LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2024-2025

(Reference: Inquiry into Appropriation Bill 2024-2025 and Appropriation (Office of the Legislative Assembly) Bill 2024-2025)

Members:

MS N LAWDER (Chair)
MS S ORR (Deputy Chair)
MISS L NUTTALL

TRANSCRIPT OF EVIDENCE

CANBERRA

THURSDAY, 25 JULY 2024

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

By authority of the Legislative Assembly for the Australian Capital Territory

APPEARANCES

Privilege statement

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Amended 20 May 2013

The committee met at 9.00 am.

Appearances:

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

ACT Health Directorate
Peffer, Mr Dave, Director-General
Lopa, Ms Liz, Deputy Director-General, Corporate, Communications and Delivery
Chambers, Ms Kate, Acting Executive Group Manager, Health System Innovation and Performance
Travers, Ms Maria, Acting Executive Group Manager, Policy, Partnerships and Programs Division
Kaufmann, Mr Holger, Chief Information Officer, Digital Solutions Division

Canberra Health Services
Zagari, Ms Janet, Acting Chief Executive Officer
Lang, Ms Kellie, Executive Director, Nursing and Midwifery and Patient Support Services Division
Coulton, Ms Janette, Executive Group Manager, People and Culture Division
Smallbane, Dr Suzanne, Executive Director Medical Services

Major Projects Canberra
Geraghty, Ms Gillian, Director-General
Cahif, Mr Ashley, Deputy Director- General

THE CHAIR: Good morning and welcome to the public hearings of the Select Committee on Estimates for its Inquiry into Appropriation Bill 2024-2025 and Appropriation (Office of the Legislative Assembly) Bill 2024-2025. The committee will today hear from the Minister for Health, the Minister for Population Health, the Minister for Human Rights, the Minister for Trade Investment and Economic Development and the Minister for Tourism.

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

The proceedings today are being recorded and transcribed by Hansard and will be published. The proceedings are also being broadcast and webstreamed live. When taking a question on notice, it would be useful if witnesses used these words: "I will take that question on notice." This will help the committee and witnesses to confirm questions taken on notice from the transcript.

In the first session we welcome Ms Rachel Stephen-Smith MLA, Minister for Health, and officials. I remind witnesses of the protections and obligations afforded by parliamentary privilege and draw your attention to the privilege statement. Witnesses

must tell the truth. Giving false or misleading evidence will be treated as a serious matter and may be considered contempt of the Assembly. Could you please confirm you understand the implications of the statement and you agree to comply with it?

Ms Zagari: I have read and acknowledge the privilege statement.

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

THE CHAIR: Thank you. As we do not have opening statements, we will move directly to questions. Minister, I would like to start with a question about emergency department wait times. On 15 June there was a *Canberra Times* article called, "Canberra ED wait times have nearly halved, new data shows". The article reports that the latest quarterly performance report shows 63 per cent of ED patients were seen on time and the median wait time was 25 minutes. According to the article, it was a drastic improvement on the 2021-22 year, where only 48 per cent of patients were seen on time and the median wait time was 47 minutes. There were also a few quotes from you, Minister, about the hard work and commitment shown by staff across the ACT public health system. Minister, am I right in understanding this is due to establishing the Acute Medical Unit to quickly take patients from ED and introducing a medical navigator nurse to ensure patients are cared for in the right ED location?

Ms Stephen-Smith: Thank you, Ms Lawder, for the question. There are a number of initiatives that have all contributed to that outcome. I think it is really positive to see the improvement in ED wait times over the last 18 months or so. The team has worked really hard to deliver on that. The Acute Medical Unit is one part of that and the Liaison and Navigator Service is another part. I will hand over to Ms Zagari to provide some more detail on what else has been done and what they have achieved.

Ms Zagari: Thank you, Minister. There has been a real focus not only in the emergency department but all through the hospital. We know that ED performance is not just about what happens at the front door; it is also about what happens, particularly, at the back door. It is about being able to get patients well and out of hospital to an appropriate place in the shortest period of time that is right for that patient. So there has been a real focus on being able to move patients through the hospital—whether that be to rehabilitation or out to the community with appropriate care at home.

The increased size of the AMU has really assisted at the front end in being able to move patients through the emergency department into a unit that is staffed at a higher level than a general medical ward tends to be, so that you can provide a more acute level of care, rather than waiting for definitive diagnosis and treatment to be complete in the emergency department.

An increase in the provision of emergency surgery hours, so that we do not have patients waiting in hospital for an emergency surgery procedure, has also assisted. We have increased the emergency surgery capacity, both into the evenings and on weekends, quite significantly. That means that the wait time in hospital after an ED presentation until the person actually receives their surgery is shortened—meaning, again, the flow-on effect to emergency is that we are able to move patients through more quickly rather than patients being in the emergency department waiting for access to beds.

THE CHAIR: Lovely. For the purposes of reporting, at what point is a patient going from ED to the AMU counters being seen or receiving clinical care?

Ms Zagari: Being seen and treated in the emergency department is counted in the same way, irrespective of where the patient is going to go to. So it is not about if the patient is going to AMU. Once they start to receive care, there is a series of definitions that are about initiation of care—for example, the review by a medical team or the administration of medications. There is actually a definition, and we can provide that formally as an answer to a question on notice, if that would be useful.

THE CHAIR: So you will take that on notice?

Ms Zagari: Yes, I will take that part on notice.

THE CHAIR: Thank you. For the 63 per cent of patients seen on time, is this when they are seen by the medical navigator, when they exit ED, or when they commence assessment or treatment in the Acute Medical Unit?

Ms Stephen-Smith: That is when they commence treatment in the emergency department. That measure is a commencement of treatment in the emergency department. The other measure, which we colloquially refer to the as the four-hour rule—the proportion of patients have either been seen in ED and discharged home or seen in ED and admitted to the hospital within four hours—counts, as I said, as discharge or admission. An admission to AMU counts as an admission to hospital—someone is being admitted to a ward; it is just a ward that is for those kinds of undifferentiated patients that Ms Zagari talked about.

THE CHAIR: Does the medical navigator provide any clinical care or are they just there to ensure patients are cared for in the right ED location or transferred to the right inpatient ward?

Ms Zagari: The medical navigator has a role in providing oversight for the whole of the emergency department—so making sure that patients are being seen in a timely manner and are receiving the care they need, as you say, in the right location within the emergency department, but also to ensure that the flow and review of patients happens. It is about having somebody who has complete situational awareness about the breadth of care being received in the emergency department and making sure that there is an ability to reprioritise resources to see the most acutely unwell.

There are times when a medical navigator does provide care. With priority 1 patients coming in, for example, it may be the medical navigator that forms part of that response. It is a shift-by-shift basis, depending on what is happening in the emergency department and what the most appropriate response is. But their primary role is to ensure that the collective of the patients in the emergency department are receiving the right care in a timely way.

Ms Stephen-Smith: I might just add, Ms Lawder, in relation to navigation services and oversight of that length of time that people have been waiting in the emergency department, Canberra Hospital has just recently set up an operation centre that has visibility of all of those patients and how long they have been waiting. They then

support patient flow and will connect in with the emergency department when they see someone flag up as "This person has been waiting too long; we will go down and see if we can help figure out what the problem is and whether we can help smooth the path there as well." That is a relatively new initiative, but it is helping to improve the flow through the hospital as well.

THE CHAIR: I must say, I went with a family member recently to the emergency department and the Acute Medical Unit, and it all worked pretty well.

Ms Stephen-Smith: Good; pleased to hear that.

MS CASTLEY: When you say that the median wait time is 25 minutes in the case of patients going to the AMU, is this from arrival at ED to whatever point?

Ms Stephen-Smith: The median wait time measures your arrival at ED to probably the time that you are initially seen at reception and triaged through to when you have commenced treatment in the emergency department.

MS CASTLEY: The budget papers record that for 2023-24 it is expected that 56 per cent of ED patients will spend four hours or less in ED. So this is from arrival at ED to when they are transferred to AMU or—

Ms Stephen-Smith: They are not necessarily going to be transferred to AMU—so that is some patients. It is either that they are discharged, as in sent home, sent to another location or referred into Hospital in the Home, for example, which is another improvement to patient flow—that direct referral into Hospital in the Home—or they are admitted to some kind of further treatment space, whether that is a usual inpatient ward or the AMU.

MS CASTLEY: So they may not have received clinical care within that four hours?

Ms Zagari: No; the four hours is from triaged to leaving ED having received care.

MS CASTLEY: I see. When a patient is transferred to the AMU, there is obviously a wait time there, or are they receiving immediate treatment? How do we start monitoring how long they are there? Is there a timeframe for getting out of there as well?

Ms Zagari: The AMU is a ward. It is an inpatient ward. Like any other inpatient ward, you arrive on the ward and you have an allocated nurse who's responsible for you and allocated medical staff. It is like our other wards, but it has a higher level of staffing to ensure that we can provide that more acute care. Care commences immediately on arrival to the ward. It is not a part of the emergency department and there is not a clock associated. Your length of stay counts for however long you are in hospital, whichever inpatient ward you are on.

MS CASTLEY: So you are basically admitted to hospital at that point.

Ms Zagari: Correct.

MS CASTLEY: I note that we are talking about medians, and this might be more of a

comment. I have had a few people just texting me the wait times. My son was in last week and the estimated wait time on the website was eight hours and seven hours, and this has been fairly consistent all week. So how does that blow out? What does that mean?

Ms Stephen-Smith: I do not know if there is someone here who can explain how the wait times work, but if you read what it says and how it describes what those times are on the app, that is the time within, I think, 80 per cent of all patients will have been seen. So it is not a median wait time and it is not an expected wait time. It gives an indication, if you are in the 80th or the 20th percentile—however you describe that—of how long you might wait. Most people will not wait that long.

Mr Peffer: Categories 1 or 2 patients—patients who require immediate care or care within 10 minutes—are not represented on the app either. Those two categories of patients who require immediate care are not reflected in those numbers; it is essentially, categories 3, 4 and 5. The endeavour with the app is to not set an expectation that we cannot meet. It is essentially the time someone might wait if they are a category 4 or 5 patient at that point in time.

MS CASTLEY: So a category four or five. I note that, at the same time, the walk-in centres basically had nobody waiting nearly across the board. Is a category 4 or 5 something you would expect someone to go to the walk-in centre for?

Ms Stephen-Smith: Yes. I think you have highlighted, Ms Castley, the exact purpose of that, which is to let people know, "This emergency department is busier than that emergency department," if you need to go to the emergency department but also to raise awareness that you might not actually need to go to the emergency department and you could go to one of these walk-in centres. I have not looked at the app recently, but there is also the indication that, say, Weston Creek has medical imaging. So awareness is being raised that, if you have a limb injury, you might want to go to Weston Creek where you can also get your x-ray at the same time and then go back to the walk-in centre and get fully treated within that Weston Creek centre.

MS ORR: I have a question on sexual and reproductive health and the funding in the budget to make medical surgical abortions more affordable. Can you provide an update on how this work is progressing?

Ms Stephen-Smith: Yes. I will ask Maria to talk about that.

Ms Travers: I have read and acknowledge the privilege statement. The abortion measure is proceeding very well. We have contracted Marie Stopes Australia to provide both medical and surgical abortions for people in the ACT who need them. That is everybody in the ACT as well as people without a Medicare card. We have also contracted Women's Health Matters to work with pharmacies and also raise awareness and make sure that women who are accessing this service are fully supported.

MS ORR: Can you run me through how some of the provision arrangements might be changing as to how you can access abortion in the ACT?.

Ms Travers: With regard to prescriptions or with regard to surgical abortions?

MS ORR: You can do both, if you want. I know there are some changes afoot.

Ms Stephen-Smith: There are probably two things. The medical termination of pregnancy initiative has expanded to include some general practices, providers of medical imaging and tests that are required to support a medical termination of pregnancy. That has certainly been very welcomed by those practices that have been involved.

In addition, the Assembly obviously just passed the legislation to enable nurse practitioners and endorsed and authorised midwives to prescribe as well. That aligns the ACT rules with the change by the Therapeutic Goods Administration to enable that expanded scope of practice for nurse practitioners and authorised midwives. I do not know if Ms Travers wants to talk about what that then potentially means for our work in this space in terms of providing free access.

Ms Travers: It certainly provides easier access for many people, particularly through our walk-in centres, for example, which have nurse practitioners, and with general practice also coming on board. There are many nurse practitioners in general practice. So it will just mean more ease of access for people that need it.

MS ORR: I know previously Marie Stopes was one of the few places that you could access an abortion in the ACT. Often I would get feedback from people that it was not always the easiest, not necessarily because of anything Marie Stopes was doing but just because it was the sole provider. Do you think now we will start to see people who want to access this medical procedure getting much easier access?

Ms Travers: Certainly. I think the funding that has been provided has really been able to boost the services that Marie Stopes can provide. They are very skilled and very knowledgeable and are providing a good service to women in the ACT.

Ms Stephen-Smith: Increasing access to medical termination means that if you can get medical termination early, and that is your choice, fewer people are going to end up needing surgical termination. That also potentially is a benefit. I do not think we have got any data on that at this point, but continuing to expand access to medical termination of pregnancy is often an easier process for people.

Ms Travers: Another important part of the initiative is the long-acting contraceptives that are provided to women on request, if they wish, when they arrive for a medical or a surgical termination. Again, that may decrease demand in the future.

MS ORR: That one is during the consultation for the procedure; they can also access that. Is there anything else with extra parts? When we think about that budget line, we think about just the one procedure. Are there any other bits that go with it that might cover more than that one visit for long-acting contraception?

Ms Travers: Essentially, at this time it is just long-acting, reversible contraception and counselling.

Ms Stephen-Smith: Again, that long-acting, reversible contraception is a significant

expense for some people, if they choose to do that. It is very evidence-based to say that, if someone is having an abortion, offering long-acting, reversible contraception will reduce the chance of them needing an abortion in the future. I have heard from one of the GPs who is providing this service that it is helping to make them feel valued in their expertise because there is a significant difference in the Medicare benefit that is received by a gynecologist if they are providing long-acting, reversible contraception, versus if a GP is doing it, and we are paying what it actually costs for that GP's time to deliver that service, versus the Medicare benefit, which would then result in an out-of-pocket cost for most patients if all they got was the Medicare benefit.

MS ORR: I might come back to reproductive health later.

MISS NUTTALL: Page 15 of budget statements C says that $49.9 million has been allocated in the 2024-25 budget to the ongoing delivery of the Digital Health Strategy. That is a lot of money for a project that has already supposedly been delivered, so do you mind me asking: what is this for? Is it a payment to a service provider or is it work being delivered by ACT Health or CHS employees?

Ms Stephen-Smith: Obviously, Miss Nuttall, establishing an electronic medical record system is not a one-and-done process. There is a requirement for ongoing training for people, for ongoing ICT support. This is a 24/7 environment and that support needs to be 24/7 support for people, so there are a range of things. As our health service grows, the need for additional licences increases as well. I will hand over to Ms Lopa to provide some more detail on that.

Ms Lopa: I have read and understood the privilege statement. Thank you. The investment in this budget builds on quite a significant investment that we have made in the delivery of digital health care and the Digital Health Record. The decision to move to the Digital Health Record has really changed the way we deliver care to patients and how we deliver services in hospital.

ICT costs are not immune from all the other cost increases that we see happening around the country, particularly in some of my other areas of responsibility, like infrastructure. I am happy to break down the costs for you for what has been funded in the 2024-25 budget. There is $20.6 million in expense funding for support and hosting costs. That is the contract with our hosting suppliers for actually hosting the DHR. We have got just over $13 million for 70 full-time equivalent staff to support the DHR and the Digital Health Strategy.

We have got $3.6 million in expense funding for decommissioning of systems and offsets. We are working through the decommissioning of systems. We have decommissioned quite a few systems, but we are still working through that. As the minister suggested, we are now supporting a 24/7 operation, so we have about $3 million for staff overtime and allowances for that 24/7 support centre that is supporting the DHR in hospital.

We have got some $2 million for DHR software licences. Every time we put on staff we need more licences, so as staff increases so do ICT costs. We have got $1.7 million for refreshing assets like smartphones, monitors and scanners, for actual equipment. We have got almost $500,000 for increased cybersecurity requirements. The Security of

Critical Infrastructure Act 2018 is having an impact on what security we need to do on our digital assets, as well as our infrastructure and physical assets.

We have just over $2 million for continuing the work on a data warehouse, which we are working towards. We have got just under $700,000 for medical equipment integration, ECG machines and those sorts of things, integrating with the Digital Health Record. We have got some $5 million for continuing funding for the data remediation project. There is also some capital funding underspend from the year before, so there is a $4 million offset in that as well.

Ms Stephen-Smith: I would just note, Miss Nuttall, that, while you pointed to budget statements C, page 150 of the budget outlook also indicates—and I think this is in the line that you were looking at—that there is a provision in future years as well. It recognises that there is going to be an ongoing expense associated with the implementation of the Digital Health Strategy. In 2026-27 and 2027-28 that is fully offset from the health funding envelope, and it is partially offset in 2025-26.

MISS NUTTALL: Thank you. Just to clarify: how much of this is through an external provider, as opposed to in-house infrastructure?

Ms Lopa: I cannot break down 100 per cent all the funding I have given you as to what is going external and what is staying internal. The DHR is hosted by external providers, so we have Epic, who was our delivery partner on DHR, and we are in a long-term contract with them. We also have NTT, who does some of our hosting arrangements.

Obviously, the licence fees are to outside providers; we have to buy the licences. Things like the FTE funding et cetera are internal funding for staff that will be working in the Health Directorate and that 24-hour, seven-day-a-week service. Some of the medical equipment, for example, we would be purchasing from medical equipment providers, so it is a little bit of both.

MISS NUTTALL: It is sort of interspersed.

Ms Stephen-Smith: I think their estimate is that there are around 70 full-time equivalent ongoing positions to support the DHR and the Digital Health Strategy, and then some additional positions are provisioned for the data remediation project, which is an insourced project.

MISS NUTTALL: That is great to know; thank you. For the parts that are conducted by an external service provider, how do we ensure that we are getting the deliverables that we should be getting for this money?

Ms Lopa: We have got a 10-year contract with Epic that was entered into when we started doing the DHR and then a six-year contract with NTT. They are the main suppliers. We have a contract management team within DSD, in the Health Directorate, that is monitoring those contracts, looking ahead strategically at when they might need to be renewed, looking at contract extensions, variations or any procurements—anything that we need to do there. They are supported by our corporate, finance and procurement units.

When those invoices are coming in, the project managers who are working on the DHR check the invoices. They are looking at them and making sure that goods and services have been delivered, but we also then have that back-up where our finance section looks at that. There have been occasions when the finance section has said, "Hold on. This invoice was not addressed properly. You actually should not be paying it." We have got checks and balances in there to make sure that the invoices are being looked at and to make sure that all those boxes are ticked, the services were delivered and it is within the contract; those sorts of things. We have a contract management unit, we have the project managers and then we have got the corporate functions, who check those things as well.

MISS NUTTALL: Thank you.

MS CASTLEY: With regard to NTT, ACT Health has entered into a contract with an IT auditor and quality insurance contractor. I have got the text here. It is to review all NTT invoices submitted to the Health Directorate for the month of June 2023, so last year. It says:

> This review's findings will be within the following constraints: a review of the services provided by NTT according to the invoice period, reasonableness check for the invoice amount and expert opinion on the level of substantiation of document support provided by NTT for each invoice; a review of the Health Directorate's work order documentation and review period, including any NTT invoice paid or accrued by the Health Directorate for the month of June 2023; and any other findings that will result in improved practices.

Looking at the latest ACT invoice register, we have counted 300 invoices that have been paid to this company from the ACT government, totalling more than $114 million. That is an enormous amount of money to send a company, but as they are under contract for six years they are obviously doing a significant amount of work. What was the outcome of the consultant's report? Did they find that it was indeed a reasonable amount for their services?

Ms Lopa: Thank you. Yes, we did procure somebody to come and look at the NTT invoices. What I should have said to you, Miss Nuttall, is that, on top of all the other checks and balances we have, we also have internal audit processes. We have spot checks and all of those things. This was one of those spot checks, for exactly the reason, Ms Castley, that you have raised. It is a lot of money to be paying a company. It is one of the highest contracts that we have in Health and we wanted to do a spot check and just see how things were going.

We did get the results of that. The consultant that did the check for us did find that there could be some improvement in practices around the paying of invoices, so we put those improvements in place. That is where I was talking to the involvement of the contract management unit and the project manager, and then also having that other check by finance as well. That is just to make sure that the vender is doing the invoices right—addressing them to the right people; they are valid; all those things—and that actually the project manager is doing the check and making sure that those goods and services are delivered. As you would expect from any audit process, there are always improvements that you can find. They did find that there were some improvements to make, and we are implementing those improvements.

MS CASTLEY: It was not an internal audit? You paid $30,000 for this?

Ms Lopa: Yes. Just to clarify: I was talking about an internal audit that we get done on ourselves, as opposed to the Auditor-General doing an audit. We got an external provider to do it, but we asked for that audit to be done on ourselves, if that makes sense.

MS CASTLEY: So up until June 2023 there were no ACT government checks and balances. How many years of unreasonableness did we go through?

Ms Lopa: It was a spot check of a point in time. I cannot speak to before that time—I was not in this role—but that is not to say that those things were not in place. It was to say we are strengthening them, we are making sure that everybody is leaning into that, being part of it and making sure that things are being done properly. Indeed, our finance area continue to do those kinds of spot checks on the invoices as we go along. They might, say, pick five travel invoices this week and have a look and just check whether they are being done right or not. If there are areas for improvement, they work with the project managers or the executives who are signing off the invoices and say, "Hey; we picked up this. We picked up that actually they have double-charged for that." Then we go back and say, "Guys, you double-charged for that. We want that off the next one." So there is more active monitoring that happens.

MS CASTLEY: Will you be able to table the report for us so that we can see what the investigation found, how much money was doubled up or whatever the problem was? It is $114 million—a significant amount of money.

Ms Lopa: Sometimes there is GST. There are always complications with companies charging GST and input tax credits, which I do not really know much about, but we pick up things like that. I will take that on notice. I think we would be able to table it, but I will take advice on that because I am not 100 per cent sure.

MS CASTLEY: Minister, at what point were you aware that ACT Health believed that there might have been an issue with NTT's invoices and services?

Ms Stephen-Smith: We have an ongoing conversation about audit and integrity and about the Digital Health Record because, as you say, this is a very large project and it does involve a lot of money. A project board was overseeing the implementation of the Digital Health Record. That project board ceased, following the implementation of the Epic Digital Health Record, then was effectively re-established to support some of the data remediation work. Mr Peffer can talk a bit more about that. Clearly, it is the role of the director-general to ensure that all of these processes are in place to undertake internal audits.

Yes, this is a big and expensive project, but Canberra Health Services is a $1.8 billion a year organisation. They spend a lot of money as well. They have a series of internal audit processes, which are not necessarily them doing the auditing because that would not be appropriate, getting different things audited at different points in time. It is actually a standard part of the way the public service works. Mr Peffer might just want to talk about the—

MS CASTLEY: I asked you, Minister: when did you find out that there were some concerns over the NTT contract?

Ms Stephen-Smith: I think you are putting words in Ms Lopa's mouth by saying that there were concerns over the NTT contract. Ms Lopa's been very clear—

MS CASTLEY: The words were "to check the reasonableness" and—

Ms Stephen-Smith: Yes, but Ms Lopa has been very clear, Ms Castley, that it is a part of standard operating procedure that you do these spot checks. So I do not think—

MS CASTLEY: There were concerns with specific invoices in June.

Ms Stephen-Smith: No. The spot check related to invoices in June. That is part of a standard auditing process. I think you are drawing a long bow from what Ms Lopa said.

MS CASTLEY: Could you explain when you found out that there was an investigation into $114 million worth of taxpayers' money being looked into for reasonableness?

Ms Stephen-Smith: I will take that question on notice to see if I was specifically advised. To be clear: I would not expect to be advised about every internal audit process that the directorate and Canberra Health Services are undertaking. That is part of the standard work of the public service. As you have indicated, a lot of this is publicly available on tender registers and invoice registers and that kind of thing. It is part of the day-to-day operation of the services, so I would not necessarily expect to be advised about every audit that was commissioned of this type.

MS CASTLEY: Can anybody give me the—

Ms Stephen-Smith: I will take it on notice, though. I will have a look and see if I was specifically briefed about this one.

MS CASTLEY: Yes. I know you will look at tabling the report, which will be great, but can anyone just explain: were they overpaid and by how much?

Ms Lopa: I would have to take that on notice. I do not have it in front of me. My recollection from it was that we could improve practices, as I said, and we did. I am not sure if it went to whether we overpaid or not. I would have to take that on notice and have a look. I cannot recall.

MS ORR: Picking up on the processes for internal audits and reviews of pieces of work, you said that this was pretty standard practice. Can you give me an indication—Mr Peffer might be able to do this—across the Health Directorate, particularly considering that you do have a lot of large projects in the infrastructure spends on health requirements? How do you manage the risk of making sure that you are applying good governance to these larger projects?

Mr Peffer: Thank you for the question. Traditionally, I sit in CHS, but I am in the Health Directorate at the moment. The practices are quite similar in any directorate right

across the ACT public service. You will have an internal audit function; that will look at the key deliverables of the agency, and it will also look at an assessment of the key enterprise-level risks that you might be carrying at a point in time. That could be anything from fraud and corruption to workforce, expenses and other things.

Each directorate each year will develop an audit plan where it looks at where we think those exposures could be. Generally, that is overseen or at least developed in partnership with the independent audit and risk management committee. Each directorate has an independent committee of appointed lawyers, accountants and others that do not work within the entity, who bring a range of expertise and sit on that committee.

A program will be stood up and, depending on the nature of the audit that needs to be undertaken, that might be outsourced potentially to a big four, or it could be a specialist audit, such as the NTT. We had a specialist IT contract manager have a look at that particular audit.

With the audit findings, standard practice is that they will be shared for fact checking within the directorate, with the D-G and having regard to the reasonableness and practicality of the recommendations. There is no point in undertaking an audit for it to come up with recommendations that you cannot implement.

Generally speaking, the auditors will look at implementability of those recommendations. We will go through a process with a management response to say, "Yes, we agree with the findings, they are fair findings and here's how we intend to address the recommendations on any sorts of shortfalls." That then goes into a process of implementation. Depending on the scale and complexity of the organisation or directorate, that might be one or two audits a year; it could be eight or nine, for major audits.

MS ORR: It is pretty common practice to have audits. Would it be fair to say that if you had not had an audit for this project, that would have been unusual, as opposed to having an audit for this project?

Mr Peffer: Yes. Certainly, it is standard practice for projects of this scale or complexity or where there is a high risk element to it. For example, we are undertaking an internal audit at the moment into the transition of Calvary Public Hospital into Canberra Health Services—standard practice. It is a high-risk activity; we feel that it went reasonably well, but there are always lessons that you can learn, so you undertake these audits, bring in an external expert to have a look at it, and assess.

MS ORR: The point of the audit is to actually find the learning. You would expect that there will be some sort of feedback. You would hope it comes back and says everything is rosy and you did it perfectly, but that is not the norm.

Mr Peffer: In a sense you do not get the value out of an audit if that is what finds. It is better if it does identify opportunities for improvements.

THE CHAIR: Going back to the review of the NTT invoices, how many spot checks has the Health Directorate asked for or engaged external companies for in the past year

or so, and how many were investigated internally rather than getting an external company to do that review?

Ms Lopa: I will take the exact number on notice. I know that, with our internal audit plan, there are usually four or five a year, and they are usually done by external providers. I just signed off that plan this week, so you would think I would remember it, but there are usually four or five. Our finance team, under the CFO in the corporate and governance area, does little deep dives into things every now and again. They are less formal. They are more about, "We looked at 10 invoices and this is what we found," and then they give a little bit of feedback.

I will take the exact number on notice and come back to you, but it is standard practice on those things to have external auditors come in and help us. Every audit I have ever had anything to do with always finds something; they always find something that you can improve on. And that is why we do it, so that we learn as we go along.

Ms Stephen-Smith: Can I clarify, in terms of taking the question on notice, whether your question is specifically related to the NTT contract and spot checks on NTT invoices?

THE CHAIR: No; how many similar spot checks and audits have been commissioned out or contracted out, and how many might have been undertaken internally.

Ms Stephen-Smith: Yes.

MS ORR: On the Digital Health Record, we have had a lot of chats about implementation, but I was hoping to get a bit more of an assessment of how the project, given it is so big and it is now in a progressed stage of implementation, is supporting health professionals to provide the health care that we are seeking for Canberra Health Services.

Ms Stephen-Smith: I can give you one example straight off the top of my head, going back to Ms Lawder's first question about emergency department performance. When I was visiting the emergency department a few months ago, one of the things they pointed out to me was that everyone having access digitally to the same health record at the same time meant they could call the registrar who is up on a ward and say, "We've got this patient, we think they're for you; this is what we've done." The registrar can log onto the DHR, look at that patient, look at their presentation, look at the treatment they have already received in the emergency department, and make a decision then and there, "Yes, you can send that patient up to our ward," without having to walk down and look at what used to be a paper record in the emergency department. That is one example of how it has improved.

I have also had a nurse talk to me about the fact that they can look at the Digital Health Record and use the chat function or the video function to talk to the specialist about, "This patient of yours, this is what's going on with them at the moment," without needing that specialist to be right there with the patient and with the health record in front of them. Those are just two examples of how it is making that communication easier.

Ms Zagari: Minister, we might ask Dr Smallbane to step up, given that she is not only our EDMS but actually a clinician in the emergency department, and she can speak to this.

Mr Peffer: While Dr Smallbane is joining us, an important point to make is that it has replaced 37 separate clinical systems, and each of those systems was designed around a workforce, a department or a specialty in the hospital. The difference with the Digital Health Record is that it is actually designed around the patient, so it follows the patient throughout their journey. Previously, we did not have that in a business system that actually backed the patient care that we were attempting to provide.

Dr Smallbane: I am an emergency physician by trade. I have read and acknowledge the privilege statement.

The Digital Health Record has been an absolute godsend in many ways. I can really only talk about it from an emergency perspective. One of the major things that both of our emergency departments do is to see patients, clearly, across the territory and we accept patients into the territory.

For patients that are in one emergency department and that need to go to the other—usually, this would be from the previous Calvary, now North Canberra Hospital, through to Canberra Hospital—we used to have phone calls and we would have to describe all the things that were going on with the patient and the treatment; it would take forever on the phone. These days, we can open the record, look at what is happening to that patient, open the actual patient record, and it really facilitates patient care across the territory. It is very easy to say, "Thanks, I can see what's going on, you need to send that patient to us," or we will call plastic surgery, or show them this record, while we are waiting for the patient to arrive. It is an absolute godsend.

It is also fantastic from an IT perspective. We previously had to open multiple platforms—one for radiology, one for pathology, lots and lots of things to look at the patient care. Now, all of that is consolidated into one digital platform. Those results are known to us the second they arrive. We can open them straight up and have a look at them, and there are not multiple layers of IT programs that we are opening. That has really facilitated care. Instead of having to log on to pathology five times and see whether my results are there, now we know when they are there, and they are straight in the record, which is fantastic.

Ms Stephen-Smith: That is probably a good segue to the other advantage, which is the patient-facing MyDHR, which means patients can get their own results and their own discharge summaries in a very timely way. They are getting the same information that their GP is getting. Often people have to go back to their GP for follow-up after they have been to hospital, for whatever reason, or go to another specialist, and all of that information is available to them and to their GP. I have had this experience myself; I have been to see a private specialist after having gone through the emergency department, and I can show them, "This is what happened, this is what they did; what do you reckon?" And it is all there.

Dr Smallbane: The only interesting workflow that has happened is that you need to be incredibly cautious and much quicker in telling the patient what is going to happen to

them. If we actually type the letter before, they actually get the letter before we have had the conversation. There is a bit of a workflow, but it is a good workflow.

Mr Peffer: On 8 July, earlier this month, we had clocked up 967,714 results that have been provided directly to patients through MyDHR. Given we have moved on a couple of weeks from there, it is possible that we have cracked a million.

MS CASTLEY: Somebody contacted me; they had had a fall at work and went through ED, ended up being admitted to a ward and then moved to another ward. The nurses on the ward were doing everything, such as, "Who are you? What can we do for you?" This gentleman did not get fed for a couple of days, no-one really knew what to do with him, and he ended up checking himself out. How many stories like that do you hear? If it really is following the patient through, how many complaints have you had with regard to that? I note, Minister, we talked about the notifications coming through to sort out your end-of-life care. How quickly are you able to sort those problems out and how much is being reported to you as not working?

Mr Peffer: That is the first time I have heard of a patient not being fed for a number of days; that is the first complaint I have heard of that nature.

Ms Stephen-Smith: It is fair to say that I sometimes get correspondence from people who are concerned that their loved one missed a meal, sometimes missed two meals, for various reasons. Usually, it is to do with fasting, awaiting surgery; their surgery is postponed and then they have missed the meal order or whatever. It is also true that there is a lot of work going on in food services and reorganising that to minimise the times when people are unable to get a meal. I certainly have not had that experience, where someone would have missed out on meals for two days. If you are able to forward that to us, we will absolutely look into that.

MS CASTLEY: Going back to the NTT project, in a project set-up, especially IT project set-ups, there are governance models. The company would explain to you all of those checks and balances that you have mentioned that possibly were not in place. I am trying to work out where the breakdown occurred and how long NTT had been working before the check happened. Can we get, in real dollars, the amount? I know you said there was no money doubled or whatever, but if there were significant changes to be made, how long was the project just running along, with no checks and balances?

Ms Lopa: I can take all of that on notice. NTT itself is not a project. It is part of the DHR. It is a contract with a provider.

MS CASTLEY: They are a company that are providing to you?

Ms Lopa: Yes.

MS CASTLEY: They would have a responsibility to explain how many staff they have and how they are going to report to you?

Ms Lopa: Yes. As part of the DHR project, there was governance over that, but NTT itself is not a project. It is a contract for hosting services.

MS CASTLEY: I understand, but they have to report to you on the services that they are providing, in order for you to be able to justify giving them money?

Ms Lopa: Yes. There is a contract in place that would have service levels and all of those things that have been signed up to. When you get invoices in, you check them: are they consistent with the contract? Have they delivered the services? You would do that with any contract. I can take all of that on notice and go through that. The NTT contract itself would not have had governance around it because it is just a contract with a provider, but the DHR project—

MS CASTLEY: The provider, surely, would have given you something?

Ms Lopa: Yes, there is a contract in place that—

MS CASTLEY: Wrong words used on my behalf. NTT are people providing a service for the DHR.

Ms Lopa: Yes, a company providing hosting services and some other services to the territory.

MS CASTLEY: That is right. They have a responsibility to justify to you guys why they are worth $114 million.

Ms Lopa: Yes. They send in invoices for services they have delivered. We pay invoices, as with any contractual arrangement, within the framework of the contract.

MS CASTLEY: They have not been found in breach or they have not been referred to any auditor, especially since there is an investigation of the program. This has not been flagged as something that needs to be considered by the Auditor-General?

Ms Lopa: Not at this stage, to my recollection. I will have to re-look at what the recommendations were. It was before my time in this role. From my understanding, what Health has done, as it does with all audit recommendations, is look at what needs to be improved and put systems and things in place to make sure that anything that has been highlighted as happening that is not best practice improves and becomes best practice. I do not believe that there has been any referral to any other entity as a result of that spot check at this time.

MS CASTLEY: The critical services building: how many beds was the critical services building designed for?

Ms Stephen-Smith: It has 148 inpatient beds; that is my recollection.

MS CASTLEY: 148; that will be when it opens?

Ms Stephen-Smith: We will double-check that.

MS CASTLEY: Also, was the critical services building initially designed for those beds? Have we been able to increase them or has it decreased from the initial design?

Ms Stephen-Smith: Ms Lopa might be able to discuss this. In the very initial design, we did have some space that was initially planned to be shell space for inpatient wards. We made a subsequent decision to invest in fitting out that space so that we did have an expanded capacity in the critical services building. Ms Lopa might have the details on those numbers.

Ms Lopa: Thank you, Minister. You are testing my memory now, going back to that 2019 business case. Yes, the critical services building had two floors of inpatient units that it was designed for. One was initially funded to be fitted out and functioning when the building opened and one was going to be a shell space. But two budgets ago—the 2022-23 budget, I think—the government funded that shell space to be fitted out. I think those inpatient units are 64 beds. That was an extra 64 beds, so there are 128 inpatient unit ward beds, which are on the top two floors of the building, and they are a combination of four-bed, two-bed and one-bed rooms. They are the inpatient unit beds, so there was an increase of 64 as the project went on.

As far as the other spaces are concerned, the intensive care unit originally had space for 60 beds, but 48 are fitted out. There is some shell space in there for future growth. Temporarily, that is being used for some teaching and training space et cetera, and that can be expanded in the future.

MS CASTLEY: So it was designed for 176?

Ms Lopa: That is not including the emergency department points of care and beds. Off the top of my head—and Major Projects Canberra might correct me because I am going into my memory here—I think the emergency department had an increase of 70 points of care at that time. But please do not quote me on that.

Ms Stephen-Smith: I think part of the reason we are sort of struggling with this is that we tend to break it down to inpatient unit beds, cardiac acute care beds and ICU beds and then in the emergency department it is points of care. I will hand over to Ms Geraghty to talk more about that.

Ms Geraghty: Thank you, Minister. I have read and acknowledge the privilege statement.

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

Ms Geraghty: I can give you the numbers going through each of the breakdowns, if you would like, Ms Castley.

MS CASTLEY: I was keen on totals, really. Is anyone able to tell me how many people can be treated in the Critical Services Building and what it was designed for?

Ms Geraghty: The total inpatient beds that were designed for is 156, and that is what is delivered. Those inpatient beds consist of inpatient unit beds, generally, intensive care unit beds and coronary care unit beds. What is not included in that are the day surgical beds or the emergency treatment bays.

MS CASTLEY: What are those figures?

Ms Geraghty: The day surgical beds number is 55 and the emergency department treatment spaces number is 127. But there is a total of 147 because there are 20 additional ancillary points of care.

MS CASTLEY: And that is what it was designed as and it is what we have got?

Ms Geraghty: That is correct. That is what was within the contract.

MS CASTLEY: Thank you. In March, it was announced that there will be 22 operating theatres in the Critical Services Building, but the *Canberra Times* reported that 17 will be used for surgery immediately and the other five will be available in case the population grows. In June, it was reported that 13 full-time equivalent theatres would be available when the Critical Services Building opens but more could be used to deliver that capacity. Is there any change on that? In August, when it opens, will there be 13 theatres?

Ms Stephen-Smith: One of the things about the Critical Services Building, the theatres, the ICU and the emergency department is they are designed to accommodate future growth. There are 22 physical theatres in the Critical Services Building, of which 17 will be available for use and 13 full-time equivalent theatres will be funded for operation. That might mean that you might use two theatres for one full-time equivalent, for example—so people move between one theatre and another, particularly because there are specialised theatres and hybrid theatres that are for particular types of activity that you would not be using all the time. In addition, there are also going to be two theatres that continue to operate in building 12 specialised for gynaecology and obstetrics—for things like emergency caesareans, gynaecological procedures and those sorts of things—so they are closer to the women, youth and children's area.

MS CASTLEY: So 17 can be used, however we choose to. Are the remaining five just empty rooms at this point and, when you decide to budget to bring them on, they will have the capability to be an actual theatre?

Ms Zagari: They are theatres and they have much of the major equipment in them. There are some items of equipment that have not been provisioned for day 1 but that we have since ordered. They will be available for use shortly afterwards as required to ensure that we have fully fitted out all of the theatres. There are some delays. There are some lengthy time lines to delivery of some of that equipment, just because of the nature of supply lines internationally at the moment.

MS CASTLEY: So "shortly after"? Are we expecting that by the end of the year?

Ms Zagari: Absolutely.

MS CASTLEY: So if one broke down, for instance, you could use one of the five?

Ms Zagari: Correct, and that is why we equipped the 17.

MS CASTLEY: Why haven't the 17 opened? Is that for that reason, the supply, or is it staffing issues?

Ms Zagari: The entire capacity of the Critical Services Building is intended to provide for Canberra into the future. We are intentionally not bringing on all capacity at the opening, because we actually need to be able to respond to increasing demand over the forward years and have a pipeline to bring workforce online as we go. We have increasing theatre capacity across the territory. We are increasing theatre capacity at NCH concurrently. Having a robust pipeline for bringing in new staff and theatre staffing is one of those areas that is challenging nationally, but we have been able to do really well in that recruitment space. We continue to recruit to those and then would seek funding in future years for bringing online additional capacity as it is required.

Ms Stephen-Smith: Just to add to that, the other advice that we have received in terms of opening a new facility is that a lift and shift of largely current capacity with some slight expansion is easier to manage than trying to move existing people plus expand and change models of care at the same time. So it does have to be a staged delivery.

MS CASTLEY: Okay; but we do have the appropriate number of staff to go with the 13. We have looked at elective surgery waitlists over the past few years, and I am sure there are a few specialties that would love the opportunity to get in there and have a go at clearing some lists. Has any of that been considered?

Ms Zagari: It has. We are considering all the mechanisms that are available for elective surgery to be able to get the volume done that we need to over the coming years. There is a part of increasing the capacity at North Canberra Hospital so that North Canberra Hospital can contribute greater numbers to that elective surgery. That is really important because you want the patient to receive care in the most appropriate facility. Not everybody should come to the tertiary hospital campus; that is not good practice. So NCH has an opportunity therefore to do more and are really pleased to be doing that—in fact, we have the North Canberra general manager here who could speak more specifically to that.

We are increasing theatre numbers at Canberra Hospital concurrently and then looking at what can be appropriately performed in the private sector as well, rather than, as the minister has described, significantly increasing theatre throughput in that opening period, which adds another layer of change and complexity. Transitions in health care come with risk. So keeping things as consistent as possible whilst getting used to the new building is important, and then there can be a progressive uplift in capacity going from there. We are considering in specific specialties how we get through the volume of work that is required.

MS ORR: On the Critical Services Building and the expansion of the hospital, can you give us a bit more information on how that space is being set up, how the staff are being engaged and moving into the new space and how you are bringing them online?

Ms Stephen-Smith: My understanding is that more than 4,000 staff—and Ms Zagari can correct me if I am wrong—have undergone the first training orientation in relation to the operation of the Critical Services Building. There is a big focus on orienting staff to the building at the moment. When I was there yesterday, they were undertaking a simulation of a major trauma helicopter arrival, with the teams that would have been involved in something like that working together to understand the flow through the

building and how they would all work together in that new space. That is the kind of work that is underway at the moment, but Ms Zagari is right across it and can talk more about it.

Ms Zagari: Thank you. I can wax lyrical for some time on this, but I will try to keep it relatively brief. All staff are having an orientation to the building itself and to the elements of the building that are different. In every area, there is then a very specific training program and orientation to the equipment elements that are different. For example, if your cardiac monitor is different to the monitor that was being used, all staff get trained in the use of that monitor any workflow changes that may flow because the theatres are a little different to the existing theatres—so ensuring that everybody understands how we work within that environment and how they can get assistance or who to turn to if, for example, someone does not know where the pillows are kept in the ward now and who to talk to. There is a program of "super user" training. In every area there are people that have either volunteered or been identified to do additional training so that they can then become a really embedded resource within the unit for their teams.

In addition to that orientation to the building, we will have DSD support at the elbow of the clinician. If there is something new in DHR or something different, we will have people there during the move and the period immediately afterwards and, as the minister said, those simulations with departments coming together to say, "This is how we will do these things," and focusing on the high-risk elements of the work that we do that are changed by the building so that everybody understands how they will operate within that environment.

Additionally, on the weekend or when we undertake the move, there will be a hospital operations centre stood up, in the way that we would in an emergency circumstance, for example, as well as a move command centre. So there will be a very managed approach to how we move patients through the hospital and then the initiation of all of the buildings. The staff who are in there at the moment are getting familiar, identifying last-minute fixes or changes that we need to make so that we will be ready to go live in August.

MS ORR: Once you go live in August, what are the next steps for the building? Is it like all done and dusted and we are all good, or is there some more work to do?

Ms Stephen-Smith: One of the next steps will be commissioning a new provider for the main cafeteria in the building. I think staff have been very pleased to hear that Zouki has not taken up its first right of refusal for the new main cafeteria. So an important piece of work once the building goes live will be to go out to get a new cafe provider, and then they will fit out the cafe. Sorry; I just had to get that in there. It is very exciting for staff.

MS ORR: Is there anything other than the cafe?

Ms Stephen-Smith: Back to Ms Zagari.

MS ORR: I know that is a very important one for everyone who works at the hospital.

Ms Zagari: There are some stage 2 works being undertaken. I am actually going to throw to MPC if that is okay, rather than speak on their behalf.

Ms Geraghty: No problem at all. We have a series of things that we will do post-occupancy. Most importantly on the main build, we will do a post-occupancy evaluation with CHS about six months after the operation starts to assess what we can learn for the future, particularly now the northside project is underway, and whether there are any tweaks needed in the design and whether there are any modifications we need to make. So that is the first thing. The other thing is that we have just submitted the DA for the Amber Drive entry. The old emergency drop-off will become a new entry for the hospital. We are working with our construction partner Multiplex at the moment on the final designs for that to be able to start construction this year. They are the two things from us.

Ms Stephen-Smith: There are also things internally, including that the current intensive care unit will be transitioned to become a dedicated palliative care ward, which consumers have been seeking for a long time, and then the work in the theatres in building 12 to refurbish a bit for the women's, youth and children dedicated theatre space and endoscopy space as well. So there is going to be quite a lot of work going on in parts of the building that people are moving out of.

Mr Cahif: I would also add that there is also minor defects work, and that will continue.

MS ORR: That is just a standard thing to go back in and check everything is working.

Ms Geraghty: Correct.

THE CHAIR: In terms of the theatres that will be available when the Critical Services Building opens, how does that relate to the work being done by private theatres and private hospitals? Is that work to bring down the waiting list and you expect it to end at some point, or is ongoing contracts? Why aren't you doing that work yourself?

Ms Stephen-Smith: That is an ongoing conversation, Ms Lawder. As I said earlier, the initial plan is a lift and shift of our activity. But having those additional theatres and having the budget funding for additional emergency theatre activity, freeing up the theatre space for elective surgery, will enable us to bring more in house and to do more elective surgeries through this financial year than we have done in previous years.

Our private sector partners at the current time remain very important partners in the delivery of surgery. A really good example of that is the elective joint replacement program at Calvary John James. They do a really excellent job. Every year, between 300 and 400 joint replacements are done through that program. That is something that we will have to continue to consider in future years, because obviously we do not have an endless resource and we do need to think about how we most efficiently use that resource. But, for this year, certainly, our private partners remain a very important part of delivering our elective surgery target.

Mr Peffer: I might just add that, to a large extent, it is our workforce undertaking the work. So it is generally our anaesthetists and our surgeons who are doing that work in the private on behalf of the public service provider.

MS CASTLEY: I have a couple of follow-ups on DHR, and that will finish the session. Is someone able to tell me the total spend to date for DHR?

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

MS CASTLEY: Yes, and what the original budget was and whether there has been a bit of a blowout, additional spending, that we were not expecting. expecting.

Ms Stephen-Smith: We will come back with the information but, again, I would just say that, with a project like this, there is always going to be ongoing funding that is not necessarily funded on day 1.

MS CASTLEY: I understand that; I'm just wondering what that looks like. I know projects carry on. Is it possible to get a full list of internal audits that ACT Health and CHS completed for 2023-24? With regard to NTT, out of that report—and I know you would look into tabling it—were there any reprimands or any recommendations other than just, "Change your processes; do things better?" Can you let me know about that.

Ms Lopa: I can talk to that now if you like.

MS CASTLEY: Yes.

Ms Lopa: From the NTT audit and also some of our spot checks, we have put in place a business improvement program in DSD, the Digital Solutions Division. That business improvement program has all the recommendations out of spot checks and audits et cetera that we have done. I chair an oversight group, which has people from corporate and governance in it—so procurement, finance and governance—as well as the DSD executive to work through things. As part of that, the first step was to ensure that everybody had training. We wanted to make sure that the people who had been brought on for the DHR, a big project—some of them from clinical backgrounds and some of them from very ICT backgrounds—had been given the appropriate training. Often when people come in in the middle of a very fast project, you don't often stop and do your training program. So the first step of that was to make sure everybody had procurement, financial management training and had delegate training—all of those things.

As we continue to do our spot checks, if someone has had the training and they keep paying an invoice without checking it, for example, then we start to get into those management conversations where people are starting to have management conversations. Then if they happen again, you start going down the HR path of performance management et cetera. There are a number of conversations that are taking place as a result of what we are finding through our spot checks et cetera, with the first being, "Okay; let's make sure these people are trained and supported to do the job that they are doing." Then, as we move through, if issues continue to come up, that is when you start having some of those performance management conversations.

MS CASTLEY: Ms Lopa, when I asked if they have been referred to the Auditor-General, given that there is an investigation as a whole, you said, "Not at this time."

Ms Lopa: What I did forget, Ms Castley, when I answered, is that the Auditor-General is actually doing a performance audit of the DHR. They are due to start that. They have been doing document gathering, and we have got some documents for them. They are due to start their audit in earnest in August or September. The Auditor-General is coming in and having a look at the DHR program.

MS CASTLEY: Have you referred NTT specifically?

Ms Lopa: That contract is part of DHR, so it is part of a bigger project.

MS CASTLEY: Just to clarify: no action has been taken?

Ms Lopa: The business improvement program has been put in place, that oversight committee has been put in place, and the Auditor-General is doing a performance audit, as they call it. There have been actions taken internally in the Health Directorate to start to look at the recommendations out of the internal audits et cetera. To my knowledge, there have been no other referrals. That does not mean that there might not have been, but not to my knowledge.

MS ORR: I will come back later and ask about north side health issues, because that is what I am really interested in. Before we go to a break, Minister, can you talk me through the investments that have been made to support junior medical officers at Canberra Health Services?

Ms Stephen-Smith: You might recall that, last year, the 2023-24 budget invested $8½ million to improve wellbeing and promote CHS as an employer of choice for junior medical officers. This was in response to the feedback that the team had from junior medical officers, including as part of the medical practitioners enterprise agreement negotiating process.

Some of those improvements include things like providing longer contracts to improve job security for graduating doctors. Rather than the two-year contracts that were being offered to graduating doctors, it was about extending those to three years, with an option for a two-year extension, to improve their job security and match up with what other jurisdictions were offering.

There is also a process of expanding pastoral support for junior doctors within CHS beyond the first two years to include all trainees, with an initial focus on those who are not registered with and supported by college-accredited training programs. We have a number of un-accredited registrars that do not have a college supporting them and also were not being supported with that pastoral support by CHS. That is in place. We are also investing in a director of clinical training and a chief medical wellbeing officer to support and enhance development, supervision and wellbeing of medical officers, including but not limited to junior doctors.

Others might have a bit more to say, but, overall, I have been really pleased to see that the 2023 medical training survey showed a really significant improvement in results for Canberra Hospital compared to the 2022 survey, which, I think it would be fair to say, was a bit dire in terms of comparison of junior medical officers' satisfaction with their training experience at CHS versus other jurisdictions.

For example, 66 per cent of physician adult medicine trainees said they would recommend their current workplace, compared to 40 per cent in 2022. Overall, 73 per cent of ACT trainees said they would recommend their current workplace, compared to 60 per cent in 2022. Almost every specialty saw an improvement, with the exception of obstetrics and gynaecology, which we have talked about previously in the Assembly, where there is some specific targeted work underway. We are starting to see some of the results flow through, but we have also heard very clearly through the medical practitioners enterprise agreement vote process that we have more to do.

The other thing I would mention is the embedded psychologist in the CHS JMO welfare team, which we understand is an Australian first. The other thing that has been really welcomed is bringing forward the junior medical officer orientation to January. That means new doctors have a two-week handover with the outgoing intern cohort. They are not coming in cold, with the outgoing intern cohort moving on to their next thing. They are actually having an opportunity to do some warm handover.

MS CASTLEY: On the $8.5 million for wellbeing, you said there are longer contracts now; they have gone from two years to three years. Is that a bonus? I know other jurisdictions are giving 40 grand. Is that it or is it just that they get a longer contract?

Ms Stephen-Smith: No, it is more about job security. Maybe Dr Smallbane can talk about how that is being implemented.

Dr Smallbane: I have to say that I was new to this, so I was not involved at the beginning and the inception of putting this process in place. I really welcome it. It has been fantastic. That funding is for the chief wellness officer, the psychologist, and the international medical graduate senior doctor who is responsible for helping our international medical graduates when they arrive to culturally assimilate with our healthcare system. There are three or four new part-time positions involved in that funding, which goes over several years.

The longer contracts themselves are an initiative where we would be trying to recruit to those positions, anyway, every single year. We are now saying, "We want you to stay. We want to make your life better. We want to give you some job security so that you can invest in the ACT, get a loan, buy a house and all the things that you need to do, for which you need proper security."

We are offering that to our juniors for much longer terms. There used to be just one-year rolling contracts, where you applied for your job every year. Now we are saying, "We will employ you for four years. You are welcome to leave." We do not want them to. It is not like they are stuck with us for four years, but we offer them the security from our side.

MS CASTLEY: Of the $8.5 million, how much is for international medical graduates? Is that a training program or is that the cost to bring them here?

Dr Smallbane: That is purely the cost to employ people to help train them and to set up a training program specifically for international medical graduates. They now make up 30 per cent of our junior medical workforce.

MS CASTLEY: Can you give me the breakdown of those costs—the $8.5 million? You said there was a psychiatrist, the training for the junior medical officers, out of that $8.5 million?

Ms Stephen-Smith: We will take that on notice. We will have that from last year's budget, so we will be able to provide that.

MS ORR: I want to get a little more on the health and wellbeing fund for the workforce and progress on the initiatives, particularly in the context of some of these groups, such as the junior doctors, that have reported that they would like to see an improvement.

Ms Stephen-Smith: While Janette is taking a seat, one of the really positive things about this program is that it has been designed by, with and for staff. They are designing it for themselves. It is very self-determined about what initiatives are put in place. Part of the strength of that has been engaging staff in a conversation about wellbeing before any of the initiatives are implemented.

Ms Coulton: I have read and acknowledge the privilege statement. In relation to the wellbeing and recovery fund, that commenced in October 2022. There are a number of initiatives under that program. We have what we call foundational programs—things like employee assistance programs. You can get free counselling and support onsite or there is a phone-in option. With that EAP initiative, those foundation programs, we have wellbeing and peer support officers. We have introduced wellness spaces so that staff can go to areas that are quiet spaces or have an opportunity to debrief within that wellness space with a counsellor.

We have also launched the wellbeing index app, which enables people to register on their app, fully confidentially, as to how they may be feeling, or what the last month may have looked like. Depending on how you respond to those questions, it then links to further support and resources that you might want to utilise.

Under that fund we also have cultural transformation programs. That is where we start looking at our Speaking Up For Safety Program, our SUFS portal, which enables staff to confidentially raise issues of concern that may not be something on which they want to move to a formal complaint; they just want to raise their hand based on an observation or an experience that they feel may not have been appropriate. They work through a triage, if you like, depending on the issue that they have raised. A peer support officer can meet with them, to understand the issue in more detail and take that up with the people that they have made the observation about.

We also have, under that cultural transformation, opportunity for leader-initiated acts of kindness. Each quarter a leader, a manager, is able to raise their hand and say they would like to recognise their team in some way, providing them with a wellbeing outcome. That could be simple things within a staff respite area, staff rooms, staff meeting or lunch areas—coffee machines or toasters, and simple things like that, so they are not having to go off to a main kitchen area, and there is something closer to their main coffee station, if you like. There could be funded lunches or afternoon or morning tea, to have during a training opportunity or a staff meeting, so that they have that funded time to bond and be in a bit more of a relaxed space. We have also had

wellbeing expos and wellbeing symposiums.

We have had a number of local workplace initiatives. There has been different training that we have rolled out around fatigue management, for example. All of those types of initiatives are coming under that wellbeing banner and under that funding.

MS CASTLEY: The funding for afternoon teas and lunches, are we talking about frontline staff?

Ms Coulton: All staff.

MS CASTLEY: All staff, okay.

Ms Coulton: Yes. It is predominantly frontline staff who participate in those activities, but it is open to all staff.

THE CHAIR: The committee will now suspend the proceedings for morning tea.

Hearing suspended from 10.28 to 10.45 am.

THE CHAIR: Welcome back, Ms Stephen-Smith MLA, Minister for Health, and officials, for more questions on health. Over to you, Minister.

Ms Stephen-Smith: Thank you, Chair. I will hand to Ms Geraghty to correct some of the figures that were provided earlier.

Ms Geraghty: Thank you, Minister. My apologies. I misunderstood the bed table. I will clarify the number of beds that are in the new CSB. There are 128 inpatient beds. I said 64 previously. That accounts for the cold shell that the minister and Ms Lopa spoke to. There are a total of 220 inpatient beds, plus the day surgical and emergency department treatment spaces. I will pass to Ms Zagari to talk about the operational considerations for the 220.

Ms Zagari: Thanks, Gillian. At opening, there are 160 ward type beds. Those are the inpatient beds. We have five 32-bed wards. That is a combination. Coronary care is included in that number. Then there are the 48 ICU beds. The other 12 beds—the gap between the 208 and the 220—as minister referred to earlier, are the 12 future growth beds for ICU that are currently being used for teaching and learning space. That was not very clear. I can provide that more clearly. There are 160 inpatient beds, 48 ICU beds and a further 12 ICU bed spaces that are currently being used in the teaching and learning simulation space.

THE CHAIR: We have finished on the question from Ms Orr, so, Miss Nuttall, do you have a question?

MISS NUTTALL: I do indeed. Minister, the government has committed to invest, I believe, $86 million to increase the ACT's nursing and midwifery workforce. However, since the commitment was made, hundreds of third-year registered nursing students from the University of Canberra, and others, have been indiscriminately offered graduate jobs without any interview or conventional recruitment process. That is my

understanding. Please correct me if I am wrong. My understanding is that the only criteria is eligibility for registration. With that being the case, could you tell us why the government thinks that it is a good idea to recruit one of our most crucial and important workforces only on the basis of them having completed a degree, with no additional requirements?

Ms Stephen-Smith: The fundamental requirement is that they will be registered nurses and will be qualified to do that job. Something that we have heard very clearly in terms of attraction and retention of our medical students is that a guaranteed job at the end of their study is something that will help to attract them to the ACT to study here and keep them here. I have a lot of faith that the University of Canberra will not graduate people who are not ready to do the work that is required of them as graduate nurses. I note that, in other jurisdictions, part of their attraction and retention strategy is to bond students to places, which is effectively the guarantee of a job. There is a requirement that students work there if they are going to receive the bonuses that are offered. Mr Peffer.

Mr Peffer: Thanks for the question. This is a decision I made in discussions with the University of Canberra. Each year, we go through a process across our various facilities—across the health services as a whole—where we tend to recruit a certain number of graduate nurses. Each year, it is safe to say that we would prefer to have more than we are actually able to recruit. For many of the nurses in their final year, there is obviously the pressure of the final year of a university degree and all that goes along with it, and then, of course, there is the concern about what happens next—what about next year? Time and effort go into job applications, CVs and that sort of thing. Once you settle your CV, it is pretty easy to send that around to many different health services.

Those who have trained locally have done their placements in our health service. They are known to us as a health service. We really do want to retain that workforce here in the capital. We thought about the best way to do that, in terms of removing any obstacles or concerns that people might have, and the level of work that might be required to effectively offer them permanent positions—if they would like to take that up, subject of course to APRA registration and everything that goes along with finishing a degree and being qualified to work in our health service. Of course, many of them have done those placements in our health service. Once they start with us as a day-to-day service provider, there is a lot of training and support that goes along with that. I will ask Ms Lang to expand on that a bit.

Ms Lang: I have read and acknowledge the privilege statement. In relation to the undergraduates, we have sent out approximately 390 offers and we have received feedback from approximately 290, so it has been a really good response. The students come through our hospitals et cetera. We also have a very detailed new graduate program that the new graduates will come into when they start employment with us. There is one at the North Canberra Hospital and there is one at Canberra Hospital. The Canberra Hospital goes out to the community and other broader areas. That is a 12-month program. They are precepted individually with senior staff within the organisation. We do particular skills development and other pieces of development throughout those 12 months. At the same time, there are particular areas that run specific foundation programs—for example, in operating theatres, where they identify that they are places that they would like to work in. There is a very consolidated

program that we run within that area and also in the emergency department. There are some key processes in place to support new graduates.

MISS NUTTALL: To confirm, is there a compulsory requirement to complete the grad program as part of the offer? Is it like saying, "You can have the job if you complete the grad program"?

Ms Lang: It welcomes them into the program, and, as they start their first year, it is advisable that they do that and have that level of support. Some people who are enrolled nurses can work with us and then graduate as registered nurses. They might be in mental health or other specific areas. They would want to continue in that space. They can continue in the particular space that they want to work in, but we help them, touch base with them and keep them as part of the program so we can keep an eye on them, making sure that they are okay and ensuring that we are monitoring their wellbeing and their clinical development along the way.

MISS NUTTALL: If you do not mind, could you confirm the concrete requirements that students need in order to be offered a place?

Ms Lang: Obviously, completion of their program and then, ultimately, registration.

THE CHAIR: Does the same guarantee of an offer to nursing students apply to midwifery students?

Ms Lang: Yes.

THE CHAIR: Thank you.

MS CASTLEY: I would like to ask about frontline staff. Page 34 of budget statements C estimates that Canberra Health Services will have 9,504 staff for 2024-25, which is an increase of 171 from the estimated outcome in 2023-24. I have previously asked for breakdowns of CHS staff at each unit or branch at the Canberra Hospital, North Canberra Hospital and other locations, including the university. Could I have updated figures of new staff, including the latest estimates for June 2024, by hospital division, and where they are expected to be based?

Ms Zagari: To clarify, are you comfortable that we use the same presentation that we used in response to the previous question, for comparison?

MS CASTLEY: Yes. Also, I am keen to distinguish the difference between frontline staff and admin staff. I would like someone to clarify for me what you guys mean when you talk about frontline staff.

Ms Zagari: I will take that on notice.

MS CASTLEY: Okay. Distinguish between administrative roles and frontline roles. Do you have an idea of the ratio—how many frontline admin and frontline clinical staff we have? Is that something you could take on notice?

Ms Zagari: We will take that on notice. Thank you very much.

MS CASTLEY: Of the 171 expected FTEs—the increase—do we know how many will be frontline clinical staff as opposed to administrative staff? Could we get a breakdown of that?

Ms Zagari: I might just clarify. Administrative staff can also be frontline staff, if we think about ward clerks, clinic clerks and the sort of staff that are in patient-facing roles.

MS CASTLEY: So they are all frontline staff?

Ms Zagari: If you are looking for a breakdown of patient-facing staff verses back-of-house staff, we can provide that. Those 171, as a footnote, largely relate to the commissioning of Building 5. The new staff for Building 5 are almost entirely patient-facing, but we will provide a further breakdown for you.

Ms Stephen-Smith: To emphasise what Ms Zagari was saying, "patient-facing" does not necessarily mean clinicians. There are a lot of additional wards people to open Building 5. It is a large building. It will need a lot of that kind of support. There is a concierge desk in the emergency department which was not there before. That is a patient-facing position, but it is not necessarily a clinician.

MS CASTLEY: Maybe it is clinical staff. I am keen to understand.

Ms Stephen-Smith: So you would like the clinical numbers?

MS CASTLEY: The clinical frontline numbers. I think that is what I am trying to get my head around.

Ms Stephen-Smith: We will provide medical nursing, allied health—the defined professions who provide—

MS CASTLEY: That would be amazing. Minister, we have an increase of 171 for this year. I do not have the page in front of me. Is this enough to get you to the 800 health workers that you have committed to?

Ms Stephen-Smith: Yes. This is a really significant increase. What we see is 800 health workers in this budget—through the term of the next government, if we are re-elected. To have 171 full-time equivalents in this budget is a very significant investment. The number funded in this budget builds on additional staff over the forward years as well. The 171 are not the full number of FTEs funded in this budget. The ratio numbers will continue to grow in the outyears as well. I do not think I have those figures in front of me. I will look at my information. The total number of FTEs funded in this budget is larger than 171 and starts us on a very good footing to reach the 800.

MS CASTLEY: Of the 800, do you have a breakdown of the staff you are expecting to employ? Are they in allied health or are they clinical? What does that breakdown look like? Do you have that plan?

Ms Stephen-Smith: We do not have the entire plan. I can tell you that the new initiatives in this budget, over the four years, will fund 346.3 FTEs across the health

portfolio. Those are not all frontline staff. We would have to look at how many were health worker staff, because that figure includes some positions in the Health Directorate doing other work, but the vast majority are health workers. In relation to the breakdown of the 800, that is obviously a Labor election commitment, not a commitment that I have made as health minister. That is somewhat tangential to this particular hearing. However, to answer your question, that forms the basis for election commitments that will be made and activity that will need to be funded over the next term of government, as well as activity that was funded in this budget. There will be some things that we have already committed to, and, for some things, we will continue to make commitments as we get to the election.

MS CASTLEY: I understand that was a Labor commitment. Has the directorate instructed you, as the minister, that we need 800? Is this the reason? How do you know you need 800?

Ms Stephen-Smith: We know that our community is continuing to grow, so we have looked at what the growth has been over recent times. We have also looked at some of the spikes in numbers—for example, with the opening of the critical services building. So it is not always a smooth trajectory, in terms of the number of additional staff that we will fund, but we have looked at the growth in population, the aging of the population and health needs into the future, and our expectation about how the budget will grow over time. That is what guided our commitment in 2020 to 400 additional frontline healthcare workers. Before this budget, we had already funded 580 full-time equivalents. We had exceeded that, and my expectation is that we will probably exceed 800 as well. Certainly, in terms of the growth of the population, that is what we think we will be looking at.

MS CASTLEY: That is the reason I am very keen for your explanation of the frontline workers. Where did the 400—or 800 or whatever—frontline workers go? That would be much appreciated. Thank you. The 2022-23 annual report showed $47 million was overspent on supplies and services, which was primarily due to higher utilisation of VMOs and agency nursing staff. Then, in 2023-24, the estimated outcome for supplies and services is an overspend of almost $170 million. It was $168.6 million. Can you explain how much of this overspend was on agency staff and VMOs, as well as the number of agency staff and VMOs? Can we get an understanding of that overspend?

Ms Stephen-Smith: We will take the detail of that question on notice. What I can say is that this is something that has been seen in the health system across the country. There is an escalation in the need for additional agency and locum staff because of the demand that we are seeing in the system. It is demand that cannot be put off—demand in the emergency department, the intensive care unit or paediatric inpatients, for example. Midwifery has obviously been a challenge across the country. We have made a decision to have longer term agency midwives to provide stability in some of those spaces so that we have breathing space to recruit and provide support to the less experienced midwives that are coming in. But we have also seen cost escalation. We have seen cost escalation that reflects the inflation that we are seeing in the broader economy. I do not know whether Ms Zagari wants to add to that.

Ms Zagari: I will add to that, Minister. Thank you. The other part of this is that, internally, we budget to directly employ all the staff. That is the government

commitment. However, in health care there is always a requirement for a component of agency staff and VMOs. That is part of running hospitals. So, whilst the budget line reflects an overspend, there is a movement of costs between categories. Regarding utilisation over time, this is about where we would expect to be. There have been increases, particularly in housing provision for long-term agency staff in midwifery. The significant difference we have seen over the last 12 months is the ability to staff all our shifts, and part of that is about where we have somebody coming from interstate to take up an agency midwifery contract, for example—that is, in a long-term contract; I am not talking about day-to-day agency staff. We had to support housing for a period of time so that we can actually get staff.

MS CASTLEY: That is obviously one of the benefits of having an agency midwife. What other benefits are there for having agency staff compared to employees?

Ms Zagari: That is a quite esoteric question. Agency staff are often paid more—

MS CASTLEY: Do they get parking allowance?

Ms Stephen-Smith: Benefits to them; not benefits to the health service.

MS CASTLEY: Benefits to them. That is right.

Ms Zagari: Depending on the particular arrangement with their agency, they are often paid more than staff we directly employ at the site. They are not entitled to annual leave and those sorts of things with us, and they do not have security of employment. Some of it is just about how people like to work. Some people prefer the variety of agency work or the ability to take contracts in different places. It very much comes down to the individual. On a parking allowance, Ms Lang is shaking her head at me.

Ms Stephen-Smith: We have free parking.

Ms Zagari: Yes; we do have free parking in the ACT. That is correct.

MS CASTLEY: It is disappointing that there is a need for so many agency staff when we have nurses and midwives leaving the health service. I wonder what the justification is, or what the plan is to stop that happening. It involves millions of dollars.

Ms Zagari: There will always be a requirement for some agency staff; you would appreciate that.

MS CASTLEY: Of course; yes.

Ms Zagari: There is lots of work underway to sustainably recruit our workforce. What we are seeing is consistent with both the national and international state of health at the moment. There has been a really successful recruitment campaign recently for both nurses and midwives in particular. Ms Lang has, under her remit, what we have called a tiger team, who are focused on being able to recruit both nationally and internationally to get a sustainable workforce and to be able to move away from an agency-provided workforce.

MS CASTLEY: Minister, you said that it is across the country, so it is expected that there will be this massive spend, and we have had the overspend for a couple of years now. In the forward estimates, it is projected to increase by only $45 million, yet in the last year the overspend was a lot; it was $170 million. What is that about? Will we see another overspend? You have not forecast—

Ms Stephen-Smith: Which page are you referring to?

MS CASTLEY: The forward estimates, in the annual report. I do not have the page number with me. We were talking about the VMOs; there was the overspend of $168.6 million last year. The year before there was a $47 million overspend. Over the forward estimates, this expense is projected to increase by only $45 million, despite the overspends over the years. Why is it such a low figure?

Ms Stephen-Smith: Which expense are you talking about?

MS CASTLEY: VMOs and agency staff. There have been overspends on those.

Ms Stephen-Smith: We have a continuing effort, as Ms Zagari has just spoken to, regarding the permanent recruitment of staff. We will continually aim to reduce the amount of expenditure on agency, VMO and locum staffing, to the extent that we can. Ms Lang can talk about the recruitment that we have underway, particularly for nursing and midwifery staff. We have also been successful in recruiting, for example, four cardiac stenographers in a work force that is quite a challenged one nationally, in terms of staff shortages; there are additional staff specialists. We know that some of those will come online this year, but they have taken a while to get here because they have existing commitments, or they are coming from overseas and they have visa requirements, and they need to work out their existing contracts. Mr Peffer might be able to talk a bit about that.

Mr Peffer: Ms Castley, the 2023-24 budget for CHS was established at a time pre-acquisition. If you look down the column, for all of those numbers, and you compare that to the 2023-24 estimated outcome, you will see a sizable increase in terms of employee expenses and other expenses—operating and so forth—and it actually reflects the acquisition of in the order of a $300 million business, moving into the operating statement. If you simply compare what the budget was, and what the estimated outcome was at the end of the year, it is not a like for like comparison, if that makes sense.

MS CASTLEY: It is page 51, table 25. I understand, Mr Peffer. However, in the year before, 2022-23, there was a $47 million overspend. In 2023-24, there was a $170 million overspend, and in these estimates we are back down to $45 million, if I am reading this correctly. I am happy to be corrected. There was an increase in staff. I like the fact that it is much lower—do not get me wrong—but is this a pipedream?

Mr Peffer: No.

Ms Stephen-Smith: It probably also reflects the funding that has been committed in this budget. There has been a significant increase in funding for CHS through this budget, which would then flow through. I have page 51 in front of me, and I am not

seeing the numbers that you are talking about. Part of it is that this budget has reflected the increase in costs at Canberra Health Services and the increase in demand that Canberra Health Services is seeing. That is why so much of the additional funding in this budget has gone into health. More than half of the additional expenditure in this budget is in the health portfolio, reflecting the fact that we have seen this significant increase in demand and costs.

THE CHAIR: I have a question about health spending. In the budget outlook, the financial expenditure statements are in chapter 4, and table 4.2.7 shows health-related asset purchases. From 2024-25 to 2027-28, purchases are falling from $305 million to $249 million—$56 million over four years. Can you explain why there is a bit of a fall in asset purchases?

Mr Peffer: We will have to take the specifics of that on notice. I suspect that what you are seeing there, in terms of the jump from one year to the next and then back down, would reflect the acquisition. Essentially, there is a transfer of assets that occurred on 3 July, related to the acquisition of a range of hospital buildings at the Bruce campus.

Ms Stephen-Smith: There may also be some assets associated with the opening of the critical services building that were purchased, but we will take it on notice.

THE CHAIR: Take it on notice and provide a breakdown of those purchases over the forward estimate years as well—what assets were purchases then, and the ones over the forward estimates years.

Table 4.2.6 shows the total expenditure on health increasing by $177 million over the forward estimates, or around 2.3 per cent per year, but the government's CPI forecast in table 1.1.1 of the outlook shows that inflation will be at 2.8 per cent per year. That means health spending is falling by 0.5 per cent a year in real terms. Is the budget actually cutting health expenditure? It is not keeping pace with inflation.

Ms Stephen-Smith: No. I have seen some of the analysis. This is probably a question that is better directed to Treasury, in terms of the way that budget papers are presented. You will understand that, when Treasury is projecting the inflation, they are projecting what that will be every single year for the outyears, in terms of inflation. When they are projecting forward the funding, that is the funding that has already been allocated by the government up to and including in this budget.

No-one in their right mind would think that there will never be future additional health spending allocated in the 2025-26, 2026-27 and 2027-28 budgets. Health spending will grow into the future. New spending will be allocated in every budget. Comparing what inflation will look like over each year to what current expenditure on health looks like based on one budget, when you know there will be additional expenditure added in every future budget, is not in any way an apples with apples comparison.

THE CHAIR: Just to confirm, there will be no cuts in real terms to health spending?

Ms Stephen-Smith: Our experience over the last four years is that there absolutely has not been, and there have been very significant increases in expenditure in every budget, as there is in this budget—an enormous increase in expenditure in health, reflecting

both the growth in services and the cost growth.

I note that there has also been some commentary recently that it is not appropriate to include cost growth as a budget measure when real, additional resources are being spent to address that cost growth. From my perspective, it is important to be transparent with the community when you are increasing funding for something. Sure, there are some things where you will make a technical adjustment, but when you are making a deliberate decision to increase funding to accommodate additional costs, that is a legitimate budget measure. That is something where we have made a deliberate decision to increase funding.

MS CASTLEY: I am struggling to understand this. Health expenses have been cut by $23 million and asset purchases by $81 million. That is $104 million, and we were told it was going to be all about health. Can you explain to Canberrans what these cuts mean?

Ms Stephen-Smith: They are not cuts, Ms Castley. We have already taken on notice the question about asset purchases. As a general proposition, that is not necessarily something that will be reflected in the budget measures, in the way that we think of them. As Mr Peffer has already indicated, it is likely that the acquisition of Calvary Public Hospital and bringing that into the public system would represent a significant one-off asset purchase in this particular year that will not occur in future years. Similarly, the opening of the critical services building probably resulted in asset purchases on a one-off basis that will not occur at the same level in future years.

We will take on notice whether that is or is not the right explanation, but it is a pretty logical explanation as to why you would see asset purchase numbers going up and down from year to year. Those assets still exist. They do not disappear.

MS CASTLEY: But based on that, because you chose to take Calvary, there is possibly money gone that could have gone to other assets that are slow or late—infrastructure projects that are not complete. Is that what you are saying?

Ms Stephen-Smith: No.

MS CASTLEY: Can you explain that again? This year—

Ms Stephen-Smith: I think also—

MS CASTLEY: we have had cuts because you took over Calvary.

Ms Stephen-Smith: I completely dispute your interpretation of that. The other thing in relation to North Canberra Hospital is that, when it was acquired on 3 July, there was still significant remediation work underway in relation to the theatre complex, following the theatre fire in December of the previous year. All of those assets associated with the refurbishment of the theatre would have been purchased for Canberra Health Services, rather than being purchases on behalf of Calvary and going onto their asset books, which would have been what happened previously. That is another thing that probably contributed to a significantly larger asset purchase in the last financial year than this financial year. But those assets still exist. They do not disappear at the end of the financial year.

Mr Peffer: Just to expand on that a little bit, we did have some questions the other day about the use of offsets in the health central provision. I spent a little bit of time in recent days talking with the Under Treasurer about the provisioning of that funding.

The health central provision, which is being used to fund a number of the initiatives, is essentially a provision that is held centrally within Treasury, and it is genuine use spend. It is held centrally, so it is not allocated within the health portfolio, but it relies on decisions made by ERC, by cabinet, and the initiatives that you see in the budget to then draw on that provision—that future growth funding—which is then reflected in the budget.

MS ORR: I would like to get a little more insight into the north side health initiatives, starting with the north side hospital, and noting that there has been quite a bit of funding invested in this budget to continue the work. Can you outline the next steps of this investment and how that will support the new north side hospital?

Ms Stephen-Smith: There are a number of next steps, in terms of the early supporting works that will be required to ensure that the site is ready to be built on in due course. That includes relocating some of the existing services on the North Canberra Hospital site, including the childcare centre, the CAMHS Cottage, Directions Health—Arcadia House—alcohol and other drug service, and some consideration of what happens in relation to the Gawanggal Mental Health Unit. There are those preparatory early works; there is also the early activity in relation to the contractor engagement for the project itself. The project has been designated as a major project and is now in the hands of Major Projects Canberra, so I will hand over to Ms Geraghty.

Ms Geraghty: Thank you, Minister. I am happy to start with the major project itself. We have had an expression of interest go out for very early contractor involvement. That is looking to engage a delivery partner with Major Projects Canberra and ACT Health to deliver a state-of-the-art facility in the future. That EOI has now closed, and it is under evaluation; a full tender will be released next month that will enable that partner to be engaged later in the year, in the new year. I will ask my colleague to run through the other preparatory works.

Mr Cahif: In relation to the early enabling works which will allow the main works to occur, we are working very closely with our colleagues in the Health Directorate. The CAMHS design RFT is in the market at the moment; it closes at the end of the month. That will enable us to undertake the design moving forward to a construction contract.

The other early works are under investigation. Part of what we are looking at is what makes sense to effectively work with the delivery partner on the main works, to undertake that design work, and potentially delivery as well. Those investigations are currently underway. In addition to that, a series of work is being undertaken by Major Projects Canberra in terms of reference design to inform the delivery partner RFT, and ultimately handing over that contract.

Ms Geraghty: In addition to that, we are doing some precinct-wide investigations, particularly around traffic and thinking about the other developments in the area of Bruce, and making sure that the overall project fits within a precinct-wide approach for

the territory.

MS ORR: At this point in time, would it be fair to say that it is about doing the scoping and design work?

Ms Geraghty: And early procurement.

MS ORR: How does that fit with what the minister was saying, regarding moving some of the other services?

Ms Geraghty: Ashley spoke about the couple of different pieces of CAMHS.

MS ORR: You mentioned this a little earlier, Ms Geraghty, but I am keen for you to go into a bit more detail. With the learnings from the critical services building and the expansion project, how are you bringing those to the north side hospital and how is that informing the work that you are now undertaking?

Ms Geraghty: In a couple of different ways. First and foremost, Major Projects Canberra are establishing a north side team, which will be largely made up of our Canberra Hospital expansion team. They are bringing a lot of their learnings. With the project governance that we had established on the Canberra Hospital, some of the elements of that will also transition to the north side project. Certainly, there will be a transition there.

The post-occupancy evaluation that we are doing on the hospital after it opens will inform the new project. We have also used a lot of the learnings in the development of the reference design of north side. It is a similar architect to the one we used on Canberra Hospital. There are lots of different elements and we are very focused on making sure that we deliver the best we can for north side.

Mr Cahif: We are conducting formal "lessons learnt" workshops within the team, as well as with our delivery partner in the Canberra Hospital expansion, Multiplex, to ensure that we capture the lessons learnt on both sides of that contract.

MS ORR: What is the thinking at this stage for doing things like maximising the sustainability aspects of the building, and things like supporting local industry with construction opportunities and jobs? The other thing that has been done quite well in the critical services building has been looking at how the building itself can add to the wellbeing of patients. Have all of those things been fed into this process?

Ms Geraghty: We are really proud of what was achieved at Canberra Hospital. I think the advantage of using the very early contractor model is that we can work with our partner to optimise our sustainability. There are lots of things that we achieved on the Canberra Hospital expansion. For example, with the local participation we had a target of 50 per cent but we actually achieved 71 per cent. With apprentices we achieved 30 per cent. The spend on Aboriginal and Torres Strait Islander enterprises was ten per cent. Those sorts of things we will continue to build into the contract.

There are other sustainability things, like the green star five-star rating, that we achieved on Canberra Hospital. We are looking at what will be the right level of accreditation for

the north side as we go through the design. We will also adopt some of the initiatives that the ACT government is currently looking into: the circular economy and decarbonisation initiatives, including the use of low-carbon concrete. The new facility will be fully electric, like the Canberra Hospital expansion is.

The connection to country design, which is a lot of the welcoming aspects, we will continue to develop on the north side. One of the other things we are focused on is female participation in the workforce delivering the project. On risk sharing, we are working with industry at the moment on the fact that the risk facing the local industry is different from what has ever been experienced before, so we are quite keen to make sure we have got a risk-sharing model.

We are also working on the culture on the project itself. On the Canberra Hospital expansion, we had what is called a project health indicator. That gave us an indicator of how we were going on the project with our partners. That indicator was actually the highest I have seen on a health project. We will continue to use that on our future projects to make sure that not only are we providing a long-term wellbeing space in the built form but the people who are working on the project are also enjoying what they are doing.

MS ORR: Minister, this might be one for you. That has been a good oversight of the building itself and the construction of it, but can you give me a bit of a better understanding of how the new hospital will fit within the health service and what service provision improvements we can expect to see on the north side?

Ms Stephen-Smith: Yes. Thanks, Ms Orr. There has been quite a lot of planning across the health system. One of the benefits of the acquisition has been the ability to freely plan right across the hospital system, not only between the two acute hospitals but with our community-based services and virtual care planning as well, and to take a whole-of-territory approach to that.

Ms Lopa can talk about how that is being done. One of the things that we are clearly recognising, not only with the new north-side hospital but also with the investments in the north Gungahlin health centre and the west Belconnen health centre, is that the north is growing quite significantly. It is not the intention that the tertiary hospital would move to the north side; we did have a look at whether that was an appropriate option, but, given the significant investment in Canberra Hospital as a tertiary trauma centre, the Canberra Region Cancer Centre and the women and children's hospital that is there, that is not going to be an appropriate option. I will hand over to Ms Lopa to talk about how that plan for the north side has occurred.

Ms Lopa: Thank you, Minister. We have done quite a bit of work over the last 12 months looking at the networking of services across Canberra Hospital, on the Woden campus, and at North Canberra Hospital. We are working with CHS on what they are doing now but then also in the future: what does the future north-side hospital look like?

Ms Zagari spoke before about some of the benefits we are seeing in the emergency department in having the one provider across the two sites. The government made the decision quite late in the business case process for the north-side hospital around it

being one provider. So we went back and said, "What does it look like? Does it look any different to being one provider?" We went right down to: "Do we actually just build a new tertiary hospital on the north side? We looked through a whole bunch of scenarios, which came back saying no because of the investments that we have made on the Woden campus.

But what it does allow us to do in the planning for the new north-side hospital is look at some centres of excellence on the north side, in particular for the treatment of older Canberrans. We are also looking at some women's health initiatives over on that north-side campus. When it was Calvary beforehand, they did a lot of the breast cancer work and the breast cancer surgery. In staff consultation, they are really passionate about that and they really want to continue providing that. We have looked at that being something that will continue and grow in the north-side hospital.

Obviously, the hospital now has the older persons mental health unit and a lot of older people's services. Again, when we did staff consultation and community consultation that was something that they continued to want to see on the north side. I think there are great opportunities for those centres of excellence to be over at the North Canberra Hospital, the new north-side hospital. We are also looking at high-volume elective surgery type work, because in that tertiary trauma centre elective surgeries can get bumped when things come in. We are looking at that north-side campus taking on some high-volume elective surgery.

Some of these things will actually occur before the new hospital is built. It will not be a case of: "We will just start doing them when the new hospital is built." I know that Ms Zagari and Mr Peffer and the North Canberra Hospital team are moving towards those sort of things as we go. We have got the new building in our sights, but we are not going to just wait and not make any of those changes till then. There are some really great opportunities for services in the north.

MS ORR: So the focus of the thinking at the moment for the north-side hospital is centres of excellence around specialised healthcare provision and elective surgeries. Obviously, we will continue to see things like maternity services offered. Can I get a clearer picture on what sorts of services? I get asked this. I am a north-side member. I get asked: "What is changing? What is it going to look like?" Can you give me a three-minute answer I can memorise so that I can just repeat it to people? That would be great.

Ms Stephen-Smith: Fundamentally, you are not going to see a complete shift in the services that the north-side hospital delivers.

MS ORR: And that is because the trauma-based stuff is staying in the south.

Ms Stephen-Smith: The trauma and the women and children's hospital will continue to be based in Woden. But one of the things we have heard really clearly from the community is the need to have more paediatric capability in north Canberra and at the north-side hospital. I do not know if Ms Zagari can speak to the consideration that Canberra Health Services has given to that. In terms of a very simple message, it is more of what we have got now, but then it is specialising in some specific things, like women's health and older people and some of those areas where people have said, "We

need more capability here," even if it is not going to be the centre of excellence for paediatric services, for example. I do not know if you want to speak to that.

Ms Zagari: Thanks, Minister; thanks, Ms Orr. It will be a focus on general capability: increasing that ability to manage what comes in the front door without trying to be a tertiary specialist service in some of those smaller specialties. For paediatrics, it is not about being a paediatric tertiary facility but about that ability to manage children who are coming into the emergency department and have conditions which will mean they have a relatively short length of stay. The thinking is around paediatric short-stay capacity, rather than a paediatric ward. It is about sustainable staffing and ensuring that staff care for enough children to maintain confidence and capability, and that understanding about when the care needs to transition to a more specialist site.

We brought together some groups of staff, both NCH and Canberra Hospital staff, to talk about it, and that was certainly reflected back as the safest model across the breadth. It is reflected from other states. It will be a general hospital with some specialist areas of expertise. We will see the north-side hospital really taking on that focus as a specialist provider of geriatric services. In fact, that will be one of the areas where it becomes almost a specialist provider for the territory.

There will be a very clear role for the north side so that staff can say, "That is what I want to do, so that is my preferred hospital." Each campus has a specific role to play within the health system, and that is really important from a culture and staff pride perspective. The minister has spoken about the role in women's health in particular, given that that is an affiliation that staff feel. It is also about providing care at the most appropriate level closer to home, wherever possible, so that we can provide those more general services.

MS ORR: What general services will be provided?

Ms Zagari: There will still be an emergency department but a larger emergency department. There will continue to be general medicine and geriatrics. Clearly, these are subject to decisions of government still. I will caveat it so that I do not promise anything that does not arrive. There will be greater capability in cardiology, for example, so that more patients who come into the emergency department can be managed at north Canberra without needing a transfer. There will be the capacity for a cardiac catheter laboratory; those sorts of things.

MS ORR: Again, it will be the shorter stay type of treatment.

Ms Zagari: Correct: less specialised and more generalised. In cardiology, in terms of procedural work, it might include a cardiac catheter laboratory that does the routine cardiac categorisation procedures—angiograms, for example—rather than the highly specialised procedures, which you would retain in the hybrid facility at Canberra Hospital. Those are the kinds of conversations that we are having at the moment about what is the capability that we need to be able to provide on the north side and at what point does it become something that is the tertiary facility's role to provide.

MS ORR: That is a pretty straightforward question for most health systems: tertiary and non-tertiary.

Ms Zagari: Correct. It is that sort of delineation that we would typically see in other jurisdictions, with some additional specialisation and those centres of excellence being at a higher level.

MS ORR: How does it start to fit with some of the other infrastructure investments that are going on the north side for the provision of health services—things like the University of Canberra Hospital? I know there is some funding for inpatient beds and whatnot. How is the whole picture coming together?

Ms Zagari: How does it all fit together?

MS ORR: We will start with Canberra university hospital.

Ms Zagari: The University of Canberra Hospital has a focus on specialist rehabilitation medicine. It is a really subspecialised field. Being able to put the different kinds of rehabilitation into one centre together means that we get that concentration of really specialist skills and are able to provide for the health of Canberrans who need those rehabilitative services.

There will be the tertiary centre, providing highly specialised, small volume services. The secondary hospital will have the capability to do high-volume, lower acuity elective surgery, moving it away from the tertiary campus where appropriate, and then there is the rehabilitation hospital capability at the University of Canberra Hospital. Looking at the whole system, it is about having all the services we need to provide and where the most appropriate place is for each of those.

MS ORR: I guess the next part in the link, and the minister has already alluded to this, is the health centres in north Gungahlin and west Belconnen. It is also about how the walk-in centres are supporting this. Let us start with the health centres.

Ms Stephen-Smith: It is important to remember that we also do have community health centres already in Gungahlin and Belconnen. Belconnen is our biggest community health centre. It also has a walk-in centre, as does Gungahlin town centre. Then there is the inner north walk-in centre and community health centre and the city community health centre. If we are talking about the entirety of the north side, there is a lot of footprint there.

From my perspective, this is partly about how we ensure that people can get care close to home when they have chronic conditions, when they are pre-surgery or post-surgery, so that they do not have to come into a hospital. We know parking is always a challenge. Building multistorey car parks at hospitals is necessary but a very big investment, and then people come need to travel in for that.

If they can get that pre-surgery support, that post-surgery follow-up, that community nursing closer to home, the allied health support to keep them well in the community so that they do not even need to go to hospital, that is preferable. They also need to have the capacity to be well linked in with specialists, with the different specialties, so that their care can be coordinated with their general practitioner, with those nursing and allied health teams, out in the community and then with the specialist in the hospital in

a really patient-centred way. This is the epitome of integrated care and patient-centred care that I have this vision of.

We have already planned for the capability in Conder of having a virtual care space, where people will be able to access virtual care services, potentially with a bit of support. Not everyone can access telehealth in their own home because they do not have the capability or the technology. It might not be an appropriate place for them to be receiving care without any support or receiving service without any support. Or they may have other people around—privacy issues and all of that stuff. Having somewhere in the community they can go and be supported to access telehealth, rather than having to get themselves to a hospital campus, is one aspect of the way we are envisaging a networked system.

Mr Peffer: We can talk through the needs assessment process that we use to inform the health centres, if that would be helpful.

Ms Chambers: I am happy to do that. I acknowledge and have read the privilege statement. When we are planning for our new services to come online, such as our community health centres, we do a population scan so that we understand the needs of Canberrans and the other regions that we service. Southern New South Wales is also taken into consideration. We also use planning tools that look at what types of chronic conditions we have that are suitable for tier 2 clinics—those that are not fit for hospital administration but are fit for a community health centre.

Then we do the service modelling, in collaboration with our partners at Canberra Hospital, in terms of what services would fit at what locations. For instance, with our new north-side community healthcare centres, we are looking at the population that will have a larger growth, in terms of new babies, new mothers, women's health matters. We then do a service location plan on what complementary services would be fitting in at each centre. We also do system scans, looking at new models of virtual care coming on, how they will impact people's lives, how beneficial they will be to patient care and what services they will need. There is a great deal of planning that we do that lifts and shifts models from a population planning point of view.

MS ORR: I believe there is a survey out at the moment—and I must admit I have not done it; sorry—for the north Gungahlin community centre, asking people what sorts of services they would like. Can you explain to me how that survey fits within the planning, what comes from it and how it will be reflected?

Ms Chambers: When we do our planning models we always go out to the community and do service needs and assessments. We also take a scan, and it is usually a partnership approach with our colleagues in the infrastructure team or colleagues at Canberra Hospital. We lead those consultations to provide input into lived experience. We want to understand the needs, how people are accessing their care, whether they are accessing that through GPs or through a shared care arrangement with primary care and our tertiary hospitals. We will always go out to have consultations. We generally partner with the Health Care Consumers' Association to also strengthen the input. A number of forums are held. Liz might be able to speak about pop-up centres at community—

MS ORR: I think the chair is going to wind me up soon, so I just need to get my

questions in. I want to get a bit of a better idea as to what services might be offered in north Gungahlin and how you will arrive at the decision. Is it the case that there might be some maternity services to support people with infants? Everyone talks about Gungahlin being a very young population; we have plenty of old people too, so there might be some support. I think we have a really high prevalence of asthma as well, so maybe there will be some asthma treatments. Once those services go in, once we have determined what is needed, do they stay that way or do we look at how we can continually use that facility to respond to the community need? I guess that is my question.

Ms Lopa: It does not always stay that way. We do service revisions. I think we work with Canberra Health Services. They are constantly looking at their services, looking at presentations, who is coming in, whether it is being utilised; all of those things. We do change around the service offerings in our community centres. Once they are in, they are not set in stone.

As for how we make decisions on what we are putting in, it is a little bit of a melting pot. It is all the things. It is the demographics. We look and we say, "There is a large prevalence of asthma." Then we go out to the community and say, "What do you think is missing? What do you really want?" We do not just put something in there because the community wants it. We look at it and we say, "Does that align with what we think?" We bring it all together and then we go for a decision to government, to say, "These are the services we think you should put in."

MS ORR: Those are sort of specialised ones. The other part, too, is just picking up on the stuff that can support the other parts, if I have understood correctly. That includes pre-admissions to hospitals. Those sorts of things would, for lack of a better way of putting it, be the bread and butter of what these centres are going to do.

Ms Lopa: Yes, and what we can put in there to mean that people do not have to go to hospital at all. If you put medical imaging in, like we did in Weston Creek, it means that if you fall over and break your arm you can go to Weston Creek. You can get seen, you can do your X-ray there, the results come back there and, if you do not need surgery, you can get plastered there. You can go through a whole limb break without ever having to go near the hospital. We are looking at that too, because we want to not have people coming into the hospital who do not need to be there. They can access things closer to home. We do not want to duplicate and have five health centres all doing dentistry. Obviously, we do have to make some decisions about where certain things are going to be. That all goes into the decision-making.

MS CASTLEY: Are we using "community health centre" and "walk-in centre" interchangeably?

Ms Stephen-Smith: No.

MS CASTLEY: We are calling them health centres?

Ms Stephen-Smith: No, they are health centres. Walk-in centres are a very specific thing, for minor injury and illness—urgent care. If you look at what we said in the election in 2020, these health centres were always about supporting people with

preventive health, for people with chronic illness and people who required care in the community for ongoing care, and they were potentially a mix of appointment-based and walk-in services. It is really about drop-in services, not urgent care.

Having said that, a lot of the feedback we are getting from the community is that people love walk-in centres. A lot of the feedback we are getting, both in the inner south and in north Gungahlin, is, "Can we have a walk-in centre?" As Liz was saying, that is part of the melting pot, in that everybody wants a walk-in centre close to them; how many walk-in centres can we sustain and how many really make sense when we also have two emergency departments? Are we creating more demand for things that would probably be better treated in general practice, for example? Those are the kinds of judgements we then have to make about everyone wanting a walk-in centre in their suburb; how many walk-in centres do we really need across the city, and where are they best located?

MS CASTLEY: You mentioned earlier a community health centre in Gungahlin; that is the walk-in centre?

Ms Stephen-Smith: There is a community health centre—

MS CASTLEY: Yes, and a walk-in centre—

Ms Stephen-Smith: and there is a walk-in centre, both in Gungahlin town centre. They are in separate buildings but they are close together.

MS CASTLEY: For north Gungahlin, I think you said something along the lines of, "Just because the community wants it, it doesn't mean we're going to do it. We'll just tell them what they need."

Ms Lopa: No, that is—

MS CASTLEY: That will be—

Ms Stephen-Smith: I do not think that is a fair interpretation of what Ms Lopa said.

MS CASTLEY: You guys have done the reports, and you know what we need in Casey. That will probably lean more towards that model of making an appointment, less walk-in?

Ms Lopa: We are going through that process now. We do not go out to the community and tell them what they are getting. We have our evidence that we build up; then we go and test it. We talk to the community, and we say, "What do you see happening? How are you accessing health services? How are you finding it?" We do community consultations. There was one last night; there is one tonight. We have done focus groups as well. It is genuine consultation. We also do not just go out and say, "What health centre do you need?" We go out and say, "This is what our figures show. There are a lot of kids with asthma out here. How are you finding it?" It is a genuine conversation. We then bring that all together to make decisions.

Ms Stephen-Smith: One of the important elements is that Canberra Health Services

will have the data on who is accessing what services. The Health Directorate will have the data on the demographics and the models of care that are coming through, and that are evidence based. But what we do not have is those people who are not accessing services because they are not accessible to them. A rich source of information that we get from the community is, "Actually, if I had this available closer to me, or if I had some support to get to it, I really would value this service."

One of the things that we can point to that we know is different about Gungahlin from, say, the inner south—and you have talked about it in forums as well, Ms Castley—is that Gungahlin is a very multicultural community. With putting in multicultural health hubs, we know that from the demographics, but we can also hear back from the community that having people in health centres who speak the languages that are spoken in people's homes in Gungahlin might be something that we need to take on board as we are designing for that, in a way that we would not for Conder or the inner south, for example.

MS CASTLEY: I believe you are advertising on free to air—I am happy for you to tell me where else—about the walk-in centres. Is that correct? Someone told me that they have seen some ads on what the walk-in centres do. Given the figures that they seem to be quite empty, and we have lots of category 4 and category 5 people in ED, what is the price of that advertising? How effective is it? How long has it been going for? Could I have a bit of information on that, please?

Ms Stephen-Smith: There is a broader healthcare navigation piece that is out in the market at the moment. That responds specifically to feedback from healthcare consumers, including through the Health Care Consumers Association, that people do not understand what services are available and what they are used for.

This is about encouraging and supporting consumers to get the right care in the right place at the right time. It is not just about walk-in centres. GPs feature heavily; the care that pharmacists can provide is also included. Partly, it is about walk-in centres because we want people to use them when they can, when they do not need to go to the ED. They should also be going to their GP, if they can.

I note that, when you looked at the health app earlier, it looked like there were not very many people waiting. There are currently zero people, apparently, waiting in Weston Creek, but there are people waiting in every other walk-in centre. That is the value of the app. We track what the busy times are in different walk-in centres, but the app helps people to understand what is going on as well.

Ms Lopa: That campaign is really about that health literacy—where to go to get the services that you need. We found in our research that, in particular, a lot of the community who are new Australians or have English as a second language do not understand that you can go to a free service and get treated. That is what was behind this campaign. It is a $400,000 campaign. I am being told that it is $412,000, and it will run until about mid-August. It went from May and it will go to mid-August.

MS ORR: The minister touched on this a little bit. I have not done a survey, but the thing I hear from a lot of people is about the diversity of the Gungahlin community in particular. You have mentioned providing services in languages other than English or

having staff who can speak languages other than English. Has any other thinking gone into how you can have a more culturally responsive health service across the diversity of the community?

Ms Zagari: The minister referred to the multicultural community and the opportunity to tailor health services to that community. We know that health service demand differs between different multicultural communities, so it is about putting in services that actually respond to those very specific health needs. It is not just about language fluency or interpreter services. It is about the health service itself. It may be about having appropriately gendered staff available to provide services; sometimes it might be about the way we discuss services.

It is about the service composition itself. We are looking at the need for specific services according to different multicultural groups, to be able to reflect that in the offerings of the health service, and the health centres in particular. CHS have done quite a body of work looking at what we would offer across that spread.

MISS NUTTALL: Minister, significant staffing shortages and bad workplace culture in the ACT healthcare system have featured in discussions for the best part of a decade, if not longer. On 17 June this year, I understand that you announced a $52.7 million investment to support a plan to provide 60,000 elective surgeries over a four-year period. Noting the historical and ongoing health workforce issues, what exactly will you do to resolve these in order to meet that four-year 60,000 elective surgeries commitment?

Ms Stephen-Smith: They are actually two different questions, Miss Nuttall. In relation to the elective surgeries and the investment we have made in this budget, with nearly $53 million, it is about boosting both the emergency capacity and elective surgery capacity. There is $7.3 million to boost operating theatre capacity across Canberra Health Services, to undertake more emergency and elective surgeries, and $790,000 in expense funding to purchase an additional 300 cataract surgeries from private providers. That goes to Ms Lawder's question earlier about what the continuing role of private providers is.

There is $2.64 million over four years to fund additional weekend and twilight theatres, as Ms Zagari mentioned earlier, ensuring that we can get through our increased emergency surgery demand. Currently, CHS is funded to operate three weekend theatre sessions. This will enable them to operate five weekend theatre sessions and some evening and twilight theatre sessions during the week, to meet that demand for emergency surgery.

There is $21.2 million, almost, over four years for surgical flex beds. This represents the cost of an average 10 flex beds—beds flexing up—to support that additional surgery demand. These beds are run throughout the year in wards to service the increased demand and prevent the delay in discharging patients from having a flow-on impact right through surgery and back to the emergency department.

In terms of how we are achieving our emergency and elective surgery goals, that is what this additional funding is for. We have seen some really good planning and achievement, despite the significant challenges we have had over the last few years in

elective surgery, particularly at what was Calvary and now North Canberra Hospital, particularly around the theatre fire, as well as the slowdowns that they had during the COVID period.

In relation to culture, this is something that Mr Peffer has taken, since he has been in the role, and others before him have taken, very seriously. We have seen, and staff surveys would indicate, an ongoing improvement overall in the culture survey outcomes for Canberra Health Services. I would emphasise that this is not a challenge for Canberra Health Services alone. Part of the culture survey also benchmarks CHS against other health service organisations and benchmarks outcomes for different craft groups against the craft group outcomes for other health services. Again, on that, CHS is continuing to improve in comparison with like services. We have invested significantly in things like junior medical officer wellbeing, with $8½ million, and the $8.75 million wellbeing initiatives. Those are quite specific investments.

All staff across all hospitals, even when it was Calvary Public Hospital, are being trained in Speaking Up for Safety and understanding that this is about patient safety and staff safety. If you see something, say something. It is about having the shared framework across all staff to understand how those issues should be raised and can be raised, and how to have those conversations. The next phase of that is promoting professional accountability. I will hand over to Ms Zagari to talk about how this is all rolling out and what the promoting professional accountability next step is.

Ms Zagari: I will hand over to Dr Smallbane, because she actually provides a great majority of the Speaking Up for Safety training in that promoting professional accountability space.

Ms Stephen-Smith: It is important to recognise that what we have seen reflected in anonymous surveys, where people are saying what they think, is an improvement across both our full culture surveys and our junior medical officer surveys. We have also seen areas where people have raised issues and they are now seeing those acted on. It is absolutely true to say that, a decade ago, they were not necessarily seeing that; the same person would come up again and again in anonymous comments, and that would not be acted on. Now it is being acted on. That is not easy, but people are noticing it.

Dr Smallbane: Full open disclosure: I am actually a master trainer in Speaking Up for Safety, so I am a very enthusiastic Speaking Up for Safety person, and I train a lot of our organisation to perform that task. With Speaking Up for Safety, we have had 350-plus observations since we introduced it, where people have noticed behaviour, they have let us know anonymously, and that behaviour has been acted on. That is an amazing thing. It is also a little unusual, so we are a bit of an outlier.

We have really started to have an impact. People now realise that, when they see something, they can say something; and, when they say something, something will actually happen. That is really positive in a world of trying to promote increased workplace culture. I think that is reflected in our workplace survey, in that we are implementing things and people know that we take it seriously, and we mean to improve workplace safety and the culture that people work in.

That is the Speaking Up for Safety overview. It is now in both of our big hospitals, and

everywhere else, and people really like it.

MISS NUTTALL: I understand that we have seen improvements in wellbeing. With the difference in improvement—because improvement could be from 15 per cent satisfaction to 30 per cent—what is our target for staff satisfaction and staff wellbeing, and are we meeting that target in real terms?

Dr Smallbane: Full open disclosure: I do not have a target in my head that I can give you. I suppose it is a little early, Speaking Up for Safety has been in for a while, but a lot of the other wellness initiatives are relatively new. In particular, we have introduced a chief medical wellness officer—someone who works 0.5 as a senior staff specialist in the organisation. They started in April. Since they started they have had multiple conversations with groups of more junior doctors rather than consultants—and subsequently with consultants—who have been given an avenue to have a conversation with someone who is not directly related to their training; therefore it is a bit more of a safe platform, if that makes sense.

It has only been a few months, so we do not actually have any data at this point in time, but we are hoping to develop data as we work out what the organisation needs. Because it is a new thing, it is hard to know what the organisation needs, or how it will respond to that, to know how to construct that data coming in. I cannot be more specific than that.

Mr Peffer: Outside the medical workforce, and for the health service as a whole, I do have a view of what I think a great place to work looks like, and we are not there. We still have a lot of work to do.

Ms Stephen-Smith: The other thing to say—some of this is publicly available—is that BPA, who conducts the regular culture survey and pulse survey updates, does have a measure of where you are on a scale, from a culture of blame to a culture of success. It is bumpy; it is always bumpy. Moving up that scale is really the goal, so that every team is in a culture of success. Ultimately, that is the goal.

MISS NUTTALL: The investments that we are making in elective surgeries may well mean an increase in demands made of the workforce, in order to meet the additional surgery targets. Will an increase in workforce hours be required, in order to meet those targets?

Ms Stephen-Smith: Absolutely. Effectively, what is funded is the people to do the work. Did I misunderstand your question?

MISS NUTTALL: No, that makes sense. Before, when you talked about it, you talked about boosting the operating theatre capacity, having additional cataract surgeries, and additional weekend and twilight theatres. That is the physical infrastructure.

Ms Stephen-Smith: That is the operation of the infrastructure. The infrastructure is there; it is the people to work the extra hours, to do the twilight theatres, to work on the weekends, and enabling us to recruit the staff so that people can be rostered on to do that, rather than ad hoc overtime being required in order to catch up on those things.

Ms Zagari: It is actually about reducing additional hours by individuals and bringing people on board to supplement the workforce in order to do that.

MISS NUTTALL: That makes sense. Thank you.

MS CASTLEY: I have a question about the 0.5 FTE, the wellness officer. You said there will be data soon. Is that just to justify the ongoing position?

Dr Smallbane: That is funded in the $8.5 million, about which the answer to the question on notice will let you know whether that position is funded for three or four years.

MS CASTLEY: Sure. When can we expect data on how many—

Dr Smallbane: They started in April, so I am thinking probably at least six months until there will be some data available.

MS CASTLEY: I would like to talk about infrastructure program cuts and delays. With regard to the ACT Health and CHS infrastructure programs, can someone tell me how many projects have had the physical completion dates pushed out, compared to what was reported in the 2023-24 budget?

Ms Stephen-Smith: We will take on notice to provide a complete record of that. I would certainly say, as a starting point, that the whole Watson precinct is not going to progress at the speed that we thought it was going to in the 2023-24 budget. That has largely been around development application approval processes and some further work that needed to be done on bushfire abatement that required some redesign of the Winnunga alcohol and other drug facility, and the two other facilities on that site. That is definitely delayed, compared to where we thought we were going to be at this point. We thought we would be well underway in construction now, and we are not.

The south-side hydrotherapy pool is probably also somewhat delayed from where we thought we would be this time last year. Again, it is about finalising development application approval, and finalising the tender process for construction. I might hand over to Ms Lopa, who has probably got a fuller list.

Ms Lopa: Thank you, Minister. The minister is absolutely right on the Watson precinct. That is delayed because of some bushfire referrals in the DA. We have had to do some redesigns there, but we are hoping to get that DA next month and to move on with that project.

Similarly with hydrotherapy, it was a bit delayed for a couple of reasons: one, we went out and did a bit more community consultation on the design, and that led to some design changes. We were hearing that people with a disability did not want to have to go past the whole pool to go into hydrotherapy and about change rooms and those sorts of things, so we changed some of the design. That has been handed over to the head contractor, so that is now under construction, and we think we will be done mid next year. Usually, once we get through the procurement and to the head contractor stage, things move really quickly because then they are in there constructing. They are definitely two that we know are running a bit late. I will take on notice the rest.

From time to time, we do experience delays in either getting out to procurement or after procurement, when we are doing the evaluation. We constantly seek to make sure our profiling is good and we are not trying to roll over too much et cetera. That is ongoing learning and an ongoing process that we go through for each infrastructure project.

MS CASTLEY: Thank you, I would appreciate that on notice. From a quick look, there are around 15, from what I am able to tell.

Ms Stephen-Smith: I am not sure if you know about the eating disorder centre, whether that is on track.

Ms Lopa: The eating disorder treatment centre is one that has reached construction completion now. It is being handed over to CHS next week to do their commissioning and will be open soon. That is one that we have reached construction completion on, which is great. The health centres are the other ones; we got funding in this budget. We are planning on being in the head contractor stage for the Conder centre later this year. We are in tender evaluation for that now, so things are moving along. Sometimes, when we are reprofiling and when we are rolling over, it does not necessarily mean that there has been a delay to the project. It can be just that we got our profiling wrong and when we are paying the bills it does not quite add up. I will take on notice all the dates questions that you have asked.

Ms Stephen-Smith: For completeness, we can include the CHS-led projects as well, like the cancer research centre. There was a remediation that needed to occur in the pharmacy area that has resulted in a bit of a delay in the completion of that project as well.

MS CASTLEY: We will get that back on notice?

Ms Stephen-Smith: Yes.

MS CASTLEY: How many ACT Health infrastructure projects have received funding cuts in the 2024-25 budget?

Ms Stephen-Smith: I do not think anything has received a funding cut.

MS CASTLEY: Okay. Great. Is there anyone who has oversight or knowledge of the implementation of the Canberra Hospital master plan?

Ms Stephen-Smith: That would be Liz.

MS CASTLEY: There are a couple of things that I would just like to go through with regard to the time line and to confirm a couple of things. The 2021-22 budget included funding for a feasibility study for a new car park at the Canberra Hospital; I believe there was $3 million. In 2022-23 there was $52.4 million appropriated to commence design work for a new pathology building, inpatient building and other campus staging strategies. Do I have that correct—that a feasibility study was done on the pathology and inpatient building, and are there plans for it to be built? Also, has the feasibility study for the car park been completed and are there plans for that to be built?

Ms Lopa: We are still on the journey as far as car parking goes. We are still doing some work around car parking on the campus. We know that it was the number one issue that got raised in our master plan consultation, and we know that it is usually the number one issue that everybody wants to talk about. We did develop the new staff car park over at the CIT Woden campus and that has reduced the pressure on that multistorey car park on the Canberra Hospital site in Woden.

The master plan looked at two places for new car parks: one on Yamba Drive, across the road from the hospital, and one on the helipad site, what we call the gateway precinct. That is a car park currently, but it could be a larger car park once the helipad moves to the top of the new building 5, which is opening soon. We are still working on giving the government advice on what the best option would be, going forward, for car parking for the hospital. We hope to have that advice to them soon. I think we are planning for the mid-year review.

MS CASTLEY: Next mid-year?

Ms Lopa: Yes.

Ms Stephen-Smith: The mid-year review of the budget, meaning sometime between December and February.

MS CASTLEY: Okay.

Ms Lopa: Sometime later this year.

MS CASTLEY: And the new pathology and inpatient building?

Ms Lopa: We have done the early concept design and service planning for that building. That, on the master plan, was shown to be on the site of buildings 6 and 23, which is annexed to the new building that is just about to open. We have got on and demolished the buildings that were on that site. If you go to the Canberra Hospital campus today, you will see that building 6, next to the new building, is down and so is building 23. So that site is ready. It just—

Ms Stephen-Smith: Not quite ready.

Ms Lopa: Not quite ready, but the buildings are not on there anymore. I did have a drive down the other day just to have a look. Again, we will be giving the government advice on the cost of that building et cetera. There was some money in this year's budget for us to continue to do a bit more work, particularly around the services that will go into it and how big that building will be and what we want to decant out of other buildings and put in there. We know pathology definitely needs to go in there, but there are some discussions around whether we will put pharmacy and medical imaging in there. Those conversations are ongoing at the moment, before we give advice to government.

MS CASTLEY: Okay. The 2023-24 budget dropped the total project value, from $52.4 million to $26.8 million, and now in the 2024-25 budget it has received a further

cut; there is only $11 million appropriated over the four years. I am wondering if you—

Ms Lopa: They are not cuts; they are on top of. We got the $53 million. We have it. No-one's taken that away. This is extra funding on top of that, so it is continuing to be funded.

MS CASTLEY: Great. Page 349 of the budget outlook, under the title "Hospital infrastructure", states that the remaining costs of the Canberra Hospital master plan will be considered in future budgets. There is a bit of a track record of health projects being pushed out. I will just say it: money got taken out for light rail years ago. Is that what is happening here in this budget, where it says the master plan will be considered in future budgets? Why not now?

Ms Lopa: We are still doing the work on the car parking and the pathology building, so we will go with advice to government about funding those projects. They did not have a deadline on them; they were just the next phase of the master plan. So we have got on—

MS CASTLEY: So we could probably not have a car park for years yet?

Ms Lopa: We will need a car park, and there are options for government to consider, such as where that car park is, how much it would cost and when we would deliver that. At the moment, regarding the demand for car parking on the Canberra Hospital campus, we have that CIT site, which has reduced some of that pressure. We know that that site is probably not going to be there forever for a car park for Canberra Hospital, so we are doing that analysis now to give advice to government. We have got on with the demolition of the buildings in readiness so the sites will be ready to go. We are rolling on. Nothing has been cut. We are not running late on anything; we just need to give advice to government to inform their decision-making.

MS CASTLEY: Minister, there were several election commitments back in 2020, such as the pool on the south side that you have just talked about; the elective surgery centre; endoscopy rooms; Canberra Hospital palliative care ward; and additional walk-in centres. There are feasibility studies coming towards you. You have gone to Canberrans and said, "These are coming; these are what we are going to do," but we hear that you do not have, on a couple of these things, a firm idea of where they are going to be. We are still waiting on it. Now we are at the end of this term, I am wondering what you have to say. I know we talk about this often, but health seems to come last. These are really important things.

Ms Stephen-Smith: I do not think that is accurate, Ms Castley. With all of those things we absolutely can tell Canberrans where they are going to be and—

MS CASTLEY: Just not in the term you promised.

Ms Stephen-Smith: what we are doing for them. This budget invests in not only the design but the build of both the north Gungahlin and the inner south health centres. We have already committed funding and we are underway in the development of the south Tuggeranong health centre. We will shortly be making an announcement, as I indicated to Mr Cain in the Assembly recently, in relation to the west Belconnen health centre

location.

In relation to the endoscopy and palliative care wards, there was some sort of Tetris work within Canberra Hospital, I understand, as to where those would best be developed to be sustainable, ongoing models. The outcome of that consultation with staff and with consumers, and understanding what was going on at Canberra Hospital, was that the palliative care ward will be in the current intensive care unit, when that moves over to building 5. That work cannot start until the intensive care unit is vacated. The best place for the endoscopy suites will be in the current theatre centre, in building 12. Again, that work cannot start until the theatres move over to building 5.

I absolutely accept that that planning work has resulted in these things not being delivered in the time that we had initially envisaged, but it has meant we have had a very thorough planning process. We now understand where all of those things that we committed to are going to go, except for the elective surgery centre. We did the feasibility study for that and determined that, by the time we built it, it would actually not be required anymore because of the Canberra Hospital expansion and our plans for the north side and the way that we were thinking differently about delivering elective surgery.

That was the one thing where we said, "Yes, we said we were going to do it, but we are actually not going to do it because we have listened to the evidence." If we say we are just going to keep doing something, even when the evidence tells us we should not do it, that is not a good use of taxpayers' money and that is not how government should operate.

MS CASTLEY: I understand that. That is not my point. My point is: do you think maybe you are coming out with some of these announcements a little too early, because we do not have the walk-in centres or the health centres? Can you tell me, hand on heart, that they will be built mid-decade—that is, next year? Parking is a nightmare. Why was that not considered earlier? I think the point then goes to: can you really tell me that the north-side hospital will be built on time and on budget, and does anybody know what the budget is?

Ms Stephen-Smith: What I can tell you, Ms Castley, is that if Labor is re-elected the north-side hospital will be built. What Canberrans do not know is what will happen if the Canberra Liberals are elected. There is no commitment from the Canberra Liberals to any of this infrastructure being delivered.

THE CHAIR: I do not know if that is the point here.

MS CASTLEY: But I am asking you, because my—

THE CHAIR: Can we just answer the question.

MS CASTLEY: My question to you, as the minister, is: how much is the north-side hospital going to cost to build and when will it be built by? If Canberrans are going to hang their hat on your announcements that are late, that we do not have yet, can you tell me when it will be built?

Ms Stephen-Smith: The first thing to say is that the critical services building, which is a major infrastructure project which has been managed through Major Projects Canberra—

MS CASTLEY: Has been changed, gone through iterations and is late.

Ms Stephen-Smith: Since the announcement in December 2018 of where the location was going to be and the time line, it has been on time and it is on budget, and it will open in August.

MS CASTLEY: But there were many iterations before that, so how do we know that that is not going to happen with the north-side hospital?

Ms Stephen-Smith: More than $1 billion has already been provisioned, in last year's budget, for the new north-side hospital. We have gone out for expressions of interest for the very early contractor involvement. Those expressions of interest have closed. There is a next stage in the process. We are actually ahead of schedule in terms of where we would have been—

MS CASTLEY: What about budget?

Ms Stephen-Smith: in relation to the Canberra Hospital expansion at this stage of the project, and we have got funding to do that early planning work around the relocation of the facilities that will need to move in order to clear that site. Absolutely, Major Projects Canberra has demonstrated a capacity to deliver major projects on time and on budget.

MS CASTLEY: And on budget?

Ms Stephen-Smith: There have been changes to the budget over that time because decisions have been made to expand and change the services that are being delivered, but they are delivering within the budget that has been allocated.

MS CASTLEY: When we tell Canberrans at one election, "We are going to give you this, it is going to cost this and you will have it by then," and then we change our mind or something changes, Canberrans all of a sudden realise that it is years and years later, and "by the way, we got the budget wrong in the first place so it is going to cost you way more as well".

Ms Stephen-Smith: I do not think that is an accurate characterisation at all. We went to the 2020 election with a budget, having made the decision in December 2018 on exactly where the critical services building was going to be, and that is what has been delivered. Major Projects Canberra has demonstrated that it can do that, and that is what we will do on the north side as well.

MS CASTLEY: Can you tell us what you believe the complete cost for the north-side hospital will be?

Ms Stephen-Smith: We have said it is going to be a more than $1 billion project. It is going to be a very big—

MS CASTLEY: Is it $2 billion? $1.2 billion?

Ms Stephen-Smith: It is going to be a very big project, but we are still doing the early design work on that. We need to go out to market. We know that we have seen a significant escalation in the cost of infrastructure more broadly, but we are actually in a good time to go to market for this. I might go to Ms Geraghty to talk about why we have chosen to do the very early contractor involvement process in order to manage the significant infrastructure pressure we are seeing across the country.

THE CHAIR: I just point out that I want to finish this question by 12.25.

Ms Stephen-Smith: Okay.

Ms Geraghty: Thank you, Minister. I spoke previously about the opportunities that the model brings to the specific project. One of the things that we are very aware of is that there is significant health infrastructure being delivered across the eastern seaboard and in South Australia. The reason we have gone with this model now is that we have an opportunity to engage with a partner early and lock in our supply chain, and therefore get the best value for money out of the investment for the north-side project.

THE CHAIR: Excellent. A minute early. Thank you. I will just point out to members that there will be five minutes, maximum, for a question from now on, to ensure that everyone gets one more question before we close.

I am going to ask a question about veteran liaison officers at the Canberra Hospital. What consultation has taken place in implementing the ones that you now have? It used to be funded by DVA; that is my understanding. Is this now being funded by the ACT government? How have you recruited and what consultation or communication have you had with veterans' groups and ex-service organisations to let them know what is in place now?

Ms Stephen-Smith: I understand there has been consultation. I might ask Ms Zagari to speak to that, if possible.

Ms Zagari: Thank you. Formal consultation occurred across Canberra Health Services between May and June last year. That was about a proposal to consolidate the veteran liaison officers and a residential aged-care liaison nurse into a team so that there is a multiskilled team that could provide a breadth of services, rather than being dependent on individuals, and there was no loss of FTEs in that. It was about maintaining the same level of services but across a broader team. There was some redundancy. At the time, there were about 12 to 15 patients in a given week who needed the veteran liaison service, and about 30 to 35 patients needed the residential aged care service. The ability to provide services across that group was important. It meant that they would work flexibly. We received a total of nine responses, and those were supported with the change.

There was then a meeting with the President of the Woden Valley RSL Sub-Branch and the Chairman of the National Veterans' Affairs Committee to discuss the change proposal and reinforce that the service would continue to be provided within CHS. In

addition, discussions were held with the ACT Totally and Permanently Incapacitated Ex Servicemen and Women Association. After that consultation, the proposal was approved and implemented across CHS, with the exception of NCH, because that was a separate role and process. That has been put in place since then. At NCH in particular, prior to acquisition, the service was provided across the breadth of Calvary public and private hospitals. With the acquisition, there was a need to make a change to that. I am going to the item on North Canberra Hospital, unless Todd would like to speak to this. We will keep it brief but informative.

THE CHAIR: On Saturday, at the veterans expo, I heard from a number of organisations that they did not know what was occurring with the NCA's organisations. You have outlined a bit of consultation that you did, but, for example, the families of veterans organisation and the Kindred Organisation Committee told me they were not aware of what was going on. So, apart from the consultation to develop this and bring those groups together, how have you promoted it?

Ms Zagari: There was communication with the groups that we just described. From what you have been told, it sounds like we have missed organisations in that process. We need to now inform them about the change to ensure that there is an understanding and a communication pathway. We will take that on board, and, if you have any other specific groups, we will include them.

THE CHAIR: The Kindred Organisation Committee has 51 member groups, so they could—

Ms Zagari: Thank you. We will start there.

Ms Stephen-Smith: Did you want to hear about North Canberra Hospital changes?

THE CHAIR: I also wanted to check: are they the same people delivering the service? A bit of concern about combining with aged care has also been expressed to me, because many veterans are younger; they are not just older.

Ms Zagari: At the time of the change, there were two existing people in the VLO role and one in aged care. When the change was implemented, 67 per cent were the same people and there was one new person. There was upskilling. I cannot tell you if we have had changes in that team since that time, but certainly the existing VLOs continued in those roles.

Mr Kaye: I have read and acknowledge the privilege statement. As Ms Zagari mentioned, our VLO services were offered by a person who worked across the Calvary entities—not just the public hospital but also the private hospital. That staff member decided not to transition to Canberra Health Services, so we then had a vacancy. For a period of time, we covered our VLO services through our social work team and we had a dedicated social worker who was delivering our VLO services for that time.

Since then, we had the consultation that occurred at Canberra Hospital and we are combining our discharge liaison officers roles with the veterans liaison role a little bit differently. That combined role will give us some increased capacity. We will not just have one person with that knowledge but a group of people with that knowledge. Some

learning can happen and there will also be some security if a staff member is on leave, if they leave the service or whatever it might be. We are leaning into Canberra Health Services for the training of those staff members. We currently have two. We are looking to increase that number, and that is how we will deliver our VLO services and discharge liaison at North Canberra Hospital.

THE CHAIR: Perfect. Thank you very much. Ms Orr.

MS ORR: I have a question on the Disability Health Strategy. I believe there was some funding in the mid-year review for the strategy and the first action plan. Can you outline what that funding will cover, where the work is up to and the progress made on the initial delivery of priorities in the first action plan? I asked all my questions together.

Ms Stephen-Smith: I do not have that immediately in front of me because that funding was from the previous budget, but I am sure that Maria can help.

Ms Travers: My apologies. I am in the same position because that was from the previous budget. I do not have that to hand, but I am very happy to take that on notice and provide some details for you.

Ms Stephen-Smith: Ms Orr, I can say, however, that the Disability Health Strategy investments have been very much welcomed. If we can come back to you, we will have a bit more information in a couple of minutes.

MISS NUTTALL: Minister, the Community Assistance and Temporary Support Program, or the CATS Program, which focuses on hospital avoidance, was rolled out in October last year, if I am correct. Strangely, when the program went live, it was done so without having its central intake service implemented. I understand there was a commitment that the central intake service would be implemented by 1 July 2024, which did not seem to happen. Can you explain why the central intake service has not been implemented and, indeed, how a program comprising eight different providers is being coordinated nine months after the program became operational?

Mr Peffer: I can provide a little bit of insight into that. Thanks for the question, Miss Nuttall. We have had some delays in settling the protocols. There is an MOU between the ACT Health Directorate and Canberra Health Services which outlines how that central intake model is intended to work. CHS and the central health intake team is in the process right now of recruiting to those roles for the central health intake. It is essentially about how the model will work, the protocols, and so forth. It is in the process of being settled, I think. A lot of that detail is now known, so it is just about recruiting those people, having those bodies on board, and then that service will commence.

MISS NUTTALL: In the interim, was the CATS Program designed to work with a central intake service?

Ms Stephen-Smith: Yes.

Ms Travers: Absolutely; it was. There were certainly several different providers before we had the CATS Program trying to coordinate different services, and it was certainly

the intent to have a central intake service to make it a more streamlined process for patients and people coming directly from the hospital.

MISS NUTTALL: Have you received any feedback? Have you had any issues in commencing the CATS Program, given that there is currently no central intake service online?

Ms Travers: The providers have alternative arrangements in place. As you said, when we started the program in October last year, the central intake service was not available, so they put other arrangements in place, and they are still operating relatively well.

MISS NUTTALL: Do you have a time line for when the central intake service might come online to support the CATS Program?

Mr Peffer: I can respond to that. At this point in time, it is looking like it will be September. There are a few reasons for that. We are settling the protocols and the model for how it will operate, recruit a workforce and have them ready to go. The third component of that is building the central intake service in the Digital Health Record. It requires a bit of IT work to have that stood up.

MISS NUTTALL: Thank you. Just to clarify, will it be 10 months or 11 months—sorry, my maths is not very good—since the program commenced and the central intake service support will operate?

Ms Travers: That is right. But there have been other arrangements in place to support the community. As I said, they were previously in place, and the providers are dealing quite well with it.

MISS NUTTALL: Thank you. That is it from me.

THE CHAIR: Are you ready for Ms Orr's question?

Ms Stephen-Smith: No.

THE CHAIR: Ms Castley.

MS CASTLEY: I have a lot of questions—some might have to go on notice—about whole-of-government savings. Regarding the measures that are being implemented across a number of directorates, has either CHS or ACT Health conducted any analysis about how they will realise these savings? Can both ACT Health and CHS provide some examples or suggestions on where they are seeking cuts across any of the following areas: supplies and services; consultants, contractors and professional services; communication and professional services; travel accommodation and transport; printing and stationery; and material, equipment and supplies?

Mr Peffer: From a Canberra Health Services perspective, at this point we do not have documented analysis about, precisely, where those savings will come from. However, we have made a decision that it will not be at the expense of any frontline workforce or services that we deliver. We will look at the rest of the organisation and how we can effectively meet those targets.

MS CASTLEY: Have any requests from the business areas outlined been denied?

Mr Peffer: Not that I am aware of at this stage.

MS CASTLEY: There is a brief description on page 113. It says:

> Savings have been applied to directorates and agencies and will be achieved by the relevant Director-General or agency head but must have no impact on frontline service delivery.

I am after a guarantee that none of the savings identified to supplies, services, consultants and contractors in this budget will impact frontline service and delivery?

Mr Peffer: That is right.

MS CASTLEY: Can you guarantee that no employees will be made redundant due to these savings in your health budget?

Mr Peffer: That is our intent.

MS CASTLEY: Output 1.3 for the ACT Health Directorate, on page 12, is titled, "Enabling a strong and safe health system". Is there someone at the hearing responsible for this output area?

Mr Peffer: There will be. Ms Castley, what is the question in particular?

MS CASTLEY: I would like a bit of an overview of what this output area does: output 1.3, ACT Health Directorate, page 12, "Enabling and strong and safe health system". No-one knows who enables the strong and safe health system?

Ms Stephen-Smith: It looks like this is about strategic policy and service system planning. It says:

> The directorate collaborates with stakeholders on strategic policy and service system planning.

That is what we are talking about. I do not know which division that would specifically refer to, but we do a lot of service system planning.

MS CASTLEY: There has been around a 15 per cent cut to recurrent funding. I am wondering how you can still manage to get your work done in a timely manner if there has been a real cut. Were you briefed on the cuts with regard to the budget?

Ms Stephen-Smith: The accountability indicator is in relation to ACT health system digital services. Mr Kaufmann might have more information.

Mr Kaufmann: Good afternoon. I acknowledge that I have read and understood the privilege statement and agree with it. I assume your question is about the accountability indicators?

MS CASTLEY: Yes. It seems to have reduced with a 15 per cent cut.

Mr Kaufmann: And in relation to the savings?

MS CASTLEY: Yes.

Mr Kaufmann: Accountability performance over the last four quarters has declined, especially in the last two quarters. In quarter 4, we did not met one of our accountability indicators. The reason for that is threefold. Firstly, we are significantly understaffed in our call centre right now. There is 33 per cent understaffing. That is due to a number of factors that are being addressed. In addition to that, we had excessive demand through the commissioning of the new critical services building. In addition to that, we made some changes in our onboarding processes, in identity management. We moved our services from an in-house managed service to a whole-of-government DCS managed service, which is not automated to the same degree as our service was and resulted in more calls to our service desk. That is being addressed as well. We are expecting that the numbers will go down again. There is no impact on costs.

THE CHAIR: We are out of time. Are you ready to answer Ms Orr's question?

Ms Stephen-Smith: What I can say in relation to the Disability Health Strategy is that the budget investment was to ensure people with disability have equitable and appropriate access to health care. There was $4 million in the 2023-24 budget review. The funding will establish the Disability Health Reference Group, easy English training for healthcare services, and accessible healthcare information and scoping support programs for people with disability to access services. I do not know if Maria is in a position to provide an update on where those activities are up to. We have gone out for expressions of interest for the Disability Health Reference Group and some progress has been made on easy English, but I do not have an update in front of me.

Ms Travers: That is right. I can give you a detailed update of what the spending from the 2023-24 financial year has been used for. For health literacy, we have a deed of grant with the Health Care Consumers' Association for a disability health literacy program for people with a disability, their family, carers and also advocates. We also have a new initiative under the action plan—which is, as the minister mentioned, the Disability Health Reference Group—to provide support for people with an intellectual or cognitive disability.

There has been a grant to ACT Down Syndrome & Intellectual Disability to recruit and support people with intellectual disabilities as members of Disability Health Reference Group, which is a really important initiative. That was for $24,500. We are also supporting a testing panel for easy English. Again, ACT Down Syndrome & Intellectual Disability is helping us with that. There is a grant of the same amount: $24,500. Easy English training for disability and healthcare providers is being provided by Scope. That was for 2023-24 and is ongoing. As the minister mentioned, we had expressions of interest for the Disability Health Reference Group. That was on 6 May. We subsequently received interest from other organisations who said they would like to be part of the reference group. We went out again. Applications closed on 8 July and we are assessing those. That will take place over the next month or so.

THE CHAIR: As there are no supplementaries, on behalf of the committee I thank witnesses for their attendance today. If you have taken any questions on notice, please provide your answers to the committee secretary within three business days of receiving the uncorrected proof *Hansard*.

Hearing suspended from 12.44 pm to 1.50 pm.

Appearances:

Davidson, Ms Emma, Minister for Community Services, Seniors and Veterans, Minister for Corrections and Justice Health, Minister for Mental Health and Minister for Population Health

ACT Health Directorate
Peffer, Mr Dave, Acting Director-General
Coleman, Dr Kerryn, Chief Health Officer
Travers, Ms Maria, Acting Executive Group Manager, Policy, Partnerships and Programs Division
Ganeshalingam, Mr Muku, Chief Finance Officer, Corporate and Governance Division

Canberra Health Services
Zagari, Ms Janet, Acting Chief Executive Officer

THE CHAIR: Welcome back to the public hearing of the committee's inquiry into the Appropriation Bill 2024-2025 and the Appropriation (Office of the Legislative Assembly) Bill 2024-2025.

The proceedings today are being recorded and transcribed by Hansard and will be published. The proceedings are also being broadcast and webstreamed live. When taking a question on notice, it would be useful if witnesses used these words: "I will take that question on notice." This will help the committee and witnesses to confirm questions taken on notice from the transcript.

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

Ms Zagari: I have read and acknowledge the privilege statement.

Mr Peffer: I acknowledge that I have read and understand the privilege statement.

Dr Coleman: I have read and acknowledge the privilege statement.

Ms Travers: I have read and acknowledge the privilege statement.

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

THE CHAIR: Thank you.

MS CASTLEY: I have a question that I asked earlier in the week about budget statements C, page 19. Table 17 shows the reclassification of $1.069 million from 2023 to the 2024-25 budget for the Community Health and Hospitals Program alcohol and

other drug residential rehab expansion and modernisation. The project agreement between ACT government and the federal government was signed in 2023 and commits to the completion of the expansion and modernisation of the alcohol and other drug rehab program by the end of February 2024. Did this program meet its deadline of February?

Dr Coleman: Thank you very much for the question. This refers to some of the funding under the 2020 Community Health and Hospitals Program project agreement, under which the commonwealth government allocated us $4.3 million towards community-based alcohol and other drug residential rehabilitation and modernisation. The point of that was to increase treatment to expand capacity of residential alcohol and other drug rehabilitation services in the ACT.

This funding has been allocated to quite a few different projects, which are all in progression. The first one is a project at Karralika. The works at Karralika Fadden and Karralika Isabella Plains are actually complete. This included upgrades to combine kitchen and lounge corridors, laundry—a whole lot of infrastructure support stuff.

The original February 2024 CHHP milestones are associated with a $2 million payment from the commonwealth. This has been delayed until 2024-25, to align with time frames for the upcoming projects and agreed with the commonwealth. The payment is not at risk, I have been advised, and there is clear and ongoing communication with the stakeholders as the project has progressed.

MS CASTLEY: Even though it was not complete, we are definitely not losing that money from the commonwealth?

Dr Coleman: We are definitely not losing any of this money. In any case, if it needs to be projected into the next year, that is in agreement with the commonwealth.

MS CASTLEY: Can you expand a little bit more on what this money was to go towards and when you think it will be complete? These are obviously really necessary services. The commonwealth are willing to give money towards it. What is the hold-up and what are we missing out on?

Dr Coleman: There are two other projects that we would like to talk about. At Toora, we have had some upgrades of plans there, for their residential service site. Those buildings are owned by Housing ACT. All of these are to make the infrastructure and the residential more reasonable to live in, and they are important, from the point of view of the residential therapeutic environment.

We are also doing that work at Arcadia House. Arcadia House is a little more difficult, and we will need to relocate them ahead of doing the work on the house. We are still working through how we do that in a way that has a minimum impact on both the staff and their client load.

MS CASTLEY: A relocation is significant, obviously, but what is the hold-up with Toora?

Dr Coleman: At the moment we expect the funded work to be complete by 30 June

2025. The commonwealth has agreed to this time line. I cannot really talk to whether there has been much of a hold-up.

Mr Peffer: The only note I have is that there were some rectification works that Housing ACT needed to undertake before these refurb works could occur.

MS CASTLEY: Just to be clear, those two projects are still underway. You said there were four, from memory, that the commonwealth were funding; is that correct? The $4.3 million was from the commonwealth; something was supposed to be ending in February 2024. Toora and Arcadia House have been pushed out. You did a little bit of work in Isaacs and another suburb?

Dr Coleman: There are two Karralika locations.

MS CASTLEY: Are they complete? So none of the four—

Dr Coleman: They are complete. I am just not sure that the payment has been finalised.

MS CASTLEY: So the services have been delivered?

Dr Coleman: Yes.

THE CHAIR: Karralika in Fadden have put in a really nice playground out the back; is that right?

Ms Travers: That is right.

Dr Coleman: Yes.

Ms Travers: Can I go back to Toora? I confirm that they relocated last year, so we had to readjust the scope; hence the delay.

MS ORR: I want to get an update on the progress of work on sexually transmissible infections and bloodborne viruses. I understand that the sector has recently gone to a commissioning round. I want to get an update on how that is progressing.

Ms Travers: The STIBBV commissioning round commenced in April 2024. There was $2.885 million available across a number of streams. That process has now been completed and contract negotiations have been finalised with four of the providers. They are Companion House, Sexual Health and Family Planning ACT, ASHM Health and Hepatitis ACT, and there is still one contract under negotiation with another provider.

MS ORR: When those contracts are finalised, when will we actually start to see the services outlined in those contracts being delivered?

Ms Travers: A lot of the services are ongoing from what they were previously. There are some new services that have been in scope, as part of the funding. It will take some time for those services to ramp up, particularly with the provider that we are still negotiating with. I think you will see little change in some of the services. I would

probably have to get back to you and take on notice exactly—

MS ORR: I was going to ask what things we could expect to see. I have a feeling you are going to tell me we are still finalising that.

Dr Coleman: We can talk a little bit about Hepatitis ACT because there has been an ability to increase the funding associated with Hepatitis ACT in line with the significant burden of disease that we have in that sector. There is some increase in aspects there around the hepatitis C point-of-care testing and treatment peer work that will be happening. Hopefully, this year we will see some more activity in that space.

MS ORR: Is it fair to say, Dr Coleman, that hopefully the contracts will be finalised imminently, and we will start to see whatever is coming from that flowing by the end of the year?

Dr Coleman: Just to reiterate Maria's comment, what has happened is that we have consolidated the existing services that have occurred.

MS ORR: Existing services will continue. With any new ones, will we see those coming before the end of the year?

Dr Coleman: There are potentially a few new ones. I want to acknowledge the fact that part of this is about putting our services on a sustainable footing. It is about reassuring and being able to continue on a much more sustainable footing moving forward.

MISS NUTTALL: Doctors for the Environment, ACTCOSS, the Health Care Consumers Association and many others are increasingly concerned about the health impacts of climate change and how we are adapting. We heard a lot about this on the community day as well. This is increasingly being raised by witnesses in parliamentary committee hearings. How are we going with adaptation in particular, and do you have any concerns regarding population health in our adaptation to climate change?

Ms Davidson: It is very fair to say that we do need to work on the climate change impacts on health. We know that climate change is already happening. Just this week we have had a new record for the hottest day ever for global average temperature, and the record was broken again the very next day. That was two record-breaking global average high temperatures in the same week. We know that this is something that is already happening.

We know that heatwaves have a very significant impact on people's health. This was reported by the Victorian Legislative Council Standing Committee on Finance and Public Administration in 2009, following the Black Saturday bushfires. It showed that the heatwave resulted in a 62 per cent increase in deaths. That was around 230 people, and another 180 people died as a direct result of the bushfires themselves.

Heatwaves in particular have a really big impact on people's health and wellbeing. They can cause an increase in pre-term births. A 2015 CSIRO publication on climate change adaptation for health and social services goes through the detail of that. We can expect to see some impacts of that in the ACT.

We know that what we experienced in the bushfires of 2019 and 2020 had an impact on population health. A report was published in March 2020 by the *Medical Journal of Australia* that talked about an additional 229 hospital admissions—82 for cardiovascular issues, 147 for respiratory issues, 89 emergency department presentations for asthma, and an additional 31 deaths.

We know that, for people over 65 years old and for children under five years old, there are particularly important things that we will need to be prepared for in our future. These are the kinds of things that we need to take into account as we are planning for the future of our health system, knowing that this is happening. It also means that we need to be even more committed to reducing climate change itself, as much as we possibly can, so that we do not have those population health impacts at that same level.

MISS NUTTALL: Absolutely. Just on that, do you think that there is a real risk that we will leave our vulnerable community members behind?

Ms Davidson: We are doing everything we can to make sure that, as we prepare for future climate change related disasters, we are thinking about those people who are most at risk in the community. The work on a social recovery framework will help us a lot there. That is one of those areas where this kind of work requires a whole-of-government response. It is not just going to be about what happens in ACT Health or in our health services. It will also be about what our social and human services can do. It is about making sure that our public housing is prepared for future climate impacts, that we are looking after people who are in the private rental market, in terms of what they are able to access, to make sure that their housing can deal with those kinds of fluctuations in climate.

We will also have to think a lot about how this impacts on mental health services. That is why we have been so focused on getting more services out into the community and doing more primary prevention and early intervention work on mental health, because climate anxiety and climate grief are very real things that we are seeing people experience.

MS ORR: Minister, can I get an update on the climate and health strategy, and where it is up to? I think that some of the money was rolled over between this budget year and the last budget year.

Ms Davidson: Is that different from the current ACT Climate Change Strategy that runs through to 2025?

MS ORR: Yes; it is the climate and health one.

Dr Coleman: I can speak to that. Ms Orr, I think you are referring to some money that was allocated to Health last year and this financial year to assist us in research towards climate change adaptation. There has been a lot happening in this space in the last year, particularly last October or September.

MS ORR: This was specifically going to the health impacts of climate change?

Ms Travers: Yes, this was a health item and it was to look at what research we need to

assist us in some of these adaptation plans around climate change, particularly with our priority populations.

MS ORR: Is this identifying what health issues you might see increase as a result of climate change or is this looking at what practices you need to modify because of climate change impacts? Is it all of the above?

Dr Coleman: My preference is the second. At this point in time the reason why the money has been rolled over is that there was so much happening in the national space last year, and there is so much to be promised and progressed underneath the national space, that we are trying to get a handle on where the added value is in the ACT money and how we can use that for our specific context.

We know it is there and that we have it and, once we get a bit more information from the commonwealth on how they are going to implement their components of the National Health and Climate Strategy, we will have a little bit more understanding about what we should focus on here.

MS ORR: Have the commonwealth given you any indication of when they might give you the direction you are seeking?

Dr Coleman: We know that the national strategy was released in September or October last year. We understand that there is work moving ahead on some of the work, such as a national health vulnerability capacity and adaptation assessment. These are expensive things to conduct. We are hoping that, out of that, there will be some tools for us to assist smaller populations to go through that work.

MS ORR: Was that this year or next year?

Dr Coleman: We are hoping to see that this year, but we have not been advised of any specific dates. That does not mean we are doing nothing in this space. We continue to work with ANU, UC and all of our priority population groups as we progress. A lot of work to address some of the issues that the minister highlighted is being done under other programs of work that are moving us ahead in our adaptation.

MS ORR: The main premise is that you do not want to duplicate; you want to find out what you can—

Dr Coleman: We want to add value.

MS CASTLEY: In budget statements C, output 1.2, there is an item "proportion of current clients on opioid treatment with management plans". It is noted that the target is 98 per cent in both 2023 and 2024 and 2024 and 2025. However, only 87 per cent was achieved in 2023, a more than 10 per cent miss of the target. There is a footnote saying that the implementation of the Digital Health Record will enable better performance against this measure. I asked about this earlier. Can we get it on the record for this part of the hearing? Does this imply that some people are on opioid treatments but not recorded correctly and DHR will gather them up?

Ms Davidson: In terms of how DHR is helping us with that information management,

Janet can speak to the details.

Ms Zagari: I acknowledge that Ms McKenzie would have been here to speak to this, but she is unavailable. Fundamentally, within the DHR there are two ways that people can record the information, and the reporting is directed at one of those flags. Currently, there is a piece of work that we need to do on the workflow to make sure that people know this is how this is recorded. We are confident that the issue is that the particular "tick" box is not being ticked, so that the flag is not flowing through into that reporting. We are working with our clinicians to educate them. It is not that it is not appropriately prescribed; it is. There is a particular flag that feeds the report that is not always being ticked in that process. It is just our workflow.

MS CASTLEY: With the recommendations of the 2018 review of the opioid replacement treatment program, recommendation 2 stated:

> That Justice Health ensures that an individual case plan is prepared for all vulnerable detainees being inducted onto the ORT program, as required by the ACT Guidelines, including Aboriginal and Torres Strait Islander detainees.

Can you talk about how that is going?

Ms Davidson: This is about people who are on OMT within the AMC?

MS CASTLEY: Yes, and the recommendations of the 2018 review on the treatment program.

Ms Davidson: Janet might be able to talk about how people are referred into the OMT program within the AMC at the moment.

Ms Zagari: I might need to take that on notice. I will see whether Ms McKenzie happens to be online and is able to contact me via Teams; she is unwell. I will come back to that before the end; otherwise I will take that question on notice and come back to you.

MS CASTLEY: I am just concerned that it is six years after the review, and I would really like to understand how many of those recommendations have been properly implemented and have case managements in place. We chatted to some people who have been through AMC and they were quite concerned about the treatment plans or even any kind of help while they are in AMC. So I would like to get a better understanding of that.

The reprioritisation for the Digital Health Record, as noted on page 46 of budget statement C has $4.1 million from 2023-24, to 2024-25 and 2025-26 and the bulk of the 2026-27 is $2.5 million. Could someone explain to me how that money works and flows over those years? Does that imply that DHR will not be fully usable by Justice Health until 2027?

Mr Peffer: I think I have what you might be referring to, Ms Castley. Are you talking about the funding profile and then there is a series of columns where the first one is minus $4.1 million and then plus $1.1 million?

MS CASTLEY: I do not have it in front of me. We are just going from page 46 of budget statement C. Is that what you have in front of you?

Mr Peffer: That is what I have got.

MS CASTLEY: I did not bring the book with me, sorry.

THE CHAIR: "Revised Funding Profile—Investing in public health care—Digital Healthcare Record—transforming the way health care is provided".

MS CASTLEY: That is the one; yes.

Mr Peffer: Got it. Thank you. That does not mean that the Digital Health Record is not working the way that we expect it to. I think what Ms Zagari was alluding to before is that, at the point of care—and you heard from one of our emergency specialists this morning—it is actually a great tool in terms of the provision of care and that interface with consumers and patients. This relates to ongoing work in terms of building reporting capability and other capability within the system and when we expect that work to happen. This is just the profile of when we expect that work to happen. But the tool itself, the Digital Health Record, is working very well.

THE CHAIR: I would like to ask a couple of questions about table 13, the accountability indicators for output 1. 2. It is on page 14 of budget statement C. Under the first one in that table, "Total number of inspections and proactive site visits of food business", the target of 2,500 was not quite met. Can you talk me through the reasons that the target was not met?

Dr Coleman: This refers to our Environmental Health officers and their food safety inspections as part of the ongoing food compliance aspect. I think one of the main challenges that the team has is one that is faced nationally as well, in that EH officers are actually really difficult to come by. There is a shortage of them around Australia and we are all looking at how we might be able to increase that. This number this financial year is a significant increase on the last couple of years, where we did suffer because of COVID as well. So we are gradually building that up. I am not sure it is too far off the number that we are looking at. We are also looking at other mechanisms continually in an ongoing quality assurance process to "efficiencyise" it so that we can actually achieve more in in less time.

THE CHAIR: How many people are in that area?

Dr Coleman: Let me have a look for you.

THE CHAIR: There are two parts: how many physicians are there and how many people are there? Is it under resourced—perhaps for the reasons you have already outlined?

Dr Coleman: I am waiting for Victor to provide me with updated stats on that. They will be at the top of his head.

THE CHAIR: Is this what those staff do full time—go from one place to another inspecting and completing their reports? Do they have any other responsibilities?

Dr Coleman: It is a significant part of what they do, but they are also responsible for the compliance and enforcement component of all of the regulatory functions that sit in the environment space. They also inspect cooling towers. We have spas and pools. We also have some other bits and pieces around water in that space. But food, because of the priority from a public and community safety perspective, does form the vast majority of the inspections that they do. But they do not just inspect; they also spend a lot of time in terms of education and developing relationships with the food venues. The way we try and work is that the food venues will come to us when they have a problem and we will try and work through that before it actually becomes a food safety issue. We have 12 EHOs currently and 19 in the team. So there is a significant impact on that.

THE CHAIR: You mentioned cooling towers, spas et cetera. Where are the figures for those sorts of reports recorded?

Dr Coleman: I have them here. In the same time, we did about 259 cooling towers. There is the general category of six general things that were just other environmental pieces. Under swim pools and spas, we did 20. The other thing that this team has to do is review planning Das and assist in making an assessment and providing advice around the environmental health and safety component of those as well. So they are an essential part of our health protection service.

THE CHAIR: Are the swimming pools and spas public pools or private or a mixture?

Dr Coleman: They will not be private. They are individually owned. I think they are ones where the facility code of practice applies to them, and therefore there are general public members coming in.

THE CHAIR: In the same table, table 13, it talks about immunisation and the number fully immunised as per the Australian Immunisation Register—presumably, childhood immunisation. One of the gaps appears to be in the early years for Aboriginal and Torres Strait Islander children. What are you doing to try to improve those rates? It seems like they have caught up by a later age, but what are you doing to try and improve those early immunisation rates?

Dr Coleman: You are exactly right. One of the really challenging things nationwide that we experience is getting these children vaccinated in the timeframes that we need. Therefore, they are actually more exposed to risk during that period of time. We have a lot of work and a relatively big program in our Aboriginal and Torres Strait Islander community. We focus quite a lot on working with Winnunga and our other stakeholders to reach out and provide advice, recommendations, sources of education and support. We also have a follow-up and reminder method where we actually have these postcards and they get posted out. We are continuing to review what other mechanisms we can use in this population.

THE CHAIR: It would seem—and I have no real expertise in this area at all—that we have identified Aboriginal and Torres Strait Islander children as a risk group for RSV.

Is RSV covered under the Childhood Immunisation Register?

Dr Coleman: With RSV, there is no current vaccine recommended or registered for children yet. So we do not have RSV on there. But we do have a pertussis-containing vaccine, which is really important from a respiratory perception. The thing I wanted to note about the percentages in this group of children, is that it is such a small number, because it is a three-month cohort, that even one child can contribute to six per cent.

THE CHAIR: But it is important, nevertheless.

Dr Coleman: Yes. We do see a fair bit of movement, but I think we consistently see a small lower per cent there.

MS CASTLEY: I understand that Beyfortus was approved by the TGA last year.

Dr Coleman: Beyfortus is a monoclonal antibody. So that is a passive immunisation technique. The legislative mechanism under which things are considered as a vaccine, this is not considered as a vaccine and it is not able to be put on the National Immunisation Program.

MS CASTLEY: What are the other jurisdictions doing for RSV?

Dr Coleman: We are all doing our winter wellness component, which is encouraging parents and children to do their behaviours, their education and their communication. As I am sure the public is well aware, in WA and Queensland they have run a Beyfortus program for newborn babies over this winter season. We have run a vulnerable babies program as part of New South Wales program to really target the available monoclonal antibody that we have to those babies who are at the highest risk. The simple fact is that there was not enough available Beyfortus in Australia to run a national program this year.

MS CASTLEY: Obviously some jurisdictions have been able to get it. When did we know that that was the available option? Did we not order enough?

Ms Davidson: In the ACT, we have aligned our guidelines with what New South Wales is doing to make sure that we are addressing the needs of those babies that are at most risk. That is really important given that we are providing health services to people who live across the border and, equally, there might be people in the ACT who are going over to New South Wales. Having our guidelines aligned with the New South Wales guidelines is really important in making sure that those babies who are most at risk get the first access.

In terms of what might happen in the next season and the guidelines on RSV vaccines, the Pharmaceutical Benefits Advisory Committee will be thinking about what they need to certify for use with infants next year. What clinical guidelines the Australian Technical Advisory Group on Immunisation might be thinking about for the 2025 RSV season will, I guess, be released early next year. We are actually still in RSV season at the moment for 2024.

MS CASTLEY: Is the information you have that it is limited and we cannot get much

of it? When you say we have aligned with New South Wales, does that mean you have organised enough to cover at-risk children or we are dipping into their reserves?

Ms Davidson: It means that the ACT and New South Wales are working together to make sure that those babies that are most at risk are getting first access. Generally speaking, a small jurisdiction like the ACT does experience challenges in procuring vaccines of all different kinds in circumstances where there is a limited supply. We have worked with New South Wales in making sure that we get access to vaccines and then target those to the most at-risk people in our population for other things before, and we are doing the same thing with this.

MS CASTLEY: Thanks.

MS ORR: I wanted to ask about the pharmacist scope of practice. I understand that there has been some work done with pharmacists to expand their scope of practice, specifically to enable and prescribe antibiotics and the pill. Can I get an idea of where that work is up to?

Ms Davidson: Who would like to talk about that? I could talk about it all day; it is a really nice piece of work.

MS ORR: I cannot direct you how to answer.

THE CHAIR: But I will not let you talk about it.

Ms Davidson: Oh, that is a shame.

MS ORR: The chair might give you a time limit.

Dr Coleman: We currently have 15 community pharmacists engaged in the UTI trial. That officially ended at the end of May, and the data that has been collected as part of that is being analysed at this point in time, combined with the New South Wales data with the researchers. On any future direction on that particular part of this trial, we will await the evaluation piece to come out, noting that there have been no significant negative signals come out of that. So we are happy to continue with the current 15 pharmacists and allowing the UTI. I believe the OCP component of that has just started. If it hasn't just started, we have just registered the pharmacists to do that. Then we are actually looking at implementing the third phase of the trial in line with New South Wales and looking at how community pharmacies can treat minor skin conditions and supply some specified treatments.

So I think, overall, we are seeing a gentle expansion in line with how the trial is being conducted in New South Wales. We have not seen any significant safety signals that are of concern. One of the things that we are particularly looking for is how this integrates with primary care and therefore some of the other outcomes that we might see. We need to have a look at the overarching piece of evaluation, and I am really looking forward to seeing that come out in 2025.

MS ORR: You said there were 15 community pharmacists in the ACT doing the trial.

Dr Coleman: Yes.

MS ORR: Dr Coleman, you used a number of acronyms in your answer. You do not need to repeat the whole answer, but maybe just the three phases without the acronyms would be good.

Dr Coleman: The first one is urinary tract infections; the second one is the oral contraceptive pill; and the third one is looking at some basic skin conditions.

MS ORR: Okay. So the first two have been undertaken and, if I understand what you said, there have not been any negative things so far?

Dr Coleman: We have not identified anything that would cause us enough concern to put a stop to the trial.

MS ORR: So it would have progressed to the third one, which is the skin?

Dr Coleman: Yes.

MS ORR: Once the third one is done, there is a review phase in line with the New South Wales findings. What is the next step?

Dr Coleman: There is also a lot of work happening nationally. The overall preference is absolutely to have scope of practice done across all allied health practitioners nationally across the board. I am hoping that all of this information will feed into that work so that we can have the most informed scope of practice guidelines to inform that. I would be hesitant to talk to where this would go moving forward, only to say that we are committed to continue to work with our pharmacies around how best to help them expand in a way that provides an integrated primary care model for all of our community.

MS ORR: So, for the foreseeable future, it will stay at the 15? It is not going to be expanded?

Dr Coleman: Yes.

Ms Davidson: One of the other things that has been particularly useful to hear feedback from the community about on this program is that, even though it is relatively new to the ACT, people are hearing about it and are talking to each other about it, and word of mouth is spreading that this is now something that you can access here. It has been particularly helpful for people who are new arrivals to Canberra, who may not have a GP that they see regularly sorted out yet, or people who might have difficulty getting to the GP in between, say, uni commitments and work commitments. That is one of those situations where people might find that they know what it is that they need but they have not had time to go and get that prescription sorted out for things like the oral contraceptive pill or UTIs. That is something that young women, in particular, are telling me is really helpful for them to be able to go and talk to a pharmacist about it and not end up having a gap period where they know they need to take this medication and they cannot get access to it just because of that.

MS ORR: Thank you.

MS CASTLEY: Did I hear you say that we are not looking at expanding the 15—that that is not on the cards for now?

Dr Coleman: I think at the moment, within the existing structures and priorities that we have, sitting with the 15 is where we would prefer to stay, because we can manage that and provide the support necessary moving forward.

MS CASTLEY: Where are they all located? Can we just Google "pharmacy that provides UTI"? Is there a list?

Ms Davidson: There are lists, and I have promoted them as well. They are lists that can be found relatively easily online. But it is also important to know that the pharmacies that are participating in this are located all over Canberra. So it is not like there is anyone in Canberra who has nothing within their area that they can get access to. It was very much in people's minds that they have got to be accessible.

MS CASTLEY: I am hearing concerns from doctors et cetera. What are you hearing and how are you helping them feel more comfortable?

Dr Coleman: This is the real challenge, isn't it? This is a really strong evaluation study that the University of Newcastle is leading. They are looking at some of those outcomes that the doctors and the nurse practitioners are nervous about and are also looking to help us understand what systems are necessary across the board that promote that integrated system that we really do need. If we move ahead too quickly, then some of those things might fall down.

Our Chief Pharmacist, Amanda Galbraith, spends a lot of time attending AMA and RACGP meetings and trying to engage with, promote and make sure that people are understanding the aspects of the trial and that it is in a system like that.

MS CASTLEY: Great. You said that they are evaluating data. It would be hard for a pharmacist to know whether or not the medication they gave was in fact correct and that the person did end up at their GP. Is it correct that they cannot really track that?

Dr Coleman: That is what the research is looking at—actually being able to follow up on an individual basis a dataset of lots and lots of people under different circumstances to check all of that.

MS CASTLEY: Thank you.

Ms Davidson: I have actually heard from a woman who used this trial to go in and access medication for a UTI from a pharmacist. When, two days later, it was not getting better, they went to the GP and that got the problem resolved. So people are actually following up and following through on what needs to happen. I have also heard from a woman who had the experience of having a UTI before this trial existed, so this was not an option that she could have accessed. She could not get in to see her GP for a while and she actually ended up in Canberra Hospital with a kidney infection. We really want to avoid that situation. The pharmacists are very good at talking people through

the risk factors, what other health conditions they have and what medications they might be taking and redirecting them to a GP if it sounds like this trial is not going to be the one for them.

MS ORR: I want to go back to expanding the scope. Can you run me through what other jurisdictions are doing? We got the 15, and there are no plans to expand that. Are other jurisdictions taking a similar approach?

Ms Davidson: New South Wales is taking a similar approach to the ACT. I understand that similar things are happening there. There are other jurisdictions that are not trialling as much as the ACT is doing at the moment. When we are an island surrounded by New South Wales, it makes a lot of sense that we are looking at what New South Wales is doing as well.

Dr Coleman: I note that, in particular, Queensland seems to have gone all in quite quickly, and we are all watching those results with interest. One of the differences in Queensland is that pharmacies are expected to be all in or all out. They need to provide the vast range of every scope of practice if they are going to do that, so it will be interesting to see how that plays out.

Mr Peffer: Can I just add that seven of the 15 appear to be north of the lake, so it is a good mix north and south in terms of location.

THE CHAIR: Can you just, for my own curiosity, tell me what are the common skin conditions that are included?

Dr Coleman: Yes. They are very minor ones, like atopic dermatitis, if you have some eczema or some mild psoriasis. Sometimes children have a little bit of impetigo or something like that. Similar to what the minister was talking about, part of it is about determining: "Is this minor enough for me to be able to provide a topical treatment or does this require further assessment?"

THE CHAIR: Regarding UTIs, do any of the pharmacies visit aged-care facilities? I am just thinking that UTIs are very common in older women.

Dr Coleman: That is a very interesting question. From memory, UTIs in the elderly are not part of this trial because it is a much more complex situation that we are talking about. What we are trying to do here is focus on young women in particular, where we know that there is no complexity or limited complexity.

MISS NUTTALL: I am talking about harm reduction. I understand that in a lot of ways ACT is leading the charge with harm reduction. Could you tell me why we need an additional review into harm reduction services in the ACT to achieve a supervised injecting service?

Ms Davidson: Yes. Prior to the last election, both Labor and the Greens made commitments to consider the prospect of a medically supervised injecting facility in the ACT. That was reflected in the ACT's Drug Strategy Action Plan that runs through to 2026, and it resulted in a feasibility study by the Burnett Institute in 2020. The outcome of that was that a medically supervised injecting facility was feasible, but what we know

is that Canberra is a bit different to Sydney and Melbourne, where there are already medically supervised injecting facilities in areas where drug use and drug harms are more prevalent.

In the Canberra situation, drug use and supply is a lot more geographically dispersed. Our overdose prevention sites would need to function a bit differently to what we have seen in Sydney and Melbourne, because we know that most people will use the substance very close to where they have accessed it. What we are looking at is services that support overdose prevention that are designed to reflect the unique needs and circumstances of the ACT community. We are also acknowledging that we are actually seeing increases in overdose injuries and deaths nationally that are not necessarily related to injecting, so we need to look at options that respond to that.

The ACT Health Directorate has commissioned a further review of current and emerging needs related to drug harm reduction in the ACT. That review will be conducted by an expert in the field and will commence shortly. It is going to focus on options for on-site supported overdose prevention; opportunities to build on existing drug harm reduction programs and policies; and any additional measures that will increase preparedness for contaminated drug supply increases in the community. The Burnett report said that a medically supervised injecting facility is feasible, but this new review will tell us how overdose prevention sites in the ACT should work, in conjunction with other drug harm reduction programs.

MISS NUTTALL: Thank you.

MS CASTLEY: We talked about opioid treatment in the AMC. Can you explain to me what options there are for people on drugs who attend the AMC? Is it just a cold turkey situation? What support do they have during their stay at AMC and what do they have when they leave?

Ms Davidson: It is my understanding that OMT is something that is used by quite a number of people inside the AMC. There are differences in the way in which people access it inside the AMC, compared to how you might access that kind of drug program in the community, because you are in a different physical environment with different security constraints. Absolutely, there are a lot of people inside the AMC who are accessing OMT and finding it helpful.

MS CASTLEY: Does that then negate them from being part of a rehabilitation program once they leave the AMC? Do you have to be completely free and clear of any kind of drugs?

Ms Davidson: In terms of what happens when people transfer out of the AMC, there are programs that are running out of building 7 at Canberra Hospital. What is happening at the moment is that people might be prescribed OMT while they are in the AMC. Then, as the client returns to care in the community, the coordination and decision-making around what is clinically best for that person is either transferred back to that person's preferred GP or the client can attend the alcohol and drug services in building 7 to continue their treatment.

Per the national guidelines, any justice health clients who are on OMT are a high

priority for alcohol and drug services in building 7 when they are discharged back into the community. They can go there to continue their daily dosing with the nursing staff until they have been reviewed by a medical officer or have decided who they are going to be seeing longer term. During that period the nursing staff there will support them and identify any transitional support that that person might need. They will advocate for and refer clients to other support services and escalate concerns, if that is needed.

MS ORR: This budget extends the pill-testing pilot. Can I get a bit of an update as to the rationale behind why it was extended, rather than looking to make it ongoing?

Ms Davidson: We did talk a little earlier about a drug harm reduction review that is underway at the moment. That report will be due back to the next government in December 2024. That will provide us with some really useful information how different drug harm reduction programs work together to reduce and prevent overdose. Certainly, there has been funding committed in this budget to extending the CanTEST service. You know that I am on the record as saying that I think this is something that needs to be permanent.

MS ORR: So the reason for not moving to a permanent arrangement is to see what comes out of the review?

Ms Davidson: It will allow us to incorporate any findings from that review, if that is appropriate, but a number of things are being considered. That will be a decision for the government in the next term.

MISS NUTTALL: Minister, you have publicly expressed support for vaping products to be regulated as consumer products in the same way that New Zealand has. Can you explain exactly why that is, noting ongoing community concern about vaping among young people in particular and how that relates to the government's investment in vaping cessation activities in the current budget?

Ms Davidson: There is a relationship between the public health impacts of tobacco smoking and what is happening with vaping regulation, and there are things that we can learn from what other jurisdictions have been through. Currently, between 21,000 and 24,000 Australians die each year from smoking-related illness. Tobacco smoking is the leading cause of preventable death in Australia, and the way that we respond to vaping will have an impact on that. It is really important that we look at the evidence from other jurisdictions that have regulated vapes as consumer products, and how that has impacted on their tobacco smoking.

We know that since 2011 we have seen around a 50 per cent national annual increase in smoking-related death. At the same time there has been a national population increase of around eight per cent. Looking at what has happened in somewhere like New Zealand is really informative for us to consider. After New Zealand legalised and regulated vaping in 2020, the daily adult smoking rate declined by 43 per cent in the following three years. Together with targeted culturally appropriate health campaigns, the regulation of vaping products as consumer products resulted in a 42 per cent decline in smoking rates among New Zealand's Māori population between 2020 and 2023.

In Australia around 40 per cent of First Nations people smoke. The decline in smoking

rates among First Nations Australians has been slower than the national rate, even with really well-funded smoking cessation campaigns in place. We need to look at how we can support people to make better choices there. Vaping products that are regulated are less harmful than black market vaping products, and certainly less harmful than traditional smoking. When we are thinking about what happens with population groups that are more at risk and over-represented in certain outcomes, we need to think about what is actually going to work for them.

MISS NUTTALL: You have spoken about the number of Australians—I think between 21,000 and 24,000—dying each year from smoking-related illness. For decades it has been the leading cause of preventable death in this country. Noting that you have only been the minister responsible for population health since December of last year, could you please tell us exactly what you have done in this budget to address this problem, and your vision for a way forward?

Ms Davidson: We have continued to fund vaping cessation programs. In particular, we are looking at what we can do for young people and school students. There have been some vaping cessation programs included in this year's budget. There was $442,000-odd to the Cancer Council ACT for the Vape Free Sports Program. There was $264,988 for Cancer Council ACT's School Communities Supporting Students in Vaping Cessation program. There was $181,392 to the Cancer Council ACT for its Quitting together: Vaping cessation in ACT community services program, and there was $83,210 to ATODA for its Reducing Nicotine Harms program. That investment will be complemented by commonwealth funding of just over a million dollars, through a federation funding agreement over the next four years, to enhance smoking and vaping cessation services in the ACT. We are absolutely continuing to invest in programs that will support people to make healthier choices.

MISS NUTTALL: Thank you.

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

Hearing suspended from 2.45 to 2.56 pm.

Appearances:

Cheyne, Ms Tara, Minister for Human Rights, Minister for the Arts, Culture and the Creative Economy, Minister for City Services and Minister for Government Services and Regulatory Reform

Justice and Community Safety Directorate
Glenn, Mr Richard, Director-General
Williams, Ms Kelly, Acting Deputy Director-General, Justice
Ng, Mr Daniel, Acting Executive Group Manager, Legislation, Policy and Programs Division
McKinnon, Ms Gabrielle, Senior Manager, Human Rights and Social Policy, Legislation, Policy and Programs Division

THE CHAIR: We welcome Ms Tara Cheyne MLA, the Minister for Human Rights, and officials. I remind witnesses of the protections and obligations afforded by parliamentary privilege and draw your attention to the privilege statement. Witnesses must tell the truth. Giving false or misleading evidence will be treated as a serious matter and may be considered a contempt of the Assembly. Could you please confirm that you understand the implications of the privilege statement and that you agree to comply with it?

Ms Williams: I have read and understand the privilege statement.

Mr Glenn: I have read and accept the privilege statement.

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

Ms McKinnon: I have read and understand the privilege statement.

THE CHAIR: I will start by asking about the Human Rights (Healthy Environment) Amendment Bill 2023, which is to legislate the right to a healthy environment in the ACT under the Human Rights Act 2004, which was presented in October 2023 and remains before the Assembly. Can you tell us why there seems to have been a bit of a delay in bringing this bill forward?

Ms Cheyne: Bringing the bill forward for debate, Ms Lawder?

THE CHAIR: In the Assembly.

Ms Cheyne: I would not describe it as a delay; I was sick with COVID. We had scheduled to debate the bill in the last sitting, but I was unwell.

MS ORR: If you have COVID, you are not allowed in the precinct, are you?

Ms Cheyne: Correct. As soon as I tested positive, I left.

MS ORR: You could not have attended, even if you wanted to?

Ms Cheyne: That is right.

THE CHAIR: Are you having any negotiations, for example, with the Greens, about moving amendments to the bill?

Ms Cheyne: We have circulated our amendments, Ms Lawder.

THE CHAIR: You are not dealing with any other amendments coming forward from the Greens?

Ms Cheyne: We have circulated government amendments, which, in my view, incorporate the Greens' position.

THE CHAIR: In that, why was the pathway for litigation directly to the Supreme Court restricted, and what steps have the directorate taken to identify and rectify any shortcomings that may have influenced this decision?

Ms Cheyne: I will ask officials to talk you through the thinking so far.

Mr Ng: Madam Chair, the approach with the restriction on litigation was based primarily on the fact that the right to a healthy environment is a growing and further crystallising law at international law level. There is no standalone international covenant which relates to the right to a healthy environment. The reflections across international jurisprudence reflect the fact that it is still growing, and there is an evolving understanding of how the right manifests in different contexts.

That plays out in the ACT public service context as well. The intention which sits behind how the implementation will pan out is that directorates will have an opportunity to engage with the right, adapt their processes to incorporate compliance with the right into their day-to-day activities and, until that process has an opportunity to play out, the restriction on litigation is intended to be in force.

The amendments that the minister has referred to that are currently before the scrutiny committee put a sunset clause in. The result of that sunset clause will be that the restriction on litigation will be removed, save for any other legislative intervention, by 1 October 2028.

MR CAIN: If the department is not ready to fully implement this new human right, why wouldn't you delay that until the department is ready, to make sure that you could implement it properly?

Ms Cheyne: I reject that assertion, Mr Cain. We are ready to implement the human right. Mr Ng has given you a detailed explanation about the thinking. When we do introduce new rights into our Human Rights Act, it is not entirely unusual for particular provisions to be delayed in terms of their commencement.

MR CAIN: When else has that happened?

Ms Cheyne: Certainly, when the right to education was introduced.

MR CAIN: When was that?

Ms Cheyne: I am sure that we can look it up.

MR CAIN: Can you take that on notice?

Mr Ng: Mr Cain, we can take that on notice, and we might be able to respond to you before the end of the hearing.

MR CAIN: Are there any other times when you have implemented a half-hearted human right, like in this case?

Ms Cheyne: It is not half-hearted, Mr Cain. That is silly.

MR CAIN: I beg your pardon?

Ms Cheyne: That is silly.

MR CAIN: Chair, the witness should speak respectfully to committee members.

THE CHAIR: Are you going to answer the question rather than make a personal reflection?

Ms Cheyne: I am not sure if it was a question or a comment.

THE CHAIR: Okay. Ms Orr has a supplementary.

MS ORR: On this line, and going back to the comments that were made previously about the reason for having the sunset clause, and knowing that there is precedent elsewhere, how much of it is this characterisation that the public service is not ready, and how much of it is that this is quite a new area of human rights? You have given both as an answer. What weighting should we give to the different components forming this decision?

Ms Cheyne: What we have tried to do, Ms Orr, is strike a balance with the concerns that were raised by the Standing Committee on Justice and Community Safety. We responded to those with our government response earlier this year about the limitations of the right and its enforceability, as well as making it operationally viable for government.

As Mr Ng very elegantly described, this is an emerging right. We are the first in Australia to even contemplate this at this level of detail. Internationally, within the international law framework, it is also emerging. We have always sought to go with the broadest definition possible. It turns out that the broadest definition also, of course, links us to the international human rights definition. As that law evolves, ours can evolve with it. There are unknowns associated with it because it is a relatively new right at that level, and that is why we do want to have some time to work through it. That is how we have established having both a sunset clause and a statutory review.

MS ORR: There has been no precedent in Australia to direct us on how it could be interpreted, when you start looking at appeal rights?

Ms Cheyne: Within a legislative sense?

MS ORR: Yes.

Ms Cheyne: We would be the first.

MR CAIN: Noting that the government is not reluctant to pioneer new areas, Minister, is it your view that it is the incompetency of the justice system or of your own department regarding having full appeal rights on this human right?

Ms Cheyne: No.

MS ORR: I do not think it is very fair to call it the justice system.

MR CAIN: The court system.

Ms Cheyne: No.

MR CAIN: Which one?

Ms Cheyne: Could you rephrase your question?

MR CAIN: Is it your view that it is either the justice system—the court system—or your own department that is not well placed to deal with appeals on this new human right?

Ms Cheyne: It is none of those, Mr Cain. Frankly, I think that shows a very limited understanding of how this operates.

MR CAIN: When you say "this", what do you mean by that?

Ms Cheyne: Your question.

MR CAIN: No, you said how "this" operates. To what are you referring?

Ms Cheyne: Human rights law.

THE CHAIR: I think we have exhausted this line of questioning. We will move on. Ms Orr, do you have a question?

MS ORR: I do. It is not entirely the same but it is not unrelated. With the human rights complaint mechanism and the changes that have come into effect, how will the new pathway for complaints to the ACT Human Rights Commission improve accessibility for individuals seeking an address of human rights violations?

Ms Cheyne: This is a mechanism that has now been enforced for a bit over a few months. We passed this legislation at the end of last year and it commenced six months after that date. It came into effect on 11 June.

As of 1 July, I believe six complaints have been made to the Human Rights Commission. This is about providing an accessible mechanism for complaints to be made about breaches that a member of the public has identified, as it relates to our government agencies and what obligations they need to provide in that sense. It is very similar to the work that the discrimination commissioner already undertakes. This allows for a complaint to be made and for confidential conciliation to occur; and, from there, ideally an outcome and recommendations generally can be made as well.

MS ORR: You said there were six complaints since the mechanism—

Ms Cheyne: As of 1 July. I am not sure whether there has been a further update. Has the commission appeared yet?

MS ORR: No, not yet.

Ms Cheyne: When they appear, they can speak more to—

MS ORR: Can you give me a better understanding of the section in the act about notice of Supreme Court action? How does that interact with the conciliation and this new pathway?

Ms Cheyne: Yes, absolutely. Previously, I believe it was the case that the Human Rights Commission was not automatically notified when there was a human rights element raised within the Supreme Court. What this has done is make that automatic referral to them, so that the commissioner then has the information available to determine the action that she wishes to take, in a high-level sense. Officials can probably explain that more elegantly.

MS ORR: Yes, please.

Ms McKinnon: I believe Ms Orr's question may also relate to the ability of people currently to take an action to the Supreme Court for a breach of their human rights. The Supreme Court pathway is there. If people take a complaint to the Human Rights Commission, and some time elapses during that complaints process, there is a provision in the legislation now that recognises that they may need to seek further time, and the Supreme Court can allow further time for a person to then take the matter to the Supreme Court, extending that time period.

MS ORR: It is allowing you to—for lack of a better way of putting this—explore the issue in the Human Rights Commission before going straight to the Supreme Court, which is obviously quite a high bar and, for an individual, quite costly.

Ms Cheyne: The complaints mechanism, certainly; then, within that bill, we also had an element about whether the Human Rights Commission can be made aware of all human rights proceedings in a timely way that—

MS ORR: It is giving them greater oversight and getting the two institutions talking to each other a bit better.

Ms Cheyne: Yes. For things that are already in the Supreme Court, when there is a

human rights element to it, they are automatically notified, so that the commissioner can decide whether to intervene or not.

MISS NUTTALL: Would the right to a healthy environment also be an enforceable right under this mechanism, like other rights?

Ms Cheyne: It certainly would be applicable under the complaints mechanism, absolutely, and that was deliberate.

MR CAIN: How many, if any, matters have been brought to the commission for a breach of human rights?

Ms Cheyne: Six, as of 1 July.

MR CAIN: How many of those have gone to the Supreme Court?

Mr Ng: Mr Cain, with the complaints which manifest in a conciliation process in the Human Rights Commission, there is no direct pathway to the Supreme Court after that, so I could not give you an answer about how many could have directly flowed to the Supreme Court, because they do not necessarily flow from one to another. The ability to take a proceeding to the Supreme Court is a little bit independent of the Human Rights Commission process.

MR CAIN: Apart from what you have already touched on, how has this accessible pathway for human rights complaints to the commission been delivered, and what are other particular challenges?

Ms Cheyne: It has been delivered within the Human Rights Commission. They have been aware that this has been coming for some time. It sits within Commissioner Toohey's jurisdiction with the Human Rights Commission. They will be able to speak to you about the implementation of it, and whether they have any concerns about the challenges within it. As far as I am aware, there has been nothing reported to date, noting that the complaints mechanism only commenced on 11 June.

MISS NUTTALL: Earlier this year, we were thrilled to see the ACT government pass legislation to amend the births, deaths and marriages act to make it easier and fairer to change your name and sex on birth and marriage certificates. I thank the minister, JACS and Access Canberra for their work on that. Do you feel there has been adequate funding in this year's budget to properly and swiftly implement the changes that Access Canberra will need to make?

Ms Cheyne: Yes.

MISS NUTTALL: It is great to hear that. Understanding that gender-affirming processes like having key identity documents reflect your name and sex are pretty important, and should not be subject to your income, have you had much feedback about any financial barriers to changing one's name or sex on their birth certificate?

Ms Cheyne: Not that I am aware of, Miss Nuttall, but perhaps you can also ask that question in the Access Canberra hearings, given that they administer the operation of

the act. We are happy to talk about it there. I do have some data that might be of interest to you about essentially the statistics since some of those changes have been made, noting that some changes are still to commence.

MISS NUTTALL: If you are happy to provide those statistics, that would be wonderful, and do let me know if it is better to ask the question during the Access Canberra session.

Ms Cheyne: I have the statistics here, so I can speak to those momentarily. But regarding whether there has been feedback about financial issues, Access Canberra will have that information. The number of young people under 16 years who have applied to change their registered sex and/or given name is six. The number of people who have requested a birth certificate without a sex marker is 78, and the number of integrated birth certificates is 10.

MS ORR: On the changes to the births, deaths and marriages act, have you seen any outcomes, positive or otherwise, associated with lowering the age for independent applications to change the registered sex or name from 16 to 14 years old?

Ms Cheyne: This has been welcomed by young people and advocates. Certainly, I have had some very good feedback as recently as last week. This is about changing a sex marker in the register, and on a young person's birth certificate. It is not about authorising medical or other treatment. It does support young transgender and gender diverse people. It is fair to say that they do face many challenges, particularly if they do not have parental support in relation to their gender identity. For many of us, having access to identification documents that accurately reflect your gender identity helps generally; also, for young people, particularly, it is about things like seeking casual employment or participating in extracurricular activities. It is currently possible for young people under 16—or under 14; I forget.

MS ORR: Under 16, but not less than 14?

Ms Cheyne: Yes; that is right. We have lowered the age to 14. It is in recognition of the age at which we assume people have cognitive function and are able to be clear about their identity.

MS ORR: I believe the clinical treatment requirements were removed for a person wanting to change their registered sex. Have you had any feedback on how the removal of that provision has or has not supported people seeking to access their rights under this legislation?

Ms Davidson: Not in the short term, Ms Orr, but I think this was a really critical amendment. It was brought by Miss Nuttall, having worked closely with my office. The ACT was the first jurisdiction to remove the requirement for a person to have invasive or risky surgery before they could change their registered sex. The clinical treatment required now can include things like counselling rather than any surgery or medical treatment. While that was an important change to protect the human rights of the transgender community, we heard repeatedly that it can still be a barrier for people to find a doctor or a psychologist with relevant expertise in gender-affirming care. We have heard that that is where there are costs both in time and financially, and that can

prevent people from changing their registered sex.

So there is also now some more understanding that gender identity is not necessarily a medical issue that requires treatment, but is actually about something that is deeply personal, and someone's innate knowledge of their own gender. That is why we were proud to work with Miss Nuttall on those amendments, to support them and to have them pass.

MS CASTLEY: I have a question on birth certificates and adoption. Is this the forum?

Ms Davidson: You can ask it here. It straddles me and Minister Stephen-Smith. I know what issue you are talking about.

MS CASTLEY: It is about parents on the birth certificate being removed at adoption. Is that correct? Is that what is happening?

Ms McKinnon: Back in 2020 we passed amendments that allowed for integrated birth certificates, which was a certificate that provided details of both the birth parent of an adopted child and their adoptive parents on a single certificate. Until that time, once a child was adopted, they were issued a birth certificate that had only the adoptive parent's details and kind of erased the history of their birth parents. We have introduced a reform that allowed a child, when they turned 18, to seek that certificate independently or, where they have the consent of both the birth parents and the adoptive parents, to have an integrated birth certificate before that time.

But I think the issue you are averting to is that at the moment we do have that requirement that a birth parent needs to consent to their information appearing on that certificate. That reflects requirements that are currently in the Adoption Act. That is an area where Minister Stephen-Smith may have further discussions around that issue.

MS CASTLEY: Does that include siblings? Are there siblings on the birth certificate as well?

Ms McKinnon: There can be, yes.

MS CASTLEY: Do you have to wait until you are 18 to make that change?

Mr McKinnon: It would not normally change the sibling details, just the parent's details.

MS CASTLEY: Okay. My understanding was that, if the siblings are like half-siblings, for instance, they are not on the birth certificate. Is that correct?

Ms McKinnon: Can I take that one on notice? It might be good to find out a little bit more about that detail.

MS CASTLEY: Yes; thank you. Minister, could you give me an overview of what Ms Turnbull-Roberts has achieved since her appointment as Aboriginal and Torres Strait Islander Children and Young People Commissioner in February this year?

Ms Cheyne: As you noted, Ms Turnbull-Roberts was appointed in February this year. Under the act, she is required to produce an annual statement on her activities, and I can detail what is within the act and what relevant section that is. Obviously she has not been in that role to a point where an annual statement would be produced. I do know that she has been undertaking meetings across community. To the extent that there is detail about her achievements, I understand that she is appearing next Friday and she can speak to those.

MS CASTLEY: Did you say there was a list of expectations in the act?

Ms Cheyne: Yes. Section 12 says:

> (1) The commissioner must, for each year, prepare a statement (an annual statement) about the operation of the commissioner's office during the year, including—
>
> (a) the number and kinds of advocacy matters the commissioner's office engaged in during the year; and
>
> (b) a summary of the inquiries the commissioner conducted during the year; and
>
> (c) a summary of the activities of any advisory committee assisting the commissioner during the year; and
>
> (d) a summary of the community engagement undertaken by the commissioner's office during the year; and
>
> (e) anything else the commissioner considers appropriate; and
>
> (f) anything else prescribed by regulation.

MS CASTLEY: I look forward to the report. All I really know is that, back in 2023, she stated that she is a big advocate for de-funding of communities and justice departments—I believe that may have been in New South Wales—in order to address over-representation of Indigenous children in out-of-home care. Have you heard much about that, and do you agree with her approach?

Ms Cheyne: I have not seen that comment, Ms Castley, and I am not sure if you are quoting directly or if it is within a broader context. So I might reserve my right to comment on it, if that is all right.

MS CASTLEY: Okay. I might follow up with her. It would be good to know.

Ms Cheyne: I think that would be appropriate.

MS CASTLEY: I have a bit of concern about de-funding government things, but we will let that go.

Ms Cheyne: I would note that, as a commissioner, she is not the Treasurer. So, in terms of her ability to fund or de-fund other functions of government, it is not her.

MS CASTLEY: I completely understand that but, given her role in the government,

I am just wondering if it is at all a concern that there have been statements made and what your thoughts are about that. But, if she is willing to appear, I can ask her.

MR CAIN: Minister, I know you touched on this a little bit earlier, but could you give us an update on the process of opening up a human rights complaint pathway to the ACAT as anticipated under the Human Rights (Complaints) Legislation Amendment Bill 2023 last year?

Ms Cheyne: As I have stated repeatedly, it is something that we intend to explore in the next term of government.

MR CAIN: What is the time table on that? Any steps? Any community consultation, for example, with Civil Liberties Australia or any other civil rights groups?

Ms Cheyne: That is a matter for the incoming government.

MR CAIN: So there is nothing extra happening in the remaining part of this term of government?

Ms Cheyne: No; there are 50 days until caretaker.

MR CAIN: So there is nothing happening within now and caretaker mode?

Ms Cheyne: The complaints mechanism began on 11 June and there are now 50 days until caretaker.

MR CAIN: So is that a no; there is nothing further happening?

Ms Cheyne: No, but I do meet regularly with Civil Liberties Australia. We continue to have those conversations and I appreciate their representation.

MR CAIN: So there are conversations ongoing?

Ms Cheyne: When I meet with them, yes, but this is not a consultation.

MR CAIN: How frequently do you meet with Civil Liberties Australia and other similar civil rights groups?

Ms Cheyne: It would depend. Certainly I have an ongoing dialogue with Civil Liberties Australia. I believe I met with them at the beginning of this year. If that is incorrect, I will correct the record.

MR CAIN: And no further consultations with civil liberties groups?

Ms Cheyne: I would not undertake any consultation, Mr Cain.

MR CAIN: Or stakeholder engagement?

Ms Cheyne: No, because that is something that will be pursued in the next term of government.

MR CAIN: Nothing since the beginning of the year?

THE CHAIR: I think that is asked and answered.

MS ORR: Minister, you noted that it is something for the next term of government because there is 50 days to caretaker. Can you just give me a quick understanding of why you would not be able to do something in 50 days of a policy changing or legislative changing nature?

Ms Cheyne: On a very broad scale, I would say that we have always been clear that that this would be something that we would pursue after the complaints mechanism had been in operation for a period of time. I think a period of time of a month and a half is not really what we had intended. We had always said that it would be in the next term of government that we would be pursuing that, and I had said that publicly and committed to that.

On a very practical level, this is something that requires consultation. We would need to understand the workload of the Human Rights Commission with the new complaints mechanism. As I said, the data that we have so far is just six complaints. We need to get more months of data—and potentially years or data—to understand what the modelling will look like. That helps us determine the policy position regarding the approach to ACAT, the mechanism to ACAT and also, critically, what funding would be required for them as well as what funding would be required for the Human Rights Commission.

MR CAIN: Minister, I frequently receive correspondence from constituents who are victims of crime or related parties and in need of support. As you would know, I have written to you on behalf of some of these to advocate on their behalf and because many of them claim to have not received appropriate support from your office. Minister, can you please outline your office's standard operating procedures for handling constituent matters involving a victim of crime?

Ms Cheyne: If a victim of crime has concerns around access or wish to have access or need support?

MR CAIN: About dealing with government or government process.

Ms Cheyne: We would refer that to Victim Support ACT.

MR CAIN: Where it might involve the directorate, as opposed to the Victims of Crime Commissioner, what is your standard operating approach?

Ms Cheyne: It is very difficult for me to answer that, because I cannot picture what you might be referring to.

MR CAIN: How frequently do you meet with the Victims of Crime Commissioner, or Ms Rowe in her current role, or the commission to discuss matters that come to your attention?

Ms Cheyne: We meet quarterly, at least, as well as having contact from time to time if there are matters arising.

MR CAIN: What is the general nature of these discussions? Have you worked through relevant matters involving victims of crime that have contacted or been raised with your office as an initial point?

Ms Cheyne: We would not wait for a quarterly meeting; we would be referring them as a matter of priority.

MR CAIN: What are some of the standing items for your discussions at these quarterly meetings?

Ms Cheyne: We do not have a standing agenda. The commission would provide me with the areas that they wish to discuss and, if there is anything I also wish to discuss, it is decided between us before we meet.

MR CAIN: What is the average time your office takes between receiving a representation from a victim of crime or from an MLA on behalf of a victim and then responding to them?

Ms Cheyne: That is not data that is kept.

MR CAIN: You do not keep track of how long you take to respond to a constituent inquiry?

Ms Cheyne: No.

MR CAIN: That is very surprising.

Ms Cheyne: We receive hundreds and hundreds a day.

MR CAIN: So you do not have a target in which you expect to respond to a constituent inquiry—for example, 80 per cent of the time in a certain period and all of them within another period?

Ms Cheyne: I would be very surprised if I met any MLA who is tracking themselves against a target, Mr Cain.

MR CAIN: I am asking if you have such a process, Minister?

Ms Cheyne: No, I do not. We try to respond to everyone as quickly as possible. As I would expect, all offices do, we triage matters and we escalate them from receipt to me or to my chief of staff or to a senior adviser to determine whether a matter is a priority issue or requires a particular level of interest, focus or referral.

MR CAIN: Minister, I am very surprised to hear your answer. From a customer service delivery point of view, customer service 101 would be, "We will meet constituent correspondence within a certain period in X per cent of the cases and all within a certain extended period." So you have no targets for responding to constituent queries in terms

of delivering a response to them?

Ms Cheyne: Mr Cain, I have a variety of portfolios as well as—

MR CAIN: No; we are here for this portfolio.

THE CHAIR: Do not interrupt while the minister is answering, please.

Ms Cheyne: Thank you, Chair. I have a variety of portfolios and I am also the member for Ginninderra. I do attempt to respond to all correspondence as quickly as possible in the most helpful way that we can.

MR CAIN: What priority do you give to vulnerable victims of crime inquiries?

Ms Cheyne: It would depend on the nature of it. But, on face value, I would say an extremely high priority.

MS ORR: Minister, I think it is fair to say that it is not unusual for MLAs—and you have probably experienced this yourself—to receive inquiries from constituents on a range of matters, including difficulties they might be having in approaching the bureaucracy or navigating bureaucracy. In the circumstance that Mr Cain has just given, where someone comes forward and says, "I am having trouble dealing with a victim of crime issue. It might be going to the commissioner or it might be going to the directorate. Can I please have some assistance?" what is the best process for us as MLAs to follow in interacting with your office to raise that issue?

Ms Cheyne: The Victims of Crime Commissioner and Victim Support ACT exist to support victims of crime. Referrals can be made to them or through us to them. I would say that it can be difficult sometimes for privacy reasons for us to be able to report back in a fulsome way. But there is no issue and I believe no barrier in the communications stream.

MS ORR: I would like to talk about the changes to the Discrimination Act, please. Can you remind me when these are due to take effect?

Ms Cheyne: That is a good question. Some have already taken effect—the vast majority—and then the positive duty provisions regarding sexual harassment commence in 2025. We also have a positive duty regarding reasonable adjustments for someone who has a projected attribute, and that commenced in April, if I recall correctly.

Ms McKinnon: Do you want me to just add to that?

Ms Cheyne: I would love that.

Ms McKinnon: Thanks, Minister. Most of the amendments, including amendments in relation to narrowing and more targeting exceptions, expanding areas of public life, and that positive duty in relation to protected attributes, came into effect on 11 April this year. There has been a further positive duty that requires agencies to take reasonable,

practicable steps and proportionate steps to eliminate discrimination, sexual harassment and vilification as far as practicable. That duty will come into effect for government agencies next year, on 11 April. Then, on 11 April 2027, that applies then to non-government agencies. So it has been staggered.

MS ORR: Is that the one where they have to prepare an inclusion plan? Have I got that right or am I mixing up matters?

Ms McKinnon: It is around showing that you are taking positive steps to do what is needed in the organisation to eliminate discrimination. It is an obligation that is scaled according to the nature of the agency and the resources of the agency. It would really depend on the particular organisation as to where discrimination could occur and the positive steps they may take to address that.

MS ORR: That one is in April next year?

Ms McKinnon: In April next year for government.

MS ORR: This might not be a question for you, because it probably cuts across all of government, but what sorts of steps are you looking at in responding to and meeting that obligation when it comes into effect, or what would you recommend?

Ms McKinnon: At the moment, the Justice and Community Safety Directorate and the ACT Human Rights Commission are working together with agencies to educate them about that obligation coming into effect. We have established a human rights community of practice that meets pretty much monthly. We have a whole range of officers from directorates across government and we talk about what that positive duty will mean for them, the steps they can take, how they might review their policies and procedures to identify areas where discrimination may occur, and the steps they can take in a really practical and positive way to predict and eliminate that. So, rather than waiting for complaints to come and then dealing with them on a case-by-case basis, this is about looking proactively at where discrimination could occur. It often focuses on inclusion and working out areas where your employment may not reflect the diversity of the community and how you can target your practices so it is more welcoming and accessible to a broader range of people. That is certainly something we are working on really actively with directorates to understand the steps they will need to take.

MS ORR: Great. Thank you.

THE CHAIR: Miss Nuttall, do you have a substantive question?

MISS NUTTALL: I do. Obviously, we have had a Human Rights Act in the ACT for 20 years. Do you believe there are human rights that should be included in the act that currently are not? Perhaps human rights law and practice has evolved since 2004.

Ms Cheyne: Yes, Miss Nuttall. I can say that we have evolved with it. Additional rights have been included, such as the right to work and the right to education. Perhaps at the end of this question, Mr Ng can respond to the question we took on notice, if that pleases the committee. There is the right to a healthy environment, should it pass before this term of government ends. In terms of future rights to be included in the Human Rights

Act, we are aware of social rights, economic rights and cultural rights. We are certainly aware of the Human Right Commission's view about expansion of those rights, but those matters are for the decision of a future government. Ms Lawder, perhaps we can respond to that question—

Mr Ng: Madam Chair, I took a question on notice from Mr Cain earlier in relation to the legislation which introduced the right to education. I can provide some further details about that to obviate the need to take that question on notice, if that is all right. The right to education was introduced in the Human Rights Amendment Act 2012, and that was introduced without the imposition of an obligation on public authorities. Following review and consideration by government, the restriction on the applicability of public authority obligations was removed in an amendment act in 2016.

THE CHAIR: Thank you.

MR CAIN: Have there been no other restricted appeal rights with a new human right introduced?

Mr Ng: No, Mr Cain.

MR CAIN: The minister is relying on a decision in 2012 to justify a decision over 10 years later to not allow for a new human right. It does not seem very relevant.

Ms Cheyne: Mr Cain, I was referring both specifically and broadly—specifically to this element as it relates to human rights and the Human Rights Act, and broadly that the government often has provisions that commence or are subject—

MR CAIN: Could you speak up, please, Minister? It is hard to hear you.

Ms Cheyne: I am sorry. I am doing my best. It is completely not unusual for the ACT government, in legislation, bills or whatever it might be, to have sunset clauses, to review clauses or have commencement dates that are in the future. That is what I was referring to broadly. This is not something that is strange or anomalous whenever it comes to legislative drafting or policy consideration.

MR CAIN: But it is in the human rights context when the last example was over a decade ago.

Ms Cheyne: I will take that as a comment.

THE CHAIR: A supplementary, Ms Orr.

MS ORR: Minister, help me out here. Picking up on Mr Cain's line of inquiry, it seems to me that one example that has been changed goes quite far back. I have been here for two terms and I do not remember a lot of changes to the Human Rights Act—the addition of clauses and rights in the Human Rights Act. I want to confirm: it is not something that happens a lot and there are not a lot of other precedents that would suddenly make this one example unique or contrary to normal practice.

Ms Cheyne: That is right, Ms Orr. What I said to Miss Nuttall is also true: our Human

Rights Act has evolved and we have included more rights as time has gone on. Human rights, of course, is not just limited to the Human Rights Act; they are also in our Discrimination Act and our policy on that; surrogacy; births, deaths and marriages, as you have heard; and voluntary assisted dying. So, in terms of overall reform, I would say that this term of parliament has been most ambitious and has achieved a significant amount, largely thanks to a very small team of people who have progressed this work. But, as a matter of course, in terms of adding a new right to the Human Rights Act, I believe it has happened three or four times in the last 20 years.

MS ORR: Thanks for that.

THE CHAIR: Ms Orr has a supplementary to Miss Nuttall's question.

MS ORR: Yes, if I can remember it. It has suddenly gone out of my mind. Sorry. We went off on too many tangents and I lost my train of thought. If it comes back to me, I will let you know.

THE CHAIR: Mr Cain, do you have a substantive question?

MR CAIN: Indeed, I do. Thank you, Chair. In table 24, on page 29 of budget statements D, it states that $205,000 has been allocated to investing in the Human Rights Commission, with a further $209,000 estimated for the next financial year, $185,000 for 2026-27, and $192,000 for 2027-28. Could you please outline what this funding is allocated for.

Ms Cheyne: I will check, Mr Cain. Again, what page is it on?

MR CAIN: Page 29 of budget statements D, towards the bottom of table 24.

Ms Cheyne: Thank you. One moment, please.

MR CAIN: Perhaps one of your officials can explain.

Mr Ng: Mr Cain, could I clarify: did you refer to the budget policy decision to invest in the Human Rights Commission, which has a figure of 205 for 2024-25?

MR CAIN: Correct. That is the line.

Ms Cheyne: Mr Cain, this is funding for ICT and whole-of-commission information management systems within the Human Rights Commission to support the delivery of their expanded functions commencing this year.

MR CAIN: Okay. Given the usual costs of ICT projects, it seems a rather small amount. Could you expand a little bit more on what is actually happening?

Ms Cheyne: Mr Cain, the bulk of it is for ICT licensing fees.

MR CAIN: I am sorry; I cannot hear you, Minister. Could you speak up?

Ms Cheyne: It is for ICT and licensing fees, as well as a component delivered by

Digital, Data and Technology Solutions, DDTS. There is also a portion for complaint related deliverables to support the Human Rights Commission to implement the new complaints jurisdictions, including the national code for health workers, which commenced in January, the child safe standards, which commence in August, to promote the rights of Canberra community members and responsibilities of service providers to better protect the safety and inclusion of ACT community members.

MR CAIN: Is any of that expenditure related to the evolving PCHRM software update?

Ms Cheyne: I do not believe so.

MR CAIN: None of it is related to the failed HRIMS projects?

Mr Glenn: No, Mr Cain. The system being funded by this measure is called Resolve, which is a complaints and case management system that is used by the Human Rights Commission, the Ombudsman, and those sorts of oversight bodies quite commonly across the country. This instance of Resolve was first implemented in the Human Rights Commission in 2020. This measure is about its whole-of-life ongoing costs, plus a small additional investment to be able to deal with some of the changing jurisdictions of the commission.

MR CAIN: Are you aware of Resolve or a similar approach being used elsewhere in other jurisdictions?

Mr Glenn: Yes. It is used quite commonly in similar organisations and in the context of the Ombudsman.

MR CAIN: In New South Wales? Where else is it used? Could you take that on notice? I am interested in this package.

Mr Glenn: As I said, it is used in the office of the Commonwealth Ombudsman. From direct experience, I know it has been used across the ombudsman community in most jurisdictions. I do not know whether it is used by other Human Rights Commissions, but I know it is common across states and territories as a case management and complaints management system.

MR CAIN: Could you take on notice whether it is being used by other Human Rights Commissions?

Ms Cheyne: I am not really sure that is within our jurisdiction, Mr Cain. That is probably a question for the private company.

THE CHAIR: Are there any further questions on that?

MR CAIN: Just to follow up on the minister's comment and refusal to answer. You are obviously applying this to a human rights environment. Are there any other Human Rights Commissions using this approach?

Mr Glenn: Mr Cain, the answer is: I do not know. I have told you the places where I know it is being used. It is a case management system. The context in which we are

using it here is in the Human Rights Commission. I understand the commission is quite happy with it and I am sure they would be happy to talk to you about it more when they appear.

MR CAIN: Can you take on notice whether other Human Rights Commission offices—

THE CHAIR: Mr Cain, you have asked. I do not think it is the minister's responsibility to answer what other jurisdictions do.

MR CAIN: As part of their research, so perhaps—

THE CHAIR: We have already heard it is in others. I have made a decision.

MR CAIN: Thank you.

Mr Glenn: Thank you, Chair.

THE CHAIR: Unless there are any other burning questions, we will finish because we started a few minutes earlier. Does anyone have a very, very brief question for the next two minutes?

MR CAIN: Yes; I do.

THE CHAIR: Miss Nuttall? Ms Orr?

MS ORR: I do, but I am happy for Miss Nuttall to have her question, if she would like.

THE CHAIR: You have two minutes.

MISS NUTTALL: It may not be for this session. Would we talk about the registry-style weddings during this session or is that best suited—

Ms Cheyne: No. That is Access Canberra.

MISS NUTTALL: Sweet. Done.

Ms Cheyne: You can talk about it next week.

THE CHAIR: That was a nice short question. Ms Orr, do you have a short question?

MS ORR: Yes. How is the implementation of the Voluntary Assisted Dying Bill going?

Ms Cheyne: Minister Stephen-Smith can answer that.

MS ORR: Okay.

Ms Cheyne: We received a brief report a few days ago from ACT Health and it is progressing at pace.

THE CHAIR: Do you have a very short question, Mr Cain?

MR CAIN: Yes. It is about budget papers. It is a quick one. In table 25, on page 32 of the same budget statement, there is an estimated outcome of $7.6 million to "Improving equity in the justice system—Continued support for victims of crime". It is at the bottom of that table. There does not appear to be any further funding devoted to this measure. Can you explain what that expenditure is for and why it is not something that was forecast going forward?

Ms Cheyne: On what page, Mr Cain?

MR CAIN: Page 32 of budget statement D, in table 25.

Ms Cheyne: Mr Cain, this is to cover the increase in demand for access to the Victims of Crime Financial Assistance Scheme. There has been an 86 per cent increase in applications compared to the previous year, 2022-23. We also made an additional investment at that time. In the previous financial year, 2023-24, application numbers and victim payments remained high, with approximately 70 per cent of all applications relating to family violence and/or sexual assaults. This was about managing the scheme's cost pressures and ensuring that timely payments can be made to eligible victims of crime.

MR CAIN: So you are anticipating that—

THE CHAIR: No—that was your one question. Sorry; we are done.

Ms Cheyne: Thank you, Chair.

THE CHAIR: I thank witnesses for their attendance today. If you have taken any questions on notice, please provide your answers to the committee secretary within three business days of receiving the uncorrected proof *Hansard*.

Short suspension.

Barr, Mr Andrew, Chief Minister, Treasurer, Minister for Climate Action, Minister for Trade, Investment and Economic Development and Minister for Tourism

Chief Minister, Treasury and Economic Development Directorate
Arthy, Ms Kareena, Deputy-Director General, Economic Development
Starick, Ms Kate, Executive Group Manager, Policy and Strategy, Economic Development
Bailey, Mr Daniel, Executive Group Manager, Operations, Economic Development
Kobus, Mr Jonathan, Executive Branch Manager, VisitCanberra, Economic Development
Triffitt, Mr Ross, Executive Branch Manager, Events ACT, Economic Development
Elkins, Mr Matthew, Executive Branch Manager, Venues Canberra, Economic Development

THE CHAIR: We now welcome Chief Minister Andrew Barr, in his capacity as Minister for Trade, Investment and Economic Development and Minister for Tourism, and officials. We have a number of witnesses for this session. I remind witnesses of the protections and obligations afforded by parliamentary privilege and draw your attention to the privilege statement. Witnesses must tell the truth. Giving false or misleading evidence will be treated as a serious matter and may be considered contempt of the Assembly. Would you please confirm that you understand the implications of the statement and you agree to comply with it.

Mr Bailey: I have read and acknowledge the statement.

Ms Starick: I have read and understand the privilege statement.

Ms Arthy: I have read and understood the privilege statement.

Mr Kobus: I have read and understand the privilege statement.

THE CHAIR: Thank you. On behalf of the committee, I would like to thank you for coming along today and for being very prompt. Not everyone has shown the same courtesy today. I am going to start with a question about tourism. Chief Minister, in this budget you have allocated $10 million to progress planning, feasibility and preliminary design works for entertainment events, sporting and tourism infrastructure projects.

Funding may include a new convention centre, an entertainment pavilion in the entertainment centre precinct, the Bruce sports, health and education precinct, EPIC stage 2 redevelopment, Canberra Aquatic Centre, a reopened Telstra Tower and a new Manuka Oval eastern grandstand.

For many of these projects, this is significant funding that you have provided in the budget. The 2023-24 budget review contained $1.9 million in funding for the government to undertake further planning and project development works, including the convention centre precinct and the Bruce sports, health and education precinct. This built on budget measures in the 2022-23 budget review for strategic infrastructure planning work, $2.2 million, which was for a new stadium and convention centre. Treasurer, is the $10 million in this budget an additional amount to those other studies or has the previous funding been rolled over into this latest budget announcement?

Mr Barr: It is predominantly new funding, some of which would be drawn from some provisions and some small rollover amounts from the midyear, as in from February this year, continuing through calendar year 2024.

MS LEE: And how much?

Mr Barr: It is in the table. There is an offset of 1.855 on page 108 of the 2024-25 budget outlook.

THE CHAIR: Thank you. You have already commenced feasibility studies for the stadium at Bruce and the convention centre. Do you know how much each of those will cost?

Mr Barr: Yes. In terms of the work that we have funded or the total project cost for each of the—

THE CHAIR: Firstly, the feasibility study and, secondly, the projects themselves.

Mr Barr: The amounts that are funded in this year's budget, plus the previous amounts, will cover the work up to a certain point. We will then get further advice from the directorate on what further appropriations may be necessary. As a rule of thumb, 10 to 15 per cent of an infrastructure project's total cost is in all of the preliminaries to get something shovel ready. It will then depend on the prevailing market conditions and the type of infrastructure asset as to what a final project cost will be. A couple of these projects are very significant ones that would be in the hundreds of millions, if not low billions, of dollars.

THE CHAIR: For the stadium at Bruce and the convention centre, individually, when might construction start?

Mr Barr: The stadium project is one for the second half of this decade and early into the 2030s. I do not have a construction commencement date at this point. That would be subject to the further work that is being funded at the moment. In relation to convention facilities, the first step there is the relocation of the Civic pool. Nothing can happen on that site until the new Civic pool is built and operational. We would keep the existing Civic pool open until that point.

MS LEE: On the relocation of the Civic pool, can you tell us where that is up to and what sites have been scouted?

Mr Barr: The preferred site is in Commonwealth Park and is part of work that we have been undertaking with the National Capital Authority.

MS LEE: In terms of time frames?

Mr Barr: It is in the hands of the National Capital Authority to finalise their consultation. They have been undertaking a draft master plan consultation over the last little while. They will complete that work and make it public. That is a matter for the NCA and the territories minister, but it is well known that they are doing that work

because there has been public consultation on it. I also note the recommendations of the Joint Standing Committee on the National Capital and External Territories that referred specifically to Commonwealth Park as a preferred site for a new city pool.

MS LEE: You mentioned in your answer to the chair's question the relocation of Civic pool having to be done first, before the convention centre. Are you going to have to wait until the Civic pool relocation has been completed—that is, up and running and open—before a convention centre gets started?

Mr Barr: Yes. We need to have continued operation of the Civic pool, so we cannot decommission the existing one until a new one is operational. At that point, that site would become available for the convention and entertainment precinct that we have announced.

MS LEE: It is fair to say, then, that there is no time frame or even an estimated one in relation to the construction of a convention centre?

Mr Barr: We will have something further to say on that the moment the National Capital Authority releases its master plan.

MS LEE: In terms of the stadium aspect, you announced, I think this year, that you are now going to Bruce. That is something that you have determined. Previously, I think you have explored the Civic pool site. Can you please explain to the committee, for the record, the reasons why that was ruled out?

Mr Barr: It is not feasible for a number of reasons. I will refer you to the previous time this question was asked in estimates. We will provide a further written answer just to confirm what was previously said.

THE CHAIR: To complete our record? Thank you.

Mr Barr: Indeed, but I have already answered that question in this forum several times.

MS LEE: Was Turner parklands location one of the ones that was spruiked or looked at in the city?

MR BARR: I have heard that speculated by the *Canberra Times*, as in the land that is owned by the Australian National University near Sullivans Creek. Yes, I have heard that. That is a flood zone and so is unlikely to be a suitable location. That is owned by the ANU, not by the ACT government.

MS LEE: Is Southwell Park a similar sort of situation?

Mr Barr: Southwell Park is owned by the territory government, but it is a well-utilised community sporting facility at the moment.

MS ORR: Does it also have some flooding issues?

Mr Barr: It does, but there were some treatment works undertaken there to underground some of the concrete stormwater in part of that precinct. It is home to the

netball centre, the tennis centre, the hockey centre and a number of sports fields that are heavily utilised by the community.

MS LEE: Some of the other sites around the city that have been floated in public discussions have been Commonwealth Park and also the New Acton area. Why were those ruled out?

Mr Barr: I do not think there is sufficient land in New Acton for a stadium. Commonwealth Park is owned by the commonwealth, so it is not ours to build a stadium on.

MS LEE: They were not considered for those reasons; there were no feasibility studies or anything?

Mr Barr: The city to the lake precinct work that was undertaken in the period 2013-15 did look at possible sites but identified some of the challenges associated with any of the available land. Even the proposal that was put forward there was a three-sided stadium; it did not have any stands on the southern side because they did not fit on the pool side.

MS LEE: And nothing has been done since then?

Mr Barr: In relation to Civic sites, there was a further study to determine the feasibility of Civic pool looking at a number of different configurations on that site.

MS LEE: Yes. I remember.

Mr Barr: That was the one that found it was not feasible. It is not for want of trying to make it feasible, but it just is not, so we have had to look at alternative sites.

MS LEE: Thank you.

MS ORR: Chief Minister, Fitzroy Pavilion: how is this eagerly anticipated refurbishment progressing?

Mr Barr: It is progressing. There was the issue of the preferred contractor going into liquidation, I believe, or at least being wound down. We were able to procure a new contractor. Mr Elkins can talk about the progress on that project.

Mr Elkins: Thank you, Chief Minister. I have read and acknowledge the privilege statement. We had a contractor on board who went into administration. That contractor has been replaced. I was lucky enough to be out there just yesterday; works are progressing really well. Even with the delay, the contractor is still confident about the program; that is end of August, start of September. Anyone who has done a renovation would know that there are always little things that pop up, but they have been able to manage that through the program. So it has been quite a successful transition between the two.

The Fitzroy building has also been a really good engagement point across Venues Canberra and the multicultural community. We have seen a lot of opportunity, not just

with Fitzroy but across EPIC to engage with the multicultural community to ensure that we have a suite of venues that the community can use. The community has been really successful in accessing them over the last 12 months.

MS ORR: Can you run us through some of the engagement you have had with the multicultural community and the takeaways from that, and how you might incorporate that into future thinking around the EPIC facility?

Mr Elkins: Yes. We have done multiple workshops and multiple engagements. We ran a meet and greet at the end of last year at the Fitzroy building, with a presentation on what we were planning to do in the Fitzroy building. Some of the really good feedback we took on board was understanding not just what Fitzroy was but what Exhibition Park could offer and how we could take that to the community in a way that was clear and concise so that we could make sure that it was available to everyone to understand. We have had really great take-up on that.

I think in the last 12 months we have booked around 15 multicultural events at Exhibition Park. The real benefit of that has been the choice. Fitzroy is a big building—1,000 people. Generally, a bigger building is a little bit more expensive, but we are able to say, "We have a suite of buildings." We have lots of opportunity. We can right-size for the community to make sure that we can get people into the right venue at the right time. It has been really well received across a large group of the community.

MS ORR: Getting down into the detail of it, is it about making sure you have the right size of building for the event or are there some other things that you also have to do? One of the things that always come to me from the multicultural community is having kitchen facilities. Usually they like to have their own specialised food and culturally appropriate food to go with the event. Have those sorts of considerations also been factored into the Fitzroy refurbishment?

Mr Elkins: Yes. When we did the consultation around Fitzroy, one of the things that became really clear to us was how we developed kitchen facilities that were accessible to the community. Traditionally, Venues Canberra has industrial kitchens for our caterers. But how do we make sure that they are accessible, that they are designed in such a way that meets the community's needs but are really functional and feasible? We took a lot of feedback on that and that has been fed into the Fitzroy design.

MS ORR: Have there been any other features adapted in the refurbishment that have come about as a direct result of the feedback from the multicultural community?

Mr Elkins: Yes. A lot of things we considered were access to the building; the look and feel of the building; making sure that, as we went through the process, the requirements for furniture and fittings could be met; and we made sure that we had the right number of facilities, water closets, for people on site.

MISS NUTTALL: This is a bit of a lengthy one. I would like to refer you to a previous question on notice that my colleague Mr Braddock asked, No 1928. In that question he asked about an ACT Defence and Advanced Technology Manufacturing Symposium held at the ANU Research School of Physics. In your answer you mentioned that the ACT government contracted Sierra Rising Pty Ltd, its director being Dr Karen

Schilling, for the provision of defence industry support services.

If possible, I would like to table a printout of the website for Sierra Rising, sierrarising.com.au. Feel free to pass it down the table. It is fairly light on detail. For the benefit of the committee, the page that I am tabling is the whole website. The page has no links on it. It might also be worth noting that Sierra Rising's ASIC details appear to have been registered in 2022 to an address in Pialligo. On the surface of it, I am worried that the ACT government has engaged another systems thinker. What is your impression and why are we engaging the services of Dr Schilling?

THE CHAIR: Systems and complexity thinker.

Mr Barr: The question's commentary, if repeated outside this room, might be considered defamatory. I will let that go by. Ms Arthy may be able to provide some further information on the procurement process for defence industry support services.

Ms Arthy: Thank you, Chief Minister. As the Chief Minister said, we do contract services to support the government working with the defence industries, as you know, within the ACT. It is not just defence; it is advanced tech. It covers cyber, space, quantum and other advanced tech arrangements. Having a position in place that has contemporary knowledge of Defence—who the people are and how Defence procures, because they are probably the biggest customer for a lot of our businesses in the territory—is important. Having someone who knows that and knows how to connect people is really, really critical.

A number of people have been in that position over time, including Kate Lundy and Geoff Brown, who was a former Chief of Air Force. We select people who have that knowledge. It is a very, very important function because we do not have those connections. We see it as really successful. We run an open process when it comes to procuring those services, through a short-term expression of interest, and it goes through a cabinet process. We run an expression of interest. We are currently finalising the latest procurement as well.

MISS NUTTALL: Thank you. On the notifiable invoices register, for Sierra Rising I have been able to find an invoice for $28,875, dated 17 December, but cannot find anything on the notifiable contracts register. Do you mind me asking why that might be?

Ms Arthy: Can I take that one on notice? I can ask the team if they might be able to give me the answer prior to the conclusion of today. I just do not have that information on me.

MS CLAY: Can you advise the total value of the services or the contract?

Ms Arthy: I think we are talking about separate contracts here. If I understand Miss Nuttall, your question is around this particular conference and this particular symposium; is that correct?

MISS NUTTALL: Yes.

Ms Arthy: Ms Clay, is your question around the defence industry advisory service more broadly or just this contract?

MS CLAY: No, just the total value of the Sierra Rising contract or the invoices, however it is described.

Ms Arthy: Sure. I will come back to you on notice or by the end of this session.

MS CLAY: That would be great. Thank you.

MISS NUTTALL: Thank you.

MS LEE: I want to go back to some of the infrastructure spending. Following on from Ms Lawder's question about the $10 million—and I know that you have talked about the offset, obviously, from the previous feasibility—it talks about there being a preliminary design and it lists a number of projects: the Convention and Entertainment Centre Precinct; the new stadium at Bruce; EPIC stage 2 redevelopment; Canberra Aquatic Centre; Telstra Tower; and the Manuka Oval eastern grandstand. I have gone to the page that you helpfully referred me to, Mr Barr, and it has the $10 million. I just want to confirm that that is the $10 million that was announced by the federal government towards that.

Mr Barr: No.

MS LEE: It is an additional $10 million?

Mr Barr: No; it is a matching component.

MS LEE: So it is an additional $10 million.

Mr Barr: Yes.

MS LEE: Noting that that is for preliminary design and noting that in the 2026-27 year and the 2027-28 year there is no further budget allocated, what is the time frame and when can we expect more budget to be allocated to progress on those projects?

Mr Barr: They will vary, as obviously there are projects of different scale and on different time frames. But I would envisage, given there is funding for fiscal 2024-25 and 2025-26, that, unless there is a compelling reason for the directorate to come forward seeking additional funding, the next ask would be in fiscal 2026.

MS LEE: But that has not been allocated yet in the forward estimates?

Mr Barr: There are of course provisions within the forward capital works program for further works, but they are yet to be allocated against specific projects.

MS LEE: How much is in that budget?

Mr Barr: In the provisions for capital works?

MS LEE: Yes.

Mr Barr: I will get that page. Page 247 outlines central capital provisions of $1.826 billion over the next five years.

MS LEE: In terms of the projects that have been listed on page 108; there is nothing that is contained in the provisions as outlined on page 247?

Mr Barr: There are provisions for new capital works and then there are provisions against specific projects.

MS LEE: Sorry; just to clarify: I am talking 2026-27 and 2027-28.

Mr Barr: The provisions in 2026-27 are $412 million and $575 million in the central provisions. There are also allocations within the asset renewal program in those years of $119 million and $123 million. Depending on the project within the earlier list, there would be some elements of those programs that would be eligible for funding under the asset renewal program.

MS LEE: But it has not been allocated yet?

Mr Barr: That has not yet been allocated, no.

MS LEE: Thank you. In terms of federal funding partnerships for any or all of those projects, can you confirm whether you have formally requested funding partnerships with the federal government and, if so, whether you have submitted business cases?

Mr Barr: In relation to the Convention and Entertainment Centre Precinct, we will be submitting an application under the Urban Precincts Framework. It is a commonwealth government program that was announced in last year's federal budget. Applications have just opened. In relation to the Bruce Sports, Health, and Education Precinct, the commonwealth made a $10 million allocation in the federal budget. Money here plus our internal staffing resources will be allocated towards that partnership with the commonwealth.

On EPIC stage 2 redevelopment, there is obviously a team within Venues Canberra who are working on that. There may be some small further consultancies that will be led out of the $10 million. The Canberra Aquatic Centre—that is the new Civic pool—is a project that we are engaged on with the commonwealth and NCA in particular in relation to its location in Commonwealth Park. A reopened Telstra Tower is a partnership between the government and Telstra. Telstra are the ones who will provide the capital in relation to that particular project. The new Manuka Oval eastern grandstand is the design work towards that facility.

MS LEE: Aside from the convention centre and the entertainment centre, which you have confirmed that you are about to submit under the Urban Precincts Framework, and aside from the $10 million that has already been announced in the federal budget this year, for all the other projects, have you formally requested federal funding?

Mr Barr: We certainly have engaged with the commonwealth in relation to the Bruce

precinct. I have outlined to the commonwealth interest in exploring a partnership on Manuka. Telstra Tower is obviously with Telstra. The Canberra Aquatic Centre is a partnership, essentially, with the National Capital Authority.

MS LEE: Are you able to table any of those letters to the committee?

Mr Barr: Not at this point. They are both cabinet and intergovernmental sensitive at this point in time.

MS LEE: Are any business cases completed on any of those projects?

Mr Barr: Obviously, a lot of what is being funded here will go to the next stage of getting projects shovel ready. As to a business case, as you might describe it, there will be different processes that the commonwealth will require and different levels of submission for particular areas. You could describe the submissions into the urban precincts program as business cases. They are effectively that for the two streams of that particular program. Part of that is planning and precinct development; another are the actual works components within that program stream.

We are determined to proceed with many of the other ones. So it is not the case that a business case is necessary. They are projects that will need to be delivered. So there will be a project sketch plan, a development application and those sorts of works. But we are not making a determination on whether we will invest in these projects. They are not at feasibility level. A number of them are at the point where we are progressing a budget business case, as opposed to a speculative "Is this a feasible piece of work?"

MS LEE: In terms of the work that I suppose you have loosely said would be categorised as a business case for the urban precinct application, is that going to be made public?

Mr Barr: I believe the commonwealth may do that at some point in their assessment process. I suspect that they will list them at some point. As to whether they will be made public or not, I am not sure. It is their program. I do not think it would be useful for us to make them public ahead of commonwealth consideration. But, at the conclusion of that process, successful projects will undoubtedly be announced, and I presume there will be a level of detail at that point.

MS LEE: Sure; and the deadline?

Mr Barr: We will check the deadline for the first-round ones. It will be on the website. It only opened recently.

MS LEE: No worries. So you will get that information by the end of session?

Mr Barr: Yes, we will do our best. Someone can google it.

MS CLAY: Chief Minister, you have referred the redevelopment proposal by the horse racing industry to a committee made up of senior public servants and horse racing industry officials. There are a lot of ways that site could be repurposed. The draft Inner North and City District Strategy that was first circulated by government suggested two

options, including a redevelopment that had no racetrack on it. When the Canberra Racing Club consulted with the community back in 2021-22, they included residential and commercial uses alongside their racetrack, and they were only looking at developing their own site, block 9, section 69 line of the Thoroughbred Park site. Is the current proposal by Canberra Racing Club solely confined to Thoroughbred Park?

Mr Barr: I believe there are a couple of adjacent sites. Ms Arthy, who is chairing the government process, can provide some further information.

Ms Arthy: Thank you, Chief Minister, and thank you for your question. The scope of the proposal that we are looking at is the section that Canberra Thoroughbred Park is on, which we refer to as section 69. There is the Pony Club, which is next door, which is section 70. There are a couple of small areas across Randwick Road. If you go down there, it is a dirt car park, which is either 74 or 76. I think it is 76. In terms of the actual proposal that has been put forward, we are looking at what the options are for some form of partnership to certainly look at the land currently occupied by the Pony Club and Canberra Thoroughbred Park. We are also looking at what other complementary activities could happen on EPIC, noting that, as part of the work on EPIC, we are looking at how we move the main entrance down to the light rail stop. Given that there is going to be development on both sides of the light rail stop, we are looking at how they complement each other. We are also talking about moving the racing aspects of harness from EPIC into Canberra Thoroughbred Park.

So it is not necessarily bound by a geographic location. There are several aspects to this. We are looking very much around how the proposal that came to us was creating an equine precinct in the current footprint of Thoroughbred Park with housing, commercial and other complementary activities and potentially bringing in section 70 as well as parts of the bike or the car park and then looking at what parts of EPIC we can have as a complementary development.

MS CLAY: Has the Canberra Pony Club been advised that they might be evicted?

Ms Arthy: "Evicted" is probably not the right word.

MS CLAY: Redeveloped?

Ms Arthy: We have been talking with the Pony Club. We have met with them, and on Monday a few of us went out to the actual site to have a look. We have been very open with them about what the proposal is. We have talked to them about whether they want to be part of the redeveloped equine precinct, and they have come back with no; they are not, because there are not complementary activities. Now we are at the point of trying to understand what their needs are, how they use their site and whether there are options for another location. That is in the very, very early stages at the moment.

MS CLAY: The Canberra Racing Club is not a developer. Are you considering entering into a joint venture agreement with the Canberra Racing Club to develop the land?

Ms Arthy: The terms of reference for the group that I am chairing is to come back to government with advice about what options there might be—for example, what could

be the various forms of partnerships. The considerations of the group are not quite there yet. We expect to start that more detailed analysis very shortly. At the moment we are finalising scope—for example, with the harness racing, whether they are in or out—and we are looking at what the arrangements are for Pony Club. Once we have a few more things lined up, we will be getting into that more detailed analysis about the potential financial models for how this could be delivered.

MS CLAY: So not currently under consideration because it is too early?

Ms Arthy: We have been beginning discussions. But, in terms of being able to give you anything that is remotely considered, we are not there yet.

MS CLAY: The 2021 horse racing plan only had residential and commercial, and you have only mentioned residential and commercial so far. Does the proposal that your committee is considering have any community facilities? Does it have a school? Are there any other facilities in there for the people who might live there?

Ms Arthy: Again, for the work of my committee, which is very much about, "What are the options for how we can enter into an arrangement to do the planning for that?" is not within scope yet. At the moment, all we are looking at is, "Can we make a bigger partnership work?" The actual content about what happens on the land will be subject to further planning with whoever the partners may be—whether it is through their Suburban Land Agency in partnership with Canberra Racing or whatever the government decides the venture will be. That is when the more detailed planning will happen.

MS CLAY: We do not have the Education Directorate in that committee at the moment, though, and I noticed this week we had a headline run that "ACT schools are bursting at the seams", and Lyneham was one of the schools mentioned as the top seven already full, at capacity and in desperate need.

Mr Barr: That is not true.

MS CLAY: No? Please correct me.

Mr Barr: There is no school that is "bursting at the seams". I think there was one that was at its capacity. The other six in that list are at about 90 per cent. So they have got 10 per cent capacity.

MS CLAY: Thank you for the correction. I did say there was a headline this week that said, "ACT schools are bursting at the seams". I will do this next time, *airquotes*, so that you can see what I am quoting the media.

Mr Barr: The headline was incorrect.

MS CLAY: I quoted a media headline. I think there is concern about schools planning, particularly when we are putting a lot of housing in a new area. That is obviously not part of the consideration right now, is it?

Ms Arthy: That will be part of the next phase. It is not right now, but it will be part of

the next phase. This is not a simple exercise in terms of how to pull all the parties together. What actually occurs on that block will be part of the consultation that will happen once the decision has been made to proceed with some form of a joint venture or partnership.

MS CLAY: Is it likely to be a joint venture? You just said that we were too early in the process to decide.

Ms Arthy: I said "some kind of joint venture" without necessarily meaning an uppercase JV, joint venture. It is very much around how we proceed with a partnership arrangement.

MS CLAY: I am so sorry. This is a genuine question. Can you just start the sentence again?

Ms Arthy: This is around having a partnership with relevant parties, whether it is the Suburban Land Agency, Canberra Racing or whoever else might come in. I know that "joint venture" has a particular meaning, and I do not want to pre-empt any outcome. That is merely the point I was making. I did not want it to be implied that it was a joint venture—that is all.

MS CLAY: I am glad we clarified that. Is your committee considering any other plans? Noting that government has already circulated two versions in the draft district strategy, are you only looking at the Canberra Racing Club plans or are you looking at all options for the site?

Ms Arthy: The terms of reference for my committee is very much focused on the Canberra Racing proposal.

MS CLAY: I am interested in that. This is a publicly funded committee. Why is it only looking at an industry drafted plan and not even looking at the plan drafted by government earlier in the piece?

Mr Barr: In that draft there were two options. One was not preceded with in the district plan. The final decision was made that the district plan as presented to the Assembly finally is the one that has been enacted.

MS CLAY: And that decision was made earlier by?

Mr Barr: Cabinet.

MS CLAY: What are the next steps in this partnership project?

Ms Arthy: Where we are at the moment is working with all the different affected stakeholders, particularly harness and Pony Club. We are still doing a lot of intensive work with the Pony Club to see what options are there, because we really need to have an answer for that. Alongside that, we have looked at affordable housing requirements. We are working very closely with harness racing, and I think they are at the point of having nearly an agreed design with Canberra Racing in terms of the racing elements. Our next steps are going to be more about how we move to the next phase of the

partnership model and what some options might be, just so we have got some options ahead of sorting out Pony Club and harness. We are also still working with the Conservator around the sections across from Hendrick Road and also working with the NCA, because this comes under the NCA.

MS CLAY: I will just summarise here. I am going to check that I have all that information right. Please jump in at the end and correct anything that I have misattributed. So your steering committee is looking at the racing industry's plans and looking at Thoroughbred Park, the Canberra Pony Club site and also a car park site, and they are the only areas of land that you are currently looking at, and you are looking at a partnership model but no decisions have been taken on what that would be. Is that basically where we are up to?

Ms Arthy : That is basically right. The only thing that I would add is that, as I said, this is not just about the physical boundaries; it is also about some complementary development that can happen on EPIC as well. That is the other dimension.

MS CLAY: Just within the current existing footprint of EPIC, though?

Ms Arthy: Correct. What I am talking about there is, again, as I mentioned, if we have to redevelop near the light rail stop, it makes sense that we work together—so, for example, we do not put a hotel on one side and Canberra Thoroughbred Park put a hotel on the other side. So it is about things like that. That is what I am talking about. It is making sure that everything sort of works together.

MS CLAY: Thank you.

THE CHAIR: I have some questions about tourism advertising and strategy. I can see $5.6 million in the budget to grow the visitor economy, including funding to increase domestic and international tourism, support for major events and tourist venues, continuing the Aviation Stimulus Fund, funding activities and partnerships in international markets to promote the territory, and funding for Brand Canberra. It does seem like a relatively small amount of funding that is going to a lot of different areas. Can you provide a bit more of a detailed breakdown of how the funding will be spent?

Mr Barr: Sure. That is not the totality of the budget for these areas; that is new initiatives in this budget—just to address that potential misconception of what the budget initiative is.

THE CHAIR: That is why you are the Treasurer.

Mr Barr: Thank you, Ms Lawder. I will invite Mr Kobus to talk about the new initiatives.

Mr Kobus: Thank you, Chief Minister. From a tourism perspective, the budget makes a number of commitments. They are commitments that will support a range of other initiatives that would be undelivered with the existing tourism budget. The initiatives, as you outlined, include, for the 2024-25 financial year, a million dollars for the aviation fund, which goes to support a whole range of aviation programs that we have with both domestic and international carriers. That funding essentially supports route

development and more specifically supports our activities with airlines to leverage their distribution systems through a range of marketing programs to drive demand in to Canberra, so that we benefit from the patronage coming in, as well as supporting opportunities for the community to use our services.

The budget also provides ongoing funding support to continue our in-market representation in Singapore. At the moment we have a full-time person based in Singapore who represents our tourism interests in the Singapore market, India and a number of other South-East Asian markets. We will be going out to renew that process.

THE CHAIR: How much was that one?

Mr Kobus: That is $160,000 a year over three years. We have $200,000 that will be utilised for retaining the investment that we have made in 2023-24 in India for some dedicated PR services so that we can communicate with the Indian media network, which is one of our fastest growing international markets. That has made a big difference in terms of getting messages about Canberra into the Indian market and telling stories about the city to help the Indian market to understand Canberra.

We will be expanding that in 2024-25 into the US market as well, as a primary opportunity to again raise awareness of Canberra as a place to visit, given our connections with Fiji Airways, connecting LA, San Francisco and Vancouver in Canada to the ACT.

We also have $150,000 set aside for content partnerships that help us to work with Tourism Australia. Essentially, from an international perspective, our approach is largely to leverage off the investment that Tourism Australia make, and partner with them where they are able to secure significant partnerships with other content providers, to get information into tracking markets. We have dollars set aside to capitalise on the efforts of Tourism Australia in markets such as India, the US and China.

Those dollars are in addition to a range of other programs that are funded to drive demand, essentially. Our tourism budget is invested in the things that we think will make the biggest difference to secure overnight visitation for the ACT. That can be spread across marketing campaign activity; equally, it can be spread across initiatives such as our Major Event Fund, investment in growing the value of business events through investment with the Canberra Convention Bureau, capitalising on the schools market with the National Capital Educational Tourism Project, and a range of other initiatives that we do across our domestic and international markets.

Having regard to the totality of all of that demand-driving investment, across both marketing and supporting other industry groups, and covering off all of those industry sectors for the 2024-25 financial year, it will be approximately $7.7 million that we will be investing in all of that activity.

MS LEE: In terms of any offsets, was there any money unspent last year?

Mr Kobus: From our Tourism Product Development Fund, there were funds that were re-profiled because the projects are still ongoing. For those projects that had contracts signed where the project is still to be implemented, some of those projects require

planning approvals, building approvals and those types of things, and the funding is brought over to this financial year.

Where we have grant programs—for example, with the Major Event Fund—on occasion there are events that do not neatly occur within the same financial year for which they are funded, so we need to wait until the event is acquitted before we pay the final amount of funding at the end.

MS LEE: Can you confirm how much that is, in total, that has been rolled over from previous years?

Mr Kobus: The re-profiled? I do not have the figure in front of me. I will have to take that on notice. I can certainly provide that.

MS LEE: Thank you. In terms of a comparison of money spent on tourism and events from the 2022-23 financial year, there was a forecast of a spend of $33.1 million in the previous budget, but you only ended up spending $30.3 million. You see again a forecast of $34.1 million, but an underspend, with an actual of $33 million, and now there is a forecast of an increase in spend of around $278,000 for 2024-25. Is there an explanation as to why there has been an underspend over the last couple of years?

Mr Kobus: Purely from a VisitCanberra budget perspective, some of the underspends were probably related to those dollars that are re-profiled, linked to those projects. They would be the only areas where there has been an underspend. The rest of the VisitCanberra budget is allocated to those projects. In terms of that totality, that $30-odd million figure that you are describing, the component that relates specifically to VisitCanberra is between $14 million and $15 million.

MS LEE: Is it enough? We have seen an increase, in terms of a forecast, of $278,000. It is less than a one per cent increase. You will probably say, "We can always have more money."

Mr Kobus: Every destination marketing manager would love to have more dollars, but we are seeing some great outcomes from the programs that we are delivering. As I described, we are investing in projects that we think provide the best return on investment, to bring people to Canberra and generate that overnight visitation. One of the opportunities for Canberra, when we think about destination marketing and how we spend those dollars, is not to focus solely on marketing campaign activity, but on the effort that goes into leveraging all of the different parts that make our visitor economy tick, and that is across leisure visitation, business events, school visits, visiting friends and family, and our international program is on top of that.

With the budget that we have, it enables us to think really carefully about how we leverage partnerships as well. With our international approach, for example, it helps us to understand the value of having an entity like Tourism Australia leading the promotion of Australia into an international market. They are able to say, "This is why Australia," and we can be very purposeful about how we connect the "why Canberra" message, as part of that visit to Australia, when we get to the conversion stage of those conversations.

MS LEE: Mr Kobus, you mentioned that it is going great, or something along those lines. How do you measure it? Do you measure it in terms of visitor numbers? Do you measure it in terms of dollars spent here? How is it measured?

Mr Kobus: Both.

MS LEE: Anything else? I have given you the answer, but are there any other metrics that you use?

Mr Kobus: Absolutely. Total visit numbers are a good measure. We measure visitor spend. We measure visitor nights. We measure the return on investment that we get from our Major Event Fund investment. We measure the return on investment with partnerships that we make with our aviation partners and airlines. The sum of all those parts helps us to understand exactly what is happening.

Hotel occupancy is another good measure as well. For example, through the recent Kanga Cup period, a record number of teams participated in the Kanga Cup. We saw a significant upswing in hotel occupancy across that period compared to the same time last year. Again, the Kanga Cup is an event that we invest in through the Major Event Fund to support them and get the message out to different teams and groups. We saw the result come through; then we saw the upswing in hotel occupancy, which gives us a really good indication that that event drove some interstate and overnight visitation.

MS LEE: Do you measure these metrics on a yearly basis?

Mr Kobus: All states and territories subscribe to data that is collected through Tourism Research Australia, which is an entity of Austrade in the Australian government. That collects both international visitor survey data and national visitor survey data. We get that information on a quarterly basis, so it is provided quarterly, but from a year ending perspective to that quarter. It is retrospective for three months, so there is always a three-month lag. The last set of results we have is for the year ending March 2024; then we can do a trend analysis on that data.

That is checked. That is collected consistently by all states and territories, so we can benchmark ourselves compared to other destinations. For example, over the last 12 months, we have consistently had the same amount more domestic overnight visitors than the Northern Territory and Tasmania. It gives us a really good sense of where the ACT sits in relation to other jurisdictions.

That also enables us to track how we are recovering from pre-pandemic levels for key markets, particular at an international level. For example, China has recovered to about 45 per cent of pre-pandemic levels in terms of total visitation. However, even though it has recovered to 45 per cent, it is now our number one international market, which shows the opportunity to grow volume in those markets. So there are a range of different measures.

Aside from that, obviously, the most immediate data that we probably get on a fortnightly basis is hotel occupancy data, where we can see exactly what is happening at a point in time with hotel occupancy. We also get a 90-day forward forecast of hotel occupancy through a forward-style report. If we know there is an event coming up, we

can see what hotel occupancy is looking like two months ahead, leading up to Floriade, and we can get a sense of whether the market is responding to that event being in the market.

MS LEE: Do you collect any qualitative data in addition to quantitative?

Mr Kobus: We collect qualitative data through the visitors centre. We run a survey at the visitors centre that looks at people's experience, both within the centre and the experience they have had in Canberra. We have some qualitative data as part of that. The other qualitative data is probably data that we receive from the visiting journalists program that we run. We always collect data. With the visiting travel agent programs, we always collect qualitative data from those people about their experience and where they see opportunities for improvement, from their professional experience, regarding the experiences they have had.

MS LEE: You mentioned the Kanga Cup. Obviously, that is a very well-loved event, especially for a lot of schoolchildren having their first experience of Canberra. I have had some concerns raised with me that, while they love coming here and it is obviously a great event, and there is some funding support from the ACT government to make sure that we host it here, they are actually slugged more than that funding support in terms of high fees and the like. They obviously need to look at that. I want to make sure that that is the type of feedback that is being taken into consideration.

Mr Kobus: Yes. All of the events that we support through the Major Event Fund have to do event evaluations and post-event acquittals. Part of those evaluations, whether it is the Kanga Cup or a major exhibition at a national attraction, is to collect a whole range of data. Often that is from surveying the people that attend or participate in those events, and that gives us some great feedback like that.

MS ORR: Going to the partnerships that you have put in place to develop and attract tourist numbers to the ACT, that was quite comprehensive, so I do not need to go back to that. Can I get a little bit of an indication of how you are also using the Aviation Stimulus Fund to tie into that project to realise opportunities for tourism in Canberra?

Mr Barr: We are actively engaged with both Australian and international airlines. That is done in partnership with Canberra airport. They have released a forward strategic plan for their targeted airline partners—new route establishment. The domestic element of that is one that is principally a partnership under the stimulus fund between VisitCanberra, the airport and the domestic airline. Where it is an international route, Tourism Australia can also be a partner.

The priorities that the airport has outlined are formed on the basis of their detailed understanding of the aviation market and travel patterns. They also reflect alignment with the broad ACT government agenda of making it cheaper and easier for people to travel to Canberra in the domestic context. In the international context there is a pretty strong alignment with our international engagement strategy, our trade and investment strategy, our brand strategy, and higher education and tourism strategy.

The key point here is that the government has done a lot of work to focus our efforts on about a dozen key markets. There is pretty strong alignment with the Aviation Stimulus

Fund with those markets and those aviation partners. We are particularly pursuing low-cost carriers in the domestic context, and more market competition. On probably the busiest aviation route to and from Canberra in a domestic sense, which is Canberra-Melbourne, there are four airlines flying it: Qantas, Rex, Virgin and Jetstar. That is helpful not only in terms of total market capacity but also competition. There are not many other city pairings in Australia that have that level of competition.

We have used the Aviation Stimulus Fund to support the expansion of Jetstar's network. With Jetstar's operations in Canberra, their entry into the market has certainly added significantly to seat capacity inbound, and at a price point that is obviously very competitive. It has also elicited a response from Virgin and Rex in those markets, which is particularly useful.

In the international context, to be frank, we have had more success with international partners than Australian airlines flying internationally out of Canberra, but I was pleased to see in the media this week comments from Qantas's CEO in relation to their new aircraft acquisition, and one of the routes that was highlighted by the CEO was Canberra-Singapore.

MS ORR: Internationally, the Fiji flights have been quite popular. With respect to working on re-establishing some of those connections, you have just highlighted, Chief Minister, Canberra-Singapore, which was a route prior to COVID and the impact it had on international aviation. It was quite a popular route. Can we get a bit of an update from you, as the aviation industry recovers and airlines are actually looking to expand, as to what we might hope to see?

Mr Barr: Yes. We have been focusing our short-term efforts on engaging with the Australian government on the Qatar Australia aviation bilateral. There has been a little bit of media about that over the last year. An element of that bilateral is a capping of the number of flights into the main four airports in Australia, but there is also a regional component of that which allows Qatar extra flights into Australia provided they service what is referred to as a secondary airport. Secondary airports that are competitive in this context include Adelaide, Canberra and Gold Coast.

MS ORR: Perth?

Mr Barr: Perth might be one of the big four—Sydney, Melbourne, Brisbane and Perth. It is airports outside that. I have written to Minister King outlining our support for an element of any renegotiated bilateral with Qatar to include an additional regional element that would support Qatar resuming the services into Canberra that they offered pre COVID. It is obviously a regulatory decision that the Australian government will need to make, but our engagement with Qatar has indicated that they would be willing to fly to Canberra if the regulatory environment was supportive of that. We hope that there will be consideration of that in the not-too-distant future.

Qantas, as they acquire their new Airbus A220 and Airbus A321 extra-long-range aircraft, would suit both Canberra-New Zealand on the A220s and Canberra-Singapore—and, indeed, in theory, some other markets that are in the 6,000 to 10,000-kilometre range from Canberra. The advantage is that that aircraft has around 200 seats, in the configuration that Qantas is proposing to fit it out in, which has about

a 25 per cent fuel efficiency improvement on aircraft that are currently in the market. It is both a more economic and a low-emission pathway for that airline. It is the sort of aircraft that would make the most sense, coming out of Canberra.

They are our two short-term areas of focus. We remain in contact with Singapore Airlines. There is obviously a lot of value for them in bringing passengers into their Changi hub. They then have 180-odd different connection points from there, within their network.

There is the work that we are undertaking with Fiji Airways, given they are already flying here. We are working with them. We have outlined some of the initiatives to grow the inbound market from the US. That is a key component and a key driver of increasing the frequency of those Fiji Airways services. I would say, looking at that, that east, west and north-west are the priorities at the moment.

THE CHAIR: There are two minutes left on this question.

MS ORR: Okay. You have said it is about re-establishing flights to New Zealand, Asia through the Singapore gateway, and onwards from there. There was the US prior to COVID. The impacts on aviation were quite a big focus for you. Are you now looking largely at Fiji or are you looking at other opportunities too?

Mr Barr: Qantas is a potential, and so is Air New Zealand, through Auckland. Qantas has established Auckland-New York flights, so Canberra-Auckland and Auckland-New York, I would imagine, would be a reasonably attractive set of city pairing. A smaller aircraft would fly Canberra-Auckland and then you would get on a bigger plane to go to the east coast of the US. Clearly, Qantas also has a desire for Project Sunrise, for direct flights from Sydney to New York. That is a long flight, nevertheless.

MS ORR: I am not sure I would want to take that flight.

Mr Barr: Auckland is Air New Zealand's hub, and they then connect to multiple destinations. Before I conclude this answer, at one point, before China recovered back to a level above it, the US was our number one inbound market.

THE CHAIR: A substantive, Ms Orr. We will only get through another four questions in a maximum of 6½ minutes.

MS ORR: The chair is getting tough! I will have to choose my question wisely. Could This is a joint one with the federal government: Telstra Tower and the rejuvenation. Everyone was a little bit excited about that, to be honest. Could I get an update on the project and when we can expect to see it?

Mr Barr: Yes. This is one that has been a little while in the making. I have met with two Telstra CEOs over the years to get them to the point where they are prepared to make a capital investment to reopen the tower. I am pleased that the work has paid off. They have approached us to work with them on the reopening. The target year is 2026. They are currently undertaking the necessary works—pre-tendering work to get to the next stage of development on the project. The advice from them is that the works that they will fund will modernise the tower, make it accessible and bring it up to current

building standards. We will then work with them on the visitor experience. There is an opportunity to think about how we might assist them in the curation of that space.

Since the news, there has been a lot of interest from hospitality and tourism providers around what the opportunities might be at the tower. We will play an enabling role in trying to consolidate some of those ideas and present them to Telstra, as we have the local knowledge that they do not have. We are also discussing a longer term approach and partnership model with them, with a view to being able to play a longer term role in managing visitor aspects of the tower. We own some of the land surrounding it, obviously. That is the partnership approach.

The physical works will be undertaken in stages. The first stage is the ground floor and the main observation deck. Telstra are proposing a new layout on the ground floor, with a cafe, retail and gallery space. The observation deck would obviously provide an extraordinary perspective of the city and the region. Telstra have also been working closely with traditional custodians, and the redevelopment and experience they have committed to will feature strong elements of Ngunnawal history and culture, as well as telling the story of the capital.

We are not yet sure what the cost of fit-out will exactly be. Telstra have an internal budget for that. The CEO assured me that they want to do a great job here, and we certainly welcome that. They will have some further announcements and we will undoubtedly be there to support those in the not-too-distant future.

MS ORR: I have two follow-ups, Chair, and I am sure you will tell me when I am out of time.

THE CHAIR: I will.

MS ORR: The first one is: in all of that, you have not mentioned the revolving restaurant.

Mr Barr: That is a matter that I do not think is in the first stage for Telstra. It last revolved a decade ago or thereabouts. I think Alto was the—

MS ORR: It has been a while.

Mr Barr: Yes. That is something that has interested a number of Canberra hospitality—

MS ORR: Everyone keeps asking, "Is it coming back?"

Mr Barr: Yes. Hospitality has changed a little in the last decade, but, if I can use this public forum to encourage those in the hospitality industry who would like to provide Canberra with a destination restaurant in the tower, I am sure Telstra would be interested in engaging with them on that possibility. It would obviously be a fantastic feature for a rejuvenated tower.

MS ORR: I will leave it at that.

THE CHAIR: I am interested too. I proposed to my husband in the revolving

restaurant.

Mr Barr: Did you? That is possibly not the only romantic gesture that has occurred at that tower over its history.

THE CHAIR: And, on that occasion, he said no!

Mr Barr: There you go. I am not sure I am allowed to ask the questions, but obviously there was a subsequent venue?

MISS NUTTALL: I have a supplementary.

Mr Barr: That is the line of estimates! Sorry, Ms Lawder. I am not sure that anyone will top that this fortnight.

MS LEE: It is better than the hot monkey sex reference!

MISS NUTTALL: There are a few iconic ones.

THE CHAIR: The two are completely unrelated! It is past five o'clock, isn't it?

Mr Barr: It is past five o'clock on Thursday of week 1.

MS ORR: We're not even halfway through!

THE CHAIR: Miss Nuttall has the call.

Mr Barr: There you go. All sorts of interesting things are revealed in this room.

MS ORR: And we are not even halfway through.

MISS NUTTALL: On to mountain biking. I understand that mountain biking spans a number of areas in the ACT government—by my count: CMTEDD for tourism, EPSDD for parks and conservation, TCCS for sports and recreation, and Special Minister of State. Do let me know if I have missed anything. Who in government is taking a question on mountain biking in general? Is it you?

Mr Barr: No. It would be Minister Steel, on the facility side—

Mr Triffitt: On Monday morning, we are with—

Mr Barr: Yes. Obviously, there is an element of our tourism marketing of Canberra that features not just mountain biking but the cycle tourism experience overall. On the specific infrastructure elements, that would be Minister Steel.

MISS NUTTALL: I am glad you mentioned the specific tourism side. As Canberra's destination of choice for mountain biking tourism, is there a plan for Canberra Tourism to attempt to draw in biking tourists who will be in the region for Sea Otter Australia in Mogo next year?

Mr Triffitt: Yes. We actually work quite closely with some partners in regional New South Wales. We have a great relationship with Destination Southern NSW—an offshoot of Destination NSW—which looks after this area. There is connectivity between Canberra and a range of different mountain biking venues in southern New South Wales. We are looking at how we collaborate and build on that as a logical journey for people to do. If you are travelling from Sydney or Melbourne and are not just looking at one location, how do you, as a mountain bike enthusiast, potentially make a week of that? You could stop in Canberra, go to Mogo, Eden and then up to Thredbo. There is a potential cycle trail product to be developed there. That is in the early stages of what that would look like. That would feed in well to that project. There have been a number of new mountain bike facilities built in the area of southern New South Wales. Canberra, Mount Stromlo and other quality mountain bike facilities in and around the territory provide a great base to explore that region. So, yes, there is definitely an opportunity.

MISS NUTTALL: Awesome. Thank you. The draft Mount Stromlo master plan was due to be released in late 2023. To the best of my knowledge, there has been no update, to the detriment of the prominent Canberra mountain biking community. When will the full master plan be released?

Mr Barr: That is for Minister Steel. That is for Monday morning.

MISS NUTTALL: We will save that for then. He knows what is coming.

Mr Barr: Yes. I will forewarn him that the question is coming.

MISS NUTTALL: Thank you. Please do. Is the government committing to any additional funding for the development of the Stromlo trail network?

Mr Barr: Again, that will be one for Minister Steel on Monday morning.

MISS NUTTALL: Last but not least—and this may well also be related to the trail: would the proposed Stromlo to Cotter trail be for you or would that be for, once again, Minister Steel?

Mr Barr: That is for Minister Steel.

MISS NUTTALL: Awesome. Thank you very much.

MS CLAY: Could I supplement on that, Chair?

THE CHAIR: Yes.

MS CLAY: I will be brief. It is quite difficult for people to work out who is in charge of mountain biking, because it crosses so many directorates. Would it be easier if it were more streamlined and people knew where to go?

Mr Barr: There is the question of asset management versus marketing. From a tourism perspective, Jonathan and his team are a marketing agency. They do not have any specific skills in asset management. The asset management side sits with venues, and

those venues sit within Minister Steel's portfolio of responsibilities. We endeavour to consolidate territory venues in one group that manages a diversity of venues. You could dice up ACT government responsibilities and allocate them in many different ways, and you will find some efficiencies in some elements and you would create difficulties in others. All of the mountain bike questions, with perhaps the exception of tourism marketing, can be directed to Minister Steel on Monday morning.

MS CLAY: We often have questions that stray into Parks and Conservation, EPSDD, as well. The stakeholders find it quite difficult when they talk to us, because they find it quite hard to work out who to talk to.

Mr Barr: Again, unless we had one minister for everything and only one directorate, it is very hard. You have to have some silos and a division of responsibilities, and it does not always fit absolutely perfectly and neatly. I understand that. I will stop there. In a multi-party government, Ms Clay, it can be even more complex. Let me tell you that much.

MISS NUTTALL: I have one more supplementary, with the chair's indulgence. I will be so quick.

THE CHAIR: Sure.

MISS NUTTALL: Would an office for mountain biking or a similar sort of thing solve some of that bureaucratic inefficiency?

Mr Barr: No. It might create more.

THE CHAIR: A substantive question, Ms Lee.

MS LEE: Thank you, Chair. I want to go to the work that is done in promotion by Visit Canberra, specifically in relation to the work that is handled by Universal McCann and the $25 million three-year contract with the ACT government. Is there central coordination? Regarding the services that Universal McCann deliver, is there a set allocation per agency, for example? How does it actually work?

Mr Barr: That was actually in the CMTEDD area, which was the other day. I will take that bit on notice for you.

MS LEE: Sure. I will go specifically to the Visit Canberra part of it. Do you get a budget for the Visit Canberra part of the Universal McCann work?

Mr Kobus: No. We get an overall budget. We break our budget into the various bits. There is a marketing budget and we break that down further into the bit we are going to spend on paid advertising—whatever the component is that we spend on paid advertising. Then we liaise with Universal McCann, as the whole-of-government media buying provider, on how to spend that money appropriately.

MS LEE: Do you have to coordinate that through CMTEDD, for example?

Mr Kobus: We brief them on the type of activity. We do not have to coordinate it

through them. We have a direct relationship with Universal McCann. The reason for that is that so much of the activity that we do is outside of Canberra, rather than inside of Canberra. The whole-of-government media buying activity is generally activity that happens within the borders of the ACT, whereas our media buying activity extends beyond those borders. The conversation that we have with them and the strategy that we use to inform where we invest those dollars is a bit different.

MS LEE: That makes sense. I will go to the media booking authority spreadsheet. It talks about the campaigns. I am talking specifically about the Visit Canberra one. In the first half of 2023, more than $1.95 million was spent by Visit Canberra, which probably made up about 70 per cent of the total spend in that time, but, when you compare that to the first half of 2024, only $77,000 was spent, which is less than three per cent of the total. It seems like a really big difference. Is there a reason for that?

Mr Kobus: It is probably to do with the way the media plan is set up and how those dollars are spent, just from a phasing perspective. It is not reflective of the amount that we are actually spending on paid advertising. That has remained fairly consistent over recent years. We will develop a media plan and, depending on the timing of when we think the best period of the calendar year is to execute certain campaign activity, that is when those dollars will be spent.

MS LEE: Still, when you are looking at the first half of 2023 compared to the first half of 2024, it is $1.95 million compared $77,000. That is a massive—

Mr Kobus: Regarding when some of the money is spent, the execution date might be separate to when the actual investment is made. The dollars are spent on a campaign strategy and then that is rolled over in a period of time. So, depending on when that activity happens, additional dollars are spent. It would probably line up if you looked at the total of what was spent in the 2023 calendar year and the 2024 calendar year, but, even then, you would still look at crossing over periods of time when campaign activity was booked compared to when the actual investment was made.

MS LEE: Are you able to provide, I assume on notice—I do not think that you would have this on the top of your head—the terms of the allocation? You are talking about this money representing what you have actually booked compared to the actual spend.

Mr Kobus: It is when the activity then actually happens. For example, you could pay for a billboard here, but it does not happen until three months later.

MS LEE: That is right. Are you able to provide that information on notice?

Mr Kobus: Yes.

MS LEE: for 2023 and 2024?

Mr Kobus: Yes.

MS LEE: Thank you very much. I appreciate that.

MS CLAY: I would like to talk about the ACT government's support for the space industry. It is a really important industry here. It develops a lot of technology that we use in really useful applications like bushfire detection and climate change monitoring—and that is really good to see—but it can also have military applications. What safeguards do we have in place to make sure that ACT government resources are being directed only towards companies and activities that serve peaceful purposes?

Ms Arthy: The support that we are providing for space is really around how we put frameworks in place to assist businesses to connect with clients. I will hand to Ms Starick shortly because she has been doing some work with the sector around developing a concept for a space hub, but the work that we do with the different sectors, whether it be space quantum or cyber, is to identify what would make a difference to help that industry develop.

In the ACT we are quite unique in terms of our proximity to the commonwealth government, which, as I mentioned earlier, is the biggest customer of some of our businesses. So we tend to focus on higher level frameworks—for example, if a business wants to grow, how do they independently get access to, say, services like our Canberra Innovation Network, for example? It is also about providing information. For example, through cyber, which we are looking at for space as well, how do we provide information to people about where to get skills? How do we promote the sector? How do we promote the ACT's capability? That is typically the way that we support them. But, as I said, Ms Starick has been working with the sector in a fair bit of detail over the last year and can tell you more detail.

MS CLAY: That was an excellent explanation of what you do, but the question was actually about what safeguards we have in place to ensure that our Canberran funding is not going towards military applications—to make sure that it is only going towards peaceful applications and I do not think we have touched on that aspect of it. Is that something you can cover?

Mr Barr: Just to unpick that, there is the implication that there is no potential for any military application to be peaceful.

MS CLAY: I have just asked an open question to see what safeguards we have in place. Do we have any safeguards in place? Is that maybe a good way to start?

Mr Barr: We certainly have a series of criteria in relation to our investments, and that forms a reasonable basis and framework to transfer across to grant funding. But I think the distinction or what you are effectively saying is that anything in the defence industry, by definition, cannot be peaceful, which do not I think is a reasonable statement to make.

MS CLAY: I have not said anything like that. What I have said is: can you tell me what safeguards or policies are in place? If the answer is that there are none, that is a perfectly acceptable answer. Just what policy and framework is there in place?

Mr Barr: And the rest of your question—the other line you used?

MS CLAY: What safeguards and policies are there in place that address whether our support is going to peaceful applications or not peaceful applications? Is there any policy or framework in place?

Ms Arthy: As the Chief Minister said, there is the overarching investment framework within government. I think the other part of this is the nature of the support that we provide. We do not really run a lot of grants programs for businesses in this area. We have the Priority Investment Program, which is an open grants scheme that we run that is heavily scrutinised by an independent selection committee. While there is no specific criteria within that about military technology, it is assessed against a whole range of criteria, which does come back into the government's investment framework.

MS CLAY: Putting aside military or not military, is there anything in there about assessment against peaceful purposes?

Ms Arthy: Not so much peaceful. There are environmental, social, ESG and governance criteria that are considered.

MS CLAY: Could you maybe come back and provide the ESG framework that you are using and how it is used?

Ms Starick: As the chief talked about, that is part of the overall investment criteria that is used.

Mr Barr: Yes. Given that we are now over time, we will take it on notice.

MS CLAY: Thank you.

THE CHAIR: That is the end of our proceedings today. On behalf of the committee, I would like to thank all of our witnesses for your attendance today. If you have taken any questions on notice, please provide your answers to the committee secretary within three business days of receiving the uncorrected proof *Hansard*.

On behalf of the committee, I would like to thank all of our witnesses today who have assisted the committee through their experience and knowledge. We would also like to thank broadcasting and Hansard for their support. If a member wishes to ask questions on notice, please upload them to the parliament portal as soon as practicable and no later than three business days after the hearing.

The committee adjourned at 5.27 pm.