally, colleagues in states and territories are leasing floors in hotels and adjusting the floor in order to support people who cannot currently get a permanent place in an aged-care facility, for instance. It is a strategy being used nationally.

MR RATTENBURY: In that vein, with Burrangiri, we have had a whole process around that. I want to get an update on the preparations, because we have a time window now. Are we getting organised to deal with that question within the two-year timeframe?

Ms Stephen-Smith: Ms Stoddart and the team have been having a number of conversations with the commonwealth Department of Health, Disability and Ageing in relation to respite in the ACT. Again, it is important to recognise that the issue is broader. Clearly, we have quite a number of maintenance care patients for whom Burrangiri is not an option, not a step-down that is appropriate, and it is not permitting them to be admitted from hospital.

Ms Stoddart: To add to what the minister said, we are having ongoing conversations with the commonwealth. As you would be aware, the new Aged Care Act only came into effect on 1 November, so they have been focused on some of those things, in terms of what the impact of the new aged-care system will be on things like respite. We continue to have conversations about the capacity of residential aged-care beds in Canberra. Part of the current difficulty for the ACT is that not having capacity in residential aged care means residential respite does not become an option.

We are also having conversations with the commonwealth in relation to the $10 million commonwealth election commitment to support respite going forward. There are still further conversations to work out what the right model for that is. Advice will be given to the government in due course as to what the options are. We are also having conversations at the local level with the individual aged-care providers. The ACT are having those conversations, to see what options we can work through with local providers in relation to future respite options.

MR RATTENBURY: That will do, given the timing, Chair. We will come back to this one in a subsequent hearing, probably, as the time gets closer.

THE CHAIR: We will go back to a question that Ms Barry asked prior to the break. I received advice from the minister during the break that that can be discussed confidentially, in camera, which we will do now.

Ms Zagari: Chair, I have had a message directly from a clinician saying that there are bottles and fountains in ED. We carry and provide small bottles of water. There are kitchenettes with sinks and tap water. There is a challenge with provision of a fountain in the waiting room, but bottled water is provided. You also asked, Ms Barry, about the access review which was undertaken, and it identified 10 high priority actions, all of which have been addressed. We are now working through the medium priority actions across CHS.

MS BARRY: Thank you. Is that report publicly available?

Ms Zagari: We could provide some information from it.

MS BARRY: Thank you.

Ms Zagari: Finally, Ms Castley, going to your question, to date, one paediatric ICU specialist has been recruited, and continuing recruitment is underway to employ a total of two FTEs, but it is likely to be more than two people—a combination of people to give us the full two FTE for ICU.

MS CASTLEY: One at the moment?

Ms Zagari: One so far.

Hearing suspended from 11.56 am to 2.05 pm.

Appearances

Paterson, Dr Marisa, Minister for Police, Fire and Emergency Services, Minister for Women, Minister for the Prevention of Domestic, Family and Sexual Violence, Minister for Corrections and Minister for Gaming Reform

Health and Community Services Directorate
Bogiatzis, Ms Vasiliki, Acting Executive Group Manager, Inclusion,
Connor, Ms Tina, Acting Executive Branch Manager, Women, Youth, LGBTIQ+ and Multicultural Affairs
Dyall, Ms Mimi, Acting Executive Branch Manager, Domestic, Family and Sexual Violence Office

Justice and Community Safety Directorate
Marjan, Ms Nadia, Acting Executive Branch Manager, Civil and Regulatory Law Branch, Legislation, Policy and Programs Division

THE CHAIR: Welcome back to the public hearings of the Standing Committee on Social Policy for its inquiry into annual and financial reports for 2024-25. We welcome Dr Marisa Paterson MLA, the Minister for the Prevention of Domestic, Family and Sexual Violence, and officials.

Please note that, as witnesses, you are protected by parliamentary privilege and bound by its obligations. You must tell the truth. Giving false or misleading evidence will be treated as a serious matter and may be considered contempt of the Assembly. You do not have to acknowledge the privilege statement, though; you are just bound by it. When taking a question on notice, it would be useful if witnesses used the words, "I will take that question on notice." This will help the committee and witnesses to confirm questions taken on notice from the transcript.

As we are not inviting opening statements, we will now proceed to questions. I have a question about sexual violence crisis response. My understanding is that the Nguru Program at Canberra Rape Crisis Centre is being discontinued. Why is that?

Dr Paterson: That is a question for the Canberra Rape Crisis Centre.

THE CHAIR: Is funding for the Nguru Program from the ACT government?

Dr Paterson: The funding has not been discontinued. We provided significant funding to the Canberra Rape Crisis Centre in the last budget, and it is up to the board and CEO of CRCC as to how that money is allocated throughout their service and what services they deliver.

THE CHAIR: There is no requirement in that funding arrangement for funding for the First Nations specific program to be delivered?

Dr Paterson: Not within CRCC. We have focused on supporting Aboriginal community-controlled organisations in the last budget. As a result of the *Long Yarn* report, there was significant funding for Aboriginal community-controlled organisations and their response to domestic, family and sexual violence.

THE CHAIR: Have you had any conversations with Canberra Rape Crisis Centre about the discontinuation of the Nguru Program?

Dr Paterson: I have responded, in a letter a while ago to the CEO of Canberra Rape Crisis, basically outlining that it is up to them how and what they deliver.

Ms Bogiatzis: I acknowledge that I am bound by the privilege statement. We have been in discussions with CRCC following the 2025-26 budget, and have been in negotiations with them about how the new portion of funding can be allocated to meet the needs of the Canberra Rape Crisis Centre in support of its delivery of programs and services. The point we have reached is an arrangement where CRCC has a level of flexibility in what it delivers, but the kinds of programs and services for particular groups like the Aboriginal and Torres Strait Islander community are a matter for them.

What we do require is that the Canberra Rape Crisis Centre, and all domestic, family and sexual violence services, deliver a culturally safe and a culturally responsive service. How they do that is different across organisations.

MR RATTENBURY: Is there a specific organisation now funded in a dedicated way to do family and domestic violence support for the First Nations community?

Dr Paterson: There are multiple programs that are funded. Yerrabi Yurwang have $2.3 million to 2029 for a Strengthening Families Program to provide outreach, cultural support, clinical interventions, life skills education, and support to access accommodation, legal and health services. Yeddung Mura also is funded for two programs that provide family, domestic and sexual violence support for Aboriginal and Torres Strait Islander people. There is also the Caring Dads program that they have just been funded to implement, to support fathers who are at risk of or using domestic family violence.

There is also the Yurwang Bullarn funding. We are currently working with Yurwang Bullarn through some challenges that that service is experiencing. They are funded ultimately for the women's outreach program, and we are working with them to see that continue. Sisters in Spirit Aboriginal Corporation received $2.6 million in the last budget for culturally tailored systemic and individual advocacy for domestic, family and sexual violence.

THE CHAIR: Are any of those organisations able to receive a phone call from a hospital, from a police officer, hospital staff or a woman who has been raped and who needs support in that moment, in the way that Canberra Rape Crisis Centre receives those phone calls and goes and supports such women?

Ms Bogiatzis: Mr Emerson, with the services that the minister spoke to, none of them operate a crisis line like the Canberra Rape Crisis Centre and the Domestic Violence Crisis Service. None of them are funded to operate in that crisis way, 24 hours a day, for example, around the clock. Each service has a slightly different offering. For example, Yeddung Mura offer a range of supports, including crisis case management, and have workers for men and women who are in crisis. That kind of specialised safety planning that we see Canberra Rape Crisis Centre do is unique to their service offering,

and they really do have that specialist expertise.

We are working with ACCOs to continue to grow and build on their expertise. A number of them have done significant training in specialist offerings around sexual violence and domestic and family violence, which has really improved their understanding of and their response to people in those situations. What we are seeing a lot of is ACCOs working closely with crisis services, shoulder to shoulder with their clients, helping them to navigate the service system.

THE CHAIR: I understand that you cannot have five different organisations doing 24-hour crisis support in a jurisdiction as small as ours. I would think that, given the government's commitment to Aboriginal-led service delivery, or at least to provide options for a choice between mainstream and Aboriginal-led services, you would be concerned about the loss of the one sexual violence crisis service that is—

Dr Paterson: But there is no loss. We have provided CRCC with $7.1 million over four years to expand their critical service capacity. I think that this advocacy needs to be better directed to the CEO of the CRCC.

THE CHAIR: Fair enough, but she is not here. I am asking whether you have a concern, from a government perspective, given this is a government-funded organisation, and given the government's commitments to Aboriginal-led service delivery for Aboriginal people.

Dr Paterson: One of the principles of the levy that was developed and that we have implemented through this budget was to fund Aboriginal community-controlled organisations to respond to domestic, family and sexual violence. This has also stemmed from significant work that has occurred out of the *Long Yarn* report. This is why we chose to fund the package in the last budget to support the development of the ACCO sector and work to strengthen these organisations to be able to respond.

We know there is a lot of complexity in the Aboriginal and Torres Strait Islander community in the ACT. We do want to be offering different services. Different services will support different people in different times of need. We want to be able to provide as broad an offering as possible to the Aboriginal and Torres Strait Islander community. That is why we have chosen the path that we have chosen. It is a matter for CRCC in terms of what they see, in terms of people who are presenting to their service, and what they are seeing and understanding is the need in offering to the community.

THE CHAIR: Is the government committed to ensuring that there is no gap? If the aim is to upskill other organisations to provide a sexual violence crisis response, has some kind of commitment been made in terms of government policy to ensure there is not a period where, say, Nguru is discontinued? I accept your point that that is not your decision, but if there is no other organisation ready to step in and provide that service, I think that is a question for government.

Dr Paterson: I do not think we want to take away from the fact that CRCC do offer a specialist service response and a very robust one.

THE CHAIR: No, I am not making that claim. No-one else does what they do. That is

my concern: the existence of Nguru is unique. Given the government's commitments, I struggle to accept the response that it is not your problem if that is discontinued, because I think it is, until another organisation, through the funding arrangements you have provided, is prepared to deliver that service from an Aboriginal perspective.

Dr Paterson: CRCC will continue to offer services to the whole of the community, including the Aboriginal and Torres Strait Islander community. How that program works is a matter for CRCC, and CRCC will continue to offer services to the whole Canberra community. As has been identified through the *Long Yarn* and as has been developed through the principles of the Safer Families Levy, we will prioritise funding to Aboriginal community-controlled organisations to grow and support that sector to be able to respond, with the idea that eventually, down the track, ideally, we are in a situation where a specifically tailored Aboriginal and Torres Strait Islander community-led crisis response can be offered. But we are a long way from that, and CRCC will continue to be the primary crisis response service in the ACT.

MS BARRY: Minister, are you responsible for the Solid Ground program?

Dr Paterson: Yes.

MS BARRY: I want to ask about the plan to introduce electronic monitoring for high-risk perpetrators. Where is that up to?

Dr Paterson: That has nothing to do with Solid Ground. Electronic monitoring comes under the corrections portfolio.

MS BARRY: I have another question around the Room4Change program. Can you advise why that was terminated, and what have you put in in place?

Dr Paterson: Room4Change is currently funded.

Ms Bogiatzis: The ACT government has funded the Domestic Violence Crisis Service to provide the Room4Change program. That has been in place since 2016. The initiative provides residential accommodation, men's behaviour change programs and case management for perpetrators and their families. In the 2025-26 budget, $1.528 million was committed from the ACT government to DVCS for the Room4Change program.

MS BARRY: What corresponding funding goes to the multicultural community? Specifically, I think it is MARSS.

Ms Bogiatzis: Can I clarify: is that in relation to perpetrator intervention?

MS BARRY: That is correct.

Ms Bogiatzis: Yes, I have that information.

Dr Paterson: That is mHub.

MS BARRY: mHub?

Dr Paterson: Yes, that has been funded to deliver that service. That is part of the national partnership program with the federal government.

Ms Dyall: I acknowledge the privilege statement. The Multicultural Hub is funded to deliver a men's non-violence behaviour change program. It is one of the innovative perpetrator responses under the federal funding agreement for DFSV—domestic, family and sexual violence. They have provided funding over three years to deliver a culturally and linguistically diverse men's program, so they are targeting that cohort. That program is funded to 2027 under the current commonwealth funding arrangements.

MS BARRY: What has been reported about the capacity of the program? How many clients are there? Is there a waitlist? Is there a demand for the service?

Ms Dyall: Thanks for the question, Ms Barry. This is a pilot program. It has only just begun. Participation in the program this year has only just commenced, and they have already received 15 referrals to the program and currently have 10 participants engaged.

MS BARRY: In the program?

Ms Dyall: Yes.

MISS NUTTALL: The Multicultural Hub also runs a women's program which, in a lot of ways, is complementary. Our understanding is that the funding for that runs out halfway through next year; in practice, you would expect that they would have to start winding down the program. From what I have heard, this women's program is really helpful and a necessary complement to the men's behaviour change program because it supports the women whose current or ex-partners are in the men's program. What consideration has been given to that? Have you managed to secure more long-term funding?

Dr Paterson: This will be a matter for budget consideration over the coming budget process, recognising that it is a really valuable program, and it is identified that there need to be specific offerings to the culturally and linguistically diverse community in Canberra. mHub does a lot of really good work. It will be a matter for future budget consideration.

MISS NUTTALL: I suppose probably a point of concern is that, if nothing happens to support this program before the end of this year, I am worried that the program might wrap up and, by the time it gets to next budget, we will not actually have the things in place to support women who are victims of family, domestic and sexual violence.

Dr Paterson: That is a very relevant concern. There are multiple programs; this is not the only program. This is what will be taken as part of budget consideration for the current budget process.

MS BARRY: What other programs are there, Minister, to support the multicultural community?

Ms Bogiatzis: Ms Barry, we spoke about the perpetrator intervention delivered by

mHub. They also deliver the Multicultural Women's Service, which is specifically around domestic, family and sexual violence support for women and their children from the multicultural community. This includes direct client support through case management, counselling, brokerage and information sessions to other mainstream services on strategies to address and be culturally safe and responsive in addressing domestic and family violence, and they also develop resources in different languages to support women to access services. As Miss Nuttall mentioned, we are seeing strong referral between the two programs within mHub.

MS BARRY: Thank you. Is there a waiting list? What is the capacity like?

Ms Bogiatzis: I believe that there is not a waiting list. The information I have is that 188 individuals were supported in the last 12 months for the mHub program. I understand that they have a couple of workers that provide support. A critical function that they do is that immediate brokerage and support to women, and then they put a lot of effort into trying to connect them into other mainstream services who are well placed to provide that domestic and sexual violence support. Some of their brokerage has gone to helping women escape violence by paying rent for a very short period, paying other bills, buying groceries and access to medical support and, importantly, tapping into other services that are available to support their navigation of the broader services system.

MS BARRY: Do you know how many women were turned away?

Ms Bogiatzis: I do not.

MS BARRY: Is that something that you can take a notice?

Ms Bogiatzis: I am not sure we would have that information. I would need to ask mHub for that information.

MS BARRY: Is that something you can do? I am hearing that there is stress on the program and that they are having to turn women away because there is not sufficient funding. So, whilst they do not have a waiting list, there is not enough money to accommodate as many people as they would want to and they at times turn people away. I was just wondering if there was any way that we are capturing that.

Dr Paterson: We can continue to work with mHub around any concerns. If they are having those concerns and are having to turn people away, we can work with them on that and discuss that with them.

MS BARRY: The question was: could you ask, for the people who have been turned away, if any, whether they capture that data? I think it would be really important to capture that so you understand, in the context of the next budget, for example, what funding requirements or capacity you would need to accommodate. I think it is important data to capture—not just the people they see but the people they turn away.

Ms Bogiatzis: I am happy to take on notice whether mHub has a waitlist.

MS BARRY: Thank you.

MISS NUTTALL: Ms Barry, correct me if I am wrong, but I understand that your earlier question was: what other services are out there to support women? The service that you have just described is the one that is at risk of winding up. Are there services other than the Multicultural Hub?

Dr Paterson: That is the main service. There are a lot of community organisations out there that run culturally specific services and they work with the local community. They are not funded by government, but there are a lot of different community organisations that do have domestic, family and sexual violence services. A lot of the religious groups in Canberra and cultural groups also have a range of different culturally appropriate supports that work with both men, families and women who are experiencing domestic, family and sexual violence.

My discussions with mHub, in particular, are around the complexity, in that there is not just one cultural identity; there are a lot. There is a lot of complexity, a lot of language barriers and all that kind of thing. I think it is really important that we support the services that exist, but I think recognising that there is a lot of complexity in this community and understanding the broader framework is important.

MISS NUTTALL: Probably to Ms Barry's point, without knowing if there are people being turned away, how would you know whether we are funding services enough across the board and where those gaps are so that we can fund them?

Dr Paterson: At this point in time, we are not aware that mHub has a waitlist. But we will find out that information. But, as I said, it is a priority to see this service continue, and this will be under consideration in the next budget process.

MS BARRY: Thank you. I just want to clarify the question taken on notice. It is: how people have been turned away? It is not if they have a waitlist—because sometimes these community organisations do not have a waitlist.

Ms Bogiatzis: I can ask mHub, but I expect it would be difficult for them to answer that question. I expect they do everything in their power to find services and supports for their clients—whether that is through the services and programs that they offer or another through a warm referral and explaining the client's situation. I think it would be easier for me to clarify with mHub whether they have a waitlist.

MS BARRY: It would be good if you could clarify the questions and then come back with whatever they say. If they say, "We do we not do not turn anyone away,' that is fine, but I would really appreciate it if that question is put to them.

Ms Bogiatzis: Okay; we can take that on notice.

MS BARRY: Thank you.

MISS NUTTALL: The *Canberra Times* reported on 13 October that dozens of AFP officers were charged with domestic violence offences since 2017 and that most have kept their jobs. Amongst other things, this shows that no area is immune to the perpetration and experience of domestic, family and sexual violence. We have seen

investment for police to increase their skill and capacity to respond to domestic and family violence in our community. This report shows us what we all know: that domestic and family violence is everywhere and in every community.

But, with the power that policing have in our community, this makes it pretty essential that local specialists, domestic and family violence agencies are consulted, they are engaged and they are resourced to support enhanced training, cultural and attitudinal change for the institution that is the police. Can you tell us how ACT agencies are being engaged in this?

Dr Paterson: I think that question is probably best put to the police portfolio, where the Chief Police Officer would be able to support answering that directly in terms of what police are doing. In respect to that report, that was for the broader AFP. So that was not just the ACT; that was nationally. As you said, I think it highlights that no sector of the community is immune to the impacts and the perpetration of domestic, family and sexual violence. We are also seeing significant discourse around the Army, and there are lots of other sectors and workforces that experience these challenges.

So I think it would be best to put the rest of that question in terms of what processes ACT Policing are putting in place to deal with those kinds of situations when they arise in the ACT Policing annual report hearing.

MISS NUTTALL: I hear where you are coming from, but I suppose what I am interested in getting at in this session is how the ACT domestic, family and sexual violence organisations that you fund and that you work with are engaging with police and how, perhaps, the office is encouraging them to engage with police or supporting them through that.

Dr Paterson: Engaging in communication between our services that work on the ground, the police and hospitals, as Mr Emerson said, and a broad range of government-type services—for example, Corrections, victim support and child protection. Having this level of information sharing and relationships between the services and the government agencies is really, really important. I think there is a lot of work that happens every day to build and sustain these relationships and work to help victim-survivors in the ACT.

Our community service organisations are not paid by the government to engage with the government in that way. I think it would best to talk in the policing portfolio around what ACT Policing is doing directly in this space. There is a lot of education. There is the Family Violence Unit that has been established. There is an extra sexual assault and child abuse team that has been established in police. The Chief Police Officer will be able to speak to the complexity and what happens when an officer may be charged with domestic, family and sexual violence offences and how that would proceed and impact on their employment in the organisation.

MISS NUTTALL: I understand that community organisations are not necessarily paid to do this work. But do you find that, in practice, they are doing this work or that government is expecting them to do it, or—

Dr Paterson: What work exactly?

MISS NUTTALL: Essentially to liaise with police to sort of provide education.

Dr Paterson: I do not believe that they are being expected to provide education. I think what makes our system work is having really strong relationships between government agencies like police and child protection and our community service organisations and continuing to support those relationships. I think it is everyone's priority that those relationships are really strong and working.

MISS NUTTALL: What sorts of resources do you provide to your sector to train and educate police and government bodies like the Family, Domestic and Sexual Violence Office and the programs that you have mentioned? Forgive me; I cannot recall the list off the top of my head, but—

Dr Paterson: There was extensive training across the whole of government a few years ago.

Ms Bogiatzis: That was some years ago, to train public servants. It commenced many years ago—perhaps in 2018—to train public servants, including frontline workforces, in health settings and education settings around domestic and family violence. I understand that ACT Policing have a fairly robust training program that they put their staff through. As the minister indicated, they are probably better placed to talk to that. But I do understand that it includes training in domestic and family violence. I am not sure who they engage for that training and how that is sorted.

Dr Paterson: There was also funding two budgets ago for coercive control training for the police and the courts. So there is that funding plus, I think, there is some federal funding from the Attorney-General's department that is national implementation of more training for police for domestic and family violence and coercive control.

I would see police and other organisations who work in this space, victim support, as requiring continuous training and improvement in what they are doing. The risk assessment framework is currently being developed. That will be rolled out across the ACT to provide a standardised understanding of risk. So there are things like that which will require training across the ACT public service to implement. It is not a space where you just sit still and tick off your box of training.

We are seeing the complexity of domestic, family and sexual violence increase year on year with the complexities around technology-facilitated abuse and around online abuse. Trying to keep ahead of where the abuse is happening and how rapidly that environment is changing is a real challenge for governments and requires continued working together across a range of agencies to highlight where there are either gaps or where there are new and emergent forms of abuse that are occurring. As we are seeing more and more, it is increasing in complexity and increasingly technology facilitated.

MISS NUTTALL: Thank you.

MS TOUGH: I want to pick up on the issue of coercive control but also the recent affirmative consent campaign. Is there any data or insight in relation to the impact of the community education campaigns on both these areas?

Dr Paterson: The consent campaign was a really successful campaign. The campaign was released into the market from 16 July to 15 October this year. The campaign targeted Canberrans aged 18 to 40 and had a range of paid advertising across social media, dating apps and in clubs and licenced venues across the ACT. It had a really, really great response online and there was very high engagement with the ads.

Ms Bogiatzis: I have some performance data, Minister, in relation to the campaign. The campaign ran from 15 July until 7 October 2025. It was promoted through a number of platforms—through social media platforms and through Meta—so that is Facebook and Instagram. It achieved 162,731 views. That outperformed the benchmark that we expected. We also know that the target group of 25- to 34-year-olds were most engaged through those platforms. In Snapchat, we got 27,252 views of the 15-second video—again, outperforming our benchmark. TikTok achieved 23,994 views and Reddit 71,461. We also promoted the campaign through Tinder, which achieved 253,766 views with impressions—with a lot of engagement through that platform—and we also put it through various advertising platforms, which got a further 429 clicks.

MS TOUGH: Wonderful.

Dr Paterson: There was also some evaluation data on the coercive control campaign, which looked at benchmark figures from before the campaign ran to after the community's understanding of coercive control.

Ms Bogiatzis: I have the same sorts of metrics. For the coercive control campaign, on Facebook and Instagram, we got over 1.7 million views, which was more than the 1.6 million that was anticipated. That was translated into a range of languages, like Mandarin, Cantonese, Arabic, Vietnamese et cetera, and got views mostly in those languages. It was also promoted through the ACT government's own channels and through posters across Canberra. We do not have a sense of how much impact the posters had but they were pretty prevalent.

MS TOUGH: From those views and impressions online, do you have data on whether people then clicked through to the websites to learn more about either of the campaigns?

Ms Bogiatzis: I do not have that information.

MS TOUGH: Is that something that the evaluation will be able to find out?

Ms Bogiatzis: I will take that on notice.

MS TOUGH: Awesome. Thank you.

Mr Rattenbury: I want to ask about the coordinator-general for family and domestic violence. Who currently holds that position? I am not after a name; I am interested in what position it sits with. I am not trying to identify the individual.

Dr Paterson: DDG of HCSD.

Mr Rattenbury: Okay. Do they still have a sort of whole-of-government or cross-

government remit?

Dr Paterson: Yes.

Mr Rattenbury: How many staff do they have supporting them in that role?

Ms Bogiatzis: The Domestic, Family and Sexual Violence Office reports through to me and it has 26.75 FTE.

Mr Rattenbury: That is great. I want to ask about young people exhibiting harmful sexualised behaviours. Which organisation, organisations or government agencies provide support for children and young people exhibiting these behaviours, and what are those types of supports?

Dr Paterson: The Canberra Rape Crisis provides support to children in that context.

Ms Bogiatzis: In addition to the Canberra Rape Crisis Centre, the Canberra Health Services also delivers an intervention for young people. I am not sure of the age range, but I know that they have an FTE dedicated to providing that service to young people exhibiting harmful sexualised behaviours. I understand that that is a therapeutic intervention delivered by the enhanced child health services as part of Canberra Health Services.

Mr Rattenbury: Do you have any information on the level of demand for those services and whether it is being met? Is there a waiting time for access to those services for those young people?

Ms Bogiatzis: I do not. Harmful sexualised behaviours is not a violence that is perpetrated typically between intimate partners. It is sometimes perpetrated by very young children. It is not a form of violence that the Domestic, Family and Sexual Violence Office typically would consider within its focus. Harmful sexualised behaviours require a therapeutic and health intervention.

Mr Rattenbury: That is interesting. Thanks.

MS MORRIS: Output 1.5, Safer Families, which is on page 363, shows recurrent payments for the program were approximately $27 million in 2024-25. That was probably $4 million more than the original target because of commonwealth funding. With that context, there has been a 34 per cent increase in domestic violence incidents, according to ACT Policing's annual report, from 4,478 incidents in 2024-25 as opposed to 3,352 in 2023-24. Why are we seeing an increase in domestic violence incidents despite the increase in safer family funding?

Dr Paterson: I think, broadly, a societal problem that we are experiencing across Australia is an increase in gender-based violence. This is very concerning to the government and concerning to the community. In saying that, over the past 20 years, there has been a significant shift in understandings of violence in the offering of services and supports for people who are experiencing violence. This is why we have invested heavily in ACT Policing to be able to address domestic, family and sexual violence and appropriately, in a trauma-informed way, receive reports from victim-survivors. So we

are seeing an increase in reporting of these crimes.

This is why we have also committed to a range of different advocates and supports for victim-survivors when they do touch into the criminal justice system to be able to advocate for them, to support them when they do report to police or do go in to get a family violence audit, for example. I think in some ways it is a reflection that the community is more aware of domestic family and sexual violence and that individuals are more prepared to report, which is a good thing. But, overall, the overarching picture is that those who do report is actually just skimming the surface of the level of violence that does happen in the community. We have seen national survey after national survey show that it is really only a small percentage of people who ever go to police.

We know that we have a broader societal issue with violence, and this is exacerbated by the online environment and international environments. This is why the federal government are doing their social media ban, in a large part. There are a lot of international and external influences that have very, very strong voices and narratives that are reaching particularly young people in our community and potentially having a detrimental impact, which is why looking at this as a whole-of-community problem is really critical. The domestic, family and sexual violence strategy that we are developing will be a key part of the government's response to addressing this issue in terms of a really cohesive and holistic look at the whole spectrum from prevention to crisis response to healing in this space. But, again, that is government and government services, and this requires a broader community response. It requires everyone recognising this is an issue and working towards solutions and supports.

MS MORRIS: Does ACT Policing get any funding from the Safer Families Levy?

Dr Paterson: No.

MS MORRIS: Why is that?

Dr Paterson: Ultimately, SACT Policing are getting their own funding. In the last budget, there was significant funding around the sexual assault response for the sexual assault advocates and also another sexual assault and child abuse team implementation. I guess the priority from the perspective of government on the Safer Families Levy is for it to go to our frontline services. There is funding in that that does go to victim support. That supports victim-survivors. As you are well aware of the amount and the calls from community service organisations for more funding, I think it is appropriate at this point that that funding is going to them, and there will be separate advocacy for funding for police.

MS MORRIS: Police are there on the front line, responding to those incidents—now, on average, 12 incidents a day, as opposed to nine in the previous financial year. That is on top of every other category of crime that they need to respond to. Given the nature of the specialised training that is required, which we discussed earlier, wouldn't it make sense if they did have, in some part, a top-up to help them respond to the increase in crime in the community? You have mentioned how prevalent it is and that it is growing; it is systemically wide, and they are the first ones who are being required to respond to it.

Dr Paterson: Ultimately, this is police core business. As you said, they are seeing a change. This is really a question for the police hearing. It would be much better—

MS MORRIS: In terms of the administration of the levy, if the purpose of the levy is to fund frontline services, they are typically the first ones to respond, and there is an increasing number of incidents that they are needing to respond to.

Dr Paterson: The levy is a very small part of the proportion of funding that the government makes to fund the response to domestic, family and sexual violence. As I said, with the Safer Families Levy, particularly, I can speak to the last budget, where the focus has been on the frontline community organisations receiving that funding. There has been a lot of advocacy from the community sector to see that all of the levy goes to frontline community organisations.

There was a business case in the last budget around the sexual assault advocates, and around a new sexual assault and child abuse team and the implementation and funding of that. I will continue to advocate for more resources for police, but I really see that as separate advocacy to the distribution of the Safer Families Levy. It is a substantial amount of money, but, in the grand scheme of things, it is definitely not the entire investment in response.

MS MORRIS: Okay; I wanted to understand the rationale behind that. How do we know whether the Safer Families Levy is performing well? What measures do you use to—

Dr Paterson: With programs that are funded, many of them are evaluated. The intention is that most of them would be evaluated. There is some funding that is a core service contribution to the key services, and we will continue to work with them to see joint best outcomes for the community, in terms of working together to see the outcomes that both they and the government identify as a priority.

A lot of the programs that have been funded by the levy have been evaluated, and we will continue to seek to do that. Solid Ground is a really good example. They were a pilot program that was evaluated. The evaluation came out, and it looked like the program was having a very positive impact, so it was funded in the last budget through the Safer Families Levy.

More and more, there is a requirement that the investment decisions are based on evidence, so continuing to work with the services around evaluations is a priority.

Ms Bogiatzis: Just to add to that, as you know, there was a recent Auditor-General's report into the Safer Families Levy, and recommendation 2 spoke to the development of a monitoring and evaluation framework. The government responded to that levy audit report and accepted all recommendations.

As part of our strategy that is currently under development, we are developing a monitoring and evaluation framework that will sit alongside it. We hope that this framework will help us to measure things both at the system level and at the program level, so that we get that good understanding of how the government's investment is being effectively used and managed, as well as the impact that the programs are having

on the community.

MS MORRIS: Is that monitoring and evaluation framework the one that you are referring to that will be presented in December?

Ms Bogiatzis: The monitoring and evaluation framework will be coupled with the domestic, family and sexual violence strategy that is being developed, which is on track to be released in the middle of next year.

MS MORRIS: That framework is under development at the moment?

Ms Bogiatzis: Yes.

MS MORRIS: There is currently no framework for monitoring and evaluating?

Dr Paterson: We do not have a strategy yet. The framework will provide an evaluation and monitoring tool for the strategy.

Ms Bogiatzis: Previously, as the minister indicated, individual programs were evaluated at the individual program level, so the evaluation methodologies were very much designed around the program, the intended outcomes and the offering. Each evaluation is unique to each program.

We are hoping that, with the framework that will be developed, it will give us a level of consistency as to how we do that ongoing performance monitoring, as well as the broader scale of evaluation of programs.

MS MORRIS: Roughly 10-odd years into Safer Families, we are still waiting for an evaluation framework and strategy?

Dr Paterson: No, it is not to evaluate the Safer Families Levy; it is to evaluate the strategy. There have been national strategies. There have been previous ACT strategies, and previous governments have made decisions around whether there should or should not be strategies.

As you would be well aware, there are a lot of strategies. There is the national plan; there is the First Nations plan. There is a raft of different report recommendations. There is a lot that comes out of this one pool of funding. Different decisions of different governments have been made. In the past government, the decision was made to progress a strategy, and that is the work that has been undertaken over the past year. As part of that, it will have a monitoring and evaluation framework, to be able to understand the impacts of the strategy.

MS BARRY: The Solid Ground program: is there any way I can find the evaluation report? Is it public?

Dr Paterson: Yes, it is online.

MISS NUTTALL: I hope Ms Morris forgives me if she has already asked this question: output 1.5, Safer Families, lists the sole accountability indicator as "family

violence statement presented to the ACT Legislative Assembly". Why was this the only accountability indicator for Safer Families?

Ms Bogiatzis: That is a historic indicator. I understand that the previous Director-General of the Health and Community Services Directorate made a commitment in the last budget estimates to consider all indicators and revise them.

MISS NUTTALL: Are there any early steers on what that might look like or what will be taken into account?

Dr Paterson: No. It is all under consideration at the moment. It is similar to the women's portfolio as well. It is about how we may best describe to the community the outcomes of these portfolios.

MISS NUTTALL: When will we know, if you do not mind me asking?

Dr Paterson: At the next budget.

Ms Bogiatzis: The statements of performance are provided through the budget papers and listed in the annual report. Hopefully, in the next budget, there will be updated indicators.

MISS NUTTALL: Do you have any views on what might be a good indicator? How do you currently check how effective the Safer Families output—

Dr Paterson: The work that is going on at the moment is to understand what that might be. I would not want to speculate and just pull things out of thin air. I think it is important that we do revise them. I do not think they are fit for purpose. Looking at the work that is being done on the strategy, it would be good to have some alignment with that as well.

THE CHAIR: I have a question about DVCS. The Domestic Violence Crisis Service recently indicated publicly that insufficient funding meant half the calls to their crisis line were not answered. What has since been done to address this issue?

Dr Paterson: I appreciate the reporting and the feedback from DVCS. That is what we have heard directly from the CEO as well. We appreciate the challenges that this sector faces, and the ongoing and increasing demand. That is why, at the last budget, we provided the additional funding to DVCS. We are continuing to work with them to understand how we can better support the community; that is an ongoing discussion.

THE CHAIR: Has Ms Webeck indicated what level of funding would be required to ensure all calls are answered?

Dr Paterson: We are going through those discussions at the moment. There are contract negotiations that will proceed. These are all discussions that will be had over the coming months.

THE CHAIR: Will that need to be funded through the next budget, or is that something that can be lessened? Could stopgap funding be made available?

Dr Paterson: There will not be stopgap funding, but there will be discussions around what that service offering looks like going forward.

THE CHAIR: What other government-funded services require someone to first go through a successful intake via DVCS? Are there any others?

Dr Paterson: Can you explain the question?

THE CHAIR: I hear that women are often told, "You're going to have to call DVCS if you want to access support. That's the place to go in a crisis." Is there anything sitting behind that so that, once someone has done that, they can get further support, or do they have to go through an initial intake with DVCS?

Dr Paterson: Anyone can go to any service that they want in Canberra.

Ms Bogiatzis: Different services offer different things. For example, if a client contacts the YWCA, who deliver a case management program, and they are in crisis, they need to stay in hotel accommodation and they are in quite an unsafe situation, YWCA might say, "You really need to access DVCS first, so that they can do that immediate crisis intervention." After six weeks, or whatever period of time is needed to secure that person's safety, YWCA or another organisation might step in and do that longer term case management and coordination, and make sure that the safety plan is being implemented. In situations where that might occur, it might be because of the unique offerings of different services.

THE CHAIR: I suppose what I am getting at is exactly what you have just described. A particular organisation might say, "What we do isn't appropriate for you." We have talked about sexual violence. A non-crisis service provider is not going to show up at the hospital; I understand that. I have a concern, and I am wondering whether the government is monitoring this—people who make that initial contact. They are told to contact the crisis line, which makes sense, but the crisis line does not answer the call. How many of those people are then slipping through the cracks and not engaging with any service, because all of those services are required to say, "If you're in a crisis, we can't help you right now"?

Dr Paterson: This is the landscape that we are in. Different services offer different things to people. DVCS offers crisis response—hotel brokerage and things like that. They may be the most appropriate service for people to go to. But there are other services out there, and police, that can assist people, if needed.

MS BARRY: I would like an update on the information sharing act and where that is up to. I know there were some conversations earlier in the year to delay the commencement. I want to find out where that is up to.

Dr Paterson: Yes, we can provide a very quick update.

Ms Bogiatzis: In May 2024, the ACT Legislative Assembly passed the Domestic Violence Agencies (Information Sharing) Amendment Act to amend the Domestic Violence Agencies Act, which introduced the information-sharing scheme.

The scheme had a delayed commencement. Currently, we are working to prepare for the scheme's commencement next year. The scheme was delayed for 18 months, so it has a commencement date in November 2026. That is helping us to prepare those foundational elements, such as the development of a common risk assessment and management framework, and the development of a ministerial protocol, which is a document that would sit beside legislation to guide practitioners and information-sharing entities who are prescribed under the act as to when they should and should not be sharing information.

MS BARRY: How are those pieces of work progressing? What is the timeframe? I think the conversation in the chamber was about whether it could be done earlier, rather than taking 18 months. Can you give an update on where all those pieces of work are up to and how progressed they are?

Dr Paterson: They are progressing. There are still final decisions to be made and cabinet discussions around exactly what that looks like. We are keen to get this scheme off the ground and up and running as soon as possible, while doing it in a way that is safe.

MS BARRY: Okay; thank you.

Dr Paterson: Mr Emerson, in response to your question, I think it is very important that we put on the table that there is a "no wrong door" policy. All the services in Canberra would say that, for anyone who comes to their service, they will support them to access the right kind of help.

THE CHAIR: I have heard from service providers who say, "We have to ask them to contact DVCS." They are not saying, "We can't help you at all," but they are saying that the way to get help is through that line—

Dr Paterson: I just got a flurry of text messages saying, "No wrong door policy. Very important that that is made known in the community." Should a victim-survivor approach a service, they will direct them to the right service or support them within their own service.

MS BARRY: This may not be something that the services are particularly aware of, for DVCS. The issue is that, for example, to get a family violence order, you have to have some kind of involvement through DVCS. I think that is the issue. That is what I have been told.

Dr Paterson: That is not my understanding.

MS BARRY: Victims are having to engage with DVCS to be able to appear in court and get that family violence order.

Dr Paterson: No, I do not believe that is right. I will take it on notice, if I am answering this incorrectly, but my understanding is that anybody can approach the courts to get a family protection order.

Ms Bogiatzis: Yes. There needs to be no prior engagement with a crisis service.

Dr Paterson: No.

THE CHAIR: Or there need not be.

Ms Bogiatzis: There need not be; sorry.

THE CHAIR: The committee will now suspend proceedings for a short break.

Hearing suspended from 3.08 to 3.22 pm.

THE CHAIR: Welcome back to the public hearings of the Standing Committee on Social Policy for its inquiry into annual and financial reports for 2024-25. We welcome back Dr Marisa Paterson MLA, the Minister for Women, and officials.

We will go straight to questions. I want to ask about strategic objective 5, which is promoting an anti-violence culture in the ACT to ensure that women feel safe, and specifically indicator 5, the proportion of women who feel safe when they are by themselves walking in the neighbourhood during the day and at night. The target for 2024-25 was 42 per cent and the result was 37 per cent. It looks like that proportion has gone down every year since 2021-22. What is the government's understanding of the reason for that decrease? This is on page 49.

Ms Bogiatzis: Thank you for the question, Mr Emerson. Strategic indicator 5 relates to perceptions of safety. The directorate—in particular, the Office for Women—works to enhance the status of women and girls in the ACT and to create a community where they are safe, healthy and treated equally.

I note that the results in relation to the survey have decreased. The survey is conducted by ACT Policing, and it is a survey that they do annually. I understand that recently they changed their methodology, which has meant that some of the data is not comparable. In 2024-25, they moved from telephone interviews to an online probability-based panel. I note that in relation to the results.

I also note that, as the minister indicated in the last session, addressing women's safety is a whole-of-government, whole-of-community response and obligation. The Office for Women delivers a range of programs that seek to advance women in society to achieve gender equality. One of those initiatives is women's safety audits, to help us understand and promote women's safety in public spaces.

THE CHAIR: I have asked previously about the target being 42 per cent. It did not seem like an incredibly high target. The response I received was that it was higher than the previous numbers. Will the new target now be adjusted down because of the new methodology or drop in safety? Obviously, we cannot be sure if the methodology accounts for the drop in safety. Will there be a new target that is lower than 42 per cent, or is it going to be held there?

Ms Bogiatzis: In the previous budget estimates, the Director-General of the Health and Community Services Directorate made an undertaking to look at all strategic indicators

that sit across the directorate and look to refresh those. We are progressing that work to look at our indicators and perhaps identify some that are more contemporary and more reflective of the work of the Office for Women, to measure its performance. I would expect, before the next annual report hearings, the indicator to have been updated.

THE CHAIR: Federal Senator Katy Gallagher has spoken publicly about the survey that she has done on women's safety, with over 2½ thousand respondents. It found that 86.6 per cent of Canberra's women changed their plans due to safety concerns. Lighting was the most common safety concern, having been raised by 1,164 respondents. She indicated that she had written to the ACT government about this, and I am curious about who that letter was sent to and what the extent of engagement has been with her and/or her office.

Dr Paterson: There has been engagement with her office, and she did write to me, but we have not responded to her letter yet. In terms of the lighting aspect of the survey and the questions, I will be working with Minister Cheyne to be able to respond to that. In terms of the questions around police response to women's safety, that is an aspect that I will bring to the response that we send back to the senator.

THE CHAIR: I know we have had some of these conversations in past hearings: to what extent with things like safety can the Office for Women—

Dr Paterson: Sorry, could you say that again?

THE CHAIR: To what extent, with things like lighting, can the Office for Women drive cross-government change?

Dr Paterson: That is why we have the Women's Plan, which sits with the Office for Women. The gender-sensitive urban design guidelines fall under that. They are a responsibility of another directorate to implement. The priority and the drivers of the Office for Women are really to set the whole-of-government strategic framework for gender equality, gender equity. While we do not have the actual mechanisms to be able to implement key measures like lighting, there is a requirement on other parts of government to implement those things—the gender-sensitive urban design guidelines, anyway.

We will continue to work across government to see the implementation of the action plans under the ACT Women's Plan. Also, we are about to start a process of developing the next ACT plan. We will again work to understand how we can do that more effectively, how cross-government work can happen, if the previous plan has been successful in being able to achieve the implementation of the measures and, looking forward, what is the best way to achieve gender equity.

THE CHAIR: Is there scope in that, even currently, for advocacy from the Office for Women? What I worry about, with the gender-sensitive urban design guidelines and lighting in general, is that it falls into the general City Services bucket, so to speak. Although it is stated as a priority, and it has been stated by women as a priority, it is hard to fund everything. Footpaths are there, lighting is there, and CCTV. There are all these other things that we need to focus on. What role do you see, as the Minister for Women, and as officials, in pushing for that to be prioritised more within investment

decisions made in other directorates?

Dr Paterson: These are exactly the discussions that are held across directorates and across ministers. It is far broader than lighting and footpaths, when it comes to implications for gender equity and women's safety across government. As you will see in the Women's Plan, there are broad themes, with a range of different measures that all require significant investment. The directorate officials and I all regularly advocate and work with other directorates to see these things implemented.

THE CHAIR: Has Senator Gallagher's survey shifted the government's views on the importance of lighting? I understand it is a perception of safety issue. I understand the importance of men's behaviour programs and those sorts of things as well. For you, was that a surprising finding or did it align with your existing views on the importance of this issue?

Dr Paterson: Her survey showed that, largely, the perceptions of safety in the ACT by Canberra women are very good. People do generally feel safe. As you can see in strategic indicator 5, women do not feel safe at night, which is where lights come into play. I think that is one part and one component of a very much broader picture. I appreciate the advocacy around the lighting, and Minister Cheyne will have lots to say around the government's investment in lighting. As the Minister for Women and the Minister for Prevention of Domestic, Family and Sexual Violence, I have a much broader view of priorities. Yes, lighting is a part of it, but I think there is a lot more that we need to do to address violence in this community.

MS BARRY: I have a question around the Women's Return to Work grant. Do you have numbers for how many were declined and how many applications were undecided as of 30 June 2025?

Dr Paterson: In 2024-25, $104,000 of the $160,000 allocation was provided through 101 grants. These included four grants awarded to women from the AMC. That is the data that I have. If there is anything—

MS BARRY: 104 grants were awarded?

Dr Paterson: 101 grants were provided.

MS BARRY: Out of 160?

Dr Paterson: No. In the last financial year, there was an allocation of $160,000 and grants were allocated to the value of $104,000, through 101 grants.

MS BARRY: Okay; grant applications. How many of those were denied?

Ms Connor: There were no grants denied in that round, so anyone that was deemed eligible received funding.

MS BARRY: Minister, you mentioned that included grants to women at the AMC. What is that number?

Dr Paterson: Four.

MS BARRY: Four grants; okay. How many grants were reconciled or audited in 2024-25?

Ms Connor: 101.

MS BARRY: Audited in the previous year?

Ms Connor: Acquitted.

MS BARRY: Sorry; acquitted.

Ms Connor: I do not believe we acquit those. They are a direct grant to an individual, so they do not need to account—

Dr Paterson: It is up to $2,000 for eligible grants.

MS BARRY: So there is no way of checking whether the grants are—

Ms Connor: As part of their application process, the applicant will provide information about what they are seeking the funding for. They might provide a quote for clothing or a course or child care or something like that, and then that money is paid to them. I do not believe there is an acquittal, but we can check on that for you.

MS BARRY: That is okay. Is there a way of identifying the success of these grants? Are there any outcome measures you track? Are there indicators?

Ms Bogiatzis: The grants have been in place for many, many years and we have not had the opportunity to evaluate the programs. But this financial year we are undertaking an evaluation of key programs and grants to assess their effectiveness and making sure that they are achieving what we hope that they will and aligning with our strategic priorities. The return-to-work grants are part of that process.

MS BARRY: Thank you. Is part of this evaluation also going to be looking at eligibility criteria—because 101 seems like a very low number? If there are no grants that have been denied, is part of the evaluation going to perhaps look at the eligibility criteria?

Ms Bogiatzis: There were 101 grant applications for $160,000. We acknowledge that the full quantum of funding was not expended, but that is part of the process we are undertaking now. We still got a high response rate. We think 101 applications is still pretty good for a grant process, and we were pleased to be able to support 101 grant applicants.

MS BARRY: Has there been any consideration given to outsourcing this to, say organisations like Fearless Women, who probably have a broader remit?

Dr Paterson: No, I do not believe so.

Ms Bogiatzis: I think that the quantum of funding that is available with $160,000, for

us to provide that funding to an organisation, they would need to hire a staff member. That would probably account for a lot of the funding.

Dr Paterson: There would be a lot of administrative cost.

Ms Bogiatzis: So I think our model is fairly efficient.

MS BARRY: Thank you.

Ms Connor: We moved the model on to SmartyGrants from August 2025, which we expect will improve the applicant experience and make it easier to apply for the grants as well.

MS BARRY: Is SmartyGrants the ACT government grants portal?

Ms Connor: Yes; the grants platform.

MS BARRY: Okay. Thank you.

MISS NUTTALL: Thank you. I am interested in the impact on the care economy. What oversight do you have on the funding processes for organisations in the women's sector? I am thinking often family and domestic violence crisis services will fall into it and also things like women's legal and women's health. How much oversight do you have in the funding arrangements for those organisations?

Dr Paterson: None in this portfolio.

MISS NUTTALL: Okay. I suppose from an advocacy perspective, I would like your thoughts on this. We have been informed that the current funding structures for organisations in the women's sector are essentially causing poor working conditions for the majority of women workforces. For example, funding is often limited to six- to 12-month grants, which means these organisations cannot promise their staff continuity of employment, and that is a problem especially within feminised industries. I have heard that organisations are struggling to hire and retain workers, and, in particular, experienced workers, because of these conditions, which are ultimately out of their control because they are relying on short-term grants. Obviously, with the presumption of caregiving also falling to women on a balance of probabilities, insecure work from insecure contracts disproportionately impacts women. Is this a phenomenon that has been brought to your attention?

Dr Paterson: Yes, and I believe there are negotiations with the enterprise bargaining agreements around community sector organisations at the moment. I also think that this very much an issue that is raised within the domestic, family and sexual violence sector. Looking at workforce capability and support for the workforce in that sector will be a priority through the budget strategy process. Similarly, with the Women's Plan, I think there is a lot of opportunity to have these discussions there as well.

MISS NUTTALL: Is there any opportunity for you, as the Minister for Women, to essentially advise Treasury on funding processes that better support the sector and its workers?

Dr Paterson: There are the wellbeing indicators that are applied across budget processes across all budget submissions.

Ms Bogiatzis: All budget submissions and cabinet submissions require a wellbeing impact assessment. That assessment is quite comprehensive. It requires the author of the document to consider the submission and the impact to various priority groups, including women and Aboriginal and Torres Strait Islander people, and to give cabinet that kind of information when it is making its considerations.

MISS NUTTALL: I appreciate that that happens one on one. While you might try as much as you can to take into account the impact that it will have on a feminised workforce, there is actually the overarching phenomenon where, if you are constantly relying on a number of different short-term contracts, that is where the problem is, and a single business case going through cabinet is not necessarily going to take into account the rest of the—

Dr Paterson: And that is where, I guess, the opportunity comes with the Women's Plan and the development of the Women's Plan. I am 100 per cent sure that there will be substantial consultation with the community sector and with the community through that process. That is an opportunity to have the discussions as to how or what that could potentially look like, or if that is appropriate to be a part of an action plan, for example, within the Women's Plan.

MISS NUTTALL: Okay. Speaking of the Women's Plan, I am hoping to ask a little bit about that, if that is okay?

Dr Paterson: Yes.

MISS NUTTALL: The last ACT Women's Plan is expiring next year. Your ministerial statement a couple of weeks ago indicates that you started work to independently evaluate the plan. Who is conducting that independent evaluation?

Ms Bogiatzis: Thanks for the question. The directorate has engaged Impact Co to conduct the evaluation of the ACT Women's Plan and the third action plan. Impact Co were engaged through a competitive procurement process and have demonstrated their expertise in gender equity, strategic evaluation and stakeholder engagement. We are looking to partner with Impact Co and Women's Health Matters to support the evaluation. Women's Health Matters bring subject matter expertise around our local context and sector and issues impacting women. Their recent survey results certainly spoke to their strong understanding of that.

The evaluation intends to assess the overall effectiveness of the plan and how it has influenced the economic status, safety, wellbeing and social inclusion of women, girls, and gender-diverse people in the ACT. We are hoping very much that the evaluation will help inform the design and development of the next plan. The final report of the evaluation will be provided to government in the first half of next year. We are hoping it will be really useful to help us in the development of the next plan.

MISS NUTTALL: Awesome. Thank you; that answered a few of my questions. In

parallel to that, have you started work yet on the new Women's Plan?

Ms Bogiatzis: Not as of yet. The current Women's Plan ends at the end of next year. So we still have a bit of time to kind of pull that plan together. We are hoping to commence that work on the development of the next plan next year.

MISS NUTTALL: I am just trying to work out the timing for sequencing. So you have got the evaluation due in the first half of 2026?

Ms Bogiatzis: Yes.

MISS NUTTALL: Then is it the idea that work on the plan will commence quite shortly thereafter?

Dr Paterson: Work on the plan will begin before that. I guess there are aspects of the work in establishing the baseline for the work in terms of setting up the ministerial advisory council as well. We are currently seeking community engagement in and applications for the ministerial council for gender equity. That council will form an important part in providing advice on the Women's Plan. That work has started, and we will begin the work in full next year. It will not be waiting until the evaluation is complete to begin the work.

MISS NUTTALL: To what extent have you started consulting with women's services and advocacy organisations? I am mindful that Women's Health Matters will be engaged. So not yet?

Dr Paterson: No.

MISS NUTTALL: When will that begin and what will that look like?

Dr Paterson: That work will begin at the beginning of next year. We will be able to articulate further what that will look like once the work has begun, once we have a clearer picture of how we are going to do it and what we are going to do.

MISS NUTTALL: Given that we are almost at the end of 2025 and we have the independent evaluation due in about six-months' time and we are looking to start work on the plan before that—

Dr Paterson: Yes.

MISS NUTTALL: If we are not waiting for the independent evaluation and we are not necessarily consulting women's organisations yet, or do not know what that consultation will look like, does that give us enough time?

Ms Bogiatzis: Yes. I think it does. We have a full 12 months to develop the Women's Plan. The development of the plan will be informed by the evaluation that we talked about. It will also be informed by the new council that is being established. But, as you mentioned, Miss Nuttall, there will also be strong community and stakeholder consultation and also cross-government engagement. There is a range of directorates that would be involved in the development of the plan. Early next year we will be

conducting the consultation before the evaluation findings come through. We do not feel that the results of the evaluation are needed necessarily to start consultation with stakeholders on what the new plan should look like.

The first step for us, and the thing we want to commence early next year, will be working with government and community stakeholders to map service gaps and to identify community needs and their priorities to see in the next Women's Plan. The evaluation of the previous plan and the establishment of the women's council will really help us cement what the plan is, and we will have a good six months to bed down feed-in consultation findings and bed down the final plan.

MISS NUTTALL: Obviously, the hiring for the women's ministerial advisory council is now public. It looks like it has a strong policy focus and it emphasises policy expertise. Do you think you are going to get enough women with lived experience but not necessarily a policy background from that process?

Dr Paterson: Hopefully—potentially, yes. We felt that it is a broad remit and we hope that there is a lot of interest in joining this women's council. I think we have a lot of really highly-informed people and people with lived experience in particular areas that may want to contribute to this council. So we are really excited to see what applications come through and working with the council going forward, particularly in respect of the next Women's Plan.

MISS NUTTALL: Have you done specific outreach to any women's organisations or different demographics?

Dr Paterson: Emails have gone far and wide—as far and wide as we can think. If anyone comes across your path that you think would be a really good applicant, please encourage them to apply. I think applications are open for another week—until 18 November. We are very interested in who will come through and how they can work with us to contribute to the next Women's Plan.

MISS NUTTALL: When it comes to community organisations, is there scope to engage with them, as perhaps people that the plan is designed to support, earlier on in the piece when it comes to the independent evaluation? I am just thinking of the things that they might be to tell you that might not otherwise be picked up in an evaluation like that.

Ms Bogiatzis: From women's organisations?

MISS NUTTALL: Yes.

Ms Bogiatzis: Women's organisations will be consulted through the evaluation. We also have relationships with women's organisations and talk to them often.

MISS NUTTALL: Awesome.

Ms Bogiatzis: With the valuation, I expect we will be in regular contact with the consultants and they will be feeding us information as it progresses. That is why we are not worried about starting consultation in parallel to the evaluation not yet being

finalised. So, yes, we will talk to women's organisations.

MISS NUTTALL: Thank you.

MS BARRY: So there is 12 months to develop the new plan? Is that right?

Ms Bogiatzis: Yes.

MS BARRY: So, just to confirm: the women's advisory group will be set up within that 12 months; the evaluation will be completed within that 12 months; consultation will be undertaken within that 12 months; cross-directorate consultation will be undertaken; community consultation will be undertaken within that 12 months; and then the plan will be ready within that 12 months?

Ms Bogiatzis: That is the plan. We are going to be busy.

MS BARRY: That is great.

MS TOUGH: I was going to ask about the ministerial advisory council, but I think Miss Nuttall covered everything. I am interested in the rollout of period products and whether that is now complete or whether there are further steps to progress in that rollout.

Dr Paterson: This is very exciting. It has been a great initiative rolling out across schools, libraries and family centres in the ACT. It has been really successful, and it has been really amazing to see school communities embrace period products in their facilities. The pilot commenced this year, which has seen product dispensers in targeted ACT government locations. I might pass to Tina to add to that.

Ms Connor: As of October 2025, period product dispensers were installed in three child and family centres, West Belconnen, Tuggeranong and Gungahlin; the Child Development Service at Holder; Housing ACT Service Centre in Belconnen; eight ACT Libraries—that is all except the Heritage Library; ACT courts; ACT Civil and Administrative Tribunal; 31 pilot schools, including primary, high school and colleges; Canberra Hospital and the University of Canberra Hospital; Community Health Centres and walk-in centres; and CIT Woden and Tuggeranong. For the broader rollout, we are still in negotiations in relation to other public places. That would see it expand to CIT Bruce, Gungahlin and Fyshwick.

MS TOUGH: You said 31 schools?

Ms Connor: Yes, correct.

MS TOUGH: Is there work with the other approximately 60 schools in how we get into those schools? Is it a mix of high schools, primary schools and colleges?

Ms Bogiatzis: The rollout of period products commenced in a pilot phase. That was deliberately fairly contained to see what the uptake was like and understand usage. To help us do that, we are receiving information from the supplier, Rentokil, who go out to the various sites and maintain the dispensers with the products and give us good

information on usage. We are also looking at a YourSay consultation process. In addition to usage data, we want to talk to other stakeholders to understand from their perspectives how successful the pilot has been. That will inform a broader rollout.

Dr Paterson: I think the YourSay consultation finished yesterday. It had a range of questions, asking the community how they would use the products, if they had, whether they were aware of them and that type of thing. That will inform the next stages, and they will be subject to future budget consideration.

MS TOUGH: Have you had any reports of vandalism or people completely emptying the dispensers?

Ms Bogiatzis: No; I have not heard anything.

MS TOUGH: Awesome.

Ms Bogiatzis: It has been really positive so far.

MS TOUGH: That is what I wanted to hear, but I just thought I would check. It was more just the vandalism, opening and throwing them everywhere and that sort of thing.

MISS NUTTALL: Were any free period product provided in all-gender or men's bathrooms as well, noting that some men get their period?

Dr Paterson: Good question. I am not 100 per cent sure.

Ms Connor: We might have to take the exact details of that on notice. But, yes, there was definitely consideration about placement in bathrooms other than just the women's bathrooms.

Dr Paterson: Yes.

Ms Connor: But we can take on notice the exact details.

Ms Bogiatzis: In ACT schools where the pilot is being delivered, we made very sure that our education around the pilot commencement was very clear that the products would be available to anyone who menstruates. So, definitely in schools, that is the case.

Dr Paterson: In terms of the implementation in the government buildings, there has been a level of prioritisation to have these dispensers in unisex bathrooms. For example, at 220, across the road, they are in unisex and women's bathrooms. At ACAT offices, they are in the unisex bathroom. It is the same at ACT Housing. In the Child Development Services, they are in the unisex and women's bathrooms, and it is the same in the Mingle Display Village at Whitlam. So there has been a level of carefulness, I guess, around the pilot.

MISS NUTTALL: Awesome. Thank you.

MS BARRY: I have a question around the sizes of the period products. I understand

that there has been a YourSay evaluation of that. Does that include the effectiveness of the sizes?

Dr Paterson: I believe that there are sort of free text boxes where you can write comments and feedback around your experience of the pilot through the YourSay thing. I am sure that through that process community members who have any concerns or issues or wanted to raise anything in that respect could do that through that process.

MS BARRY: Okay. Was any consideration given to the sizes for the rollouts that have already happened? I note that it is only the regular size being provided. But there are people who use super or something.

Ms Connor: I do know that there was consideration given to what in particular was being put into schools, particularly like primary schools where people might just be beginning to mensurate. That was done in consultation with the Education Directorate.

Ms Bogiatzis: I do note that we specifically were curious in our YourSay process around sizing—because, as you say, Ms Barry, typically the regular size is the size that was distributed. If we get feedback about that, that would be really useful.

MS BARRY: That would be useful, yes.

THE CHAIR: On the third action plan for the Women's Plan, will we receive an update—like an annual report on that in December or January?

Ms Bogiatzis: We will get the exact timing of the release, but we do provide publicly the outcomes of the action plans. Here we go; Ms Connor has that information.

Ms Connor: The reporting of the update on actions in the third action plan is released around International Women's Day. That is done around the same time every year—so in March 2026.

THE CHAIR: I am looking at the last reporting, from this March, I suppose, that reports on where we are up to at the end of 2024?

Ms Bogiatzis: Yes; correct.

THE CHAIR: At that point, all 30 of the actions have been commenced and six were completed. Do you have any sense now of how many more have been completed?

Ms Bogiatzis: While Ms Connor is finding the information, what I have is that the 24 actions are actually now underway. I think previously some had not commenced. I understand significantly more progress has been made on that. As part of implementing the Women's Plan, we have an executive sponsors group, which helps us provide that strategic oversight and that whole-of-government coordination on gender equity priorities. That group is the form that we use to sort of say, "Reporting is coming up; where is everyone at?" to understand progress and identify emerging issues. That is the information I have. I do not have any further update in relation to those 24 that are underway.

THE CHAIR: Is your sense through the ongoing reporting that you will reach the end of this action plan and be satisfied that most of the actions have been completed? Do you feel like you are on track?

Ms Bogiatzis: We still have another 12 months, and I think we will progress several more actions to completion by that point. This is what the evaluation will help us with. A lot of the actions identified in the action plan are things potentially that are ongoing activities that might require continual work. So, rather than having a start and finish date, these are the kinds of insights we are hoping to achieve through the evaluation around what are useful actions, what are not and how we can do this better in the future.

THE CHAIR: Will there be a final year reporting or just an entire final review? I am looking at the previous action plan. There is kind of yearly annual reporting through three years. This action plan is a four-year plan. You have got all that work we discussed over the next 12 months. Would there be fourth-year reporting and then separately a final review of the entire plan?

Ms Bogiatzis: Yes, that is what we anticipate. I do not anticipate that the reporting that will be released on International Women's Day next year would be more significant than the previous year, necessarily. But what I do anticipate is that the evaluation report will be significant and will provide that comprehensive overview of the entirety of the plan.

THE CHAIR: Thank you.

MS BARRY: Will the evaluation include evaluation of the impact of the positive duty on the Discrimination Act of 1991, which is action item 2.6 of the third action plan?

Dr Paterson: It would include all of it.

MS BARRY: Okay. Thank you.

Dr Paterson: I report on that action through the statements as well.

MS BARRY: Given that the government has decided not to proceed with the plan for a dedicated space industry hub, what is the status of action plan 3.7?

Ms Bogiatzis: Action 3.7 is to develop and implement an ACT government approach to encourage women and girls to consider careers in space. That action is led by the Chief Minister, Treasury and Economic Development Directorate. So I am not in a position to provide an update on that.

MS BARRY: So the Chief Minister is the responsible person for that particular action? Okay; I will ask him that question.

Dr Paterson: If you look at the plan, it will articulate the appropriate directorates that are responsible for delivery of the actions. They are the responsible ministers to ask about progress on those things. They will report back to the Office for Women in providing advice for the statement that I make.

MS BARRY: Thank you. Is action plan 5.2 yours—the Integrated Offender Management program?

Dr Paterson: No; not in this capacity.

MS BARRY: It would be Corrective Services?

Dr Paterson: Yes.

MS BARRY: Thank you. **I** want to understand the purpose of the recurrent grant funding for the Office for Women. What is the purpose of that recurrent grant funding?

Ms Bogiatzis: The Office for Women delivers a range of grant programs. It publishes that funding amount as recurring because that funding is divided across the range of programs and grants that are administered by the Office for Women. That includes things like the Audrey Fagan program, the Women's Participation Grant, Return to Work grants that we previously talked about—those sorts of things. Because they are annual programs, it is recurrent funding.

MS BARRY: Thank you. Are there any plans for the commissioning process to replace this at some point?

Dr Paterson: No. As was discussed earlier, there is currently some evaluation going on around how these grants are working. There will be more consideration of the future of the grants, what they look like, how we better engage with the community, what is achieving good outcomes—that type of thing. This is where the advisory council will be helpful in providing advice on these things. In the development of the next Women's Plan, it would be great to have a more integrated system of grants and strategic objectives.

MS BARRY: Thank you. Does recurrent grant funding also cover specialist homeless services delivery or is that a different—

Ms Bogiatzis: No.

Dr Paterson: No.

MS BARRY: Thank you.

MISS NUTTALL: This probably refers back to the economy. Forgive me—I was going to try to squeeze it in at the end of last session, but I think the core of it still applies here. Are you aware that multiple organisations have their funding commissioning processes early next year in the domestic and family violence space, which essentially means it will be in the December-January period, which is when staff are on leave, often due to caring responsibilities, and it is statistically more likely that people will receive or seek support?

Dr Paterson: We have not begun a commissioning process within the domestic, family and sexual violence sector.

MISS NUTTALL: I wonder where I got that from. My understanding, from what I have heard on the grapevine, is that there is commissioning for something in that space. I think this is the one due on 2 February.

Dr Paterson: The contract renewal?

MISS NUTTALL: Possibly. My understanding is that there is a commissioning element to that, but if there is not—

Dr Paterson: There is a renegotiation of the core contracts for DVCS, CRCC and EveryMan.

MISS NUTTALL: The same thing possibly applies, then. Obviously, that is a point in time when people need to take leave. Often you are operating on a skeleton crew, and it is also when these services are oversubscribed. I am a little concerned about the burden that puts on women within the organisation.

Dr Paterson: Their funding is stable through this process. There is funding for these services. It is about renegotiation of the contract and jointly negotiated outcomes from these contracts. That process has begun and will take the best part of next year—to mid next year—to negotiate.

MISS NUTTALL: What is due on 2 February? Anything? My understanding is that it was a quite short initial process before things were due.

Ms Bogiatzis: I am not sure it is relevant to this hearing. We have written to those organisations and provided them with an indicative timeline around how this contract renewal process will occur. Perhaps that is one of the dates indicated in that process.

MISS NUTTALL: Is it something that the Office for Women weighs in on at all? I am mindful of the previous question.

Dr Paterson: It is not in this portfolio area.

MISS NUTTALL: It is from the perspective of dealing with a lot of feminised workforces, and the insecurity and short-term pressures around funding structures often mean, in practice, that women do not have work that is as secure as other work. It puts a lot of pressure on the organisations. In terms of the Office for Women, I wonder whether you have any advocacy responsibility.

Dr Paterson: Working with these services is a priority for me and I am definitely receiving feedback from them on the process. This is really a process of refining contracts. For example, DVCS has multiple contracts and reporting requirements, so we are trying to streamline that, ultimately to provide a better process for that organisation so that they do not have as many reports to provide to government. They are working towards key strategic indicators. We will continue to work with those three organisations around the process and we are constantly in communication with them. The Office for Domestic, Family and Sexual Violence is constantly in communication with them. Any feedback, as we go through this process, is appreciated, and we will work with them.

MISS NUTTALL: Does the Office for Women ever do advocacy with other parts of government to hold these sorts of contract renegotiation processes at different times of the year, when they are less likely to have an impact on the sustainability of the organisation and the people working there?

Dr Paterson: Speaking to the domestic, family and sexual violence sector is work in the strategy. An aspect of that will look at workforce sustainability. Very substantial issues are raised. The strategy will aim to consider these aspects.

MISS NUTTALL: I am encouraged to hear that. Thank you.

Dr Paterson: But the Office for Women is not so much directly doing that advocacy.

MISS NUTTALL: Thank you. I appreciate you being willing to provide context in this session.

MS TOUGH: I am interested in the Audrey Fagan program. There are a couple of different streams to it. I am wondering what those streams capture, who is eligible for the program and how it was running in the last year.

Ms Connor: Thank you for the question. There are three streams to the Audrey Fagan programs and grants. The first is the Audrey Fagan enrichment grants, which offer individuals grants of up to $2,000. It is for 12- to 18-year-old girls, young women, non-binary or gender-diverse young people to enhance their skills and support them to achieve their goals. That has funding of $10,000 per annum. In 2024, 13 applications were submitted and the total amount was funded.

MS TOUGH: Were any of those 13 rejected or were all 13—

Ms Connor: Seven individuals were successful for the grants. I do not know that I have info on the unsuccessful ones. There were diverse applicants—various members of community.

MS TOUGH: Thank you.

Ms Connor: The second Audrey Fagan program is the Audrey Fagan Leadership and Communication Program. It aims to support women of any age to gain confidence and assertiveness, particularly in public speaking, with a view of encouraging women to put themselves forward for positions of leadership and promotions. Funding of $25,000 is available for this program. In the 2024-25 year, 23 individuals participated in this program, and it was delivered by Communication Link.

The final program is the Audrey Fagan Board Mentor Program. It is a program to develop the skills and expertise of ACT women to increase their participation in decision-making and leadership roles. It connects women with a board and a mentor to provide women, including those from diverse backgrounds, with an opportunity to receive support to further their interest in corporate governance. It also has a $25,000 funding allocation. At the moment, the board mentor program is paused so we can undertake the evaluation of the grants and programs that the minister spoke about

earlier.

MS TOUGH: Do you expect that to come back online?

Dr Paterson: We will do the evaluation and look at how these programs are working and if they have been effective in achieving the outcomes, what is required to resource them going forward and what is a priority. As I said, this is good timing in the work that is happening to get the advisory council up and running and also the development of the plan next year to look at how we can be strategic in how we support women and girls in the community.

MS TOUGH: Thank you.

MS BARRY: Has there been a previous evaluation of the Audrey Fagan program?

Ms Connor: There have only been evaluations done by the providers that have delivered the programs, so this will be the first independent evaluation.

MS BARRY: How long has the program been running?

Ms Connor: For quite some time. I am not sure when they started.

Dr Paterson: It has been a long time.

Ms Connor: At least a decade.

MS BARRY: Evaluating the program has never been considered?

Ms Connor: There have been evaluations done by providers, but not an independent one. This is the first time.

MS BARRY: Why is that?

Dr Paterson: As we talked about in the other hearing, we are more and more turning our heads to evidence based investment and evidence based strategic direction in the grants and the services that we deliver. It is maturing the current system. Lots of things have been evaluated, and we are currently looking at evaluating these now. It potentially means that things have not been evaluated before.

MS BARRY: Interesting.

THE CHAIR: For the Enrichment Grant Program, Ms Connor, how many applicants were there and how many were successful?

Ms Connor: There were 13 applicants and seven were successful.

THE CHAIR: And the funding was fully exhausted?

Ms Connor: Yes.

THE CHAIR: Might you be able to provide on notice the reasons six were unsuccessful?

Ms Bogiatzis: I think the reason they were unsuccessful is the funding. We would have received a range of applications, and I am sure they all had merit. A panel is convened to assess those applications. What I can say is that those that were deemed to have greater impact and merit would have been awarded, noting the funding envelope that was available.

THE CHAIR: How has that funding envelope changed over time?

Dr Paterson: Not by much.

Ms Bogiatzis: It has remained static. That is part of the reason we are doing the evaluation, to look at whether it is adequate funding and if it is still fit for purpose.

THE CHAIR: The evaluation is for the entire package—the three different programs?

Ms Bogiatzis: Yes.

THE CHAIR: And just one is on hold while that is happening; the other two continue?

Ms Bogiatzis: That is right. The one that is on hold, the mentoring program, has experienced difficulty in the last couple of years in attracting mentors, because they need to volunteer their time. In 2024, it had 10 mentees and eight mentors. This is part of the consideration.

Dr Paterson: Also, the Women's Participation Grants and Women's Safety Grants are also being included in the evaluation.

THE CHAIR: Thank you. Did we cover how many people applied for the Leadership and Communication program and how many were successful?

Ms Bogiatzis: Twenty-three successful individuals participated in the Leadership and Communication program. I have information in front of me that says that four per cent were Aboriginal and Torres Strait Islander, 17 per cent identified as living with a disability, 39 per cent were from culturally and linguistically diverse backgrounds, four per cent identified as LGBTIQA+, 13 per cent were older women, and four per cent were on a lower income. I am not sure that any participants were turned away from that program.

THE CHAIR: Perhaps you could take on notice making sure there were not, but feel free not to answer if you see that what you have said is correct.

Ms Bogiatzis: I will take that on notice.

THE CHAIR: On behalf of the committee, thank you so much 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*. On behalf of the committee, I thank witnesses who have assisted us through

their experience and knowledge during today's hearing. We also thank broadcasting and Hansard staff, and the fantastic secretariat, for their support. If a member wishes to ask questions on notice, please upload them to the parliamentary portal as soon as possible and no later than five business days from today.

The committee adjourned at 4.20 pm