HOUSE OF ASSEMBLY

Friday, 20 June 2025

ESTIMATES COMMITTEE B

Chair:

Mr E.J. Hughes

Members:

Mr A.E. Dighton
Mrs R.K. Pearce
Mr A.S. Pederick
Ms O.M. Savvas
Mr J.B. Teague
Mr T.J. Whetstone

The committee met at 09:00

Estimates Vote

DEPARTMENT FOR CHILD PROTECTION, $883,187,000

ADMINISTERED ITEMS FOR THE DEPARTMENT FOR CHILD PROTECTION $110,000

Minister:

Hon. K.A. Hildyard, Minister for Child Protection, Minister for Women and the Prevention of Domestic, Family and Sexual Violence.

Departmental Advisers:

Ms J. Bray, Chief Executive, Department for Child Protection.

Mr D. Shephard-Bayly, Deputy Chief Executive, Department for Child Protection.

Ms J. Male, Chief Financial Officer, Department for Child Protection.

Ms G. Ramsay, Chief Operating Officer, Department for Child Protection.

Ms K. Swaffer, Director, Office of the Chief Executive, Department for Child Protection.

Ms S. Wendt, Director, Social Worker Registration Scheme.

The CHAIR: Welcome to today's hearing for Estimates Committee B. I respectfully acknowledge Aboriginal and Torres Strait Islander peoples as the traditional owners of this country throughout Australia, and their connection to land and community. We pay our respects to them and their cultures, and to Elders both past and present.

The estimates committees are relatively informal and, as such, there is no need to stand to ask or answer questions. I understand the minister and the lead speaker for the opposition have agreed an approximate time for the consideration of proposed payments, which will facilitate a change of departmental advisers. Can the minister and lead speaker for the opposition confirm that the timetable for today's proceedings, previously distributed, is accurate?

Changes to committee membership will be notified as they occur. Members should ensure the Chair is provided with a completed request to be discharged form. If the minister undertakes to

supply information at a later date, it must be submitted to the Clerk Assistant via the Answer to Questions mailbox no later than Friday 5 September 2025.

I propose to allow both the minister and the lead speaker for the opposition to make opening statements of about 10 minutes each, should they so wish. There will be a flexible approach to giving the call for asking questions. A member who is not on the committee may ask a question at the discretion of the Chair.

All questions are to be directed to the minister, not the minister's advisers. The minister may refer questions to advisers for a response. Questions must be based on lines of expenditure in the budget papers and must be identifiable or referenced. Members unable to complete their questions during the proceedings may submit them as questions on notice for inclusion in the assembly *Notice Paper*.

I remind members that the rules of debate in the house apply in the committee. Consistent with the rules of the house, photography by members from the chamber floor is not permitted while the committee is sitting. Ministers and members may not table documents before the committee; however, documents can be supplied to the Chair for distribution.

The incorporation of material in *Hansard* is permitted on the same basis as applies in the house; that is, that it is purely statistical and limited to one page in length. The committee's examinations will be broadcast in the same manner as sittings of the house, through the IPTV system within Parliament House and online via the parliament's website.

I declare the proposed payments open for examination. I call on the minister to make a statement, if she so wishes, and to introduce her advisers.

The Hon. K.A. HILDYARD: Thank you, Mr Chair, and thank you to the committee members for being here. I will not make an opening statement; however, I will introduce the officials here with me: Jackie Bray, the Chief Executive; Darian Shephard-Bayly, the Deputy Chief Executive; Joanne Male, the Chief Financial Officer; and behind me, Sarah Wendt, the Director, Social Worker Registration Scheme; Gabby Ramsay, Chief Operating Officer; and Kris Swaffer, Director, Office of the Chief Executive.

The CHAIR: Mr Teague, do you have an opening statement or just questions?

Mr TEAGUE: I will just go to questions. For the purposes of the reference, I am at Budget Paper 4, Volume 1, Child Protection, Program 1, which commences on page 85 and I am over the page at page 86, where there is a program summary and table. I go first to the bottom of that table, the penultimate line, the net cost of providing services. I note there that the budget for 2024-25 had allocated $793 million for the Department for Child Protection. The 2024-25 estimated result shows an actual spend a bit in excess of $948 million, which is a budget blowout of $155 million.

First, on what was the additional $155 million spent, and can the minister explain to the committee what the budget management process looked like and whether she regards that as a failure to manage that budget? I flag that I will move on to an interest in the 2025-26 budget, having allocated $866 million for the Department for Child Protection, which is $82 million less than the 2024-25 actual spend, so it is not as though the budget is now providing for a new reality: the budget is providing for $82 million less for the coming year. The minister might deal, first, with the budget blowout and, secondly, how DCP might endeavour to reduce its spending by that $82 million for this year.

The Hon. K.A. HILDYARD: I thank the member for the question. I will first speak broadly to the situation with the child protection budget since we have been in government. It is very important to reflect and contrast the commitment we have as a government to children, young people and their families, to contrast that with the lack of investment by the former government.

Since coming to government we have invested $674 million into the child protection budget to support children, young people and their families. Prior to this budget, that investment had sat at $570 million. In this budget is an additional $94 million. I know that the member likes to characterise that investment, as he has done this morning, as a budget blowout.

We are absolutely committed to investing in helping to improve the lives of children, young people and their families. I know that I do not get to ask questions today of the member, so I will put something out there, not expecting an answer. We have invested $674 million since coming to government in the child protection and family support system and $94 million this year. Those investments have, very importantly, gone to a range of endeavours to support the children, young people and families who most need our support, and we are really proud of that investment.

Those investments go to things like—and I am sure I will get an opportunity to explain them at length—the establishment, for the first time ever, of the Aboriginal peak body for children and young people, Wakwakurna Kanyini. They go to carer payment increases, Child Abuse Report Line resources, our interagency child death review model, family group conferencing, the Finding Families program, the Additionally Approved Carer Program, kinship care assessments, programs and investments that support children and young people who are in care, reunification programs, and transitioning from care or post-18 years programs, just to name a few.

There is a question that I know I cannot ask here, but I think it is an important question to put on the record. We are proud of those investments, and we will keep investing to support children, young people and their families. I know that the member has already characterised that as a blowout, so I would be very interested to know, at some point, what the opposition would intend to cut from these incredibly important services and supports for children and young people in our state?

Mr TEAGUE: I might just remind the committee of the question I put rhetorically, back in 2022. At that stage, the government had exempted the Department for Child Protection from what it described as generalised operating efficiencies applied at that time. Without cavilling at that endeavour, I put the rhetorical question: is more money in child protection a sign of success or is it a sign of failure? That has continued, and indeed I have described repeated estimated results against budget blowing out by $100 million or more in years subsequent as budget blowouts. I am interested to know—that is the reason I asked the question—what is the cause of that blowout in circumstances where the budget, in the line item that I have taken the minister to, reduces the budget by $82 million?

The question, as yet unanswered, is: what services and programs does the minister anticipate will be cut in order to meet that budget, or does the minister tell the committee that, once again, there is no realistic prospect that the budget will be met, in which case it is a relatively meaningless exercise to set it out? I draw particular attention to the second paragraph of the explanation of significant movements that is immediately below the table, which gives us a clue. It states that:

> The increase in expenses between the 2024-25 Budget and 2024-25 Estimated Result is primarily due to increased costs associated with providing…services ($156 million).

I have described this as the budget blowout, and I repeat that. Again, for the committee's benefit, the government provided three answers to that question last year, and the minister might recall that she gave one of them. The Treasurer, in answer to questions in estimates, said that was due to the cost of providing services on a casual, temporary, short-term kind of basis, which was at additional cost. The Premier, at or about the same time, indicated that it was a virtue of employing more staff, and the minister gave, if I might say so, the kind of answer that the minister has just given in general terms.

So I would invite the minister again to indicate, with some precision if it is possible: what are those increased costs associated with providing care services, and how will they be cut, managed, trimmed or applied in order to meet the budget provision for the year ahead?

The Hon. K.A. HILDYARD: I think I have a few questions in there. First of all, in relation to what the member rightly spoke about, and that is the cruel efficiency measures that were made under the previous government, I will come back to that.

Mr TEAGUE: Point of order: that is misquoting me, as I think the committee understood. The operating efficiencies that I referred to were those applied by the incoming Malinauskas Labor government in almost all agencies except child protection. It is straightforward; it is not controversial. We know that child protection was exempted from those operating efficiencies applied in that first Malinauskas Labor budget. There is no problem with that. It led to my rhetorical question at the first

estimates that followed: is more money for child protection a sign of success or failure? I just need to correct the minister in that regard.

The Hon. K.A. HILDYARD: Just to finish what I was saying, I heard a range of topics in the question that the member put. One of them was about efficiency measures and, as I said, the efficiency measures that were applied relate to the last government. Also, he asked me about success and signs of success, so I will come back to that. Also in that question he has spoken about the cost of providing services. In that broad-ranging question, I will answer each of those things.

What I will start with is the question about success. I do that because I want to try, again, to get the member to understand the complexity inherent in the lives of children, young people and their families, and what that means for the complexity of the responses and the investments that we as a government must provide. I know the member has heard me speak about this before. Sadly, one in three children in South Australia at some point in their lives are notified to the child protection and family support system.

Children, young people and their families who are the subject of those notifications are often grappling with the most complex and deeply interconnected issues: intergenerational trauma; poverty; mental ill health; experiences of domestic, family and sexual violence; substance misuse. Those issues are really, really complex and that adds such a degree of complexity and difficulty to the lives of the children and young people who are in those situations.

As a government that is thinking deeply and acting in a very multifaceted way to tackle that challenge for our state, we have many measures of success. As I said, we have invested $674 million into the child protection and family support system. In terms of the question about success, we are beginning to see promising results.

We know that children and young people continue to face those circumstances and that therefore we have a whole lot more work to do; we know that. We absolutely know that, but we are focused on reforming the system to improve the lives of children and young people. There is more to do, but we are seeing results. One of the results that I would point to, we have—

An honourable member interjecting:

The Hon. K.A. HILDYARD: I think you asked about results and success. I am not sure if the member had another question?

Mr TEAGUE: No, I am listening.

The Hon. K.A. HILDYARD: Sorry, I thought the other member had a question.

Mr WHETSTONE: You blew the budget. That is the outcome.

The Hon. K.A. HILDYARD: Okay. Again, I will just keep talking. I am not sure what you would cut from the measures to improve the lives of children and young people, but I will continue to speak in relation to the question from the member for Heysen, the shadow spokesperson, about those signs of success.

One of those signs of success relates to the slowing of growth of children coming into care and I have, very pleasingly, the growth rate as at 31 May 2025 and that sits at minus 0.6 per cent. That comes from a high during the last government of 9 per cent growth of children and young people coming into care. We now sit at minus 0.6 per cent. Similarly, we are seeing a slowing of the growth rate for children in residential care in particular. In 2021, the growth rate for children in residential care, I am advised, sat at 46.2 per cent. That now sits, I am advised, at minus 0.5 per cent. So in terms of those signs of success, they are two that I would point to.

I would also point to the extraordinary success we are having through other measures that we are investing in. Obviously, those measures speak to our investment in programs like Finding Families, family group conferencing, and reunification. In this budget, there is more money for Finding Families, for our Additionally Approved Carers Program and for more staff at the Child Abuse Report Line and other results show we are just beginning to see that success. What I always want to add to what we say about that success is that of course we have more to do—of course we do—but those are promising signs.

The other promising signs relate to the success rate of our family group conferencing and of our reunification programs and I can certainly provide all of the detail about those to the member and I am sure I will get the opportunity to do that during the course of this hearing.

But again, in terms of his question about success, when we are seeing that difference being made in the lives of children and young people, when we are seeing our investment of $13.4 million into family group conferencing beginning to show results between 85 to 90 per cent at particular points in time, that to me is promising. We have so much more to do. We will continue our process of reform, but I am pleased that our investments are beginning to show those signs of success, noting again we have more to do.

The other part of the member's question was in relation to the cost of providing, I think, services, I presume particularly for children who are in care. I think that was where the member was going, if I am correct, and I want to speak about that. As I said, we have reduced the growth of children coming into care, which is a really important indicator.

We have also reduced the growth rate for the number of children coming into residential care in particular, but those two figures always have to be contemplated in relation to the complexity that I spoke about that a number of children, young people and their families are facing because different services need to be provided depending on what a particular child is experiencing. Different types of complex supports need to be around a particular child, so those costs do vary from child to child in terms of what we need to provide for a particular child.

Some have extraordinarily complex needs. With others, as I said, there is always complexity, but those costs do vary and they will vary literally from day to day, week to week because different children with different needs come into contact with the system. The other point I would make about that is that we are determined to progress reform that improves the therapeutic supports for all children living in residential care, whatever their circumstances.

As I have said, there are different complexities and different types of supports that children need, but our government is embarking on a groundbreaking initiative to reimagine how residential care services can be even more responsive to the needs of children and young people who most need our support. So we intend to draw on decades of practice expertise right across the sector. We want collaborative effort to stringently focus on getting the right balance of supports and services for young people and for families and communities now and into the future.

We know that the best outcome for a child, or the most desirable outcome for a child, is that they can safely stay at home with their family. Sadly, that is not always possible. When they cannot safely stay with their family, we want to try to explore opportunities across extended families and communities to have family-based care; however, there are circumstances where children and young people must live in residential care. We are embarking on work to make sure that the best possible therapeutic supports are in place for children and young people in residential care. We want to reimagine residential care. We want to make sure that, together with key stakeholders, we really look very deeply at how we can improve the supports in residential care also.

In amongst those many stakeholders who need to be part of that work, very importantly will be the voices of those who are part of the advisory groups that I have established and, in particular, the ministerial youth advisory council made up of children and young people in care, whom I want to have a voice about what the best model of residential care can look like.

There is much more to say about that particular part of the member's question, but to sum-up, we will not apologise for investing in helping to improve the lives of children, young people and their families. That is a crucial thing for us to do. I am pleased with the results that we are beginning to see, but I absolutely know that reform is really hard, and we still have a way to go. But we are absolutely committed to staying the course and reforming the system to make sure we do improve the lives of children and young people, and that means that we do have to invest. As I said, I am not going to apologise for that. It is really important that we direct funds towards improving the lives of children and young people.

I am disappointed that the opposition describes this in the way that they do. Again, I would be interested at some point to know what particular programs they would cut, given there seems to

be—and I would be very pleased to hear otherwise—a lack of support for the particular initiatives that we are investing in.

Mr TEAGUE: I start to have some more sympathy for the Treasurer, if not for this committee. I really do wonder whether the minister realises why we are here. The exercise is not one of time-filling with generalised statements. We are here analysing the budget or doing the best we can to do so according to budget lines. The minister has presided over, yet again, a $155 million budget blowout, with the result that the government has found it necessary to apply for the year ahead an $82 million cut in the budget.

Are South Australians watching this left to think that the Department for Child Protection's budget is just a completely meaningless exercise and that the amount of money that is spent in child protection is a sort of endless amount that will continue to exceed budget in an unspecified way? What I am really asking the minister to do, in the context of estimates, is to elicit, if not a command of the budget, some indication of where those costs go. I have directed the minister to the budget's own explanation, which talks in general terms about increased costs associated with providing care services.

The minister, in that long and more or less generalised answer, has spoken about—using words with which we are familiar from the minister—complexity, interconnected, and then are beginning to show promising results. Is there any possibility that the minister can enlighten the committee, by reference to an unidentified case—for example, a complex one—where costs so increased unexpectedly that the minister determined it was meritorious to blow the budget in that proportional way in order to achieve the promising result that the minister has spoken about in generalised terms?

Otherwise, we are wasting our time here, just hearing from the minister and filling time. Is there any explanation from the minister to this estimates committee about where the money has gone, by reference to one case, for example? You have all of your advisers here.

The Hon. K.A. HILDYARD: Again, briefly, we invest in a range of programs. This is what the member has asked: where are we investing the money? I will let you know: into family group conferencing, into post-care services, into the Next Steps pilot service—

Mr TEAGUE: What is the blowout in each case?

The Hon. K.A. HILDYARD: —into the Stability Post Care individual packages for those young people who leave residential care.

Mr TEAGUE: Any dollars attached?

The Hon. K.A. HILDYARD: We provide money for advocacy and support to CREATE Foundation, to Grandcarers SA. I can go through figures, money to the Stronger Start program that helps at-risk first-time parents at the earliest opportunity.

Mr TEAGUE: What exceeded budget?

The Hon. K.A. HILDYARD: We provide money for additional kinship care assessments, to family reunification services, to the National Redress Scheme, to the Interagency Child Death Review model and, as I spoke about in my last answer, to provide supports for those children in care.

Mr TEAGUE: What was budgeted and what blew out?

The Hon. K.A. HILDYARD: We provide funding to support children in residential care. Of course, what the member should understand is that when we are talking about that cost a number of non-government organisation partners and community organisation partners also run residential care. I presume that is something also that the member supports, but I have just spoken about, and I know the member has spoken about—

Mr TEAGUE: They have to meet their budgets, you see.

The Hon. K.A. HILDYARD: As I said, children have differing, complex needs which require different types of support provided both directly by the Department for Child Protection and, as has been the case for decades, also by our community organisation partners. As I have also said to the

member, that area, in terms of reimagining residential care, is something that we will continue to look at because, in amongst that complexity, we want children and young people to have the best possible support.

We also want to make sure that we are relooking at residential care and, alongside making sure that we are investing in all the programs I just spoke about—the member asked for programs and I have just given him information about those programs—to keep children and young people together safely with family where that is possible.

Mr TEAGUE: Did that cause the blowout?

The Hon. K.A. HILDYARD: We also have to—

Mr TEAGUE: What caused the blowout?

The Hon. K.A. HILDYARD: —provide funding for those children in residential care. I just want to give an example of why that question about complexity matters. I know that—

Mr TEAGUE: That was the answer but not the question. That is alright. Put a dollar figure on it.

The Hon. K.A. HILDYARD: —the member has scoffed at that idea of children and young people having complex needs, but if you think about—

Mr TEAGUE: Chair, that is not right. I have not scoffed at all.

The Hon. K.A. HILDYARD: —if you think about—

Mr TEAGUE: What I have done is I have referred to—excuse me.

The Hon. K.A. HILDYARD: Can I keep answering the question? Is there a point of order?

Mr TEAGUE: Chair.

The CHAIR: One at a time, please.

The Hon. K.A. HILDYARD: I am still answering the question.

Mr TEAGUE: Chair, if I may, point of order if necessary. Again, a mischaracterisation. What I have done, in all sincerity, is referred to a word the minister has used in an answer, 'complexity', and invited the minister to explain how complexity—and I have no difficulty with the use of that word—sounds in terms of a cause to budget blowout. Far from scoffing this is a serious matter, Chair—

The Hon. K.A. HILDYARD: Absolutely. Happy to answer it.

Mr TEAGUE: —and we are here to seek some explanation by reference to the budget for a minister who ought to have command of that. Using her own words, I have invited the minister to explain how that complexity sounds in terms of the budget. So—

The Hon. K.A. HILDYARD: I will answer the question again.

Mr TEAGUE: I do not appreciate the minister's characterisation.

The Hon. K.A. HILDYARD: Sure. No problem. I will answer the question, but again I have to speak about complexity. I know you have—

Mr TEAGUE: Please. I invited you to.

The Hon. K.A. HILDYARD: You did say something that was—you said that I repeat that word.

Mr TEAGUE: You do.

The Hon. K.A. HILDYARD: —and I do. I do—

Mr TEAGUE: You do, and I am perfectly happy; just—

The Hon. K.A. HILDYARD: —because this goes—

Mr TEAGUE: —explain it by reference to the budget.

The Hon. K.A. HILDYARD: —to the core of exactly what I am talking about in terms of that provision of care services. So if you think about a child—and I cannot give you particular names, of course—

Mr TEAGUE: No, unidentified.

The Hon. K.A. HILDYARD: —but particular children in our care—

Mr TEAGUE: Just one.

The Hon. K.A. HILDYARD: —have such complex needs, children who are living with significant disability, very, very high-end medical needs, they may require care 24 hours a day by a team of people—

Mr TEAGUE: So that is why you had $793 million to care for them last year.

The Hon. K.A. HILDYARD: —by a team of people. So when I talk about complexity I am talking about a range of circumstances, because as I said every child or young person who is in contact with the child protection and family support system deals with complex issues. They absolutely do.

Mr TEAGUE: That is why we have a budget for it.

The Hon. K.A. HILDYARD: By the very nature of being in contact with the system they are dealing with really difficult and often heartbreaking issues, and there will be—

Mr TEAGUE: What is the cause of the blowout?

The Hon. K.A. HILDYARD: —different levels of complexity. For some children that complexity means they may need around-the-clock, 24-hour-a-day care by a team of people. I was asked for example—

Mr TEAGUE: Do not set up vulnerable children as somehow your bulwark for unaccountability. You have a budget.

The Hon. K.A. HILDYARD: I was asked by the member to explain by what I mean by some of those complex needs that require particular sorts of care.

Mr TEAGUE: Excess to budget.

The Hon. K.A. HILDYARD: I will never apologise for expending funds on the care of those children—

Mr TEAGUE: But how did you? Do you even know?

The Hon. K.A. HILDYARD: —with highly complex needs. I will never, ever apologise for that, and I am surprised, frankly, that the member is questioning that. Of course we need to provide care—

Mr TEAGUE: Does the minister know how that was done at all?

The Hon. K.A. HILDYARD: —for those children and young people. I am absolutely across the different needs of children and young people in care and, as I said, there are a range of needs, and we have to respond to all of them. Of course we do.

Mr TEAGUE: You have $793 million budgeted to do so.

The Hon. K.A. HILDYARD: Of course we do. So we are expending our funds on providing for that care for children and young people with complex needs. Of course we are. We will keep doing that. Whichever child or young person comes into contact with the system, what their needs are must be responded to—

Mr TEAGUE: The minister says the minister will keep doing so.

The Hon. K.A. HILDYARD: —by the department—

The CHAIR: Maybe a little advice that might smooth things over a little. The minister does, quite rightly, talk about complexity, and we are here to examine the budget. You asked a whole set

of questions, multibarrelled questions at times. Maybe if there was a focus on program areas and you then used the program areas to elicit some examples. If you hone in a bit and make it a bit more specific then the minister might well be in a position to respond to the questions.

Mr TEAGUE: Let me put it this way—

The Hon. K.A. HILDYARD: If I can just conclude my answer—

Mr TEAGUE: —the question to the minister is—

The Hon. K.A. HILDYARD: Is there a point of order?

The CHAIR: Please! One at a time, please. The minister and then the member.

The Hon. K.A. HILDYARD: Could I please conclude my answer just to try again to explain it to the member? Each day, a child may come into the care of the system who has highly, highly complex needs—sometimes particular conditions or a complexity of conditions or a group of conditions—

Mr TEAGUE: But what are you going to cut?

The Hon. K.A. HILDYARD: —so we have to pay for the care of that child.

Mr TEAGUE: Yes, and how are you going to cut that now? It is $82 million of cuts.

The Hon. K.A. HILDYARD: We have to pay for the care of that child. We will continue to do that. I am failing to understand what the member—

Mr TEAGUE: I can see that. The whole committee can see you are failing to understand.

The Hon. K.A. HILDYARD: —the point that he is trying to make because on the one hand he says there is a budget blowout, and then he talks about cuts. I am not following his argument.

Mr TEAGUE: Let me explain it to you.

The Hon. K.A. HILDYARD: What I will say again is that—

Mr TEAGUE: The budget for 2024-25—

The Hon. K.A. HILDYARD: If I can conclude my answer: $674 million—

The CHAIR: Minister, like I said, if we can get back to specifics. If there could be a budget line item that we can work off.

Mr TEAGUE: It is the penultimate line of the table on page 86.

The Hon. K.A. HILDYARD: I will try again to explain it to the shadow minister—

Mr TEAGUE: Chair, if—

The Hon. K.A. HILDYARD: —$674 million of investment into the system for children and young people.

The CHAIR: Order! I actually think we are not going anywhere; I think we are going around in circles.

Mr TEAGUE: It might assist the committee just to bring—the minister has sought the reference point again. The line item relevantly remains the penultimate line of the table on page 86, which we have been at the entire time. The minister says that the minister is not understanding the question.

The Hon. K.A. HILDYARD: I understand the question.

Mr TEAGUE: The budget for 2024-25 for child protection is $793 million. The estimated result, if I may, for 2024-25 is $948,153,000, a blowout of the budget by $155 million, sufficient that the government has seen fit to cut the budget for the year ahead by $82 million. What are you going to cut, minister?

The Hon. K.A. HILDYARD: That is just not true. It is absolutely not true.

Mr TEAGUE: Or is this meaningless?

The CHAIR: You have asked your question, 'What are you going to cut?'

The Hon. K.A. HILDYARD: I will just say it again.

The CHAIR: The minister can now respond.

The Hon. K.A. HILDYARD: Thank you.

Mr TEAGUE: You say you will keep providing services.

The Hon. K.A. HILDYARD: There has been $674 million of new investment into the child protection and family support system since coming to government—$94 million of new money this year. That is not a cut.

Mr TEAGUE: She is not responsive.

The Hon. K.A. HILDYARD: Those figures are absolutely clear.

Mr TEAGUE: It is not responsive.

The CHAIR: Next question.

Mr TEAGUE: The minister has indicated that the minister will keep on meeting the needs, including those complex needs that the minister has referred to in such general terms. The committee, I am sure, is interested to know, and I invite the minister to seek reference to those advisers who are here present in the committee to the extent that it may be necessary, what command has the minister got—indeed, to what extent is the minister satisfied that those needs will be met in the face of the $82 million reduction that is on the face of the budget paper set out in the relevant line item from the estimated result in 2024-25 to the budget in 2026? How are you going to do that? Or are you just not going to attempt it?

The Hon. K.A. HILDYARD: We have $94 million of new investment into the budget this year—$94 million of new investment.

Mr TEAGUE: Alright, let's go there. That is the Budget Measures Statement at page 17. We can all look at that. Should we go there? That is the Budget Measures Statement, Budget Paper 5. I hope the minister has that readily to hand. Budget Paper 5 at page 17. We have budget measures, described as additional resources for out-of-home care; do you see that? There is only one table on the page—one line item—operating expenses for out-of-home care, additional resources.

This is a so-called initiative to provide $85 million over four years from 2024-25 to support young people and children in care. I say 'so-called' because those expense amounts, including $61.4 million in the 2025-26 budget, the second number from the left, are to be compared and contrasted with the $82 million budget cut from the estimated result in 2025 to the budget in 2025-26. How does the minister explain the additional resources, except by some sort of Orwellian reference of comparison between budget 2024-25 and budget 2025-26, given that the estimated result for 2024-25, which the minister has not challenged at any point, is in fact $948 million?

The Hon. K.A. HILDYARD: Kids need 24-hour care.

Mr TEAGUE: Here we go.

The Hon. K.A. HILDYARD: That costs money.

Mr TEAGUE: So the budget is meaningless for child protection; is that right?

The Hon. K.A. HILDYARD: Kids need 24-hour care. That costs money. We have invested significant funds since coming to government—$674 million of new investment and $94 million this financial year. The really important thing for the member to understand is that, as well as providing care and being able to respond to those children and young people who come to us with really complex needs, we are also expending money on programs like family group conferencing; the Additionally Approved Carers Program, which has more money in this budget; the Finding Families program; and the reunification programs.

Whilst we are working to provide care for those children and young people who cannot safely live with their families, we also need to invest in those other services that strengthen families, hence our investments in family group conferencing, reunification, Finding Families and the Additionally Approved Carers Program. We will continue to do that. We will continue to invest in all of those sorts of programs in providing funds to care for children who cannot safely live with their family. We will continue to do that: it is the right thing to do.

Mr TEAGUE: Budget Paper 5, page 17. Maybe I should stress that, after three years, none of these are trick questions, none of this is a gotcha moment. It is an opportunity to provide some precision around where the money is going. There has been blowout, excess to budget, repeatedly. If the minister had command of the budget and the department, she might care to tell the committee where it has gone, why it has exceeded budget, and there is an opportunity to do so in the table at page 17 of Budget Paper 5 in the Budget Measures.

I am somewhat sceptical of the characterisation of the Budget Measures additional resources—I have flagged that. Is the minister able to, again, enlighten the committee to any extent as to what those specific amounts—in 2025-26, $61.408 million; in 2026-27, $4.544 million; and, in 2027-28, an estimate of $554,000—those very precise amounts of money, are going to be applied to? Why are they to be spent in that way over that time, and how are they not just to be read as some papering over of this excess of budget expenditure in the department more broadly?

The Hon. K.A. HILDYARD: Again, as the member has pointed out, on page 17 of Budget Paper 5, we will continue to invest in caring, as it sets out on that page very clearly. We will continue to provide care for children and young people—of course we will. I am interested to know whether that is something that the member would back away from. Of course we need to provide funds to care for children and young people, some of the most vulnerable children and young people in our state. I am appalled that the member is backing away from providing those funds for children and young people in care. It is absolutely appalling.

Mr TEAGUE: Point of order.

The CHAIR: What is your point of order?

Mr TEAGUE: The point of order is again mischaracterisation, apart from being completely inappropriate. The minister is seeking to apply some outcome of what the opposition might do, completely without any reference.

The Hon. K.A. HILDYARD: What is the point of order?

Mr TEAGUE: I take exception, again, to the mischaracterisation. The minister should answer the question about what the government is doing by reference to the line item.

The Hon. K.A. HILDYARD: Just because you take exception it is not a point a order.

The CHAIR: I think we do need to move on. We can keep going around in circles, which is what we appear to be doing—

The Hon. K.A. HILDYARD: Could I please finish my answer? There is not a point of order.

Mr Teague interjecting:

The CHAIR: Wait, please.

The Hon. K.A. HILDYARD: Just because the member does not like what I am saying is not a point of order.

Mr TEAGUE: The point of order is that the minister answers the questions by reference to the line items, just as the questioner is required to stick to the line items.

The Hon. K.A. HILDYARD: If I can please answer the question: $85 million, as he has spoken about, is right there and will continue to be provided. The funding that is needed will continue to be provided for children and young people in care. That is exactly what we should do. I am not sure why there is this scoffing and laughing about providing care for children and young people who have complex needs. Also—

Mr Teague interjecting:

The CHAIR: Let the minister finish, please.

The Hon. K.A. HILDYARD: Also, two other points: I have listed at length all the other programs that we are investing in. I have done that twice now. I can do it again. I am not sure why the member is not hearing that. I have already answered the question. Also, we know—

Mr Teague interjecting:

The CHAIR: Can we let the minister finish, and then you will get your turn.

The Hon. K.A. HILDYARD: We know that residential care is expensive. We know that, and that is why I also just spoke about a process of reimagining residential care in partnership with our stakeholders, bearing in mind that it is both DCP and community organisations which provide those residential care services. I have spoken about the work that we are doing to make sure that it is the best it can be and that children and young people's voices will be heard in that process. We are very clear: we will keep investing to support children and young people who live away from their families—of course we will.

I am appalled that there is this commentary about the government rightly providing those services. Alongside that, we will continue to invest in all of those other programs to strengthen families, to reunify children where it is safe to do so, to convene family group conferences, and to support Wakwakurna Kanyini in its efforts as a peak body for Aboriginal children and young people. I am absolutely appalled by this commentary from these two who do not seem to support any of those measures. Again, they need to be clear about what they would cut—

Mr TEAGUE: Point of order.

The CHAIR: What is the point of order?

Mr TEAGUE: I take exception to reflections on some members of the committee; it is entirely erroneous.

The Hon. K.A. HILDYARD: Well, the member next to you is hurling insults.

Mr WHETSTONE: It is the truth.

Mr TEAGUE: Excuse me?

The Hon. K.A. HILDYARD: You heard him just as well as I did.

Members interjecting:

The CHAIR: Can the member for Chaffey please stop.

Members interjecting:

The CHAIR: Member for Chaffey!

Mr TEAGUE: I have a question, Chair. Staying with the table, minister: if the budget process is as I understand it, am I right in this proposition? There is an initiative that provides $85.1 million over four years from 2024-25 to support children and young people in care. Did the minister make a representation to the Treasurer and/or the cabinet, seeking this amount of money? If so, for what purpose? I will invite or flag that my subsequent question will be: can the minister provide any explanation to this estimates committee as to the application of that money in each of the years that are set out in the table that the government has provided for the purpose of these estimates?

The Hon. K.A. HILDYARD: I have answered this question. We provide those funds for children living in residential care, and of course all of our cabinet colleagues discuss budgetary matters.

Mr TEAGUE: What the committee is left to conclude—

The Hon. K.A. HILDYARD: Is this a question?

Mr TEAGUE: Yes, it is a question. The committee is left to conclude that this is nothing more than a reprofiling that the minister is not taking ownership for in respect of this amount and that

there is no explanation for what support children and young people in care can expect to receive in respect of the $61.408 million in 2025-26, the much-diminished $4.544 million in 2026-27 and then this rather specific, relatively minor sum of $554,000 in 2027-28. Is there any explanation to the committee as to what this means, why it is provided in each year and what it might be provided for, beyond the kind of generalised statements without reference to money that the minister has so far provided over the better part of an hour to this committee?

The Hon. K.A. HILDYARD: As I have said before, those funds go to community organisation partners who deliver residential care, and also DCP directly delivers residential care. I have been very clear that funds go to both DCP's provision of residential care and our community organisation partners to deliver residential care. Each time a child or young person comes to the attention of the system and we go through the processes and it is determined that the safest option for that child is to live in residential care, we then assess what is happening for that child and determine the sort of care that that particular child needs. It is right that that is continuously assessed and that decisions are made about the sort of package of support that each child or young person needs.

Alongside that effort and that investment into residential care services, we also invest in a range of programs to strengthen families and we invest in services to support carers who provide care for children in family-based care. For instance, on that note we have increased carer payments in 2022-23 by 4.8 per cent plus an additional $50 a fortnight, then 2.5 per cent, then 2.5 per cent this year. Also, we have introduced our flexible respite payment for carers. That was introduced at the beginning of last year. So we invest in those programs also.

Mr TEAGUE: The minister clearly does not know, Chair. I will move on. Perhaps I will slightly change the topic but bring us back to the point about FTEs that was the subject of multiple answers by government last year. I recall that I asked the minister last year if she was aware of the Treasurer's response in estimates the day before and the minister was aware. There was some focus at this time last year on the point about FTEs contributing to costs in the DCP budget.

I refer to Budget Paper 4, Volume 1, page 86. We are still in that table and we move from the penultimate line to the final line of that table. We have FTEs as at 30 June. The budget 2024-25 provided for 2,551 FTEs. Do you see that, minister? So that is where I am. The estimated result for 2024-25 was 2,582.7 FTEs, a difference of 31, if my maths is right, so there are 31 additional FTEs that were budgeted for. What roles are those additional 31 FTEs performing and what is the breakdown of the additional cost to budget for those additional 31 FTEs?

The Hon. K.A. HILDYARD: Two things, just to finish on an earlier point about the member's previous sets of questions. The other thing to be very clear about in terms of the investment into residential care and why that changes is because, as well as responding to complexity, as I said right at the beginning of this hearing but the member does not seem to want to hear it, we are reducing the rate of growth—

Mr TEAGUE: Point of order: I take exception to the reflection on a member of the committee. It is contrary to standing orders. I do want to hear it.

The CHAIR: I actually do not think it is needed and I do not think it is helpful.

The Hon. K.A. HILDYARD: I also do not think it is helpful. The slander that I have been subjected to by the member for Chaffey is not okay and I will call it out every time.

The CHAIR: Can you wrap up the summary from what is a previous question? This question is a very specific one.

The Hon. K.A. HILDYARD: I will call out that behaviour every time and I suggest that the member for Heysen call out that behaviour. I will go back to what I was saying. The other thing in relation to the costs of residential care that is really important to note, and I said it right at the beginning, is that we are slowing the growth of children in care, so that also has an impact on the funds expended in residential care.

Mr TEAGUE: What roles are the 31 additional FTEs performing?

The Hon. K.A. HILDYARD: I will get to the next part of the question. The really important thing to note is that, since coming to government, we have grown the number of staff FTEs.

The CHAIR: Okay, so we are getting to the specific question now.

The Hon. K.A. HILDYARD: The FTE growth has been 241 since coming to government—a 241 increase in net FTE. That is really good news. I am sure the member is very pleased to hear that. We are also very pleased that just recently we have had a record number of frontline youth workers recruited to provide care, support and empowerment to those children and young people, so I am very pleased by the overall result and I am very pleased about that growth in those youth workers at the frontline. The other staffing measure—

Mr TEAGUE: If the minister does not know the answer to the question, the minister is entitled to seek an answer.

The CHAIR: I think the minister is attempting to answer the question.

The Hon. K.A. HILDYARD: I am answering it actually.

The CHAIR: There is a reference to youth workers.

The Hon. K.A. HILDYARD: I am actually answering it. The other point that the member can see in the budget in relation to staffing is that we have invested an additional $2 million into this budget to increase the number of staff at the Child Abuse Report Line.

Can I say on this point to youth workers, those contact centre staff and indeed all of the staff in the Department for Child Protection and indeed right across the system, thank you for the incredible work you do to provide support to children and young people. Their commitment is absolutely extraordinary. They are the people who have to make those very difficult decisions about whether or not to remove children and their work and their commitment to those children is extraordinary.

I am very pleased—again, 241 new FTEs since coming to government, increase in youth workers, increase in this budget in the Child Abuse Report Line staff.

Mr TEAGUE: What we have learned so far in relation to these additional 31 FTEs is, if I might say so, very little indeed. I ask the minister again: what roles are these 31 additional FTEs performing? Put it in the context of a business in the real world. You employ one FTE, you want to know what they are doing. You employ 31 FTEs, it is a significant business all on its own. Surely the minister has taken some interest—

The Hon. K.A. HILDYARD: Of course I have.

Mr TEAGUE: —in what those FTEs are doing and is aware of the fact that there are 31 excess to budget. I do not know what goes on. Apparently, there is not a particular budget request for a particular outcome. In the same way, in terms of these 31 FTEs, is that just drift through the course of the year that the minister has become aware of on reading the budget papers? Is there some explanation? It might be a good one and, if so, what are they doing?

The Hon. K.A. HILDYARD: For goodness sake!

The CHAIR: Can I make what I think might be a useful suggestion? The minister did indicate, in the broad, the child abuse line and another additional service that has had the benefit of more FTEs.

Mr TEAGUE: I would love to know how many.

The CHAIR: I think you want something more specific than that. It might well be, if the information is not available at the moment—

The Hon. K.A. HILDYARD: Of course it is available.

The CHAIR: —it could be reported back.

Mr TEAGUE: Take it on notice. Good idea. Thank you, Chair, I welcome your intervention.

The Hon. K.A. HILDYARD: No, I do not need to take any questions on notice. I am well across all of the budget, of course.

Mr TEAGUE: Well, answer the question then. Just answer the question.

The Hon. K.A. HILDYARD: So those positions also include case managers and support staff who, again, do extraordinary work supporting children and young people.

Mr TEAGUE: How many case managers were employed in addition to budget? When did they commence? Who made the decision and for what purpose?

The Hon. K.A. HILDYARD: We are talking about the budget for 1 July going forward.

Mr TEAGUE: No, we are not. We are talking about the budget papers at the line of FTEs at page 86.

The Hon. K.A. HILDYARD: Again, I will break it down for the member. We have employed 241 net additional FTEs—

Mr TEAGUE: So you want to go that far back now?

The Hon. K.A. HILDYARD: —since coming to government, in sharp contrast to those opposite. We are growing staff numbers to support children and young people. That is the right thing to do. I am not sure what is funny about that. That is the right thing to do.

Mr TEAGUE: The minister just went back three years, having admonished me for analysing the budget result for the last year. That is what is funny.

The Hon. K.A. HILDYARD: I have already answered the question about case managers, support staff—

Mr TEAGUE: How many? What cost?

The Hon. K.A. HILDYARD: —and we will continue to grow staff. In that 241 FTEs, from April to April this year—so April 2024 to April 2025—just in that period we employed another 79.5 FTEs. So whichever set of questions the member chooses to give a speech about and ask some questions on, I have those figures. I have just answered the question. I will leave it there.

Mr TEAGUE: I am not going to leave it there.

The CHAIR: Can I just once again intervene?

Mr TEAGUE: We are here analysing the budget.

The CHAIR: The minister has, in part, answered the question. I guess the member is actually seeking specifics. That is why, if it is not available now—

The Hon. K.A. HILDYARD: It is available. I have just given it.

The CHAIR: —about what the breakdown is, it can be provided.

The Hon. K.A. HILDYARD: I have just provided it.

Mr TEAGUE: I appreciate that, Chair. That is on the record as well, and it is there for all to see. The minister has nothing more to say about the matter, apparently. I invite the minister to take on notice the particulars of what roles these 31 additional FTEs are performing and what the breakdown of additional costs for those 31 FTEs is. If the minister wishes to decline, the minister might reflect on that in the remaining 20 minutes.

The Hon. K.A. HILDYARD: I have not declined. I have answered the question very, very clearly. I have just spoken about April to April—79.5 FTE higher. So April 24 to April 25, I have described a range of the positions that we are growing.

Mr TEAGUE: The program summary income expenses—same page, same table—the 2025-26 budget provides for 2,595.8 FTEs, nearly 2,596 FTEs. That is an increase of 13 or so for this financial year ahead. How many of those FTEs are allocated to the CARL as per the—I think there has been a government budget announcement about that. What are the remaining FTEs for? There is apparently no reduction in FTEs to contribute to the $82 million cut, reduction in expenditure, that is budgeted for this year ahead. Is it correct to say that there will be no reduction in FTEs to meet that $82 million budget reduction for the year ahead?

The Hon. K.A. HILDYARD: As I said, we are growing FTEs. To go to the first part of the question about the 13, the member will see in the budget papers that one of our many new investments relates to new staff in the call centre and also in the additionally approved carers and Finding Families program.

Mr TEAGUE: I think my next question was: what are the remaining FTEs for?

The Hon. K.A. HILDYARD: I have spoken about the various positions across the Department for Child Protection. I have just spoken about the 13, the call centre and the additionally approved carers and Finding Families program. I have also spoken about the sorts of positions that we have been grown in the Department for Child Protection: youth workers and case managers amongst others.

Mr TEAGUE: What we have learned so far, I suppose, is that the number of FTEs from this year, with an estimated result of 2,582.7, to the year ahead of 2,595.8, is an approximately 13 FTE increase over and above the FTE increase the year before. Against that, we see this quite substantial $82 million reduction in the budget. There is an additional, one might presume—but if that is not right, if somehow these FTEs are employed at a reduced cost to current FTEs that might be one explanation, but there is a relatively significant increase in FTEs and therefore, I presume, cost and, at the same time, there is an $82 million cut to the budget as against the estimated result from this year.

Did the minister protest that result to the government? Does the minister have any reasonable expectation of meeting the budget—presumably not contributed to by FTE neutrality or cut—and, if so, what will be the contributors to achieving that $82 million budget reduction for the year ahead?

The Hon. K.A. HILDYARD: First of all, to be very clear, we are not cutting any staff, any FTEs—absolutely not.

Mr TEAGUE: You are adding 13.

The Hon. K.A. HILDYARD: We are not cutting any staff. We will continue to make reforms to the system, reforms that are finally seeing a reduction in growth in the number of children and young people coming into care. That is a really important factor in terms of assessing the cost of providing services to children in care: the slowing of the growth of numbers of children and young people coming into care. Our work on programs like family group conferencing, reunification and Finding Families are all showing results and adding to that result. It is a result I am very, very pleased about.

That reform will continue. We will continue with our investments in programs that help to keep families safely together, and we will also, as I have spoken about, continue our work to reimagine residential care, and whatever complexity, whatever needs a child comes to our system with, when they require care we will meet the costs of that care.

Mr TEAGUE: Turning to page 87 of the same budget paper and same volume—Agency Statements, Budget Paper 4, Volume 1, page 87—it is the table immediately opposite 'Performance indicators' and the first line of the performance indicators table is a new indicator, as is indicated there, as is set out by the words 'New indicator'. It is the first of them that says '% of investigations completed within 90 days from notification (response time)'.

That is a new indicator. Previous budgets, including the 2024-25 budget, had a similar line item appearing as the first line item. That no longer exists, however, here. That line item was an indicator being '% of investigations commenced within 7 days from notification (response time)'. So they are two response time indicators.

The committee will be well aware of that context, I expect. That was an indicator that was repeatedly and dramatically falling short of target. Just from memory the estimated result against the 75 per cent target was in the 50s each time. It was nowhere near being achieved. Then we see on the application of this new indicator, 'completed within 90 days' the relatively rather more rosy looking figures by reference to the target, including retrospectively—

The Hon. K.A. HILDYARD: That is just not true, Josh.

Mr TEAGUE: It is not a criticism.

The Hon. K.A. HILDYARD: It is not true, and you know it.

Mr TEAGUE: I see it is true: the estimated result exceeds the target, which I think is something the government would like to see.

The Hon. K.A. HILDYARD: That is not what I am calling you out on, and you know it.

Mr TEAGUE: The previous indicator was a seven-day commencement target, and that was not achieved, by a wide margin. So I am interested to know why the government has seen fit to do away with that previous indicator as to response time, which had repeatedly failed to meet its target, and instead substitute one which I might say members of the committee might regard as being rather less of a—call it—exacting measure of how the department is going about discharging its obligations, what policy reasons might justify that change and what, indeed, the minister can say about the good old response time indicator of investigations being commenced within seven days.

The Hon. K.A. HILDYARD: I explained this to the member last year—about the way the national bodies assess rate of investigations. We actually have an investigation turnaround period that is not measured nationally. That is a 24-hour investigation rate. So that is the difference. That is not something that is assessed nationally.

What you will be really, really pleased to know is that the most recent RoGS data actually placed South Australia as having the second highest result of all Australian jurisdictions in terms of the rate at which investigations are undertaken. Really importantly—this is a really important figure for you to understand—again, the RoGS data shows that South Australia's rate of investigations and successful completion of those investigations sits at 15.1 points higher than the national average. That is really, really good news.

The other really good news about investigations is that at the time of Nyland, the rate of cases that were not proceeding at that time sat at 55 per cent. Up until us coming to government, those figures remained worrying. The rate of investigations now, and, again, with 15.1 per cent higher than the national average, now sits, on that same figure about the not proceeding at a rate—we have reduced that by almost 40 per cent.

Mr TEAGUE: I might say, it has been interesting to hear the minister's fluency with respect to this particular data and willingness to address specifics, which stands in stark contrast to—

The Hon. K.A. HILDYARD: Is this a question?

Mr TEAGUE: —an unwillingness to address specifics in relation to the budget as a whole.

The Hon. K.A. HILDYARD: Mr Chair, is this a question?

Mr TEAGUE: The question that that begs minister is: why should South Australians, let alone this committee, not form a view that this change of indicator is just straightforward cherrypicking to put a gloss on departmental performance?

The Hon. K.A. HILDYARD: I have just explained this particular matter to the member, and, again, I would refer the member to the RoGS data, which shows that South Australia's investigation rate sits at 15.1 percentage points higher than the national average. That is good news.

Mr TEAGUE: What is the South Australian figure, and what is the national average?

The Hon. K.A. HILDYARD: That is really good news. We had, last financial year, in 2023-24, a 17.5 per cent increase on the number of notifications compared to 2022-23.

Mr TEAGUE: That is not the question.

The Hon. K.A. HILDYARD: Again, we are 15.1 percentage points higher than the national average. I refer you to the RoGS data to look further at that really pleasing result for South Australia.

Mr TEAGUE: Once again, I am not sure what question the minister was answering there; I will just ask it again. What is the national figure and what is the South Australian figure that exceeded that, as the minister said, by 15 percent?

The Hon. K.A. HILDYARD: I am happy to provide the RoGS data to the member.

Mr TEAGUE: Can the minister just put it on the record now? It is apparently in front of the minister now.

The Hon. K.A. HILDYARD: I just said I am happy to provide the RoGS data to the member, so I will take that on notice and provide the RoGS data in full to the member.

Mr TEAGUE: I am sure it is interesting for the whole committee. Is the minister able to just indicate to the committee then what percentage of investigations were commenced within seven days from notification over that relevant period?

The Hon. K.A. HILDYARD: Again, I can provide all of that data, the RoGS data, to the member. I am not quite sure how else to say that.

The CHAIR: The minister did indicate that that data will be provided, so you will get your answer.

Mr TEAGUE: I appreciate that. Is the minister willing, in doing so, just notate it to whatever extent the minister wishes to point to the figure that the minister would rely upon—

The Hon. K.A. HILDYARD: Sure; I am very happy to do that—that is the answer to that question.

Mr TEAGUE: —in order to substantiate that response?

The Hon. K.A. HILDYARD: I am very, very happy to do that.

Mr TEAGUE: Otherwise, I note that the minister declines to answer for the committee here today what the percentage of investigations commenced within seven days from notification happens to be. I do not know what the reason for that might be.

The Hon. K.A. HILDYARD: Again, I did explain this before. This is not the case in every jurisdiction, nor how every jurisdiction measures—it is not the case that every jurisdiction measures in this way—but we actually measure commencement within 24 hours, which, again, I am sure the member will be pleased about.

Mr TEAGUE: I want to move to a topic that I think the minister will welcome in the five minutes remaining. For the benefit of the committee, if not for me—and sometimes I am a bit slow—am I to be reminded that the data that the government previously placed at this point in the table, in relation to investigations commenced within seven days, was in fact a figure that indicated investigations that actually commenced within 24 hours? Is that what the minister is indicating to the committee?

The Hon. K.A. HILDYARD: We have two measures in South Australia: 24 hours and 10 days. You will see from the provision of the RoGS data our performance in relation to investigations surpasses other jurisdictions. I presume the member will be very happy to hear that. I also point the member to the fact that we are recruiting additional staff, investing in additional staff into our Child Abuse Report Line, which again will help with that receipt of information.

The other thing to point the member to, which, again, I am sure he is very happy about, is that I have been very clear in previous discussions in the parliament about the child protection share of the Digital Investment Fund. What is very pleasing in this budget is that we have the first tranche of that funding of $14.9 million for Kidsafe Connect, and Kidsafe Connect is the system that over time will replace the C3MS system.

What is really important about that replacement is that will enhance, make much more efficient and effective, how information about children and young people who are the subject of a notification to the child protection and family support system is received and how it is analysed. I very much look forward to that investment—again, that investment through this budget—delivering for children and young people and enabling those remarkable workers at the frontline to continue with their work and to enhance their work.

Mr TEAGUE: The next question is at page 88 of Budget Paper 4, Volume 1, just over the page. It is the activity indicators table. In the two or three minutes remaining, I refer to the fourth line

of that table—the number of children and young people under the guardianship of the chief executive for a period up to 12 months. The 2024-25 budget projected that that number would grow to 650 and, as the minister indicated earlier, in terms of a slowing of growth, the 2024-25 estimate is 560, which is a significant variance, and the 2025-26 projection is an increase to 580—still a somewhat significance variation to the 2024-25 projection. Is there an explanation as to why there is such a significant variance, albeit in circumstances of the continued growth of the number of children and young people under the guardianship of the chief executive for that period?

The Hon. K.A. HILDYARD: As I said, we have reduced the rate of growth of children and young people in care, which is incredibly pleasing. There are a range of measures that I would attribute that to; some of them go to the incredible success of our investment into family group conferencing, into Finding Families and also into the reunification programs that we have invested in. I am very pleased with the results that they are showing. Right now, I can let the member know that, as at 31 May, that growth rate is now minus 0.6 per cent. I am sure the member is also pleased with that rate.

The thing to understand about family group conferencing is that one of the things that happens in both family group conferencing and in reunification processes is that—with that figure there, for a period of up to 12 months—those programs are successfully intervening. So when a child or young person is taken into care through the intervention of one of those programs, it is less likely that they will stay in care for a longer period; rather, they will go back to safely live with their families within that 12-month period. Hence we measure that in the way that we do, to think about what interventions can be successful in that 12-month period. Again, that decrease relates to the success of those programs that we are investing in. What I can tell you is that I am advised that around about—

The CHAIR: Can you wind up?

The Hon. K.A. HILDYARD: Sure. I am advised that last year, in that period, around 500 children returned home. That is certainly work that we will continue.

The CHAIR: Thank you. The allotted time having expired, I declare the examination of the proposed payments for the Department for Child Protection and its administered items complete.

Sitting suspended from 10:32 to 10:45.

DEPARTMENT OF HUMAN SERVICES, $352,792,000

ADMINISTERED ITEMS FOR THE DEPARTMENT OF HUMAN SERVICES, $1,167,059,000

Membership:

Ms Pratt substituted for Mr Pederick.

Minister:

Hon. K.A. Hildyard, Minister for Child Protection, Minister for Women and the Prevention of Domestic, Family and Sexual Violence.

Departmental Advisers:

Ms S. Pitcher, Chief Executive, Department of Human Services.

Ms R. Ambler, Deputy Chief Executive, Department of Human Services.

Mr N. Ashley, Chief Financial Officer, Finance and Business Services, Department of Human Services.

Ms B. Marsden, Director, Office of the Chief Executive and Governance, Department of Human Services.

Ms S. Vas Dev, Director, Office for Women, Inclusion, Support and Safeguarding.

Ms E. Humphreys, Director, Office for the Prevention of Domestic, Family and Sexual Violence.

The CHAIR: I declare the proposed payments open for examination and I call on the minister to make an opening statement, if she so desires, and to introduce her advisers.

The Hon. K.A. HILDYARD: Thank you, Mr Chair. I will not be making an opening statement, but I will introduce the people with me. On my left is Sandy Pitcher, the CE of the department, and Chief Financial Officer Nick Ashley. We also have Deputy CE Ruth Ambler, and behind me Dr Sanjugta Vas Dev, Bel Marsden and Emily Humphreys, who is heading up our new Office for the Prevention of Domestic, Family and Sexual Violence.

The CHAIR: The member for Frome, do you have an opening statement or is it straight to questions?

Ms PRATT: Straight to questions, and I will be sharing that with my colleague the member for Heysen.

The CHAIR: Sorry, I thought you might have been the lead on this one.

Mr TEAGUE: I might get started. My opening statement is only to say I appreciate the minister's presence, the committee and the advisers here for the purposes of this estimates process. I refer to Budget Paper 4, Volume 3, where I think we will find ourselves focused, pages 114 and 115, starting with page 114, Program 1: Women, Equality and Domestic, Family and Sexual Violence Prevention.

I refer specifically to the 2025-26 targets and the first of those targets, which is to lead the development of the government response to the Royal Commission into Domestic, Family and Sexual Violence. I note, as all members will be aware, the recent gazettal of an extension of time from 1 July this year to, I think, 18 August this year for the handing down of that royal commission report. Perhaps I might then indicate a presumption. We know that is partly for the reason of there being such a strong response to that royal commission and that therefore might indicate that the royal commission is going to be coming back with some fairly substantial outcomes, recommendations and so on.

I open by inquiring what resources are available for the implementation in anticipation of the findings of the royal commission and what necessities the government anticipates will be for provision in the Mid-Year Budget Review, but first by pointing to resources identified in the budget?

The Hon. K.A. HILDYARD: Thank you to the member for the question. I will just provide a very brief reflection on that gazettal, the change to 18 August, and what the member himself alluded to in terms of the volume of submissions and hearings and use of the Share With Us tool that the royal commission has encountered.

As everybody in this place is aware, the royal commission commenced on 1 July and is led by extraordinary South Australian Commissioner Natasha Stott Despoja AO. It is largely, in a very general sense, looking at the four themes of prevention, intervention, response, and recovery and healing, and also looking at the coordination of the whole-of-system effort. The commissioner, as I said, and the commission have received a total of 381 written submissions and 251 of those have been published. There have been numerous hearings right around the state and many people providing information in confidence.

The royal commission is now, as the member has spoken about, focused on preparing its final report and, obviously, reviewing those public hearing transcripts, submissions, data and the huge body of evidence that has been collected over the last 11 months. It is due to that scale of engagement and ongoing interest from the community and the sector that that adjustment to the royal commission's timeframes was agreed upon.

I reflect on that to say that I am so incredibly grateful for the work of the commissioner and the commission and so pleased that so many women have had that opportunity to share their stories,

to be heard and to know that their voices and experiences matter. Also through this royal commission we are sending a message to our community that we will not tolerate domestic, family and sexual violence in this state.

In terms of the investment, as the member would be aware $3 million was committed to the establishment and running of the royal commission itself. As is articulated in this budget, we have also invested $1.5 million in the central response unit, the Office for the Prevention of Domestic, Family and Sexual Violence. That has been an incredibly important unit in terms of preparing the cross-government submission but also responding to requests for information from the commission and preparing and providing any documents that are required.

We have been very clear that significant investment, significant funding, will be required on receipt of those royal commission findings. We very much look forward to, in about seven or eight weeks' time, receiving those findings and examining those findings and any recommendations the commissioner has chosen to make. We are very clear that there is investment that will follow on receipt of those findings as we understand the scope, the breadth, of what the commissioner proposes in terms of South Australia addressing any system gaps and also elevating, finally, in South Australia, the opportunity we have to genuinely lead a whole-of-government, whole-of-community and whole-of-sector effort.

As I have said before publicly, significant investment will follow on receipt of those findings. We look forward to the findings and examining exactly to which efforts we direct that funding. Let me be very clear: our government absolutely embraces this once-in-a-generation opportunity to finally, comprehensively tackle the awful prevalence of domestic, family and sexual violence and the gender inequality that, sadly, we know is a driver of this terrible prevalence of violence against women.

Mr TEAGUE: It was a long answer, and I do not detect in there any indication from the minister that there is any money in the budget at all for responses to the outcomes of the royal commission. I indicate many shared sentiments in relation to the important work of the commission. If that is the case—there is no money in the budget— what contingency has the government provided for in terms of response, or, as I foreshadowed already in the question, are South Australian women and all the rest of us going to have to wait for a Mid-Year Budget Review to get any identification of the funding that is necessary?

I emphasise for the committee that this is a royal commission that has been running and, until recently, known to be concluding its work right about now. I just want to be clear and correct about that being the government's approach to the matter in terms of funding. Contrast that against the provision that the government has made of at least $50 million just now, together with some accelerated legislation for the redevelopment of the North Adelaide Golf Course, for example. It is possible to make provision for such future expectations, and the minister has given a fairly clear indication of the government's intent on receipt of the royal commission report.

So if it is another opportunity for the minister to identify any money at all in the budget, then I welcome that indication where it might be found. If it is to be found in some forward contingency that is not in the budget but in contemplation, then I would invite the minister to provide an indication of what the amount is. Otherwise, if it is a matter for Mid-Year Budget Review, then I invite the minister to be clear about that.

The Hon. K.A. HILDYARD: I will be very clear about two things. Firstly, the royal commission will provide its findings on 18 August, seven to eight weeks away. Significant investment will follow when we have the opportunity to look, rightly, at what is recommended in that Royal Commission into Domestic, Family and Sexual Violence. Of course we will look at the recommendations and then determine, again, that significant investment going forward.

In terms of the question about women waiting, again let me be very clear: this budget contains funding for the royal commission response unit, so that as soon as we receive that report, as we have already been preparing for, we will set about determining that response. Also, in this budget we have new funding for the domestic, family and sexual violence prevention and recovery hubs that were a new investment when we came to government.

An investment that we called and called on the previous government to provide was not forthcoming. We provided that investment and those hubs are established, and we are now providing further hubs. Those hubs provide an opportunity for women in South Australia, alongside the 10 regional safety hubs, which are also now funded with paid staff—they were not, before we came to government—to seek early access to support, referrals and advice close to home.

Also, in terms of that question about waiting, the member will see in the budget the significant investment into housing that is provided. In that housing what is included is $15 million towards new accommodation in the city for particular cohorts of women. That sits alongside the recent opening of the YWCA housing, and it sits alongside our ongoing and considerable investment into crisis, transitional and ongoing housing for women who are experiencing domestic, family and sexual violence. It also sits alongside our reversal of the terrible, terrible cuts to Catherine House and the Women's Domestic Violence Court Assistance Service. They are now, through this government, restored, so all of those funds will continue.

There are many other things that I will speak about in terms of funding that we have now for women experiencing domestic, family and sexual violence, and for all of the other parts of the system in terms of perpetrator intervention, recovery and healing supports, and also, on top of that, as I have been very clear about, on receipt of the findings of the royal commission—we will rapidly assess and consider those recommendations—significant investment will follow.

Mr TEAGUE: My question is again by reference to page 114, same program summary but this time focused on the first dot point under highlights 2024-25, which takes us to a highlight being described as the introduction into parliament of the Criminal Law Consolidation (Coercive Control) Amendment Bill 2024, following extensive consultation. With that in mind, again, it is the same theme: what resources are available for the implementation of that legislation? I put that in the particular context of remarks from the police minister yesterday. I will quote him for the benefit of the committee. The minister might already be aware. Yesterday, the police minister said:

> The regime will not come into effect until 2028 here in South Australia, and part of the reason why was to see how these new reforms were being rolled out in other parts of the country to understand what impact they had generally, but in particular on police resourcing as well. Hopefully, over the course of the next one, two and three years we will have a better understanding of what that researching impact looks like.

The question, against the backdrop of that claimed highlight, is: why is the legislation not coming into effect until 2028, despite it being an election commitment from the government? I think it is something that the minister has advocated for as a particular personal priority.

Again, to take up the same analogy as before, we have seen the government pushing through legislation and commitments in the budget for the golf course redevelopment in a matter of hours, but we are going to see years and years now before the implementation of the coercive control bill, despite it being described as highlight No. 1 in the highlights list.

The Hon. K.A. HILDYARD: Thank you very much to the member for his question, and he is right, it has been a priority of mine and of our entire government. That priority is evidenced by the fact that, as an opposition party, we first moved to criminalise coercive control in 2020 but, very sadly, the bill at that time was not supported. It did not progress through the parliament. On coming into government, of course I seized the opportunity—our government did—to move towards criminalising coercive control.

What has been really, really important about the process of getting to the point where a bill has now progressed through the lower house and is currently being debated in this house is that we took the time before the new bill was developed to engage with targeted groups of women—Aboriginal women, women living with disability, women from diverse multicultural communities, young women, a range of women—to really make sure that we got the content of the bill right. We went through that process. We developed the bill, taking on board their feedback, and we then took the bill out for further broad consultation with our community.

I will note one of the things that was very clear from that consultation—from those earlier targeted conversations—but that has also been very clear from evidence around the world, including from those jurisdictions in Scotland and England in the UK that were the very first to progress coercive control legislation. Their very strong advice and our very strong advice from consultation

was, 'Yes, get your legislation right, get that through the parliament.' As I said, I first attempted to do that in 2020 and it is now progressing through our parliament.

But the advice was also to absolutely make sure that following the passage of the legislation through the parliament, we take the time that is needed—and there has been strong advice that time is significant—to make sure that there is broad community understanding and that there is understanding in every sector and every government department about what coercive control is so that when women present having gone through an experience of coercive control it is recognised, particular charges are made in the best way possible and it progresses through the courts with that recognition of what it is and what the appropriate remedies are.

We have taken that advice. It has been consistent and really clear from every jurisdiction. I have talked with people across the globe who have introduced this legislation, and I have made it my business for a very long time to find out the best possible way to do this. That is absolutely the advice: to make sure you get it right so that we do not have an experience of women raising this issue and it not being understood in the way that it should be and so that the appropriate penalties and actions are taken following the raising of that issue. We are absolutely taking that advice on board.

We have also been working on that broad community awareness raising. We have been in contact with Sue and Lloyd Clarke. They have spoken at a forum here where we launched a campaign called 'See the signs' to begin that process of raising community awareness about coercive control. We had a first iteration of that campaign. The Attorney-General's Department then ran an iteration of that campaign. We also leveraged the time around the FIFA Women's World Cup to build a further iteration of that campaign to spread a message to a broad, diverse group of people about what coercive control is. We will continue to do that, and on the passage of the legislation we will take that time to absolutely, rightly make sure we get that implementation right.

Mr TEAGUE: If I may just briefly follow up, indeed I agree the minister has been calling for this. I think significantly in 2021 the minister highlighted that criminalisation of coercive control was urgently required then. In those circumstances, what is the minister's view about the police minister's remarks about the regime not coming into effect until 2028, again notwithstanding that it is a highlight of 2024-25 and in circumstances where I understand in New South Wales, for example, it has come into effect? Is this a matter of a wrestle for the minister to be having with the police minister? How would you understand the allocation of resources and the implementation time having really extended in this significant way?

The Hon. K.A. HILDYARD: Absolutely not. It is the right thing to do and that is the learnings around the world: to make sure that you get the legislation right, pass the legislation and then spend time, through whatever particular processes other jurisdictions have used, to learn from those processes, and to make sure that you have a significant period of time to make sure that once it takes effect that the community, services, everybody, is ready, each person who comes into contact with this awful behaviour from a service or response lens understands exactly what they are seeing and understands and has in place the particular processes to make sure that its implementation is effective.

I do not have the figures about the Scottish experience and the English experience on hand. I had lengthy conversations and there are lengthy articles written about the fact that one of their learnings was that, having implemented it quite quickly, there was a very, very low number of convictions. Despite there being no lessening of the occurrence of the offence, occurrence of the terrible behaviour, the convictions did not flow because there was not this broad understanding in the community and in all who interact with this particular offence of what it looked like, how to treat it, how to respond. So we absolutely want to make sure that we heed that advice and get it right.

Ms PRATT: Minister, if I can take you back to hubs, which you addressed earlier. The budget paper I am referring to is Budget Paper 5, the budget initiatives, where the budget provides $2 million over two years to continue and expand the domestic violence prevention and recovery hubs in Adelaide's north and south. Minister, what additional services will be delivered through the expansion of those hubs in the northern and southern suburbs? How many clients are you expecting to benefit from the expanded service, and what metrics will be used to measure that impact?

The Hon. K.A. HILDYARD: Thank you very much for the question. I know that this has been an area of interest for the member as well. As the member has said, there has been a commitment for an additional $2 million to be provided to ensure the continuation and the expansion of these really critical services, services that did not exist at all until we came to government and set about the establishment of those hubs. They are slightly different models because each of those communities informed us about what they wanted their hub to look like.

The southern hub, which is called The Yellow Gate, is very much about women being able to come in any circumstance to that place and either be immediately connected to counselling or referred, if there are particular supports and services that they need. I say this because it is always a double-edged sword: sadly, the demand has been strong. I say it is a double-edged sword because it is incredibly sad and I am so deeply frustrated that the demand is strong. It is good, however, that those women now have that place to go.

In relation to the southern hub, there is demand. We want to be able to respond to that demand. There are other services that are now associated with that particular hub and providing particular supports at particular times, which is great. It is growing in terms of others that are aligning their efforts there too. So that is about responding to demand.

The northern hub is a different model, because the community there wanted—and the strong advice from Women's Safety Services as to what was needed there—some co-location of Women's Safety Services personnel, police and Women's Legal Service personnel, so that women in particular circumstances could come into a very confidential environment and make those police reports, as well as be immediately connected to the Women's Safety Services. Again, the demand there has been very strong, and we anticipate that that additional funding will sustain and grow that demand, but it will look slightly different, because each of those hubs have been set up, rightly, because it was what the community articulated in a slightly different way.

The other point I wanted to make to the member is that, whilst none of us can predict the findings of the royal commission, I know from evidence right across the country that hubs as a model are being considered. There are different versions: The Orange Door and inTouch in Victoria and other iterations of hubs right around the country and in other places around the world. I look forward to continuing to explore how else we may grow or reshape them into the future.

Ms PRATT: To push the minister a little bit more in terms of data and metrics. The reference to Yellow Gate in the southern suburbs: I understand the bittersweet element of what is sad about a growth in demand. The question goes to, in a deidentifying way, how many clients, what data, what that growth looks like, how is it measured? Do we know to a number what that growth is for those hubs? How many clients are expected or are we seeing in that expansion and how are we measuring that? Is it having an impact?

The Hon. K.A. HILDYARD: We do have those numbers for each. I am looking at those now. For the southern hub, between a roughly 12 to 13-month period, there were more than 500 inquiries, and 41 per cent continued to receive a direct service. There are also figures that can be broken down around the diversity of people approaching the service. The other thing The Yellow Gate does is—because this is the model the community wanted—as well as those inquiries that come directly through the door at Noarlunga, that hub has a team out in the community.

At any community events in the broad southern metropolitan area they are there giving information, making sure people know about the hub. There is also that figure of the number of community visits they do but, as you can imagine at those community events, sometimes they are very well attended and others not. I can tell you that there were 398 attendances across 19 community events held in roughly a 12-month period, but it is a different model.

In terms of the northern hub, which started slightly later than the southern hub, there was the need to establish it in a particular way with police and Women's Safety Services to find the right secure site for that particular hub. In the roughly nine to10-month period, there has been direct support for around 148 individual women and around 406 referrals that have also come through that. When I say 'referrals', there are those direct services but also the ones where there is work with a particular woman but where the ultimate ongoing service may rightly be with another service provider.

Ms PRATT: Would the minister take on notice, then, the demographic breakdown that the minister seems to have, across both the northern hub and the southern hub particularly, to better understand the diversity you mentioned for the southern hub? Would the minister take on notice to provide those details, to identify the need?

The Hon. K.A. HILDYARD: Yes.

Ms PRATT: Thank you. If I can move us on to Budget Paper 4, Volume 3, page 114, looking at targets. The bottom dot point target states:

> Participate in the independent review of South Australia's homelessness system and support alignment between the review of the Domestic and Family Violence Safety Alliance and the response to the Royal Commission into Domestic, Family and Sexual Violence.

This is about the expansion of DV beds. I understand the DFV homelessness alliance and funding is a part of your portfolio of responsibilities. Why do the specialist women's services still only have direct responsibility for the 31 beds that were provided under the previous government in 2020? What has happened to the other 69 that had been funded and approved by the previous government?

The Hon. K.A. HILDYARD: What I can tell the member at length, and I know there was some unfortunate incorrect commentary about this recently, is that it is actually 40 crisis beds that you speak about: 31 crisis beds for women and then nine beds for perpetrators, so it is actually 40. Coming into government, we saw the lack of ongoing funding for those, so we set about funding those beds. Across the alliance there are more than 300 other properties, and those properties go across crisis accommodation, they go across transitional accommodation and they go across those ongoing housing properties. So there is way more than the figure you just spoke about, way more than that, and that is very clear.

Also alongside those hundreds of properties for women experiencing domestic, family and sexual violence, we contributed another $7.5 million to continue those crisis beds that you spoke about. On top of those 40 beds there are the more than 300 other properties, plus we have set about investing in establishing new accommodation for women experiencing domestic, family and sexual violence. Just recently, we were part of the opening of the YWCA housing development in the city, and soon the $15 million Tucker Street development will open.

As I said before, our government has restored the funding to Catherine House that, unbelievably, was cut by the former government. There were many cuts made by the former government that I was dismayed about, but the funding cut to Catherine House was just unconscionable. We have also restored that funding. We have provided ongoing funding that was not there for those crisis accommodation beds, and we continue to ensure there is accommodation across crisis, transitional and ongoing housing for women experiencing domestic, family and sexual violence.

The other point that I would make, of course—and it is very clear in this budget; it is very clear in our Housing Roadmap—is that our government is delivering in terms of growing the supply of housing. We have been very clear that a range of types of housing is included in that significant investment.

Ms PRATT: The omnibus questions are:

1. For each department and agency reporting to the minister, how many executive appointments have been made since 1 July 2024 and what is the annual salary and total employment cost for each position?

2. For each department and agency reporting to the minister, how many executive positions have been abolished since 1 July 2024 and what was the annual salary and total employment cost for each position?

3. For each department and agency reporting to the minister, what has been the total cost of executive position terminations since 1 July 2024?

4. For each department and agency reporting to the minister, will the minister provide a breakdown of expenditure on consultants and contractors with a total estimated cost above

$10,000 engaged since 1 July 2024, listing the name of the consultant, contractor or service supplier, the method of appointment, the reason for the engagement and the estimated total cost of the work?

5. For each department and agency reporting to the minister, will the minister provide an estimate of the total cost to be incurred in 2025-26 for consultants and contractors, and for each case in which a consultant or contractor has already been engaged at a total estimated cost above $10,000, the name of the consultant or contractor, the method of appointment, the reason for the engagement and the total estimated cost?

6. For each department or agency reporting to the minister, how many surplus employees are there in June 2025, and for each surplus employee, what is the title or classification of the position and the total annual employment cost?

7. For each department and agency reporting to the minister, what is the number of executive staff to be cut to meet the government's commitment to reduce spending on the employment of executive staff and, for each position to be cut, its classification, total remuneration cost and the date by which the position will be cut?

8. For each department and agency reporting to the minister, what savings targets have been set for 2025-26 and each year of the forward estimates, and what is the estimated FTE impact of these measures?

9. For each department and agency reporting to the minister:

(a) What was the actual FTE count at June 2025 and what is the projected actual FTE account for the end of each year of the forward estimates?

(b) What is the budgeted total employment cost for each year of the forward estimates?

(c) How many targeted voluntary separation packages are estimated to be required to meet budget targets over the forward estimates and what is their estimated cost?

10. For each department and agency reporting to the minister, how much is budgeted to be spent on goods and services for 2025-26 and for each year of the forward estimates?

11. For each department and agency reporting to the minister, how many FTEs are budgeted to provide communication and promotion activities in 2025-26 and each year of the forward estimates and what is their estimated employment cost?

12. For each department and agency reporting to the minister, what is the total budgeted cost of government-paid advertising, including campaigns, across all mediums in 2025-26?

13. For each department and agency reporting to the minister, please provide for each individual investing expenditure project administered, the name, total estimated expenditure, actual expenditure incurred to June 2024 and budgeted expenditure for 2025-26, 2026-27 and 2027-28.

14. For each grant program or fund the minister is responsible for, please provide the following information for the 2025-26, 2026-27 and 2027-28 financial years:

(a) Name of the program or fund;

(b) The purpose of the program or fund;

(c) Budgeted payments into the program or fund;

(d) Budgeted expenditure from the program or fund; and

(e) Details, including the value and beneficiary, or any commitments already made to be funded from the program or fund.

15. For each department and agency reporting to the minister:

(a) Is the agency confident that you will meet your expenditure targets in 2025-26? Have any budget decisions been made between the delivery of

the budget on 5 June 2025 and today that might impact on the numbers presented in the budget papers which we are examining today?

(b) Are you expecting any reallocations across your agencies' budget lines during 2025-26; if so, what is the nature of the reallocation?

16. For each department and agency reporting to the minister:

(a) What South Australian businesses will be used in procurement for your agencies in 2025-26?

(b) What percentage of total procurement spend for your agencies does this represent?

(c) How does this compare to last year?

17. What percentage of your department's budget has been allocated for the management of remote work infrastructure, including digital tools, cybersecurity, and support services, and how does this compare with previous years?

18. How many procurements have been undertaken by the department this FY. How many have been awarded to interstate businesses? How many of those were signed off by the CE?

19. How many contractor invoices were paid by the department directly this FY? How many and what percentage were paid within 15 days, and how many and what percentage were paid outside of 15 days?

20. How many and what percentage of staff who undertake procurement activities have undertaken training on participation policies and local industry participants this FY?

Mr TEAGUE: I have one final question that the minister might take on notice.

The CHAIR: One final question; squeeze that in.

Mr TEAGUE: Again at page 114, I refer to the fifth dot point under targets 2025-26, which is delivery of programs under the renewed NPA on family, domestic and sexual violence to commence on 1 July 2025. Will the funding that the government has provided here fund any new services or will it continue to fund existing ones? Can the minister provide to the committee a list of all of the services in this policy area that have been initiated during her term as minister?

The Hon. K.A. HILDYARD: I will be very brief and answer this question now. We were really pleased to sign the renewed national partnership on 4 February 2025 and have been really pleased to work closely alongside the federal government to deliver a range of programs across intervention, prevention, response and recovery, and healing, including a range of incredibly innovative programs in the perpetrator behaviour change space.

The CHAIR: The allotted time having expired, I declare the examination of the proposed payments for the Office for Women complete. Further examination of the proposed payments for the Department of Human Services is referred to Estimates Committee A.

Sitting suspended from 11:31 to 13:30.

DEPARTMENT FOR HEALTH AND WELLBEING, $6,574,901,000

COMMISSION ON EXCELLENCE AND INNOVATION IN HEALTH, $7,414,000

PREVENTIVE HEALTH SA, $33,511,000

Membership:

Mrs Hurn substituted for Mr Teague.

Minister:

Hon. C.J. Picton, Minister for Health and Wellbeing.

Departmental Advisers:

Dr R. Lawrence, Chief Executive, Department for Health and Wellbeing.

Ms J. Formston, Deputy Chief Executive, Corporate Services, Department for Health and Wellbeing.

Ms J. TePohe, Deputy Chief Executive, Commissioning and Performance, Department for Health and Wellbeing.

Ms S. O'Brien, Deputy Chief Executive, Strategy and Governance, Department for Health and Wellbeing.

Ms M. Geisler, Senior Executive and Governance Officer, Department for Health and Wellbeing.

The CHAIR: Welcome back to today's estimates committee hearing. I understand the minister and the lead speaker for the opposition have agreed an approximate time for the consideration of proposed payments, which will facilitate a change of departmental advisers. Can the minister and lead speaker for the opposition confirm that the timetable for today's proceedings, previously distributed, is accurate?

The Hon. C.J. PICTON: Yes.

Mrs HURN: Yes.

The CHAIR: I remind members that all questions are to be directed to the minister, not the minister's advisers. The minister may refer questions to advisers for a response. Questions must be based on lines of expenditure in the budget papers and must be identifiable or referenced. Briefly, I also advise that, if the minister undertakes to supply information at a later date, it must be submitted to the Clerk Assistant via the Answer to Questions mailbox no later than Friday 5 September 2025. Members unable to complete their questions may submit them as questions on notice for inclusion in the assembly *Notice Paper*.

The rules of debate in the house apply in committee. Ministers and members may not table documents before the committee but may supply them to the Chair for distribution. I will allow both the minister and the lead speaker for the opposition to make opening statements of about 10 minutes each, should they wish. I will now proceed to open the following lines for examination. The portfolio is SA Health. I declare that the proposed payments are open for examination and call on the minister to make a statement, if he so wishes, and to introduce his advisers.

The Hon. C.J. PICTON: Thank you very much, Chair, and I do so wish. Firstly, thank you, Chair, and all the other members for their participation in the committee. As we were noting just before we started, I think this is my eighth health estimates—four years in opposition and four years in government now—and it is always a delight. It is one of the favourite days of the year to be part of.

The CHAIR: I can imagine.

The Hon. C.J. PICTON: I am psyched. I would like to introduce my advisers. I am joined on my left by Dr Robyn Lawrence, who is the Chief Executive of the Department for Health and Wellbeing, and she is surrounded by a number of her deputy chief executives. To my right is Julienne TePohe. To Robyn's left is Judith Formston and behind us is Sinead O'Brien and also Melissa Geisler, who is Senior Executive and Governance Officer from Executive Services and Correspondence in the department.

This is always a great opportunity to talk about some of the exciting work that we are doing across what is such a broad portfolio. Sometimes when you are the health minister people come up

to you and say, 'I really feel sorry for you having to be the health minister.' But actually can I say that it is a real privilege to be able to not only work with and work hard for the 50,000 people who now work across SA Health in the full breadth of different services and the amazing work that they do but also of course for the hundreds of thousands of patients that SA Health cares for each and every year.

This health budget delivers a further $1.9 billion, highlighting our government's continued focus on addressing the issues in health and building a bigger health system and getting South Australians the best possible care. The funding boost means that across our last four budgets we have delivered a total of $8.9 billion in additional funding for the health system over the forward estimates. Significant investments include:

- $672 million in this financial year's budget for capital works across our metropolitan and regional health systems;
- $430 million to continue the construction of the new Women's and Children's Hospital;
- $144 million towards the construction of the main building works for the Flinders Medical Centre expansion; and
- $98 million towards construction works for the new Mount Barker hospital.

As well as that, we are delivering:

- $79 million to deliver 72 additional mental health rehabilitation beds across three hospitals;
- $56 million to complete the new SA Ambulance Emergency Operations Centre and State Health Control Centre;
- $33 million for regional health facilities, including projects in Mount Gambier, Port Augusta, Whyalla, Port Pirie, Naracoorte, Southern Fleurieu, Victor Harbor, Kingscote and Bordertown; and
- $29 million to continue the delivery of new ambulance stations at Marion, Two Wells and Whyalla and to rebuild other ambulance stations across the state.

This year, we will see some of the most significant investments over the past four years being delivered and coming to fruition, open and operational. Between now and the end of this year, we will be opening at least 160 new beds across our metropolitan hospital network. That includes:

- 36 acute beds at The Queen Elizabeth Hospital;
- 24 dedicated mental health beds at The Queen Elizabeth Hospital—so 60 beds at that hospital alone;
- 48 beds at Noarlunga Hospital, including 24 mental health beds and 24 acute beds;
- a 12-bed new surgical unit at Lyell McEwin, as well as 20 fast-track beds at Lyell McEwin—so 32 beds at that hospital; and
- the new expansion of Margaret Tobin Centre that will see 12 mental health beds there as well.

We will also see the delivery of the new SA Ambulance Service headquarters, replacing the very outdated, cramped, not fit for purpose Emergency Operations Centre. We will see upgrades to regional hospitals, including Mount Gambier and Districts Health Service, with the emergency department upgrade, mental health upgrade and detox service there coming to fruition. There is the new emergency department at Victor Harbor and the new emergency department at Port Pirie hospital. There are major upgrades to the Naracoorte and Port Augusta hospitals and upgrades to helipads, and of course—I know this is of interest to the member for Black, who is here—a fourth 24-hour pharmacy will be opening at Hallett Cove.

All of those projects will be coming online over the coming months. It is a very exciting time to see works that have been in the process of planning, construction and work with our clinicians

over a number of years now coming to fruition. By June next year, we will have opened even more projects, including:

- new cancer services at Modbury Hospital;
- a new paediatric ICU at the Women's and Children's Hospital;
- Kingscote health service upgrades on Kangaroo Island;
- a community health building at Bordertown;
- new ambulance stations opening at Campbelltown and Gawler to join the others that we have opened across the state;
- new drug and alcohol rehabilitation beds;
- a new crisis stabilisation centre in the northern suburbs to keep people who need mental health care out of the emergency department; and
- new renal chairs for patients who need dialysis in the northern suburbs.

This comes on top of all the other investments that we have been making across the health system. To highlight some of those, just in the past weekend the Premier and I officially opened the 70-bed service at Hampstead, which is an excellent service that has been pulled together in a very short period of time to be able to care for a cohort of patients who are stuck in our health system and who are waiting for aged care. That is a net increase of 55 additional beds, including a 20-bed memory support unit there.

In addition to that, we have opened up a 24-bed unit at the Pullman Adelaide for maintenance care, post recovery and care transition, as we seek to utilise every possible avenue to make sure the patients can get the care that they need while we are dealing with barriers for discharge.

Of course none of this happens, particularly not the infrastructure, without the people who work in the health system. Chair, as you will remember, we committed, when we came to government, to recruiting an additional 300 nurses and 100 doctors. We have very well and truly exceeded those targets.

In our first three years in office we have now recruited, full-time equivalent and above attrition, an extra 1,462 nurses, an extra 646 doctors, an extra 385 allied health officers and an extra 301 ambos. That is 2,794 extra health workers recruited across SA Health above attrition. Particularly the increase in terms of our workforce has been scaling up. Just in the past 12 months, there has been a 771 additional increase of nurses and a 317 increase in doctors.

While we acknowledge that there is still much more work to do, we have in this budget continued those investments, continued to focus on the health system and continued to make sure that we are using every possible avenue to make sure patients can get the care they need.

The CHAIR: Thank you, minister. Opening statement or questions?

Mrs HURN: I have some questions. Thanks, minister, for your opening statement. I would like to refer you to Budget Paper 4, Volume 3, page 17, in relation to the new Women's and Children's Hospital. Looking at the list of infrastructure projects right across pages 16 and 17, a number of them are either overdue or over budget in terms of when you compare them to last financial year. Given that, how is it possible that the new Women's and Children's Hospital is neither over budget nor has there been a delay in the delivery?

The Hon. C.J. PICTON: I am very happy to talk about the new Women's and Children's Hospital and its delivery. This is a hospital which, we have been clear from the beginning, needed a significant amount of time in terms of the delivery of it. By setting, when we came to office, the revised delivery date of 2031, it was acknowledging that both the planning and the construction of this hospital would take time to deliver.

There has been a huge amount of work on this hospital over the past three years since we have come to office. When we came to office, this was a project that was designed to be delivered on the RAH West site, which you only have to fly past on the plane and look out the window now to

see how small that footprint of land is compared to the footprint of land where we currently have works underway on the new Women's and Children's Hospital site.

When we decided to move the site, that led to a whole range of different planning that needed to occur in terms of how the revised hospital was going to be built on that site, which has been underway, and also a whole range of different works to make sure that that site has been readied. It is really exciting to see significant progress being made. The first stages of that work, as the member will know, as I think she is on the Public Works Committee—there have been two stages of works that have been approved through the Public Works Committee for the delivery of that hospital, and those works are now underway.

Of course, the delivery date of what is in the budget papers of June 2031 is six years away from where we are now. Only just this week, I had another update from the team, in going through the project, and we are still confident that that is the delivery time of this project. More than that, I think there is mindfulness from the team involved in the delivery of this project of the need to make sure that we deliver the hospital as soon as possible for a number of reasons.

First, it will make sure that women and children who need that care will be able to get that care as soon as possible at that new site. The infrastructure limitations of the current site are well known, and that is why we are going down this path to begin with. Second, the longer we take to construct the site obviously adds cost to the project as well in terms of escalation, so the more that we can make sure that construction timeline is as condensed as possible obviously delivers a budget benefit as well.

In terms of the budget, there has been no change to the budget. As I have outlined in very similar questions that you have asked in the house before, we are very mindful that there are pressures in terms of the construction market here, nationally and internationally, in terms of escalation costs. That was work that was done in 2022, looking at the construction costs, making sure that escalation was factored in in terms of that costing. But we are mindful that there are pressures there. We do not have a finalised figure in terms of any changes to that, because what will be happening over the course of the next year is we will be going through that procurement process for the construction works. As I said to the parliament before, we expect that to be mid to late next year in terms of when those final contracts will be signed, but we are working as much as possible to keep that within the current budget that we have allocated.

Obviously, this is a project which is very significant to the state and that is why, three years ago, when the revised plans were being determined by cabinet, cabinet appointed three of the most experienced and senior public servants in the state to have the ultimate responsibility and guidance of this project—Dr Lawrence, to my left, chairs the executive steering committee, and the two other members are the chief executive of the Department of the Premier and Cabinet and the chief executive of the Department of Treasury and Finance (the Under Treasurer)—to make sure that there is the most senior possible oversight of the delivery of this project, because we know how important it is.

Mrs HURN: I suppose my point is that there are several smaller infrastructure projects where it has been acknowledged that there are significant escalation costs and yet the Women's and Children's Hospital seems to be the only infrastructure build in here where you have not taken that into account. You mentioned the fact that there could be financial delays or penalties, if you like, if there are delays with the women's and kids'. Can you confirm what that is per month?

The Hon. C.J. PICTON: I do not have any advice in terms of that, but it is just common sense that we want to make sure that this hospital is delivered as quickly as possible.

Mrs HURN: Are you able to take on notice what the financial penalty per month might be?

The Hon. C.J. PICTON: With all respect, member for Schubert, there is not a particular figure but it makes common sense that the more that we can deliver the hospital more efficiently it actually might mean that there is a cost benefit in bringing it forward. We are working to try to deliver the hospital as fast as possible to make sure that we get the best possible outcome for the budget but also the best possible outcome for women and children in this state. The other thing I would like

to point out is that there was commentary by the member in that question that all the other capital projects have changed in terms of—

Mrs HURN: A number.

The Hon. C.J. PICTON: I think you said all of them.

Mrs HURN: No, a number.

The Hon. C.J. PICTON: And that is absolutely not correct.

Mrs HURN: A number.

The Hon. C.J. PICTON: I think anyone who looks at the budget papers and compares them would find that that is not correct, and I think that deserves to be corrected.

Mrs HURN: I can point to many, but you have the papers in front of you where you would be able to see that. Has the new design team that has recently been appointed to the new Women's and Children's Hospital provided any opinion on the likely cost and completion date and, if so, what was it?

The Hon. C.J. PICTON: We are really pleased with the new design team that has been brought on board in the past couple of weeks. They have been busily working. Obviously, they were working in the lead-up to the procurement process and putting their proposals forward as part of what was a very competitive procurement process. Also, in the past couple of weeks, since they started, they have been meeting with the teams, both the central women's and children's new hospital development team but also teams involved in the current hospital, to talk through their proposals, and we expect to receive further updates through the cabinet process in terms of their deliberations in terms of looking at the design.

I think it is far too early to speculate in terms of what the member is speculating about in that regard, but I look forward to, as those designs develop—certainly, we will be updated through the cabinet process and then, probably most critically, we will be updating our clinicians and our consumers in terms of what the evolution of those designs are likely to be, to make sure that we can get the best possible outcome.

I think it is worth adding that there has been a huge amount of work already done. So these designers are not starting from scratch, they are able to utilise all the work that has been done by the stage 1 architecture teams who have been part of the project. We will be bringing forth their experience in terms of the delivery of health projects across the country and across the world, including a number of very significant paediatric hospitals such as the team's involvement in the Royal Children's Hospital in Melbourne and the Perth Children's Hospital as well, making sure that we get the best possible outcome.

Mrs HURN: Have you asked BLP whether the new Women's and Children's Hospital will be able to be delivered by 2031 within a budget of $3.2 billion? Have you asked that explicitly?

The Hon. C.J. PICTON: As I said, I have had some initial conversations with the architecture team. What is happening is that the architecture team are meeting with our project team and working through their designs. They will be providing advice through the cabinet process, and then we will be discussing them publicly. They will be guided and will have oversight by the three senior public sector leaders across the state that cabinet has given the direction in terms of the management of this project to.

We really appreciate that we have brought on board some exceptional architectural services and a design team with a wide breadth of experience, but they form one of the elements of the delivery of this project. The other elements of this project are obviously the engineering teams, the construction teams, the teams involved in clinical care, and how all those elements will fit together. All of those components together will form advice through to the executive steering committee and then cabinet in terms of some of the issues that you outlined.

Mrs HURN: What is the status of the current clinical engagement on the new design with BLP? Has that commenced yet?

The Hon. C.J. PICTON: As I said, this is at very early stages—in the past couple of weeks of their involvement. It is not early stages, though, in terms of the delivery of this project. There has been a huge amount of clinical involvement in the past couple of years in terms of work on bringing together the clinical briefs and making sure that we have brought together the different perspectives of different elements of the hospital. That will now form part of the detailed design, and there will be ongoing collaboration between the architects and our clinicians over coming months. There will be a further set of more formal consultations that will be happening throughout the course of the remainder of this year and into next year as well as we get the details of that right.

Mrs HURN: When will those formal consultations with clinicians start with the new design team?

The Hon. C.J. PICTON: I will take on notice in terms of the exact timeframes, but I know the team has a schedule of where they expect different elements of consultation to be happening, as I said, over the course of the remainder of this year and into next year.

Mrs HURN: Is that able to be provided to the committee as well—just the formal set of when these consultations will be happening?

The Hon. C.J. PICTON: If we can get that, we will get that.

Mrs HURN: Thank you. The Women's and Children's Health Network board minutes from 14 November 2024 had a presentation about the project from the executive lead, and in the minutes it noted that there was 'an emphasis on refreshed modelling data and addressing immediate capacity issues'. Can the minister advise what is meant by that?

The Hon. C.J. PICTON: I was not at the governing board meeting the member refers to, so I cannot express what was mentioned in the minutes.

Mrs HURN: Let me phrase it a different way.

The Hon. C.J. PICTON: Sorry; maybe I will complete my answer and then you can ask another question.

Mrs HURN: Sorry. I thought you said you were not there so you could not provide a comment on it.

The Hon. C.J. PICTON: Chair, if it is alright, maybe through the course of today—

The CHAIR: Yes, I think you need to refer to a budget line. I think this is a broader fishing expedition—

Mrs HURN: Sorry, I am happy to repeat the budget line for every point, but it is the same one from the start, Budget Paper 4, Volume 3, page 17, on the apparently $3.2 billion new Women's and Children's Hospital.

The Hon. C.J. PICTON: Thank you. As I was saying, the responsibility for the delivery of this project does not sit with the governing board of the Women's and Children's Health Network. Obviously, they have an interest and obviously they have involvement, and we will be seeking their input at various stages, particularly in terms of the clinical design of elements of the project, but their expertise is not in terms of delivering massive capital works projects the likes of which our state has not seen before. That is why cabinet has been very clear in terms of the responsibility for the delivery of this project sitting with those three very senior public servants: the chief executives of Health, Treasury and Premier and Cabinet.

There will be updates that will flow through to the Women's and Children's Health Network governing board from time to time, and I understand they are in regular dialogue with the project team. I would caution the committee in terms of making sure that they are aware of the involvement of the governing board and that they do not have oversight for this project.

Mrs HURN: Has anybody through the department provided the minister with any refreshed modelling data and raised concerns about immediate capacity issues with the new Women's and Children's Hospital project?

The Hon. C.J. PICTON: I can say I feel pretty definitively no. One of the steps that we took early on was to increase the capacity of this hospital. I can tell you there was a number of people in the department at that time who viewed us as maybe going too far in saying that we should be increasing the capacity of this hospital. But we took the view, as the government, that we need to learn the lessons from the Royal Adelaide Hospital, that we need to build a bigger hospital to begin with rather than having to go back to the start and deal with a lack of capacity when you open these big new projects.

You only have to look at a number of the paediatric hospitals that have opened across the country to see that works have had to go back after the construction was opened to add additional capacity in. The capacity that we are adding compares very favourably with the plans that were in place when we came to government, which were going to see only one extra overnight bed in that hospital. We saw clearly we wanted to increase that and that is exactly what we are delivering to make sure that we have the capacity to grow services there into the future.

Mrs HURN: On the same budget line, in the minutes that I have referred to from 14 November—the board minutes from WCHN—it obviously also said the full completion date would be 2033-34, and it was only six months later that it was then corrected on the website, where the date was listed as 2030-31. Did the minister ask for that to be done?

The Hon. C.J. PICTON: I think it is fair to say that the Women's and Children's Health Network themselves noticed a significant amount of media commentary on this subject. I think it is fair to say that people are probably paying more attention to their minutes than they were a few months ago on this subject and others. I spoke to the chair of the board of the Women's and Children's Health Network, Professor Christine Dennis, who I think is an exceptional chair and has been doing a great job in that role. She was certainly very apologetic that this had occurred and I think they undertook to make sure that there was a correction.

Mrs HURN: The 2025-26 total budget for the new Women's and Children's Hospital project is less than what it was in 2024-25. Why the variation and what has changed?

The Hon. C.J. PICTON: Member for Schubert, they are not the figures that I am being advised. What figures are you referring to?

Mrs HURN: If I look at 2024-25, it is $3,201,316,000 compared to $3,200,944,000 for 2025-26? I did practise reading that figure out as well.

The Hon. C.J. PICTON: We will have a check into that. Obviously, in the scheme of the total budget, it is a relatively minor change in those figures. We think what is likely to have occurred is there might have been a change from Treasury's consideration of operating versus capital expenditure, but we will double-check what that minor variation has been in terms of those figures.

Mrs HURN: What is the budgeted cost for the car park at the new Women's and Children's Hospital, and when will that be complete?

The Hon. C.J. PICTON: That project was part of the stage 1 works, and to some extent some works might well be part of the stage 2 works that have been through the Public Works Committee, and, of course, I would refer you to that project. The advice that I have is that construction of the multideck car park is currently reported as being ahead of program and forecast to be complete by the end of 2027. Anyone driving down Port Road will see that substantial works have been undertaken on that car park already. I understand that they are very pleased with the works that have occurred there so far.

The car park works are, of course, intricately linked as well with some of the other works that are occurring for the site, particularly in terms of the site preparation as well as bringing the infrastructure into the site. For example, I know that recently SA Water started their commencement of works on the site, but it is also linked with the works that will be occurring shortly in terms of the preparation on Port Road.

There will be some disruptions from time to time as we are doing works on Port Road, but we will be working to minimise them as much as possible but, as you can imagine, in terms of the connections into the hospital, the works on Port Road will be pivotal, as well as making sure that the

other access to the site will be able to happen by foot, cycle, etc., during the construction works but also, of course, when the hospital opens. All of those works are being delivered by Lendlease. I think they are very pleased with the progress on that site, and I will see whether there is any further information we can provide in addition to what was provided to the Public Works Committee.

Mrs HURN: Thank you, minister. I do not want to be pedantic about that answer, but you said that the car park was ahead of schedule and that it would be delivered by the end of 2027, and you issued a media release in 2023 that said that it would be completed by early 2027. So can you just provide some clarity on that, because it builds this broader narrative about the direction of the overall project?

The Hon. C.J. PICTON: We will check that. I appreciate the member being an avid reader of government media releases.

Mrs HURN: More than you know.

The Hon. C.J. PICTON: We will double-check that and, even if we can provide an answer before the end of estimates, we will have the team looking into that. With a number of these different works, there are various definitions for the completion of things. I think we have had this discussion before in terms of some of the completion works that get referenced in the budget papers. Sometimes it is the financial close of different projects that are referred to as a completion, and it may well be that the actual completion of that project will be earlier.

My gut feel—it always makes people nervous when I start saying that—is that, if you look at the pace of the works on the car park, I suspect, with the end of 2027 being 2½ years away, it will be in advance of that that the car park will be complete, but we will try to bring back a more detailed answer in terms of the exact timing for the actual completion of the construction of just the car park.

Mrs HURN: What is the budget and estimated completion time for the hospital's two-storey central energy facility that is located to the north of the car park?

The Hon. C.J. PICTON: We will seek some information on the exact timeframe for that as well. I can say to the committee that one of the factors that we are looking at in terms of the design of the project will be whether there are changes that the design team may wish to look at as to whether some or all of the plant work may well form part of the main structure of the hospital, as opposed to being separated out.

There are different hospitals that have it within the hospital—for example, the Royal Adelaide Hospital has its plant work largely on the roof of the hospital. I have been through it and it is very interesting to look at. Previously, we were considering putting a large degree of that in a separate building. We have provision for that separate building, but we are looking at whether there are any options for that to be part of the main hospital works and whether that would be an ultimately better outcome overall for the project.

I understand some preparation works have happened in terms of the plant building. We will be seeking further advice from our design team in coming weeks and months in terms of whether the scale of that building should be changed or whether it all should be part of the main hospital site.

Mrs HURN: On the existing Women's and Children's Hospital, can you advise the committee how additional sustainment works are raised and identified? Who is responsible within WCHN to provide that feedback to you and that advice as to whether additional services will need to be provided?

The Hon. C.J. PICTON: Is there a budget line for that question?

Mrs HURN: Yes, I am happy to either point to the infrastructure one, with the $8 million of cladding, or we can move to the WCHN Agency Statement, just to furnish the minister with the contents of his own budget: Budget Paper 4, Volume 3, page 39. That gives you a little bit more thinking time as well.

The Hon. C.J. PICTON: I appreciate the cheek from the member for Schubert.

Mrs HURN: Frankly, asking about the sustainment works is a pretty obvious question and it was already in the infrastructure budget line.

The CHAIR: Can you repeat the line again?

Mrs HURN: Yes. I am happy to go to the Women's and Children's Health Network. That is Budget Paper 4, Volume 3, page 39. It is the sub-program for the Women's and Children's Hospital.

The Hon. C.J. PICTON: Okay, thank you very much. It is sad that the member is not sharing my enjoyment of estimates so early into the session.

Mrs HURN: I am loving it. I have got lots already out of it, so thank you very much. It is very enjoyable.

The Hon. C.J. PICTON: I am looking forward to the rest of the afternoon, if it continues like this. In terms of the way that budget processes work, particularly in the context of how big SA Health is, there are a lot of people who have a lot of different ideas for where we should spend money. There is a process by which the department will collate ideas and suggestions and bids from various elements of SA Health, the largest element being our local health networks.

Some of those will be for program work and some of those will be for infrastructure works, and they will collate those. Advice will be provided on those, and a large degree of those will be considered for progressing to the Department of Treasury and Finance as part of the budget process. There is always a number of different back and forth discussions between each department and the Treasurer and the Department of Treasury and Finance, in terms of what will ultimately form part of a cabinet submission, including the budget.

The process is no different for the Women's and Children's Health Network and their infrastructure needs than it is for any of our other hospitals or health services in terms of their infrastructure needs. In addition to the budget process, of course, there are also other works that will occur from time to time, whether they be minor works or other types of biomedical equipment works. A significant number of those will be able to be obtained and undertaken within a local health network's budget that is allocated to them.

In terms of the specific example that was raised of the cladding works, that was an issue that was identified by the Women's and Children's Health Network. The network had a number of discussions with the department. We also got advice from external agencies, obviously the Department for Transport and Infrastructure but also, of course, the Metropolitan Fire Service, to seek the best possible advice. The Metropolitan Fire Service has undertaken a number of works in terms of making sure that their preparations for incidents at the Women's and Children's Health Network are appropriate.

As I said, perhaps to parliament or to the media somewhere on this previously, this is a matter about which we are not alarmed, but obviously where there has been an identification of a risk we have sought to make sure that we have the budget to take that seriously and address it. Now that that funding has been provided by the Treasurer—which we are very thankful for—the Women's and Children's Health Network, in conjunction with the department and, if need be, the Department for Infrastructure and Transport, will be getting on and delivering that cladding change as soon as possible. I met with the Women's and Children's Health Network, in fact, earlier this week and they are treating that with a high priority to make sure they can get those works done as soon as possible.

The Hon. D.R. CREGAN: I would not want to truncate proceedings. It is very enjoyable, as all members have earlier observed. I am absorbing important detail that I might not otherwise have had the opportunity to reflect on. Can I take the minister to Budget Paper 4, Volume 3, page 17, the Investing expenditure summary, which has already starred in these proceedings. The new Mount Barker hospital has a budget total project cost of $365.5 million. Can the minister provide an update on the program to deliver the new Mount Barker hospital and any reflections on the scope and additional expenditure?

The Hon. C.J. PICTON: Thank you very much to the member for Kavel. Obviously, for me to say that I note his interest in the delivery of this project would be putting it mildly. He has really been the driving force behind the push to have a new Mount Barker hospital for many years. It was disappointing to hear he will not be returning to us after the election, but we might—

The Hon. D.R. CREGAN: Some are not quite so disappointed.

The Hon. C.J. PICTON: I am disappointed and we might have to think of a meritorious role for you somehow in terms of the new Mount Barker hospital project.

The Hon. D.R. CREGAN: It is a terrifying thought.

The Hon. C.J. PICTON: A statue might be too far but at least a plaque or something. This is, obviously, a critical project not just for the Mount Barker community but also for people who rely on Adelaide hospitals as well because, as we are seeing the growth in the Mount Barker community, it is obviously a hospital that cannot contain the level of activity it is receiving and that is only going to seek to increase as the population grows.

As was mentioned, the $365 million project is such a critical piece of infrastructure for our health system. It will see a tripling of the inpatient capacity of the hospital from 34 to 102 beds. This will increase inpatient capacity to support the emergency department, which has obviously been expanded in recent years, and support the needs of the growing population of the region. This will reduce the need for people in the Hills and Mount Barker residents to travel to the city, helping to ease demand at our major metropolitan hospitals.

In 2001 the population of Mount Barker was 23,000. It is now more than 40,000 and it is expected to grow substantially. Enabling and early works for the project commenced late last year and of course the member for Kavel and I, with shovels at hand, with the Premier were able to make sure that we added our heft to the works being undertaken there.

The project team has been facilitating the decanting of the community health services, including allied health, child and development health, and community nursing, into the refurbished accommodation. The decant off site was completed in March to allow for the demolition activities to commence. Early works demolition of some older structures of the hospital recently commenced in April this year, with substructure works having now commenced on the main clinical services building.

Piling rigs have recently arrived on site and piling activities for the new clinical services building, I am advised, are expected to commence within coming weeks, with concrete pile caps to commence shortly afterwards as well. A significant amount of earthworks, civil works and inground works relating to stormwater, sewerage and electrical infrastructure continue to ensure that these core foundations are provided for the new hospital.

The next significant piece of work that will be expected to be complete is the multideck car park, the second car park we have talked about in estimates already today. That will see the site's total car parking capacity increased to 654 spaces, up from 431 currently, and that will commence in early July, we believe, with anticipated completion in May 2026.

The main construction works for the hospital are anticipated to commence later this year, with anticipated completion towards the end of 2027, in line with our commitments. It will of course include some really important specialist services, maternity services, paediatric care, palliative care, and rehabilitation but also, I would note, importantly, mental health care—the first inpatient mental health beds for the Adelaide Hills, which will be another important component in reducing pressure on our metropolitan health system.

The Hon. D.R. CREGAN: I have one additional question. Remaining with the same budget paper but taking us to page 56, Sub-program 2.11: SA Ambulance Service, the highlights for the financial year, the first and third dot points: can the minister update the committee on the performance of the Mount Barker Ambulance Station and on the condition and operational readiness of the crews who recently joined the station?

The Hon. C.J. PICTON: If there is something the member for Kavel is also very passionate about, it is of course the new Mount Barker Ambulance Station. Members may not be aware that, up until the election of this government, there was only one ambulance, 24 hours a day, serving the Mount Barker community, which was wholly insufficient for the emergency needs of that community, so we responded to the need.

Immediately addressing the capacity, we brought in a second 24-hour emergency ambulance, which was brought in in March 2023, along with a dedicated Regional Medical Transfer Service, which was recruited in March 2024 to provide additional coverage. In January this year, the

new Mount Barker Ambulance Station commenced operations. In fact, it commenced operations on my birthday, on 13 January, I am told. I did not organise that specifically, but I could have.

The Hon. D.R. Cregan interjecting:

The Hon. C.J. PICTON: If I were to pick the date I would have picked your birthday, member for Kavel, I assure you.

The Hon. D.R. Cregan interjecting:

The Hon. C.J. PICTON: I would have found it out. The $9.1 million facility is home to a team of 32 ambos, including those recruited in 2023 and 2024. It is strategically placed on the south-eastern corner of Bald Hills and Springs roads, enabling faster, more efficient responses to emergencies in the growing area. The ageing Mann Street station was cramped and no longer suited to the growing needs of the region. The new facility not only addresses the immediate capacity demands but is designed to support future growth, with ample space to accommodate more ambos as the region continues to expand.

I am advised that morale in the Mount Barker team is high, with the new station up and running and the ambos enjoying their new location and settling in—and they have made it a comfortable workplace, I am advised. Further, with the integration of the station's new Regional Medical Transfer team, SAAS has increased their support to the region with timely responses and availability for transfers. The increased training facilities have enabled staff to actively train whilst on station, with staff even utilising these facilities for ongoing development on days off.

Mount Barker continues to see increasing workload, with dispatches of Mount Barker base crews increasing from 3,000 in 2022 to over 5,000 in 2024. Some of this, I would say, is accounted for by a change of call sign from one crew from Strathalbyn to Mount Barker, but there is no doubt that there is increasing need. The other thing to note, which we have made very clear, is the fact that this new ambulance station has a provision for the future growth of the region, because we know that as the population increases we will need to increase the SAAS crewing into the future as well.

Mrs HURN: I refer to Budget Paper 4, Volume 3, page 25, Sub-program 1.4: Clinical system support and improvement. I would like to ask about the elective surgery recovery plan, because last year it was a target to develop an elective surgery recovery plan for South Australia to reduce overdue elective surgeries and colonoscopies. Given the significant backlog, why was that clearly not completed, given it is again mentioned as a target for 2025-26? When will that plan be complete?

The Hon. C.J. PICTON: Thank you very much for the question. I am very happy to talk about elective surgery because it is a key area of focus for the department and for our local health networks. I would point to a couple of key things that have been occurring. The first is that we have been able to increase the number of elective surgery operations that have taken place.

The team is finding the exact numbers. But as I think I said to parliament the other day, we have now increased the number of elective surgery operations that were conducted last year compared to the year before in the order of 10 per cent, which, given the system demands that we had last year, is a very substantial increase in the number of elective surgery operations that we have been able to undertake.

The second thing to say is that that comes amidst increasing demand. The fact that we have been able to increase the number of operations is also offset by the fact that we are seeing more and more people coming to the public system for their elective surgery, particularly when faced with some of the issues in terms of private health insurance, private hospitals and private specialists, which is making coming on waiting lists for public hospitals more desirable than having to pay what are, sadly, increasing fees for specialists, hospitals and insurance.

Some of the commentary that we have seen in the national press in the past couple of days, in fact, about the costs that people are paying for specialists really bear that out in terms of the costs that people are facing. Those factors do combine, unfortunately, to see that we need to continue that pace of growth in terms of the number of operations that we do to be able to keep pace with that growth.

The third thing I would point to is that last year the government signed a deal with Western Hospital, which is quite an innovative deal in terms of the delivery of elective surgery for our state. This is guaranteeing a certain number of operations that will be coming from the public list that will be delivered by the new operators of Western Hospital, particularly for orthopaedic patients, to remove those patients from our waiting lists and ensure that a package of care is provided by Western Hospital to be able to deliver care for those patients. If we can find those details of the number of patients, then we will provide them to you—we have four people looking for them.

Those things combined are attempting to try to make sure that we can increase the number of people that we can see as fast as possible. We are keen to go even further. One of the things that we will be working on this year is particularly looking at some of the work that has happened in Queensland. What Queensland have rolled out is a program called Surgery Connect for elective surgery. Surgery Connect is a model of contracting the private system that has enabled Queensland to see a number of people come off their waiting lists and reduce their waiting lists.

We have had a contracting arrangement in place with private hospitals since Minister Wade was the minister, but I think we can do that better. We are looking at ways that we can do that better, which would not only be better for the public hospital system and better for the private hospital system but also be better for patients in getting timely care. So that is the big piece of work that we are working on at the moment.

Mrs HURN: Thank you. I am happy to see those figures. I know there is a lot of information to go through over there, so I am happy to receive that, whenever that is available. Do you have a timeframe on when the elective surgery recovery plan will be finalised, and will that be made public?

The Hon. C.J. PICTON: I would probably characterise this work as less of an actual document that would be put out publicly in the way the member is suggesting but more ongoing work. For example, between the department and local health networks we are looking at a couple of pilot projects for this work in terms of our reform of how elective surgery is delivered.

We are expecting, within coming months, we will see the beginning of some of those pilots and, hopefully, we can be in a position as fast as possible to see some changes in terms of the delivery of elective surgery that will address a couple of issues in the current system. One is that we want to make sure that we get the best price possible; secondly, we want to make sure that we can better plan for that in the future.

I think one of the reasonable critiques from the private hospital system to date has been that public hospitals will come to them at the last minute saying, 'We want to do 100 operations on people's hips,' and then they will rush to try to get that done, whereas if we can better plan for that ahead of time it will enable them to seamlessly put those procedures into their existing schedules with a reduction in cost, hopefully, but also a seamless level of activity that will be able to be fitted in.

It is also about how we make sure that the pre and after care of the elective surgery—which is critically important as well—are accounted for, so it is all of these things together, as well as making sure that we look at how our queuing processes, how we get those referrals from GPs through to our system, are best done to make sure that those procedures are conducted in a way which is as close as possible to the level of acuity that people have, and the urgency of their categorisation.

I do not think there will be one point in time where we say, 'This work is now complete.' It is going to be a very iterative piece of work and, as we are able to bring on different projects, we will be doing that as fast as possible.

Mr ELLIS: I have two questions that I hope the committee will grace me permission to ask consecutively.

The CHAIR: I will.

Mr ELLIS: Thank you. Firstly, Budget Paper 4, Volume 3, page 54, the Yorke and Northern Local Health Network pages. I note in the targets section that Clare Hospital is scheduled for an upgrade for its theatre. I wonder how that was assigned precedence over the Wallaroo Hospital birthing suite and theatre which was offline for a number of months over the summer, forcing some

women to have their babies elsewhere. Surely that theatre would be more due for an upgrade considering it was the subject of some works being required?

The Hon. C.J. PICTON: We will see if we have any information in terms of the Wallaroo theatre. The member for Frome may wish to have it out with the member for Narungga in terms of the importance of Clare versus Wallaroo. Obviously, I love all of our hospitals equally, and when we came to government one of the things that was first put to me by the Yorke and Northern Local Health Network were the issues in terms of the Clare theatres, particularly the sterilisation unit, and that work needed to occur there.

We have seen an increase in presentations at Clare over the past couple of years, but there are also clearly some infrastructure issues in terms of Clare, particularly through the ED, surgical suite and CSSD, and so they have been looking at how we can address some of those needs in terms of the Clare works. We have been working within what is a very constrained site at the Clare Hospital to try to deliver that CSSD upgrade.

For people who are not aware, the CSSD, the sterilisation units which are critical for theatres to operate, have had improved standards for how CSSDs should operate, and that has been a challenge for SA Health as well as being a challenge for every public and private hospital across the country in being able to meet those standards, and Clare is one of those hospitals where we need to undertake some significant works for that to happen.

The balance of how to do that, amongst an ongoing operational hospital on a cramped and ageing site, has meant that it has been a difficult juggle for us to be able to deliver that project. To be frank, it is costing more than we originally thought it was going to a few years ago, as we have encountered more difficulties in terms of how that project would be delivered on the existing site. I am advised that it is now a $7.3 million project for the upgrade of the CSSD. It commenced in May 2025 and is expected to be completed in September 2026.

The contract has been awarded to Pascale Construction, and I think it is fair to say probably to the member for Frome, and dare I say it to the member for Light, who would also be interested as well, that there are also more works that will need to happen at Clare over time as well. Clare does not have a dedicated area for the emergency department, and that is something that we are continuing to look at in terms of future planning for the health system.

In terms of the member for Narungga's question, we are also aware that there are other needs at Wallaroo Hospital as well and are also aware that that has an increasing population there. We have put in place a new rehabilitation unit. That has occurred, and the member for Narungga was there with me at the opening of that a couple of years ago. That has been able to be delivered within the existing footprint of the site with a relatively minor capital works upgrade but some significant operating expenditure that has been put into that site.

But we know that there are more works that will need to be happening in the future. I know the member is aware that there have been master planning works done into Wallaroo Hospital. We will continue to balance and plan for those needs with other planning that needs to happen at other regional hospitals across the state as well.

Mr ELLIS: An addendum: is the birthing suite back operational at Wallaroo after it was closed over the summer? To follow up your answer, you mentioned that there have been master plan works done. The targets for 2025-26 list master planning work at Port Pirie, Wallaroo and Clare for next financial year. Is that an addendum to the previous work that has been done, or is that a whole new clean slate master plan that will be done and presumably submitted to InfrastructureSA in the fullness of time?

The Hon. C.J. PICTON: I am not aware that there is any proposal to undertake a new master plan with a clean slate, as the member was saying. The other issue the member raised was about the birthing suite. I am not aware that there are issues in terms of that being closed, but we will try to check that quickly now with Yorke and Northern Local Health Network and come back to the member, if we can.

Ms PRATT: Minister, following on from the questions from the member for Narungga, I am happy to provide a line: Budget Paper 4, Volume 3, page 54, Clare Hospital theatre upgrade. I respect

and thank the member for Narungga for asking his questions. I think we heard more about Clare than Wallaroo. Last year in estimates, the opposition asked a question about the Clare Hospital CSSD upgrade, and three days ago the opposition got those answers. In those answers you stated that the Clare Hospital upgrade project is being funded from the regional asset sustainment program. 'Additional funding', you said, 'has been allocated to supplement the existing budget, which has experienced significant uplift in project delivery costs linked to a number of factors, including escalation of construction costs in regional areas.'

The minister just stated to this chamber that the cost of the Clare upgrade has gone up to $7.3 million. That has been ventilated in the Public Works Committee, so I will not go back over that, but can you explain for the benefit of all country members, including the members for Narungga, Schubert and Chaffey, what is driving that significant uplift, not just at the Clare Hospital but perhaps for any other regional hospital upgrades? What impact might this be having on patient care?

The Hon. C.J. PICTON: The member had a number of facts in the question, which I do not need to repeat. There is no doubt that when it comes to construction projects in regional areas we do face often higher prices than we would like when we are contracting those. Health do not do that contracting directly. That is undertaken by the Department for Infrastructure and Transport, except for very minor works, but largely in terms of those minor works it is undertaken through Ventia—through the whole-of-government facilities maintenance contract as well.

It has been a balancing act in not just Clare but, I know, a number of projects across the state, where we have been trying to get the best trade prices that we are able to get. I would say it varies from region to region as well. As you can imagine, some very remote works are very expensive.

We recently announced that we are going to be undertaking some works in terms of accommodation of nurses' quarters and other staff quarters at Coober Pedy—you can only imagine how expensive those are to deliver—whereas I think we have been able to get some reasonable prices for the relatively large upgrade of works that we are conducting at the Mount Gambier hospital. I suspect one of the factors leading to that is in the South-East you have a relatively vibrant construction industry that allows us to not have as many sort of FIFO workers undertaking that construction work.

In terms of what the impact on patients is, there is not direct impact on patients in terms of what the Department for Infrastructure and Transport is able to contract with contractors, but, obviously, the better the pricing that we can get, the more works that we can undertake. Certainly, I know through myself and the department, we are always trying to get the best possible price that we can, balancing that with the clinical outcome that we want to achieve overall.

The added thing that I would say in terms of Clare is to repeat the issues in terms of the site itself. I know the member knows the Clare Hospital site well. Even when I was there most recently for the Clare 100th anniversary, I was meeting with the team, we were looking around it, and it is very difficult to envisage other ways in which that project could be undertaken, whether it is an extension, etc., that could be done in a more cost-effective manner than what has been proposed based on the layout of where the theatres are, and even some of the infrastructure around it.

Out the back of the theatre, I think there is a large tank, and touching that would be very expensive indeed. So all of those factors add to the cost, unfortunately, as well as some of those trade prices, which can vary and can vary from region to region but also can vary from time to time depending upon some of the other works that might be underway in other areas of government or the private sector.

Ms PRATT: Minister, I would make the point that Clare is an example of construction costs in the regions possibly compromising future upgrades. Clare, as an example, was costed below the $4 million threshold for the Public Works Committee, so it was an under $4 million project, and has now escalated to above $7.29 million. That is for a room and you will appreciate, as the local member, I fully embrace and welcome this upgrade taking place; it needs to meet standards.

So it is not a criticism of the project but as the shadow minister for regional health services there is a concern that the member for Narungga, on behalf of Wallaroo, is anticipating an upgrade

to that hospital. Are construction costs for country hospital upgrades so exorbitant or complicated by their remoteness that we are at risk of future upgrades not happening?

The Hon. C.J. PICTON: I would not characterise it like that, but I certainly would characterise it that the more affordable, the better efficiency we can get from that contracting, the more that we can do. I share the member's desire to try to make sure that we can get those prices down as much as possible.

One of the things that we are doing at a national level as well is at the Health Ministers' Meeting that occurred last week—it feels like longer ago—we brought to the table, which was widely supported by all the other jurisdictions, that it is timely to have a look at the facility guidelines for health projects across the country to make sure that we are balancing the needs for the best possible outcomes that we can get but with also the best possible price and efficiency of taxpayers' dollars that we can get as well because every state across the country, every public hospital has these works that need to be undertaken. We need to make sure that we get the balance right between the best possible clinical needs and layout and specifications but with also the best use of taxpayers' funds.

Mrs HURN: Back on elective surgery: Budget Paper 4, Volume 3, page 25, again on the target to develop a comprehensive road map for elective surgery. You have stated in the committee as well that you have been around for a very long time, not just as shadow minister but as minister and previous to that working closely with health ministers, and I am sure that the figures that you would be seeing on the SA Health—

The Hon. C.J. PICTON: Are you saying that I am old?

Mrs HURN: Never—experienced maybe, wise. I am sure that it would probably shock you to look at the dashboard and to see some of those overdue numbers. Looking now, we have 23,851 people who are ready for surgery and of those people 5,628 are overdue. That is extraordinary. I suppose that is why I am really interested to get a sense of the priority that the minister and the government are giving to developing this recovery plan. As part of that, can you just flesh out what role the private sector has in eating through that backlog particularly?

I am going to throw a couple of questions at you. You might potentially take them on notice. Could you advise how many admissions from that public elective surgery waitlist were done in public hospitals? Do you have a percentage breakdown, or a number would be much better, on how many admissions from the public elective surgery waitlist were done in public hospitals? Also, could you provide how many admissions from the public elective surgery waitlists were done in private hospitals?

The Hon. C.J. PICTON: I do not think we have those exact figures in terms of the breakdown between private and public, but we are happy to take that on notice and see if we can find those. I can provide the number that I was hoping we would be able to get to when you asked for it previously, which was that in 2024 we undertook 59,603 admissions for elective surgery. That is a 10 per cent increase on where we were in 2023, which was 54,398, an increase of 5,205 people being able to get their elective surgery in that year, and that is obviously despite all the pressures the system was under last year.

It is mindful that one of the issues that is driving the government's agenda, in terms of the delivery of additional public hospital beds, is not just the emergency access to care that we face and those pressures which are well ventilated but making sure that we have the capacity for that to occur at the same time as elective surgery also to occur. If we have more capacity, if we have a lower level of occupancy, that can mean that not only can we face what comes through the emergency department but also make sure that we can have the capacity for elective surgery to occur as well.

The other thing that I would note is that these are the elective surgery cases, but we have a growing number of emergency surgery cases we are facing in the system as well. We will see whether we have these figures, but compared with where we were a few years ago a larger percentage of the work that is going through our theatres in the public system is emergency surgery compared with elective surgery, as we are seeing that more and more emergency surgeries need to occur.

I do have some figures that have been provided to me. I can advise that as at 23 May 2025, $87.2 million has been spent under those contracting arrangements that we have, the patient services panel, which has delivered 9,761 episodes of care in the private sector this financial year.

Mrs HURN: Minister, potentially you might have this in the same brief: how many beds do you have online that are utilised for elective surgery in the private sector?

The Hon. C.J. PICTON: I will see whether we have that, but I suspect not, because when it comes to surgery we do not contract for beds, we contract for operations. When it comes to the way that contracting works, it is aligned with the national weighted price activity units that we have. It would be calculations made on the National Efficient Price, and we will contract for a certain amount of work.

Obviously, as you can imagine, there will be some of that work that will not require an overnight bed stay at all. There will be some of that work that will require multiple days' stay. There will be some patients who will need longer stays rather than shorter stays. That is all risk that is borne, obviously, by the private hospital as part of that work.

If I can sort of judge where the member is going with some of these questions, I think it is worth noting that there is the capacity in the private system for this work to occur. We are not offshooting capacity that would have otherwise been there for private patients who need it. Having said that, I am very conscious of the fact that in the current way that the system and the health system is organised nationally it is very hard for people to access a private hospital bed when they need one.

A patient who has pneumonia is much more likely to end up in a public hospital bed than a private hospital bed, even if they have paid private health insurance their whole life. That is a factor of the funding situation that is in place, which makes it uneconomical in many regards for private hospitals to be expanding their bed capacity for medical patients.

This is a piece of work which is being undertaken nationally, looking at the sustainability of the private health sector. For the private health sector, there is a smaller and smaller number of pieces of work that are economical for them to deliver. They can very acutely tell you that certain procedures, certain types of operations and certain health services are worth their while investing in, because they know that they will at the very least break even, if not make a profit out of them, whereas a lot of the work that we do—and a lot of the work that patients need done—is not economical for them in the current arrangements between private hospitals and health insurance.

The other thing that I would note in particular is that in South Australia our private hospitals are even more short-changed than in the Eastern States. They get lower payments from the private health insurance industry. I have my own theories. I suspect that part of that is because we have a very concentrated private health insurance market in South Australia.

That stems back to Mutual Community, which a huge number of South Australians were members of. It has transferred to Bupa and people, such as myself, have just sort of stemmed from their family's coverage over time, harking back to Mutual Community days. That lack of diversity in membership means that it is a very, very small market in terms of who insurers are with, and it makes the negotiating position between hospitals and insurers even more slanted in one direction than it is in the Eastern States.

Mrs HURN: I am honestly just very interested in the numbers, and I am interested in the context that in 2019 you also said that, 'When you are taking patient care from public hospitals and sending it to private hospitals, that is privatisation.' I think it is interesting that obviously you have spoken to the enormous role that the private health system plays, particularly in eating through elective surgery, yet when you were the shadow minister you claimed that that was privatisation. I suppose it is just a case of saying one thing in opposition and doing something different in government, like maybe ramping.

I am going to move on to another question that I am keen to get to in relation to some of the performance indicators. I would like to move to Budget Paper 4, Volume 3, page 33. I have a couple of questions I would like to ask in relation to CALHN. Can you talk the committee through what the medical consequences are of the fact that just 38 per cent of patients attending CALHN EDs who

required emergency treatment were seen within the clinically accepted timeframe of 10 minutes? That was backwards from last year and clearly well short of the 80 per cent target. Why was that?

The Hon. C.J. PICTON: I do not think there is any doubt that there is pressure in our public hospital system and that is borne at the emergency department. When you look at what is one of the really strong factors impacting the emergency department it is the number of patients who are stuck in them on a daily basis waiting for a bed. That is most borne out at CALHN in its two emergency departments than any other network.

As you can imagine, I am very closely across the state of the system on a very regular basis. On a very regular basis, the emergency departments of the Royal Adelaide Hospital and The Queen Elizabeth Hospital are full not of people who are coming through needing treatment but of people who have had their treatment by the emergency department and are waiting for admission to a ward bed and we just do not have a ward bed for them to go to.

Partly that is because we do not have enough beds across the system overall, and that is why we are investing so heavily in building, opening and staffing additional beds, but partly it is also because, as we are building and staffing those additional beds, they are becoming full of people who do not need to be in them anymore. As the member will be aware, we have the equivalent of a Modbury Hospital size of patients who are stuck in our beds at the moment waiting for aged care.

All of that factors through to the emergency department, both for people coming via ambulance and people coming through the waiting room. Our doctors and nurses work incredibly hard to triage to make sure that all patients can be seen within the relevant timeframes for their particular type of condition, but there is no doubt there is pressure.

Obviously, there has been overall a small improvement in those times between the past financial year and the financial year before, but there is no doubt that we want to see improvement there. Clearly, there are things that can happen in the emergency department to make things more efficient, but I would be particularly sympathetic to the fact that they are full of patients waiting for a bed elsewhere in the system is a key compounding factor to that.

The other thing I would highlight particularly in CALHN is an issue that they face more than others, which is the number of patients who are in their beds waiting for a mental health bed. That is not only an issue in terms of mental health specifically but it flows through to other patients needing that care as well.

That is one of the key drivers behind, as I said in my opening statement, one of the investments that is coming on board this year that we are really excited about which is the opening of this generational investment in terms of additional mental health beds across the system because if we can reduce the blockages, the long stays that people have in our emergency departments, it is much better for those people, it is going to help their recovery and their treatment substantially and it is also going to free up a lot of capacity for other patients who need it and seek to improve those response times.

Mrs HURN: I refer to Budget Paper 4, Volume 3, page 13, in relation to the workforce, does the government have a workforce plan for each of the health professions?

The Hon. C.J. PICTON: There are a few things to say here. Firstly, we are in the process of finalising a plan across the network across all different health professions, but we are also looking in terms of different areas of health professionals where we can undertake discrete areas of planning to meet needs. We have been working through that in a systematic way.

One that we specifically committed to undertaking that we have now completed is in terms of psychiatry. We know there are pressures in terms of psychiatry across the state and across the country not just in public but in private as well, so we worked jointly with The Royal Australian and New Zealand College of Psychiatrists in terms of the delivery and engaged Ernst and Young to help us devise that psychiatry plan.

The benefit of those mental health beds I was referring to a couple of minutes ago was that we will also be able to improve the delivery for the number of trainees that we undertake through psychiatry training. That will increase the pathway of psychiatrists coming through the system.

The second area that we are particularly focused on as well is psychology. I have a real problem with the way that psychology training happens in this country, in which a huge number of people undertake undergraduate degrees through universities and a teeny, tiny number of people undertake masters degrees to enable them to be psychologists. That really is a bottleneck that needs to be addressed, and we need to increase the clinical training places to enable more students to be able to undertake masters degrees, meaning that more of those undergraduate students can actually become psychologists at the end of the day. So there is a lot of opportunity for us there, I think, to increase that.

In addition, all our local health networks are working on their own plans as well, for different areas of our health workforce. We have literally dozens of different types of health professionals across the state. Of course, we also have different challenges, depending on different areas. In particular, I would highlight regional areas; we know that is where we see a lot of our workforce shortages.

While we have been able to recruit additional staff, and while we have been able to recruit additional staff in the regions as well, we know that regional positions are always much trickier to be able to fill. That is why, when we can see opportunities to address that—for example, in the new offer that we have put to the doctors' union, we are seeking to improve the payments for doctors who work in regional areas. We are also seeking to improve the payments for rural generalists who are doctors who have a GP background or an ACRRM background and who can work across a variety of different specialties in regional areas, because we want to attract more and more of those.

The key limiting factor when it comes to medical professional training, though, is medical school places. I continue to advocate, and the government continues to advocate, for an increase in the number of medical school places—commonwealth-supported places for medicine. This is an area that is capped by the federal government. We appreciate the fact that the federal government, in their election commitments, said that they would increase that. We think that will help, but probably it needs to go much further in terms of meeting the future medical needs of the country.

Mrs HURN: I refer to the same budget line, just in relation to workforce, minister: how many nurses left SA Health last year?

The Hon. C.J. PICTON: A lot less than nurses who joined. I gave you the figures recently, in terms of a well over 700 net increase in FTEs for nurses across the board. Of course, in a system as big as SA Health there will always be people coming and going, but we are glad that we have a lot more people coming than are leaving. We can break down those figures for you.

Mrs HURN: That would be great. Would you like to do the same for doctors as well, or do you have that on hand? How many doctors left SA Health over the last financial year?

The Hon. C.J. PICTON: We have the total numbers but not the ins and outs, so we will have to take that on notice.

Mrs HURN: So you will take that on notice; thank you. In terms of vacancies, what is the current level of vacancies within SA Health?

The Hon. C.J. PICTON: I can share with you a frustration that is felt by state ministers across the board, whether they are Liberal, Labor, state or territory. It is that it is very hard to know details like that through all of our workforce systems, and a lot of that information is held at a local level rather than at a statewide level. We will see if we can, but I am very confident that that is not a level of information that we have. Obviously, it would vary from minute to minute and day to day as well, in terms of our vacancy numbers. There is not a central repository of vacancies that we are able to provide.

Mrs HURN: In terms of nurses, you have pointed to the FTEs that you have recruited, and I think your media release of 20.5.2025 stated that 1,462 FTEs have been recruited above attrition. Can you advise where those nurses are located and where they were recruited from? I do appreciate that you are not potentially going to account for every single one of those people, but I am just after some information as to whether they have been from a recruitment campaign. Where are they from?

The Hon. C.J. PICTON: I will read out the backgrounds of all 1,462 extra nurses.

Mrs HURN: Exactly; that will definitely get you through to 3.30.

The Hon. C.J. PICTON: The other thing to note is that this is the net figure and this is an FTE figure, so actually the headcount is more. The headcount is an increase of 1,874, and of course the number of people joining SA Health would be much more than that to account for the people who have left. My guess is we are probably talking about 3,000 or 4,000 people who would have joined in that time, at least.

I can break down the net increase: WCHN, 144; CALHN, 545; NALHN, 329; SALHN, 618. There was a reduction across the department in preventative health and statewide services. I think that is largely accounted for by the fact that there were temporary positions, particularly through SA Pathology through COVID, so there was a reduction of 384. The net, which I will not try to add up, are from the country: an increase, obviously, as well, the biggest being an increase in the Barossa Hills Fleurieu Local Health Network. That is the breakdown across the system: the biggest increase being in SALHN followed by CALHN, as you would probably expect.

Mrs HURN: Do you mind providing the same for doctors as well? Where are the doctors located? Your press release says 646 FTEs above attrition. Where are those doctors located?

The Hon. C.J. PICTON: Again, these are net figures so the actual number joining would have been much higher. The headcount is higher: 833 rather than 646. The figures are: WCHN, 114; CALHN, 123; NALHN, 117; SALHN, 152; Barossa Hills Fleurieu Local Health Network, 67; Eyre and Far North Local Health Network, 16; FNLHN, 5; Limestone Coast Local Health Network, 10; Riverland Mallee Coorong Local Health Network, 18; Yorke and Northern Local Health Network, 11. There was an increase of 13 across the miscellaneous section of statewide services: SAAS department, Commission on Excellence and Innovation in Health, and Preventive Health SA.

Mrs HURN: I go to Budget Paper 4, Volume 3, page 56, which makes reference to the SA Ambulance Service. Looking particularly at the performance indicators, can you talk the committee through why it is that SAAS is able to provide the percentage of cases that are seen on time for priority 1 and priority 2 but they are not able to do that for priorities 3, 4, 5, 6, 7 or 8, yet they are able to collate information on those categories for the activity indicators? I am interested because I appreciate that the government's focus is on priority 1 and priority 2 cases, but there is nowhere publicly available where we can see what the response times are for priority 3, priority 4, priority 5, etc.

The Hon. C.J. PICTON: My memory—as we have discussed, this is my eighth health budget estimates—is that there was a change that happened under the previous government. I do not want to be too critical, because I am not 100 per cent sure if that is true—

Mrs HURN: Just throw it out there anyway.

The Hon. C.J. PICTON: Throw it out there anyway, why not? There was a decision made that the key targets for SAAS in their performance agreements with the department were priority 1 and priority 2 rather than priorities 1, 2, 3, 4, 5, 6, 7 and 8, so that is why they are reported in the budget papers.

Mrs HURN: As minister, are you furnished with the response times for categories 3, 4, 5, 6, 7 or 8 by SAAS?

The Hon. C.J. PICTON: I do not have them with me, but I know SAAS obviously—

Mrs HURN: No, but in general as part of your briefings?

The Hon. C.J. PICTON: I know SAAS obviously pays attention to all of their different categories. Eight categories are a lot, let's be honest. Priorities 1 and 2 are obviously the most life-threatening cases. They are the cases in which there has been a judgement by the call takers in the emergency operation centre that these are the most life-threatening cases that need an ambulance with lights and sirens. That is not to say that there cannot be risks with priorities 3 through to 8 as well, but particularly where we were getting to the point where we were only getting to a third of those priority 2 cases on time, obviously that has been a key priority in terms of increasing the performance there.

I know, from speaking to the chief executive of SA Ambulance Service about this, that he is very mindful as well of making sure that other categories are responded to in the most timely way possible, because there is clearly potential for risk in those categories, but also sometimes those categories will be upgraded if they are waiting too long. I do not think there is an issue with the key focus being on priorities 1 and 2, with a mindfulness of other categories as well.

Mrs HURN: There is certainly no issue. I am just interested to know whether it is possible. I think the answer is that it is possible. It is just not in the performance agreement which is why it is not in the budget papers. Can you just confirm, and I appreciate that you do not have them with you today, that SAAS provides you with that information?

The Hon. C.J. PICTON: I would have to check in terms of what information they provide to me. I know that certainly—

Mrs HURN: You must know how it is tracking.

The Hon. C.J. PICTON: Yes. There is a variety of different reports that get provided to a variety of different circumstances. Obviously, the ones that we publicly report on every month are 1s and 2s, and I will have to double-check in terms of what reporting comes through to me.

Mrs HURN: Thanks.

The Hon. C.J. PICTON: But I know that certainly it is something that I have discussed from time to time with SA Ambulance Service in terms of making sure that they are meeting the needs of the community, with the focus on 1s and 2s, but being mindful of other categories as well.

Mrs HURN: Thank you, and if you could take that on notice as to what information you get or whether you get them, that would be great. Another question, again in relation to SAAS: why is fixing ramping not listed as a target in the 2025-26 budget?

The Hon. C.J. PICTON: I feel like I am speaking on behalf of the chief executive of SA Ambulance Service, who would say that ramping is a hospital issue, which I think is fair.

Mrs HURN: It has been listed as a target previously.

The Hon. C.J. PICTON: Clearly, SA Ambulance plays a role and SA Ambulance works constructively in terms of trying to address solutions for fixing the ramping crisis, but they are not the ones who determine whether hospitals are ramping. That is a determination that is made at the hospital level, and is about what is going on inside the hospital, and often not even what is going on inside the emergency department but what is going on in the rest of the hospital system. As we have talked about, it is also what is going on in the aged-care system that impacts that as well.

I think the main target for them is improving response times, and they are playing a constructive role in terms of reducing ramping. I think everyone would acknowledge that ramping is a hospital issue predominantly rather than a SAAS issue but, of course, SAAS bears the brunt of it.

Ms PRATT: Budget Paper 4, Volmer 3, page 17, helipads, the regional helipads compliance upgrade with a costed figure of $23.4 million. How much of this allocation has now been spent on repairing and reinstalling fences, and whose cost is it?

The Hon. C.J. PICTON: I am advised by the chief executive that that will not be in the brief. We do not have that level of information, and I expect that in the context of what are some relatively large constructions works any changes that need to happen to fencing will be relatively minor in terms of the overall cost of the project. These are, I think, surprisingly to me, very large construction projects. I know the member has seen some of them, and I have certainly seen some of them. They are very large helipads that have been constructed.

We have been guided by the advice from aviation consultants in terms of what the requirements have needed to be to build these helipads to meet the needs of CASA regulations and the requirements of our helicopter operators. There has therefore been a big investment made by the government: as was said, $23.4 million across these 13 helipads. I imagine a large amount of that goes to the earthworks, the concreting and the civil construction works that have needed to occur on those helipads to put them in place. While fencing and any adjustments that need to happen to

fencing would obviously be a component of that, I would not imagine they would be the major component.

Ms PRATT: Has there now been a final determination on the reason for the delays in compliance checks? On radio, about the fences, you said:

> I think that's one of the things they're looking at in terms of their final checks, but I don't think there's been a final determination on that—

With another public servant saying, 'There has been some fences that have been modified, yes.'

The Hon. C.J. PICTON: I think the issue is that it is varying from site to site. As the member would be aware, we have a number of those helipads that have now come online. Kingscote, Wallaroo and Meningie helipads all have come online and are fully operational. There are some that are still under construction, and there are some where we are working through the compliance with our helicopter contractor to make sure that they are happy with it. So it will depend on the exact site.

Can I just add, while we are on the subject—mentioning Wallaroo reminded me—we checked in terms of the member for Narungga's question about Wallaroo operating theatre and birthing service, and we are not aware of any issues in terms of the birthing operations at Wallaroo Hospital. The chief executive advises me—this is how in touch with what is going on in the health system she is—that a baby was born there this morning. I would like to wish the parents all the best. Little Ashton was born there this morning. I wish the parents all the best.

Ms PRATT: I am sure the member for Narungga will be delighted with that update. Referring back to helipads and the same budget line, you mentioned helipad contractors I think but my question goes to the contract. There has been a change in contract. When does the new contract with Toll start, if you can provide that?

The Hon. C.J. PICTON: This is a contract which is obviously of importance to us and we are very much involved with, but it is not a contract that SA Health has ultimate responsibility for. The helicopter and fixed-wing contract sits with the Attorney-General's Department and provides that service for all the agencies that need those services.

There has basically been a program of work in terms of the new helicopters that has been undertaken since we inherited it. Work was underway under the previous government in terms of the new helicopter project. That area of the Attorney-General's Department, which also looks after things like the government radio network on behalf of all agencies, has been managing that contract. We will obviously be a big user of those services and will contribute funding towards that. We do not have a date.

Ms PRATT: I will just push that a little bit further. Would the minister know whether that contract is likely to commence this year or next year? And because I believe it is some way off, has the minister had any advice about the cost of paying out the current contract to fast-track the new one starting and, if so, what was that advice?

The Hon. C.J. PICTON: A couple of things. It may well be the fact that the contract has been signed, and we will see if we can obtain that information from the Attorney-General's Department. But I think what you are really asking is when the new helicopters will come. I think we would have had to have signed the contract for orders to be put in place for new helicopters to come. There is obviously a crossover process before we will complete using the current helicopters and start using the new helicopters.

There are a couple of things to note about anything to do with aviation: one is that it is all very expensive; the second is that the timeframes are long. When we announced, together with the Minister for Emergency Services and the Minister for Police, a few months ago, the new contracting arrangements, there were timeframes put forward publicly in terms of when the new fixed-wing and rotary-wing aircraft were coming online. I will see if we can find those for you as well. Clearly, it will take some time until those new aircraft come, and we will continue to use the existing aircraft through Babcock until those new aircraft through Toll come online.

Mrs HURN: I refer you to Budget Paper 4, Volume 3, Barossa Hills Fleurieu LHN, page 42. Will you publicly release the final business case for a new Barossa hospital that is sitting with the government? I refer to a letter that was sent to a constituent of mine from the LHN, which reads:

> The State Government is committed to ensuring that the Barossa and surrounding community has the health services it needs now and into the future. As part of that commitment the Government has developed a business case which has identified the need for a new hospital to provide health services in the Barossa.

Will that business case be made public?

The Hon. C.J. PICTON: I think I have a very similar answer to what I gave the member for a very similar question in the house a few weeks ago, which is: I am happy to consider that and get advice on that subject, in terms of releasing the business case. It is a document which has gone to cabinet, so obviously is covered by cabinet confidentiality, but I will seek advice in terms of consideration of whether that can be released.

Mrs HURN: Also on the land selection for the Barossa hospital, can you advise the status of the site selection, and through the EOI, which closed at the start of the year, how many expressions of interest did the government get through that process, and how many have been ruled out?

The Hon. C.J. PICTON: We do not have the exact number. I am advised that we received several expressions of interest, but we were not inundated with as many as we would have liked. The results of that are still being analysed by the infrastructure team in the Department for Health and Wellbeing and we will be briefed through appropriately in coming weeks, I am advised.

Then, depending upon the outcome of that, it may well be that we decide to proceed with one of those, or, if none of those are satisfactory, then we may well proceed in terms of our other consideration. Of course, when it comes to hospital sites and health sites more generally, we do have the ability to look at the compulsory acquisition process as well, which we have used a number of times since I have been the minister for hospital sites and for ambulance sites as well.

So I guess all options are on the table in terms of how we use that $5 million at this stage. Obviously, the best option would be that we get a really good option that comes through that expression of interest process, but we will be mindful to make sure that we get the best possible outcome for the future needs of health services.

Mrs HURN: Can you confirm that the preferred location for the facility is within or close to Nuriootpa? That was on the EOI.

The Hon. C.J. PICTON: As I said, I will wait to see what the outcome of that analysis is. I do not want to go into specific locations at this stage. Can I say, in terms of the previous question, I believe this is for the arrival of the commencement—

Mrs HURN: What was this one?

The Hon. C.J. PICTON: Sorry, in terms of the fixed-wing and rotary-wing aircraft. A fixed-wing aircraft, I am advised, will be commencing in November 2026, and the rotary-wing aircraft will be commencing in October 2027.

Mrs HURN: I would like to ask a question about a few of the performance indicators through the Barossa Hills Fleurieu LHN: Budget Paper 4, Volume 3, page 43. This one really concerns me and I am sure it will really concern you, but this is now the second year in a row that resuscitation has stayed at 53 per cent. Why is that and how many people are we talking about who have not received their resuscitation in the clinically acceptable timeframe, which is immediately?

The Hon. C.J. PICTON: I share the concern of the member in terms of seeing some of those figures, and certainly it is something about which we have been in contact with the Barossa Hills Fleurieu Local Health Network and its chief executive officer, Bronwyn Masters. We discussed some of these figures last year, in which concerns were raised from Barossa Hills Fleurieu that some of the accuracy of these figures may well be impacted in terms of how the electronic medical records system has rolled out there.

I am advised that, with the commencement of the new system, inconsistencies were identified in the commencement of patient treatment. It was previously recorded, which impacted

recording results. The emergency department clinical teams have now an agreed definition of when treatment commences and training of the new system is offered regularly to ensure episodes of care are recorded appropriately.

That is balanced with a high number of presentations occurring across the Barossa Hills Fleurieu region as well. I am mindful that we do have increased capacity, particularly already at Mount Barker and Gawler emergency departments, compared with what was in place previously. We have additional staffing at both sites compared with what was in place previously, and we are about to have additional staffing and capacity coming online at the Southern Fleurieu site at Victor Harbor as well.

Even with additional presentations, we have additional resources to meet that. What we still do not have, particularly in terms of Mount Barker, is the back of house capacity, which is still an issue there. This will be something that we will continue to watch and speak very closely with the Barossa Hills Fleurieu about, but we do take on board what the local health network has reported to us, which is that they are concerned that some of those figures do not accurately report what is occurring in those hospitals.

Mrs HURN: Thank you. I am really pleased to see that one of the targets for the Barossa Hills Fleurieu LHN is to evaluate new virtual clinic models to support access to urgent care services closer to home. One thing that doctors in my local community, particularly around the Barossa Valley, have been talking about is having SAVES throughout Angaston and Tanunda hospitals.

Minister, I am sure you are aware, but there are some concerns that doctors have raised about the ongoing emergency care at Angaston, particularly out of hours. The Tanunda hospital has had a reduction in beds from 12 down to nine, which is largely due to staffing issues. Is the LHN, and are you as the minister, committed to rolling out SAVES across all hospitals in the LHN and, if so, by when could that be done?

The Hon. C.J. PICTON: The short answer is that I am not committed to that, because potentially there are different ways that can occur in different LHNs. The ultimate goal of making sure that our emergency departments are connected with care after hours is the right one. SAVES is used in some LHNs, but not all LHNs.

We have seen some other developments of models, particularly in terms of the Riverland Mallee Coorong LHN, which has developed a model whereby their hospitals are able to connect to the Riverland General Hospital in Berri and speak to the consultants and the dedicated doctors who are on board in that hospital after hours. They believe that is a better model for them locally than using SAVES.

I have spoken again to Bronwyn Masters, the Chief Executive Officer of Barossa Hills Fleurieu, about this a number of times. I think what they are looking at is whether a similar model to that could be rolled out in Barossa Hills Fleurieu, where they now have two, shortly to be three, relatively larger emergency departments at Mount Barker, Gawler and a soon to be larger one at Southern Fleurieu.

How can they best utilise that network of staff and team to provide support to other hospital sites? You mentioned Tanunda, Angaston, as well as some of the other smaller sites that are provided in the Barossa Hills Fleurieu Local Health Network—and Kingscote, of course. This is a matter which is under active consideration by Barossa Hills Fleurieu. It could well be that they go down the path of using SAVES, but it could well be that they develop a solution that utilises their own workforce in a locally managed way.

Ms PRATT: I refer to page 17 of Volume 3, the Mount Gambier hospital upgrade. Can you provide a project status update? Is the project of the Mount Gambier hospital still on track for completion by December 2025? Do you agree with industrial reports and concerns that ramping is taking place at Mount Gambier hospital?

The Hon. C.J. PICTON: I had a meeting last week with the chief executive officer and the chair of the board of the Limestone Coast Local Health Network. As you said, we have a $24 million package of works underway, which we are really excited about, particularly an upgrade in terms of the emergency department—the expansion there of a six-bed short stay unit—and the delivery of a

six-bed subacute mental health and rehabilitation service, and a two-bed inpatient drug and alcohol withdrawal unit. I am advised, both in the briefing I am looking at now and also in my discussions last week, that those works are progressing as planned. We are hopeful even, perhaps, that some of those works will be coming on earlier than the dates that were mentioned by the member for Frome.

In terms of the operations of the hospital, these are obviously works that we are doing because we know that the hospital needs more capacity. We know that if you compare it to some of the big base hospitals in regional areas across Australia it is a small hospital, but it is our largest centre in regional South Australia. It is facing an ageing population, it is facing increased demand and it is facing a shortage of availability of primary care services in the community as well. Hence, these investments in emergency departments and mental health are needed.

I know that the team who work in the Mount Gambier emergency department and the hospital do everything they can to make sure that they get to patients as fast as possible. They are also very mindful of releasing ambulances to serve the community. Obviously, the chief executive officer of the Limestone Coast Local Health Network has made a number of statements in terms of those reports that have been made recently, which I stand by. I would also add that we know that more capacity is needed and we know that these beds that are coming online are very much needed.

Ms PRATT: I refer to Budget Paper 4, Volume 3, page 32, a target to install PET scanners. Can you explain the investment decision to deliver those two scanners to Flinders and The QEH? Why those sites? What is the total cost? Will the minister commit to funding CT cholangiogram imaging equipment for country hospitals, as recommended by the Deputy Coroner this week?

The Hon. C.J. PICTON: I am very happy to talk about the PET scan and delivery—positron emission tomography. These are incredibly important and growing in importance and usage for a whole variety of different cancer treatments and detection. At the moment, we only have these in the public system based at the Royal Adelaide Hospital, and for some time there have been calls from our clinicians to install them both at Flinders Medical Centre and The QEH.

Flinders Medical Centre is our second biggest hospital site, with our second highest level of complexity. It makes fundamental sense for that to be there, with the very high level of acuity of cancer care that occurs at Flinders Medical Centre. To be able to expand what we provide in nuclear medicine at Flinders Medical Centre is a no-brainer.

In terms of why The QEH, The QEH also has cancer services. It also has a number of researchers who undertake research in terms of nuclear medicine at The QEH, and they for some time have been putting forward a proposition about the benefit of a PET scanner at The QEH, not only to meet the needs of the local area but also to help the research efforts. I will not even begin to properly be able to technically describe the work they are doing, but obviously they are trying to help better treat cancer for many patients.

They were the two where there were clear, well-supported views that we should roll those out. No doubt there will be future demands down the track as well, but I think those are clearly first good arguments for the first cabs off the rank. In terms of CT, I will very quickly—

The CHAIR: Very quickly.

The Hon. C.J. PICTON: In terms of CT capacity, we will obviously look very closely at what the Coroner has said and will respond to the parliament accordingly.

The CHAIR: The allotted time having expired, I declare the examination of the portfolio of SA Health complete.

Sitting suspended from 15:31 to 15:46.

Departmental Advisers:

Dr R. Lawrence, Chief Executive, Department for Health and Wellbeing.

Ms S. O'Brien, Deputy Chief Executive, Strategy and Governance, Department for Health and Wellbeing.

Dr J. Brayley, Chief Psychiatrist, Office of the Chief Psychiatrist, Department for Health and Wellbeing.

Ms L. Prowse, Executive Director, Mental Health Strategy and Planning, Department for Health and Wellbeing.

Ms M. Bowshall, Chief Executive, Preventive Health SA, Department for Health and Wellbeing.

Ms M. Geisler, Senior Executive and Governance Officer, Department for Health and Wellbeing.

The CHAIR: The portfolios are mental health and substance abuse. The minister appearing is the Minister for Health and Wellbeing. I advise that the proposed payments remain open for examination. I call on the minister to make a statement, if he so wishes, and if there are any new advisers, to introduce them. Over to you, minister.

The Hon. C.J. PICTON: Thank you very much. I will introduce our new team who have settled in to the decks for this section. Firstly, a man who needs no introduction: the Chief Psychiatrist of South Australia, Dr John Brayley. We were joking about how this is my eighth Health estimates; I think we are well into the teens for John. He likes nothing more than coming to Health estimates. Sinead O'Brien, the Deputy Chief Executive, remains; behind me, we are also joined by Marina Bowshall, the Chief Executive of Preventive Health SA, and Liz Prowse, who is the Executive Director for Mental Health Strategy and Planning in the Department for Health and Wellbeing.

The CHAIR: Over to you, member for Frome.

Ms PRATT: Thank you, Chair. Minister and Chair, I do not have a prepared opening statement as such, but an observation that I have made in previous estimates around the protocols and the courtesies due in relation to questions being taken on notice and the replies with those answers being received in a timely fashion. In the previous session I made the reference that only three days ago the opposition received answers to questions that were taken on notice not just 12 months ago but, in fact, 24 months ago, so we hope in good faith that with the questions that have already been taken on notice in session one and any future ones we can continue to work at pace with the answers, because I pre-empt some questions that are also in this pack that have passed deadlines.

Having said that, I really want to thank the public servants who have worked with you, minister, to prepare for this session on mental health and substance abuse. While I am a few years behind you in estimates presentations, it is a privilege to be the lead speaker in this session. What I would like to do to commence questions today is to focus on the government's major funding commitment on mental health from the budget, which is the Mental Health Co-Responder program.

The budget line I am going to be referring to is Budget Paper 4, Volume 3, page 19, Program 1, which is responsible for health policy and promotion for clinical services and administration associated with the provision of health services across South Australia, and Sub-program 1.2: Chief Psychiatrist and Mental Health Strategy is encompassed within that.

The first question about this program is: what is the professional classification of the mental health clinician as described in the program? Who is qualified to accompany a police officer? What is their training or their level of qualifications? How does that work?

The Hon. C.J. PICTON: Thank you for the question. The advice I have is that they are mental health nurses. Obviously, mental health nurses are employed in the same way as other nurses in the system, but they carry mental health experience and background and often additional training. I understand, from speaking to a number of people who have been doing this work, that it is quite sought after and that a number of mental health nurses are keen to do this. I certainly have been advised that there have been issues in terms of recruitment of this, and it has been something where nurses have been keen to be part of what has been a really exciting project.

Ms PRATT: That is good. In the program they will be called a mental health clinician. Most likely they are going to be a nurse. In terms of training for a nurse to be qualified, can you step us

through how many placements are available for that? Are we looking to recruit more? Where would that nurse be based at the moment that the communication comes through that they are required to participate in this co-responder model?

The Hon. C.J. PICTON: In terms of the training for mental health nurses, it is fair to say that a very tiny percentage of those will end up in this co-responder model. The vast majority of mental health nurses work within mental health wards or community settings or other mental health services that we have. My understanding is that what will generally occur is that there will be additional training that mental health nurses will do to work in those areas, or they will be enrolled in to work in those areas and undertake that training while they are in wards or in community settings.

I have had a number of discussions over the years with the Australian Nursing and Midwifery Federation about making sure that we have enough mental health nurses. They have been collaboratively working with SA Health in terms of making sure that we can have that training pipeline. If you go back a few years, you had to do the training before you could get the job working in a mental health ward. Now you can undertake that training while you are working there. That has done a number of things. One, it has obviously allowed an increase in the number of people coming into mental health nursing, but I think one of the concerns that was raised was that people want to see what it is like before they get into it in a more fulsome manner.

I think when it comes to the co-responder model, we are looking for experienced people. It will not be people who have just started their training or are a little way through becoming a mental health nurse. The people who will be doing this work, the people who currently are doing this work, and also as part of our expansion work, will have years of experience of mental health nursing, obviously, with the security and the professionalism provided by being with a co-responder with SA Police. They will be out in the community and responding to a variety of different circumstances, so we want those nurses to have a good background of experience when they are responding to things that will be potentially unpredictable.

I have been provided with some advice that I can add in terms of our mental health nursing training more generally. One of the things that we have done is, as members may be aware, the way that nurses come in to become a nurse for SA Health is that they undertake what is called a TPPP, a Transitional to Professional Practice Program.

One thing that we have changed and created a new model for is next year we are going to be piloting a bespoke mental health nursing TPPP. For people who are coming out of university, who from the outset say ,'I want to work in mental health nursing,' we will be designing a graduate program for them through the TPPP that will be dedicated to mental health nursing. It will be an 18-month program and it will be designed to attract and grow a sustainable, skilled and qualified mental health nursing workforce, with that direct entry way for graduate nurses to have that mental health specialisation, ensuring a structured and supportive transition into the field.

Again, the people who will be doing that, we are not going to be putting straight out on the road as mental health co-responders. The people who will be doing that work will be experienced and have many years of experience doing so.

Ms PRATT: Has that announcement that you have just shared—the bespoke mental health nurses grad. program—been designed to complement this program? In terms of staffing, this was based on a six-month trial. It is now being rolled out permanently. Are we on track for those experienced nurses that you mention or are we going to need more and do you have a target that we need to achieve for the co-responder program to be in full flight?

The Hon. C.J. PICTON: I would separate out the two things. When it comes to the co-responder model, there is a relatively small number of positions involved in running that program and they are for experienced people. All the advice to me, including from meeting people directly, is that it is quite attractive for people to be part of that program and we have not had any issues in recruiting experienced, well-credentialled people to be part of that program.

You have a small number of people doing that and hundreds and hundreds of nurses working in our mental health wards and our mental health community settings. The TPPP and all the work that we are doing about training pipelines is really about those hundreds and hundreds of other

nurses in the system and making sure that we have enough, particularly in the context of opening additional mental health beds that are coming online through the course of this year.

There has been a lot of work through each of our LHNs to make sure that we have the requisite staffing to have them in place. That is the much bigger piece of work. All the advice to me is we are relatively I would not say comfortable but confident in terms of our ability to attract the co-responder nurses.

Ms PRATT: As an example of this program working in real time, was the co-responder program triggered or used at the start of this week? Was a mental health clinician paired with a SAPOL officer called out to a fatal incident in Gilberton this week?

The Hon. C.J. PICTON: Obviously, I do not have particular details about particular call-outs to particular suburbs with me. I will get some advice as to whether it is appropriate for us to provide that level of detail. We have legislative responsibilities under both the Health Care Act and the Mental Health Act in terms of confidentiality of information and how we respond to things. I will get some advice in terms of what is appropriate for us to provide in terms of that question.

Ms PRATT: In a hypothetical context with the co-responder program, where a SAPOL officer and a mental health clinician are on a call-out what is the role of the mental health clinician in that moment or why might they not be called out to an incident of great threat perhaps to the staff? I guess what I am asking is: what is the threshold and the criteria that determines when a clinician would accompany a SAPOL officer? Is there a document that stipulates that level of decision-making and if there is a memorandum can that be taken on notice and provided?

The Hon. C.J. PICTON: I was just asking if we have a particular document that sets that out and we will check that, but what I can say is that, from speaking to SAPOL people when we made the announcement a couple of weeks ago about this, they do not have this co-responder team as the sort of first responders to cases. By and large, the way it works is that they will have a SAPOL patrol car responding to a matter and then triggering that there is actually a need for a mental health co-responder and then assigning that task to the co-responder.

SAPOL is obviously incredibly mindful of the safety of the nurse who is out on these cases and is triaging appropriately what the right cases are for this co-responder model to respond to. This started in NALHN and then spread to a trial now undertaken in CALHN and now we are cementing it as part of the system and also extending it to the south.

At each increment, there has been a level of sort of cautious steps forward to make sure that the safety risks are paramount in terms of how this responder has been deployed. I think that has happened very successfully and I think that they have been able to find the right cases for the co-responder to go to that has ensured the safety of everyone involved and some really positive outcomes in terms of what has been able to be achieved and obviously making sure that we can connect those people with community assessments and community care in a way in which otherwise often people would have no other option but to go to an emergency department.

Ms PRATT: As part of the incremental approach to this program being rolled out in terms of expanding it, within reason can larger regional areas expect to see this program implemented?

The Hon. C.J. PICTON: That is a good question and I think we will obviously take this next step in terms of rolling it out across the full metropolitan Adelaide network. I can say as a member of parliament for the southern suburbs that it is something the local police in southern Adelaide were very eager to ensure was able to happen. I think we are open to other opportunities to expand this in a way that is going to make a meaningful impact and we will continue our close collaboration with SA Police about the best way to do that.

Obviously, it will be a balance in terms of where you can get the best utilisation for that to occur and, as the member knows, the distances involved in regional South Australia versus population density create challenges in terms of call-outs across the broadness of the geography of our state, but I think that is something we are open-minded to in terms of working with SAPOL into the future.

Ms PRATT: I imagine it comes down to workforce, minister, where small communities with one police officer and no allied health professionals are less likely to see this program unlike larger regions, and I am imagining the Fleurieu and Spencer Gulf. To just double back, can you imagine that the government has an appetite to incrementally roll this out where the workforce would allow it?

The Hon. C.J. PICTON: I would say that we are committed to doing everything that we can in terms of making sure that people get the right level of care, and do not need to needlessly go to emergency departments if they can get that care; and also working collaboratively with SAPOL to reduce pressure on their services too. So we are open-minded about what the future might hold, but obviously it is a decent investment that has been announced in the budget and the big emphasis now is on rolling that out and making it work.

Of course, going back to your original question, you always have to balance these things in terms of making sure that, if you are putting these resources and workforce in that they are going to be appropriately utilised and have the requisite number of demand for those services to equal the services, as opposed to another use of that service or funding or personnel that could be used in a greater utilisation.

Ms PRATT: I refer to Volume 3, page 31 of the same program. The highlights document, as part of this trial, a review that indicated a 35 per cent decrease in SA Police conveyances to the Royal Adelaide Hospital emergency department, and 85 per cent avoided mental health Central Adelaide Local Health Network emergency department presentations. To put it another way, the program has prevented approximately two and a half thousand ED presentations. To classify it as a hospital avoidance program, if you like, for the person who has been identified as requiring that deployment, what care do they get, minister, and where are they going instead of the emergency department or the justice system?

The Hon. C.J. PICTON: The answer is a variety of different services. There is some level of care that can be provided on site. By having that experienced, well-trained mental health nurse there on site, sometimes the issue and the particular concern can be de-escalated if the person is home or wherever that call-out is occurring that will not involve referral to another service, or sometimes it will be a connection with community mental health services.

In many cases, the person involved will already be a client of one of our community mental health services, an NDIS service or other NGO service that they are connected with, or another mental health clinician that they are connected with. Sometimes it will be taking them to an alternative, whether that be the Urgent Mental Health Care Centre in the city, the new Elizabeth centre that we have opened—which just the other day had its one-year anniversary—or the Mount Barker service that has just opened as well. So there is a variety of different options depending upon the circumstances.

Ms PRATT: I refer to Budget Paper 4, Volume 3, page 22, in terms of the psychiatric workforce in relation to the role of the Chief Psychiatrist or the Office of the Chief Psychiatrist. How many psychiatrists have been recruited to the state public system this financial year?

The Hon. C.J. PICTON: We will have to take that on notice. I think it is—

Ms PRATT: Minister, with respect, I did ask that question in the house. It was taken on notice on 29 April and the deadline has passed for that information to be forthcoming.

The Hon. C.J. PICTON: Thank you, Chair, if I can continue. I will take that on notice. I think the issue is similar to what I said in terms of some of the vacancy data previously in terms of how our workforce data can be broken down. Obviously, we know clearly in terms of the payments that we make in terms of the staff that we have across the board—and that is how we can calculate those figures that we were referring to earlier—it will involve a deeper detailed breakdown service by service, LHN by LHN, in terms of the number of psychiatrists, because we do not categorise them in the employment system in a different way than other doctors in terms of how that employment information system works. So we will need to get some information.

I think it is clear that we continue to be quite competitive in terms of the remuneration that we offer psychiatrists compared with other states. In New South Wales we have seen a very serious

industrial issue that has broken out there, where psychiatrists in New South Wales are pointing to South Australia, among other states, in terms of the packages that we offer here, saying, 'Why aren't we getting that in New South Wales?' We very much value our psychiatrists; they play an important role.

We have additional beds coming online, as I said earlier. Clearly, a lot of the operational funding for those is for staffing, and one of the components of the staffing is psychiatrists. So there will be additional positions that are opening up, and because of that we have been undertaking an international, national and local recruitment campaign for mental health professionals, not just psychiatrists but also, as we have been talking about, mental health nurses, psychologists and social workers.

When it comes to mental health wards, particularly when we are talking about rehabilitation wards, a variety of different mental health professionals are needed to operate those effectively. It is a real multidisciplinary model that we have developed with the model of care, and so we are looking to attract to the SA Health workforce a lot of different professionals.

I know you are aware of the work we have done in terms of the Psychiatry Workforce Plan, which sets out that we need to increase the trainee numbers to make sure that we can meet those needs into the future as well. If we can do that, we actually have the opportunity to address some of these shortages in terms of not just the public but the private system in terms of psychiatry. I cannot speak highly enough of the work that we have been doing with Dr Clarke and the Royal Australian and New Zealand College of Psychiatrists, who have been very collaboratively working with us in terms of these arrangements. I think that is a very positive opportunity to address future needs.

Lastly, I would raise another issue in terms of one of the pipeline issues for psychiatrists that we have, which is child psychiatry. Not only do we need child psychiatrists to meet the need for children but also it is part of the college training pipeline that for somebody to become a psychiatrist they have to undertake a placement in child psychiatry.

If we can increase what we can do in child psychiatry then that can allow an overall increase in trainee numbers, which can lead to more psychiatrists at the end of the day. Obviously, that is one of the benefits of the investment that we made in our first budget, based on our election commitment of five additional child psychiatrists. It has a dual benefit of helping us to be able to improve our training package overall.

Ms PRATT: There are a number of questions to follow on the workforce plan, but in reference to that pipeline of trainee placements for child psychiatry, can you speak to the current challenges the system is facing through the limit of trainee placements and then delays to the recruitment of child psychiatrists?

The Hon. C.J. PICTON: I would not quite characterise it like that. What I would say is that, as I was talking about in the previous session, we know that we have delays in getting people access to mental health beds in our system, and that is absolutely not the care we want to provide for people who get stuck in our emergency departments, waiting for inpatient beds. It also deprives those emergency department beds from people in the waiting room or on the ambulance ramp.

So there is a dual benefit in terms of getting that right, and that is why we are invested so heavily in terms of these new mental health wards that are coming on board at The QEH, at Modbury and at Noarlunga. Very purposefully, each of the three major local health networks has got one of those coming.

We have a central model of care that Dr Brayley has been very involved in in putting together, and we also have lived-experience representatives in terms how those rehabilitation beds are going to work. Each of the local health networks has been undertaking the more detailed work in terms of their design and their model of care.

I have recently asked Dr Brayley to undertake work with each of those local health networks to review their readiness in terms of the opening of those beds. We discussed this when we met the other day, and I think it is pleasing to hear that there is a lot of work that has been undertaken in terms of getting those models right at a local level for those rehabilitation beds that are coming online.

Going back to your original question, there is no doubt that we need more psychiatrists now and into the future. That is not just a public sector issue, that is a private sector issue as well. People find it very difficult to access private psychiatry, and that delays people's care privately as well. One thing that we have announced today, which also has a dual benefit, is changes that we are going to make next year in terms of ADHD treatment in South Australia.

It is allowing, for the first time, people to be able to be diagnosed for ADHD by general practitioners who have undertaken training in that area. That is not only going to make it a lot more affordable and accessible for people to access ADHD treatment, but, secondly, it is going to free up, potentially, time for private psychiatrists to be able to see other private clients, because we know that is a key pressure not just in SA Health but in the broader health system.

Ms PRATT: Minister, what do you say to high-profile mental health contributors like Professor Patrick McGorry who have expressed in a public way questions about the prevalence of young people with ADHD? I have not seen the particulars of your media release by the way, but I am interested to know as there are contrary views about the prevalence of young people being diagnosed and/or receiving treatment, so perhaps you can expand on that commitment.

The Hon. C.J. PICTON: I am very happy to. I refer the member to the member for Schubert, who says she is an avid reader of my press releases.

Ms PRATT: I will leave it to her.

The Hon. C.J. PICTON: I am certainly not a psychiatrist or a clinician or a GP. I would not profess in terms of the individual clinical diagnosis, but what I would say is that my policy view is that all health professionals should be operating at the top of their scope of practice. I think there is the opportunity not necessarily for every GP but for GPs who have a special interest in mental health or paediatrics—who have undertaken training—to be able to provide assessments in this area. Models of this have been happening in other states, or are proposed to happen in other states. It has been something that we have been talking to the College of Psychiatrists about, and they obviously want to be involved in that work, but they have not rung alarm bells about that, I think it is fair to say.

In terms of the issue more broadly about ADHD diagnosis and whether we are concerned about overdiagnosis, I think that clearly is something we always have to be mindful of from a system or clinical level. It probably sits more in a clinical field, though, so I might ask Dr Brayley to give his clinical perspective in terms of what the evidence is in regard to ADHD.

Dr BRAYLEY**:** The question that is raised in public discussions, including from Professor McGorry, is both the concern about overdiagnosis but also underdiagnosis—people not getting assessments that they require. We also need to be mindful that people who might have ADHD may be experiencing another condition, so they need a comprehensive assessment. So whoever is doing that, there will need to be clinical standards upheld in that assessment and expectations of that. Similarly, as occurs now, there are expectations about monitoring and review of people who are prescribed stimulants for ADHD.

I think Professor McGorry's wise comments need to be considered, and he certainly put a challenge out to psychiatrists when he wrote on this topic concerns about potential commercialisation of the process of diagnosis. We need to learn from that to make sure that people who have this neurodevelopmental condition, which when accurately diagnosed and treated can be significantly life-changing, can get treatment. There is also access to, for example, Medicare care planning, so that some of the non-drug psychological interventions can be given either as an alternative or together at the same time with stimulant medication. I will be very interested to see the training programs that are developed and, of course, this will still need to be part of the regulatory process that SA Health is a part of.

Ms PRATT: Minister, on the same topic then, drifting a little way from the set of questions but on the matter of the ADHD program you have raised—and I have inserted Professor McGorry's contributions into this conversation. In a similar article he also references Gavin Andrews, and I cannot speak as to whether he is a doctor or a psychiatrist—Dr Andrews, with the reference to 'met unneed'.

The challenge before governments in considering policies like this perhaps is not just the unmet need but that which might be—to paraphrase you—underdiagnosis or overdiagnosis, an unmet need, and a new phrase for me which is 'met unneed', so those who are using a service that they do not necessarily require. What is the role therefore for the Office of the Chief Psychiatrist to cater for or place some weight on the risks around those who will access a service they do not need?

The Hon. C.J. PICTON: I think it is a good question, and it is a big question. Particularly drawing back to ADHD, I will give you a couple of examples that happened just this morning as we were doing this media. One is Taimi Allan, the Mental Health Commissioner for South Australia, whom I know you know. I know that she would not mind me speaking about this because she is very open about her experience.

She was open to the media about her ADHD diagnosis and she said that if she had got that diagnosis earlier there was probably a whole range of different mental health involvements and treatments that she probably would have missed through the course of her life. She said that she may well have gone down her original path of being a lawyer rather than a specialist in mental health, which would have been a loss for mental health generally, but obviously would have helped the trajectory of her life in terms of avoiding met treatment that she did not need, as you say.

Even as we were doing it, a member of the media was talking about his daughter who was diagnosed at 29 and has changed her life. If that diagnosis had been earlier, he said, her life could have been very different. She had fallen out of uni, had gone through different jobs, etc., and now can see the transformational benefit of getting that diagnosis.

I think people are right to have a certain degree of—maybe call it scepticism, maybe call it just watching in terms of the level of diagnosis happening in the community—but I think we should also be mindful that there are a lot of people who are getting other mental health care or other support where actually the underlying issue may well be ADHD and could potentially be better addressed if they were able to get a diagnosis.

For me, I actually think that this is a really worrying discrepancy in terms of people's level of access. If you live in the city and you have lots of money, you can get an ADHD diagnosis. If you live in the outer suburbs or a regional area and you do not have lots of money, you have no chance at the moment. By allowing GPs to diagnose and prescribe, not only are we improving access but also making it more affordable and more equitable for people to get good mental health care. I think that should be recognised by everybody as a good thing.

Ms PRATT: They might be able to do that in extended hours, minister. The question I would like to put to the minister goes back to the workforce plan. It is the same budget line, and I am working out of Sub-program 1.2, the Office of the Chief Psychiatrist. Hosted on the website of the OCP is the Psychiatry Workforce Plan. That document estimates that there are currently 17 open but unfilled roles in South Australia, increasing to 23 by late 2025 due to the opening of new mental health beds or mental health units to come online. How many full-time equivalent psychiatrists are currently employed across SA and what vacancies are we carrying?

The Hon. C.J. PICTON: Obviously, you have the workforce plan that talks through the projections. I think the only thing I could add, in addition to what we have already taken on notice, is that the services are expecting to employ an additional six consultants and an additional six trainee psychiatric positions, I am advised, to be added through the course of the new beds coming online over the course of the next year.

Not only does that have the benefit of meeting the need of people who will be in those beds but also of allowing a greater pipeline of psychiatrists to come through the system. One of the benefits of us being able to tackle this issue of psychiatry is that there is actually demand for doctors to want to be psychiatrists. When the college of psychiatrists opens their training positions, they are very oversubscribed. Everyone wants to be the next Dr John Brayley.

Ms PRATT: They have got no chance.

The Hon. C.J. PICTON: 'They have got no chance', the member for Frome says. That means that if we can increase the number of positions then we can increase the number of psychiatrists, because there is that demand out there.

Ms PRATT: The workforce plan, as I understand it, has been fully accepted and endorsed by the government. While the recommendations or the outcomes were independently landed on, the government has accepted them—correct me if I am wrong. What specific strategies are in place immediately? That is language from the plan. What specific strategies are in place to immediately address the growing shortfall in psychiatrists, particularly in regional and rural areas? What are the immediate steps the government is taking? That is plan outcome 1.

The Hon. C.J. PICTON: I might say a bit and then see if Dr Brayley wants to add anything in terms of the regional psychiatric workforce and mental health more broadly. The first thing to say is that a lot of our services for mental health in regional South Australia are provided through the Rural and Remote Mental Health Service, which is predominantly based in Adelaide but servicing regional South Australia. The psychiatrists who work there, based in that service, fit legally and technically under the Barossa Hills Fleurieu Local Health Network. They have beds based at Glenside campus. They provide that care right across the state.

The second thing to say is that we have mental health wards based in a number of our regional hospitals, and we have already talked about how we are expanding one of those in Mount Gambier to allow more regional patients to be seen there. We are also building another one in what is technically, I am sure the member for Kavel would argue strenuously, not part of metropolitan Adelaide, at Mount Barker in the new hospital. There will be 12 beds based there as well.

Another thing I want to add is that obviously we are working progressively through the various components of the review that we had undertaken in terms of regional mental health and workforce issues and services more broadly. There were a number of those that were subject to changes that would have to be made to the industrial and enterprise bargaining and private practice arrangements between the government and SASMOA. We are in enterprise bargaining negotiations at the moment. There may well be pluses or minuses or difficulties or opportunities to address some of those, but there are a lot of others that we are working on and working to address. John might talk about what those are or Sinead may as well.

The other thing that I would highlight as well is that one of the key benefits for how our regional patients are looked after in terms of mental health, which we have been doing a lot of work on trying to improve, is the issue of repatriations. We have a lot of patients who may well present to a regional hospital with a mental health condition, and the status quo provision seemed to be that they all got sent off to the Royal Adelaide Hospital emergency department, which was not a good outcome for them in a lot of cases, and it certainly was not a good outcome for the emergency department at the Royal Adelaide Hospital.

Sinead O'Brien, as deputy chief executive, has been leading a big piece of work, working with our clinicians on how we can improve that model of care. One of the key ways is providing more psychiatric assessments to take place, including by telehealth, based in a variety of different regional locations, which in many ways can avoid people's need to transit. We are also looking at how we can in many cases directly admit people into rural and remote mental health services rather than them having to go through the emergency department.

I am told that this work has led to a 38 per cent increase in transfers within the region and a 30 per cent increase in the direct admission to metropolitan wards rather than having to go through the emergency department. So we are starting to see some benefits from that project. I will see if Dr Brayley wants to add anything.

Dr BRAYLEY: Yes, this need for additional rural psychiatrists has been a topic that the rural LHNs have been working on even prior to our workforce plan. You see places such as the Riverland, also Whyalla, having an additional psychiatrist available, working outside of the ward. I was having discussions about this process and the increasing of these non-inpatient psychiatrists this morning—on this particular issue.

It is having a benefit and will need to be incorporated into the response to the workforce plan but is what the regional local health networks need to be planning to do anyway, which we have seen them do on their own initiative and make an impact there. But in terms of the new resources that are

going out at the moment, of course, it is the psychiatrists in the rehabilitation units and the new registrars who they will be training.

Ms PRATT: Minister, in terms of the workforce plan for psychiatry, I am about to refer to a report that has been released by the federal Department of Health and Aged Care. How might the Office of the Chief Psychiatrist reconcile a discrepancy in a projected psychiatrist FTE shortfall, where the DoHAC model suggests the shortfall for our state is going to be 72 FTEs by 2033 versus the workforce plan that says it will be 17 by 2033?

Dr BRAYLEY: We are aware of those discrepancies and a more precise answer will be required. Please be reassured, however, that in terms of the South Australian plan the providers were carefully selected by our panel and have had significant experience using microsimulation modelling for a whole range of health disciplines for the commonwealth government as well as doing it for us.

The report does reflect potential differences—depending on how you view, say, child psychiatrist numbers using Australian benchmarks versus European benchmarks—so there will always be questions about the absolute numbers, but there is a considerable amount of SA Health and commonwealth data that has gone into it, as well as appropriate evidence-based assumptions to show both what the gaps will be and how by taking these recommendations related to the different types of psychiatrists you could actually address the unmet needs scenario that was presented, with the sorts of numbers that we have been talking about, over the next 10 years.

Ms PRATT: So to clarify: there is a gap or a balance of about 55 FTEs, depending on which report you reference—the federal DoHAC report or the EY workforce plan—and the Office of the Chief Psychiatrist is aware of that gap. Can the minister then clarify what Dr Brayley is saying the state's approach is going to be? Depending on which report you read, it is a gap of 55 FTEs that we are going to be short by. What steps is the government taking to either reanalyse the modelling or increase funding or training placements to account for that shortfall in 2033?

The Hon. C.J. PICTON: I think Dr Brayley has very accurately outlined that a variety of different assumptions went into different models.

Ms PRATT: Someone is wrong.

The Hon. C.J. PICTON: We have had a look at the work that was undertaken by the federal department—presumably that was for all of Australia, not just for South Australia. We are confident that the modelling that has been done as part of our workforce plan is accurate, so we certainly do not believe that any remodelling of that would need to occur.

I think one of the benefits of undertaking a study just for South Australia, just looking at our own workforce needs, is that hopefully we are going to get a much better, more accurate and closer-to-the-ground view of what is going on rather than relying on a federal report with federal tables that are looking at the whole of a country, of which South Australia is obviously a small component.

Ms PRATT: So, minister, you are not intending to shy away from the workforce plan as it stands—the modelling for trainee placements or an increase in funding? You are confident that the EY psychiatry workforce plan is the pathway that the government needs to follow?

The Hon. C.J. PICTON: We are confident that this is the plan for us to follow. In terms of additional funding, we are providing a lot of additional funding for mental health and the budget bears that out. We certainly think that the work we have done has been detailed, meticulous, well consulted and done in collaboration between the government and the College of Psychiatrists. We have not just come up with this ourselves; it has been a joint project that we have managed between us.

Obviously, we will continue to review it over time and continue to look at how it is operating. It will not be static in terms of we just set it and go. We will keep looking at it. But we are confident that it is a detailed, highly valuable piece of work that will prove well for South Australia.

Ms PRATT: I move on to the workforce of psychologists. For the Chair's benefit, I am remaining with Sub-program 1.2 or we can look at page 13, Workforce summary, where the total workforce for the department is 41,000. If there is a query about budget papers, I am happy to have that argument.

The Hon. C.J. PICTON: That is alright; you are a lot nicer than the member for Schubert so I will let you—

Ms PRATT: Do not let her hear you say that. Psychologists report a 50 per cent vacancy rate in the public health system and they have written to the Premier. Do you know if he has written back, and is that figure correct?

The Hon. C.J. PICTON: Sorry, say that again?

Ms PRATT: Psychologists are reporting a 50 per cent vacancy rate in the public health system. They have written to the Premier. Has he written back, and can you verify that figure?

The Hon. C.J. PICTON: I would not dare speak on behalf of the Premier's correspondence, but what I would say in terms of psychology is that we do know that we have vacancies, and that has been recognised as part of our negotiating position and the proposition that we have put to the Health Services Union as part of the enterprise bargaining for a new allied health agreement that recognises an additional payment to be made for psychologists, clinical psychologists, working across the public health system to make a more competitive payment proposition.

We are really delighted that we have now been able to reach in-principle agreement with the Health Services Union and obviously that proposed enterprise bargaining agreement will be going to a ballot in coming weeks. In addition to that, I would say, though, that pay is one thing, but we need to address supply. We need to address the number of psychologists coming into the system.

When you have so many psychologists doing an undergraduate degree who do not then become psychologists, not because of lack of want but because there are only a teeny tiny number of masters placements available, then we have an issue. A lot of the work that we have been doing in terms of developing a psychology workforce plan has been about how we can improve the training that we provide. We are also looking hopefully to the federal government to help in terms of their funding that they provide for placements for psychologists to undertake training because we are going to need more psychologists, both in the public system and in the private system as well.

One thing that I am mindful of as well, which I know the federal minister would want me to speak to, is that he sees, I think, a role for how we can make sure that psychologists are operating at the top of their scope of practice as well. If there are matters in which people could be getting help in different ways outside of going to see a psychologist, then that could free up psychology time for those who really do need to see a psychologist as well. So I think there are a number of different policy moves at the federal level that they are looking at doing that.

From my perspective, here in South Australia, it is really all about supply. The good news is that in South Australia we have been able to grow the number of psychologists. So despite all these pressures, despite the fact that there are clearly vacancies, we had a 5 per cent increase in FTE and a 9 per cent increase in headcount over the past three years of the number of psychologists in the system. I do not think there is any doubt that we could hire more, and hopefully the enterprise bargaining agreement will be one element of how we can do that, but I think how we can increase supply and training positions is the other.

Ms PRATT: Minister, without a workforce we cannot provide treatment or services. On that front, psychologists report being forced to pause treatment for borderline personality disorders such as DBT (dialectical behaviour therapy), which it possibly might impact up to 68,000 people in South Australia who live with or are diagnosed with DBT symptoms. Can you verify that DBT treatment has been paused and for how long, how many patients might be impacted by that, and do you think that is satisfactory?

The Hon. C.J. PICTON: I certainly cannot confirm that. I have asked my chief advisers here and certainly we cannot confirm that, but we will look into the allegations that you have made and see if there is any veracity to them.

Ms PRATT: I am going to address that by challenging the use of the word 'allegations', because that, as I have read, is the correspondence that has been sent to the Premier and to myself. I made an assumption that perhaps the same correspondence had been sent to the minister. It is correspondence that is coming from members of the South Australian Psychologists Association.

They are not my allegations; they are reports from psychologists. So I would be happy to hear back from the minister on those concerns being raised by the workforce.

Where psychologists are reporting to me, at least, that there has been a pause at more than one practice or clinic or mental health service on DBT treatment, it begs the question about the tension we see between a diminishing workforce and the services that are required by those who live with mental health conditions.

In the public domain we have seen just this week a number of reports around drivers who have been found guilty of causing road fatalities, but they also are reported to have had a diagnosis of bipolar illness, schizophrenia, and people who find themselves working their way through the justice system, but there are suggestions of mental health diagnoses, or reports that they appear distressed in the lead-up to these incidents, and also people who find themselves remanded into the custody of the forensic mental health service.

How does the government's strong focus on building beds in hospitals support those people once they are discharged from those beds, where we see a pause on treatment services that they are going to need once they are released back to family or community accommodation?

The Hon. C.J. PICTON: There was a bit there to dissect. The first thing I would say is there was a comment made about seeing a declining workforce. There is absolutely no evidence of that whatsoever. Even with psychology we were just talking about, there is no doubt there are vacancies, but we have an increasing workforce, an increased headcount by 9 per cent and an increased FTE by 5 per cent.

My second comment, in terms of fatalities and road accidents that were attributed to mental health conditions and bipolar, etc., there have been no details that have been provided to the anecdotal statements made there.

Ms PRATT: I am trying to de-indentify.

The Hon. C.J. PICTON: I would just be a bit cautious about creating stigma over mental health conditions. There are a lot of people in South Australia who have mental health conditions and they do not all go around causing fatalities and road accidents, even people who have undiagnosed mental health conditions, etc.

In terms of the eventual question you got to, as to how beds will be helping in terms of people's treatment, I will go to the fact that one of the key reasons why we are doing these beds, and this particular model of care, is to avoid what has been an issue, which is a bit of a revolving door. This is what has been told to me by a number of experts and a number of psychiatrists: the pressure to have people put through the system in a very quick way, or quick in a couple of weeks way, does not give people enough time to recover from their conditions and does not give people enough time for their treatment to kick in.

While there are a lot of community settings that people get referred to and get supports, we actually need that middle area where we have mental health facilities, mental health beds and wards that are designed for that rehabilitation to occur for a longer length of stay, and the proposition that has been put—and this was originally put to us, and it was put to the then government as well before the 2022 election by the College of Psychiatrists themselves—was that by having these subacute facilities in place it will enable people to recover and will enable them to get the benefits out of their treatment and so they are less likely to re-present to hospital.

Of course, they will still then have the ability to connect with either state government run community mental health services, or NGO community mental health services, or NDIS services, but that next step of that subacute rehabilitation bed was a missing element of our system in South Australia. I say 'missing' because we have had those beds at Glenside for some years but they have always been under pressure in terms of their availability and getting people into them. We are now going to see a huge uplift in the availability of those and it is designed to allow people to have those longer lengths of stay.

Ms PRATT: Thank you, minister. Moving on to the government's investment in mental health through the drought relief package, but as it relates to a reference to the Chief Psychiatrist, in the

house this week you advised that you had met with the Chief Psychiatrist and Mental Health Commissioner on Wednesday. What then has been immediate about the comprehensive strategy to boost mental health and resilience for farmers, given that it was announced three months ago and it still has not been rolled out?

The Hon. C.J. PICTON: I would question the premise of the question in that some elements of this are rolling out, and some elements are in the process of being rolled out right now. As was mentioned, we worked collaboratively between the Department for Health and Wellbeing but also with Preventive Health SA and with the Mental Health Commissioner in devising a package of mental health investments that then formed part of a submission to cabinet that then formed part of the over $70 million investment in drought relief. We were mindful of doing things that were going to make a difference and also things that we could operate quickly, without extensive contracting and delays as part of it.

There are a variety of different elements of that. There are communications that have been rolling out immediately—that is one element of the package—over $100,000 going into mental health communications awareness raising. There are men's tables that we are going to be rolling out throughout South Australia in drought-affected areas, which have been seen as a key way of engaging men who might otherwise not be engaged. Further, I would add—I think I mentioned it in the house the other day as well—contracting has been happening now with Breakthrough that has enabled Breakthrough Mental Health Research Foundation to undertake a number of sessions across regional South Australia as well—they conducted the first one last weekend in the Mallee region, which was well attended.

We have also been working with NGO partners, who operate already in regional areas across the state, to extend their contracts, and those revised contracts will come into operation from 1 July. They will make sure that we can extend the works they do across regional South Australia as well.

Ms PRATT: Which contracts were they?

The Hon. C.J. PICTON: These are contracts that we have with non-government organisations across the state; we can get you the details of those providers. These are providers that we already contract with to provide a range of different psychosocial services in regional South Australia. We took the reasonable view that, rather than signing somebody up newly to move into a community that they have not been part of, it is better if we can extend the work that people who are already there and already connected to the community can do.

We are doing a whole range of other work, including with Aboriginal Community Controlled Health Organisations as well. There will be drought mental health resilience outreach occurring and also mental health access centres that we are looking at establishing. We are aiming to establish 12 of those—they are in the planning stage—that will enable people to have local connections as well. There is a variety of different elements of this package, some of which are operating now, some of which are in the process of rolling out and some of which will take longer to do, but we think will make a difference.

Ms PRATT: Minister, you have cautioned me on the careful choice of wording, and I would share back to the government a cautionary tale about using the word 'immediate' where, when the drought relief package was rolled out and where the language that still sits on PIRSA's website says, '$2½ million for an immediate and comprehensive boost to mental health and resilience strategies'. It is the immediacy that farming families are looking for, and the only time I have heard you reference immediate now is in relation to communications and awareness raising, which would be welcome. I think the use of 'immediate' has been misleading for those farming families that contact country members of parliament saying, 'We don't know how to access this or where to start.'

Did I hear you say that you would take on notice and provide back to us the list of NGOs that are currently engaged and therefore benefiting from access to the $2½ million?

The Hon. C.J. PICTON: I am happy to do that.

Ms PRATT: Great. Just quickly before the member for Chaffey asks a question, in terms of the role for the Breakthrough foundation and the very important and good work that they do, you mentioned that it has already started last weekend in the Mallee. Can you report other locations that

are going to benefit from access to John Mannion's Breakthrough foundation supports? What other regions—like Peterborough, like the Mid North, like the West Coast?

The Hon. C.J. PICTON: I do not have that detail with me, but I know that Breakthrough are working through making sure that they are widely available across regional South Australia. I do not want to speak on their behalf, but I think that some of those locations may have been locked in. They are perhaps still working on some of those. Obviously, I do not have the detail in terms of the full rollout of those times that they will be making themselves available.

I just want to say, though, that I think that when you look at their program it certainly has been tested through the Kangaroo Island and Adelaide Hills fires as a good way of being able to engage people who can be difficult to engage. Certainly, we saw that on the weekend, with a large attendance in a very small community in the Mallee turning up to be part of that. Apparently, some people were travelling a very long distance to get there because they wanted to be part of it. We are hopeful that that will be equally positive as part of this rollout.

The other thing that I would say—and obviously you are going to make the political points that you need to—is all the advice that we have is not just the immediate but the sustained as well. We are always mindful, I think, that the mental health effects from an event, particularly one that is as long running as a drought, may well go for some time. For us to be alleging we should be spending $2½ million all in one go straight out the door I actually do not think is borne out by the evidence in terms of where the mental health effects are. These mental health effects are going to be long running, so we need to have that sustained effort. That is what everyone involved in this program is mindful of.

Ms PRATT: I think the use of the word 'immediate' was unnecessary and 'comprehensive' was going to be the sustaining package that you refer to.

Mr WHETSTONE: Thank you, minister. It is an informative estimates session, and it is good to sit in on it.

The Hon. C.J. PICTON: High praise.

Mr WHETSTONE: I think the opposition is doing an outstanding job as well. I refer to Sub-program 1.2 on page 22 on developing your mental health and substance abuse strategy. Is the evidence in developing the strategy showing the different and varied needs within a regional setting compared to a metro setting? Obviously, you have just talked about the mental health impacts of drought, but there are a lot of issues in a regional setting that are wide and varied that we do not see in a metropolitan setting, whether it is weather events, drought, flood, isolation, the tyranny of distance or limited access to services. Is that something that will be taken into consideration in developing your strategy?

The Hon. C.J. PICTON: I think it always is. I think we are very mindful of some of the different issues. Obviously you know, member for Chaffey, the impacts that we saw in your community from the floods in the past couple of years. I should add in terms of the drought response that something that I made very clear to the team, but that they also agreed with, is that we need to learn the lessons from our mental health response in the Riverland, what worked well and what did not work well in how we rolled out our mental health response to the drought.

Clearly, as you have outlined, there are a number of effects that impact regional communities differently in terms of weather events, natural disasters that they face and different types of pressures that they face that impact upon mental health, but obviously the other issue is the tyranny of distance that people face. Geography is spread out in South Australia, and that makes things very difficult in terms of making sure that we have the availability of services.

This is something where we have central strategies and central views, but part of the benefit of the devolved local health networks is that we have local responses to things as well. Across our six regional local health networks, they all have their own local mental health teams. Predominantly, they all have their own mental health strategies and plans that are tailored to the needs of that community, tailored to the geography and tailored to the particular circumstances they have. That is a benefit of the devolved system that we have.

Mr WHETSTONE: Just expanding on that, one of my concerns is that there are the unseen or the hidden issues with mental health in a regional setting. There is a very good program at the moment, the FaB Scout mentoring program, which allows a mobile assessment of people who are not coming out of their houses. They have the capacity to knock on doors and speak to those people who are under severe stress, whether it is financial or mental stress. It is more of a comment than it is a question. I think it is a very valuable tool that could be part of developing your strategy. I have just one other question: in developing the Equally Well standard, will there be a regional component to that program?

The Hon. C.J. PICTON: I will pass to Dr Brayley, who is very passionate about this subject, to outline.

Dr BRAYLEY: Yes, indeed. Equally Well, as you know, refers to the high rates of physical illness that people with mental health conditions can experience and the fact that people can die up to 20 years earlier. They are very much an at-risk population. We have our Equally Well working group, which has been developing the standard that has gone out to all of the LHNs. It has rural as well as metropolitan input across professions, general physical health professionals as well as mental health.

The need to have effective health screening and appropriate diagnosis in interventions is clear. The draft that will be going out more broadly to communities and organisations as the next step will be looking at the issue of screening in services, access to physical health interventions and the work that our mental health services themselves can do to identify people's physical health problems.

There can always be more challenges in rural areas. In doing this, one of the benefits across many parts of South Australia is the close relationship between mental health and local general practitioners, because they are already sharing care in some areas, so this gives us something to build on. It is a key issue, and South Australia is hosting an Equally Well conference, a national conference, later this year.

Ms PRATT: Minister, if I can return, you have piqued my interest now. I wish I had read your media release on ADHD, but we have spent some time on it today. Can you step us through what the consultation period or process has been? Who has the government—perhaps the Chief Psychiatrist—consulted with to be informed with stakeholders about the need for this? Have we seen RACGP or paediatricians? What has been the background in the lead-up to the consultation process?

The Hon. C.J. PICTON: Clearly, it has been something where people with lived experience have been raising this issue for some time. I would put that first and foremost in terms of the need for a response here.

Secondly, we have been consulting with the Royal Australian College of GPs and clearly they see a significant need here and we are going to be partnering with them, obviously, in terms of the rollout of this and how we can ensure that they can provide the training for GPs to make this happen. We have also consulted with the Royal Australian and New Zealand College of Psychiatrists as well as the Royal Australasian College of Physicians. We have obviously been talking to other states in the past couple of months. Both Western Australia and New South Wales have made some similar announcements and we are looking at what they have done as well.

Ms PRATT: What is the view of paediatricians in terms of the role that GPs are going to play in supporting this?

The Hon. C.J. PICTON: I would not speak on behalf of all the paediatricians, and I am sure that there may well be a variety of different views amongst paediatricians in regard to this. I think we need to take a view as a government in terms of looking at all the advice and making sure that we have calibrated across the board balancing access with the quality of care and making sure that we have that balance right. I think that we can achieve the involvement of GPs in this process which can ensure the quality of care.

While we have made the announcement today, we are also very mindful that there is a lot of work still to come in terms of the detailed work of the training programs and how this will be rolled

out. We will be working with, of course, the College of Physicians representing paediatricians, but also the College of Psychiatrists, as well as the College of GPs in terms of the rollout. That is why we have said this is not happening immediately. This will be happening next year.

The other thing I would add is that currently we do allow GPs to do represcribing of prescriptions, but the take-up of that we think is quite low, perhaps because of some of the red tape involved, perhaps some of the nervousness or perhaps even just a lack of awareness or lack of detailed training in terms of that occurring. Whatever the reason is, that take-up is quite low. So not only do we hope to see a number of GPs who have specialist interests taking this up—and we have a lot of GPs who have really specialist involvement and interest in paediatrics and mental health already who I suspect will be the ones who will take this up. I suspect that will lead to more people undertaking what they already are allowed to do but perhaps do not do in the numbers that we might expect.

Ms PRATT: Did you mean the 60-day prescribing period? What did you mean by the represcribing reference?

The Hon. C.J. PICTON: I mean that if you have ADHD—so you go to a psychiatrist at the moment, get diagnosed as having ADHD, you are then prescribed a treatment by your psychiatrist. That will go for a certain period of time, usually probably a lot longer than the 60 days. There might be a number of different repeat scripts that will occur during that time. The 60-day prescribing usually refers to what you can get from the pharmacist on that day, but usually people will have repeat scripts. Then at the end of that, rather than going back to the psychiatrist, legislation allows you to go back to the GP, but we think that the uptake of that is actually quite low at the moment. So a lot of people go back to the psychiatrist once their repeat scripts have run out.

Ms PRATT: Just one more question on this to conclude, since we are on the theme. When I asked about who you consulted, you said people's lived experience. Where are the families, the parents represented in this consultation process? It is hard to know because if a diagnosis has not been made, a parent might not know yet. But how does the government go about consulting with, if you like, the beneficiaries, the guardians and caretakers of young people with ADHD? What is the families' view?

The Hon. C.J. PICTON: I am sure that we will not be able to get every family's potential view, but this is about giving them options. If people want to go to a paediatrician or a psychiatrist then they will be able to do so. If people want to go to their GP they will be able to do so in the future. What we are hearing loud and clear from people is that they are finding it very difficult to be able to access the care that they need and they are finding it very expensive to be able to access the care that they need. That is the overwhelming feedback that we have had that has led us to consider whether we needed to make a change in this regard.

I would like to give a plug for general practitioners and their professionalism and their training to treat a wide variety of different health conditions. They are specialists in their own right and they have their own professional responsibilities and accountability. If they believe that something is not within their ability to properly make a diagnosis, then they have the ability, of course, to refer that to a more specialist clinician, such as a psychiatrist or a paediatrician, for that analysis. Speaking to a number of GPs who are very expert in this area already, they are already undertaking a lot of this work. They are already doing the write-ups and then, really, it is the psychiatrist or the paediatrician who is ticking it off.

Mrs HURN: I will read the omnibus questions:

1. For each department and agency reporting to the minister, how many executive appointments have been made since 1 July 2024 and what is the annual salary and total employment cost for each position?

2. For each department and agency reporting to the minister, how many executive positions have been abolished since 1 July 2024 and what was the annual salary and total employment cost for each position?

3. For each department and agency reporting to the minister, what has been the total cost of executive position terminations since 1 July 2024?

4. For each department and agency reporting to the minister, will the minister provide a breakdown of expenditure on consultants and contractors with a total estimated cost above $10,000 engaged since 1 July 2024, listing the name of the consultant, contractor or service supplier, the method of appointment, the reason for the engagement and the estimated total cost of the work?

5. For each department and agency reporting to the minister, will the minister provide an estimate of the total cost to be incurred in 2025-26 for consultants and contractors, and for each case in which a consultant or contractor has already been engaged at a total estimated cost above $10,000, the name of the consultant or contractor, the method of appointment, the reason for the engagement and the total estimated cost?

6. For each department or agency reporting to the minister, how many surplus employees are there in June 2025, and for each surplus employee, what is the title or classification of the position and the total annual employment cost?

7. For each department and agency reporting to the minister, what is the number of executive staff to be cut to meet the government's commitment to reduce spending on the employment of executive staff and, for each position to be cut, its classification, total remuneration cost and the date by which the position will be cut?

8. For each department and agency reporting to the minister, what savings targets have been set for 2025-26 and each year of the forward estimates, and what is the estimated FTE impact of these measures?

9. For each department and agency reporting to the minister:

   (a) What was the actual FTE count at June 2025 and what is the projected actual FTE account for the end of each year of the forward estimates?

   (b) What is the budgeted total employment cost for each year of the forward estimates?

   (c) How many targeted voluntary separation packages are estimated to be required to meet budget targets over the forward estimates and what is their estimated cost?

10. For each department and agency reporting to the minister, how much is budgeted to be spent on goods and services for 2025-26 and for each year of the forward estimates?

11. For each department and agency reporting to the minister, how many FTEs are budgeted to provide communication and promotion activities in 2025-26 and each year of the forward estimates and what is their estimated employment cost?

12. For each department and agency reporting to the minister, what is the total budgeted cost of government-paid advertising, including campaigns, across all mediums in 2025-26?

13. For each department and agency reporting to the minister, please provide for each individual investing expenditure project administered, the name, total estimated expenditure, actual expenditure incurred to June 2024 and budgeted expenditure for 2025-26, 2026-27 and 2027-28.

14. For each grant program or fund the minister is responsible for, please provide the following information for the 2025-26, 2026-27 and 2027-28 financial years:

   (a) Name of the program or fund;

   (b) The purpose of the program or fund;

   (c) Budgeted payments into the program or fund;

   (d) Budgeted expenditure from the program or fund; and

   (e) Details, including the value and beneficiary, or any commitments already made to be funded from the program or fund.

15. For each department and agency reporting to the minister:

(a) Is the agency confident that you will meet your expenditure targets in 2025-26? Have any budget decisions been made between the delivery of the budget on 5 June 2025 and today that might impact on the numbers presented in the budget papers which we are examining today?

(b) Are you expecting any reallocations across your agencies' budget lines during 2025-26; if so, what is the nature of the reallocation?

16. For each department and agency reporting to the minister:

(a) What South Australian businesses will be used in procurement for your agencies in 2025-26?

(b) What percentage of total procurement spend for your agencies does this represent?

(c) How does this compare to last year?

17. What percentage of your department's budget has been allocated for the management of remote work infrastructure, including digital tools, cybersecurity, and support services, and how does this compare with previous years?

18. How many procurements have been undertaken by the department this FY? How many have been awarded to interstate businesses? How many of those were signed off by the CE?

19. How many contractor invoices were paid by the department directly this FY? How many and what percentage were paid within 15 days, and how many and what percentage were paid outside of 15 days?

20. How many and what percentage of staff who undertake procurement activities have undertaken training on participation policies and local industry participants this FY?

The CHAIR: I am told that the former member for Morphett, Duncan McFetridge, was the quickest reader of the omnibus speech. I am told the record is two minutes.

Mr WHETSTONE: That was five minutes, 16 seconds.

The CHAIR: You have a bit of work to do—maybe at the next estimates hearing. Maybe one day common sense will apply, and we can just automatically table it. Who knows? It has taken years and years of reading it out. One day it is going to be done, I am sure. The allotted time having expired, I declare the examination of Mental Health and Substance Abuse complete.

Departmental Advisers:

Dr R. Lawrence, Chief Executive, Department for Health and Wellbeing.

Ms M. Bowshall, Chief Executive, Preventive Health SA, Department for Health and Wellbeing.

Dr N. Spurrier, Chief Public Health Officer, Department for Health and Wellbeing.

Ms M. Geisler, Senior Executive and Governance Officer, Department for Health and Wellbeing.

The CHAIR: I declare that the proposed payments remain open for examination. I call on the minister to make an opening statement or introduce his new advisers.

The Hon. C.J. PICTON: We are retaining Dr Lawrence and also Marina Bowshall, who is the Chief Executive of Preventive Health SA. Joining us is a public servant you might not have heard of, Chief Public Health Officer, Professor Nicola Spurrier.

The CHAIR: An opening statement from the member for Frome?

Ms PRATT: Straight into it, Chair.

The CHAIR: Excellent.

Ms PRATT: Budget Paper 4, Volume 3, page 60, Sub-program 3.2: Preventive Health SA. The target line is, 'The prevention priorities for Preventive Health SA include obesity, tobacco smoking, vaping, mental health, suicide prevention, alcohol and other drugs, and the determinants of health.' My question relates to obesity and the use of Ozempic, using that target where the agency has a focus on reducing obesity. Figures from the Department of Health, Disability and Ageing show a national total of 2,832 under-18-year-olds on Ozempic for diabetes, prescribed through the PBS. A New South Wales figure shows that figure has risen by 700 per cent in three years. Are GPs in our state raising similar concerns? What can be done to manage the supply of this drug?

The Hon. C.J. PICTON: The first thing is, I agree with the very large concerns around the incidence of chronic disease in our community, the incidence of obesity leading to that. The evidence, I am advised, is that obesity is now overtaking smoking as the leading cause of illness in our community and preventable illness in our community.

That is obviously one of the key reasons why, as members know, we brought legislation to the parliament last year to establish Preventive Health SA and to bring together the various strands of prevention, obviously previously Wellbeing SA but also elements of Drug and Alcohol Services South Australia. I think Preventive Health SA has been doing an excellent job in refocusing our work on prevention, leading to some policy responses that are being viewed very favourably around the country, and also programs.

The question about Ozempic is a very pertinent one in that Ozempic, and other types of those drugs as well, do look very promising in terms of their ability to address some of these issues of obesity in our community. Obviously, we would be cautious in that they should not be seen as the panacea and we would be cautious because some of these have some serious side effects that need to be considered.

It is interesting hearing from a number of our researchers. You may have been present when we had the Heart Foundation in last year, and one of our leading cardiac researchers in South Australia spoke very clearly about the fact that for a lot of the patients he sees there is a limit to which prescribing exercise and diet works, and for some people there is the potential that these drugs could make a big difference.

When it comes to the procurement, distribution and supply of these drugs across the country, predominantly through the PBS—and that has its own rigorous processes, firstly approval through the TGA but then recommendation to the federal government through the Pharmaceutical Benefits Advisory Committee (PBAC)—there have been a number of applications made through PBAC that have been approved and that have now been funded and so there are South Australians and Australians who are able to access through the PBS these drugs for a number of different conditions.

I would fully expect that that number would grow over time. I expect that we will see more applications and more evidence of the ability of these drugs to help more people and that their availability will become more widespread over time. I do not think that deters us in any way from the work that we are doing in terms of prevention, because we do know that a combination of different preventable policy responses, whether that be increased physical activity or changes in food intake, can make a big difference in reducing chronic disease risk, cancer risk, etc. So we are undeterred in terms of the policy work that we are doing, but we are obviously mindful of the potential benefits that Ozempic and the other products of its type could make as well.

Ms PRATT: Thank you. You mentioned supply, and the reference to Ozempic is now a buzzword for most consumers of mainstream media, so in terms of supply of Ozempic, and we have seen it used in other ways than as a weight loss measure, is there an issue if the minister says, 'Looks promising and, yes, there are serious side effects, but we are looking closely'? Are there procurement and supply issues in accessing Ozempic?

The Hon. C.J. PICTON: There certainly are supply issues, to the best of my advice, worldwide. From my understanding, the manufacturers of these GLP-1s are expanding at a rapid rate in terms of making sure that they can meet that worldwide demand for these drugs, but clearly one of the issues in terms of further uptake is supply.

Ms PRATT: Budget Paper 4, Volume 3, page 60, highlights:

Delivered the Restriction of unhealthy food and drink advertising on SA Government public transit assets policy for commencement from 1 July 2025.

Who is playing bingo?

The question I have for you, minister, is: can you please explain the government's determination to ban food and drink advertising on public transport assets from 1 July 2025?

The Hon. C.J. PICTON: It is not banning food and drink advertisements, it is banning unhealthy and junk food and drink advertisements and it comes back to some of the statistics you read out in your opening question in terms of the incidence of diabetes and heart disease that we know is directly attributable in terms of our rates of obesity that we see in our community.

I think it is incumbent upon government to take as reasonable measures as we can in terms of trying to prevent people from being in that situation. One very reasonable measure that we can take when it comes to our own buses and trams that the government of South Australia owns—they do not need to have any advertising on them at all, theoretically, but there is advertising on them—is to say that we do not want to put junk food on them. We do not want to sell that space on what we own to sell junk food because ultimately we know that there is a direct correlation between people facing issues in the health system and rising health expenditure that we are going to have to address in terms of caring for people in the health system, not to mention the economic effects of chronic disease in the community.

So, in my mind at least, it is a very moderate approach that we are taking. We are not saying a ban for private assets. We are not saying a ban for television or radio advertisements or newspapers, etc., just for the buses, trains and trams that we own to not have junk food on them. We are working in a way that is trying to be as reasonable as possible in the implementation of that. This is not the first place in the world where this has happened and we obviously have learnt from other places in the world as well, but we think that it is an appropriate course when you look at the impact that those rates of diabetes, heart disease, etc., have in our community.

Ms PRATT: What statutory or contractual mechanism did you rely on for this announcement or this decision rather than bringing it through the parliament for all elected members to debate and discuss?

The Hon. C.J. PICTON: There is no need for a legal change because they are government-owned assets. This is something where the government owns the assets and has leased out space for advertisements. Already there have been policies in place in terms of the advertisements that the Department for Infrastructure and Transport would have in terms of the placement of ads on those and really it is updating existing government policy to consider unhealthy food and drink as part of the criteria for placement of those advertisements.

Certainly, the advice to me is there is absolutely no reason why that would have been a matter that would be a subject for legislation and, if we were to bring it through the parliament for legislation, I think we would be rightly questioned as to why we were doing that when there is absolutely no need.

Ms PRATT: My question was: which statutory or contractual mechanism through the Department for Infrastructure and Transport, as owners of the assets, or is it government policy?

The Hon. C.J. PICTON: The mechanism is government policy. The contracts that the Department for Infrastructure and Transport have with the companies that they contract in terms of advertising are that the adverts have to be compliant with government policy and this is a change to government policy.

Ms PRATT: Just to be clear, to pick up on a comment you just made about why it would come through the parliament, we have seen motions from crossbenchers and other policy considerations around banning junk food on bus stops or gambling advertisements on public transport. Those motions have been proposed by other elected members for debate.

The Hon. C.J. PICTON: That is true, but they are private members' matters. Those members, to the best of my knowledge, are not members of the executive government and I guess

the benefit of being part of the executive government of cabinet is that the government can change the policy without requiring a motion through the Legislative Council or the passage of a bill unless there is a legislative reason why we would need to do so.

Ms PRATT: With this policy setting that will start on 1 July, what was the motivation by Preventive Health SA or other advice? What was the motivation to disregard the COAG guidelines that suggested zero sugar drinks should be optional and not mandatory?

The Hon. C.J. PICTON: The advice that I have is that, as you mentioned, it was optional in terms of the COAG guidelines and that was something that was part of the public consultation that Preventive Health SA ran on this policy. It was proposed, as I understand it, in that public consultation to consider that we would draw that line in terms of those drinks and take up that option under the optional policy provisions of the COAG guidelines. The feedback from the public consultation that we had led to the decision to confirm that proposition that was put in the public consultation.

Ms PRATT: Minister, can you speak to meetings that you or the agency have had in preparation for this policy shift with industry bodies like the Australian Beverages Council or other manufacturers or suppliers of products that are now going to be banned?

The Hon. C.J. PICTON: I know we put out for public consultation for a wide variety of public comment—whether that was from industry or public health groups, etc.—and that enabled everybody to have their say as part of that process. There has been a number of people who have requested follow-up meetings, and I understand Preventive Health have had a number of follow-up meetings. I do not believe I have had a meeting with the Australian Beverages Council, but we can check if Preventive Health SA have done so.

Ms PRATT: Since your responses in the media this year about a ham sandwich in a kid's lunchbox being an example of an ad that would be banned, have you reconsidered your position on kids' lunchboxes and made any amendments or concessions to what will be ruled in or ruled out?

The Hon. C.J. PICTON: I do not know if I have reconsidered my view on sandwiches. I have maintained the same view on sandwiches. I have been consistent in terms of my view on sandwiches. I support sandwiches. I am pro sandwich. I think after I spoke to Penbo and Will on FIVEaa about this recently, I have then had to go and make my children sandwiches for lunch and made sure that they had some ham sandwiches that day, whether they wanted them or not.

Ms PRATT: That is a late lunch prep.

The Hon. C.J. PICTON: What we have said from the outset is that we want to be reasonable on the approach, and clearly there are things that everybody would agree are junk food advertisements, clearly there are things at the other end of the spectrum that everyone would regard as not unhealthy food and clearly there are things in the middle where some judgement will need to be applied. My very clear instructions to Preventive Health SA are that we should take a constructive approach to this and seek to work with industry, where we can, in the implementation of this on those issues across the margin.

As a guide for how we are doing that, can I give an example so that we are being very clear. Some of the sorts of examples that were thrown around were that if you have an advertisement for a state theatre production, and someone has an ice cream cone in the background, clearly that is not something that we are concerned about. We do not think that sort of level of incidental featuring of something would be an issue, and we have been making that clear.

Ms PRATT: As a connoisseur of continental meats and Meat Tray Friday, I am sure that Penbo will be delighted to hear about your views on being pro sandwich. Minister, has the department conducted any modelling or risk assessment of potential unintended consequences, such as shifting marketing to digital platforms or higher exposure in regional areas that might not be covered by this policy?

The Hon. C.J. PICTON: As I mentioned, we are not the first place that will be doing this. Clearly, it has happened in London previously, and the evaluation that has been done there, I am advised, has been positive and has not shown the effects or side effects that you are pointing to. Similarly, we have had work done by the Cancer Council of South Australia, which has analysed

some of those works, that has led us to one of the features leading us towards considering this policy in the first place.

I think there have been similar studies done interstate, but we will also be evaluating this ourselves. One of the features of Preventive Health SA is that we want to be evidence-led, and where we have implementations of policies we want to make sure that they work, and so we will be looking at how this rolls out.

Ms PRATT: We are the first state, though, as I understand it. In that respect, perhaps at the Health Ministers' Meeting on Friday, do you have a sense that other states are going to take the lead from the government and the agency's position and that this is something that we are going to see other governments turn to?

The Hon. C.J. PICTON: We are not the first state—or we are not the first jurisdiction, I would say. So while we may be the first state, the ACT has had this policy in place for some time. I cannot speak on behalf of other jurisdictions, but I know that there has been some interest from officials in other governments in terms of what we are doing. I would like to hope that other states would do so, but it has not been a major priority of mine to lobby other states that they should adopt this in their states.

When we come to those national meetings we have a pretty broad agenda of other things, some of which we have talked about today, that are high on the priority list. I think that this is something where we see the benefit of this in our state. We have been able to do it, as we have discussed, within our policy realm in South Australia. I certainly would encourage other states to do so, but that will be a matter for them.

Ms PRATT: Moving on to tobacco control strategy, I am still referring to Preventive Health on page 60, but there is also a reference on page 20, within the highlights. There are 5,900 community pharmacies nationally, but only 700 are choosing to stock and sell e-cigarettes. How many South Australian pharmacies are participating?

The Hon. C.J. PICTON: We do not have that figure available, and we will see whether we can find that out. I am not sure whether that is information that either the Office of the Chief Pharmacist or even the Pharmacy Regulation Authority South Australia would have access to. If we do have that information, we will provide it.

Ms PRATT: Do you have a view, then, with only 700 out of nearly 6,000 participating, that that speaks to a reluctance by community pharmacists to choose to sell e-cigarettes?

The Hon. C.J. PICTON: I think it clearly shows that a percentage are keen to do it, and there is a larger percentage who are not keen to do it. I have spoken to a number of pharmacies who have expressed that they would not want to go down that path, and I can completely understand that. Particularly, a number of pharmacies have expressed that they view their role as providing health care, and they do not want to go down the road of being involved in selling vape products. No doubt, there are others who would see their role as providing that as a cessation aid, and the whole idea of doing that through pharmacies to begin with was meant to be able to narrowcast those products for people who are using them as cessation aids.

I think my view, and I daresay Preventive Health SA's view, is that there is not strong evidence in terms of vaping being a tool in terms of cessation. I think all the evidence in terms of cessation is that the best cessation method is to go cold turkey, as difficult as that can be, but there are a number of other nicotine replacement therapies that are available through pharmacies that I think the evidence would point to as stronger, in terms of a cessation aid, rather than using vapes.

Mrs HURN: Minister, same budget line: Budget Paper 4, Volume 3, page 60, Preventive Health SA. I am interested in some more detail. One of the targets that is listed for 2025-26 is to establish partnerships for preventive health action in regional communities to improve health and wellbeing outcomes. Can you give a bit more detail about what that is and, potentially as well, just one practical example about what a partnership might look like?

The Hon. C.J. PICTON: I will pass over to Marina to give some further detail on that.

Ms BOWSHALL: Thank you for the question. We have been working with a range of local government areas in regional South Australia around establishing wellbeing hubs where the local government identifies need in a local community, whether that be around mental health and wellbeing, physical activity, smoking cessation, or a range of issues. They have been running over the last few years but, more recently, we have been having more of a deep dive conversation around specific programs that we could run in those local settings to test their effectiveness.

We have established a partnership with the Murraylands and the Mid Murray Council is leading that, with other areas like Karoonda all involved. We have also established a partnership with Port Pirie and with the Riverland. We will be testing different modalities with them over 2025-26, led by the council but also through the evidence base of public health and through Preventive Health SA, to see what we can operationalise locally within those communities to get great outcomes for the public health of those communities.

Mrs HURN: Those locations that you mentioned are fantastic, but is this something that you are looking at rolling out in all of the regional LHNs?

Ms BOWSHALL: We have put the offer out to a range of different local government areas and LHNs, and these are the first few that have come forward, so we are wanting to make sure we can land the projects well with those groups, share the learnings and the evidence that has come out of that, and then absolutely we are very keen to see that grow so there is an equity of access across the state.

The Hon. C.J. PICTON: You are really asking: is this going to happen in the Barossa, aren't you?

Mrs HURN: Of course, or the Adelaide Hills. In relation to public health, Budget Paper 4, Volume 3, page 20, one of the targets is to complete the implementation of a statewide response to eliminate the spread of tuberculosis in Aboriginal communities across South Australia. Can you give us an update in terms of how prevalent tuberculosis is currently in Aboriginal communities, and what the action plan to eliminate it might look like?

The Hon. C.J. PICTON: Yes. This is a really important public health issue that we are dealing with. Not in this year's budget, but I think in last year's budget we had dedicated funding toward addressing tuberculosis outbreaks in Aboriginal communities across South Australia. We first saw this in the APY lands. There has been a concerted effort between the department's public health team, Central Adelaide Local Health Network's team, specialists in respiratory services, Aboriginal health teams and also with our statewide services that undertake the testing, to respond in the APY lands, which, as I am sure you can imagine, is a big logistical exercise in terms of tracking those cases and undertaking the treatment.

We have now seen other cases emerge in other Aboriginal communities and also in the metropolitan area and other regional areas as well. This is clearly going to be an ongoing piece of work that we are going to have to manage, and so it is something that Dr Lawrence, as the chief executive, has been adamant that we bring together the various elements of public health responses to coordinate and respond to. I might see if either Professor Spurrier or Dr Lawrence wants to say a bit more.

Prof. SPURRIER: Thank you very much. You specifically asked about prevalence. It is useful to think about TB in terms of TB disease, which is when you have an active infection—you are coughing, you are symptomatic and clearly need treatment, and you are also infectious to other people—and distinguish that from TB infection, which has been called latent TB in the past, but we tend to use now TB disease and TB infection.

What we do know, because of the impacts of colonisation on our Aboriginal communities over generations—and it is to do with their social and economic determinants, so housing and overcrowding and such—is that unfortunately Aboriginal people across Australia have higher rates of TB infection, which is latent TB. Therefore, they might become older or they get another chronic health problem and their immune system does not work as well, they are at higher risk of getting TB disease.

We did have a very significant increase in the number of cases of infectious TB or TB disease, so that is one thing that we need to get on top of, and that involves taking contact tracing interviews and then following up people and making sure that people receive the treatment. Tuberculosis takes a very long time to develop. It is a very slow replicating bacteria and therefore the treatment is very long. It is up to six months of antibiotics. You have to take the antibiotic every single day and if there is some difficulty with that—and that happens to everybody when you are taking medication, especially for that length of time—there is a chance of getting a resistant organism as well. It is quite a complicated disease to treat compared to standard pneumonia, for example.

The SA TB service clinical staff are very proficient at treating the active TB disease and, of course, have been doing contact tracing as well. But one of the things that we are doing differently now is really embracing the Closing the Gap principles of co-design. It is so important when you have something that is so complex and can take such a long time to treat that you really listen to Aboriginal community members. We now have a steering committee which is co-chaired by Scott Wilson, the board chair of SAACCON, and me. We have as many Aboriginal people at that committee as we do clinical people. We are really making sure that cultural considerations are taken as seriously as clinical considerations and also public health considerations—i.e. considerations at that whole population level.

The rate of TB infection for Aboriginal people, that latent TB, is about the same as newly arrived migrants into Australia. To me, that is not fair. We should have it lower than that. What we can also do, and this is part of the response, is not only look for cases of active disease but also look for cases of TB infection. That means that we can offer treatment to people with the infection and therefore reduce their risk of getting disease in the future. That is something that is rather unique and we are rather forward-leaning in this state, and a large number of Aboriginal people have been offered screening because of that.

I might not have given you the exact answer on the prevalence, I can get that for you later, but it is approximately the same as newly arrived migrants. We have quite a different way of managing this now, also involving primary care, which, again, is very important—listening to the community and finding out how they would like this service delivered.

The CHAIR: Thank you for that. The allotted time having expired, I declare the examination of preventative health and public health complete. The proposed payments for the Department for Health and Wellbeing, the Commission on Excellence and Innovation in Health, and Preventive Health SA are also complete.

I would like to thank everybody for their participation, especially those public servants who put so much effort into preparing for estimates. I would also like to thank the opposition and the government members. It is an endurance sitting event. I am not sure how that fits in with preventive health in that we all know that it is not very good for you. I would also like to thank the parliamentary officers and the security upstairs, and Hansard. I think I have thanked everybody now. It is always a very big effort.

At 17:49 the committee adjourned to Monday 23 June 2025 at 09:00.