ACT Government | ACT Health

Our reference: **ACTHDFOI22-23.48**

[redacted]

Dear [redacted]

DECISION ON YOUR ACCESS APPLICATION

I refer to your application under section 30 of the *Freedom of Information Act 2016* (FOI Act), received by ACT Health Directorate (ACTHD) on **Friday 5 May 2023**.

This application requested access to:

> *'A copy of the KPMG branded report of the ACT Gender Affirming Service model development and scoping study implementation plan including analysis, assumptions and cost modelling.'*

I am an Information Officer appointed by the Director-General of ACT Health Directorate (ACTHD) under section 18 of the FOI Act to deal with access applications made under Part 5 of the Act. ACTHD was required to provide a decision on your access application by **Tuesday 27 June 2023**.

I have identified one document holding the information within scope of your access application.

Decisions

I have decided to grant partial access to one document.

In reaching my access decision, I have taken the following into account:

- The FOI Act;
- The contents of the documents that fall within the scope of your request; and
- The views of relevant third parties.

Partial Access

Redactions have been made to information that may prejudice the competitive commercial activities and the business affairs of the ACT Government and non-government entities. The disclosure of the costings in the report may prejudice future procurement and the future deliberations of the Cabinet. Further redactions have been made to information of non-ACT Government individuals.

Public Interest Factors Favouring Disclosure

The following factors were considered relevant in favour of the disclosure of the documents:

- Schedule 2, Schedule 2.1(a)(i) promote open discussion of public affairs and enhance the government's accountability; and
- Schedule 2, Schedule 2.1(a)(ii) contribute to positive and informed debate on important issues or matters of public interest.

Public Interest Factors Favouring Non-Disclosure

The following factors were considered relevant in favour of the non-disclosure of the documents:

- Schedule 2, Schedule 2.2 (a)(ii) prejudice the protection of an individual's right to privacy or any other right under the *Human Rights Act 2004*;
- Schedule 2, Schedule 2.2 (a)(xi) prejudice trade secrets, business affairs or research of an agency or person; and
- Schedule 2, Schedule 2.2 (a)(xiii) prejudice the competitive commercial activities of an agency.

On balance, the factors favouring disclosure did not outweigh the factor favouring non-disclosure as the information would not provide any government information pertinent to your request, and is contrary to the public interest and would not advantage the public in disclosing this information.

Charges

Processing charges are not applicable to this request.

Disclosure Log

Under section 28 of the FOI Act, ACTHD maintains an online record of access applications called a disclosure log. The scope of your access application, my decision and documents released to you will be published in the disclosure log not less than three days but not more than 10 days after the date of this decision. Your personal contact details will not be published.
https://www.health.act.gov.au/about-our-health-system/freedom-information/disclosure-log.

Ombudsman review

My decision on your access request is a reviewable decision as identified in Schedule 3 of the FOI Act. You have the right to seek Ombudsman review of this outcome under section 73 of the Act within 20 working days from the day that my decision is published in ACT Health's disclosure log, or a longer period allowed by the Ombudsman.

If you wish to request a review of my decision you may write to the Ombudsman at:

The ACT Ombudsman
GPO Box 442
CANBERRA ACT 2601
Via email: ACTFOI@ombudsman.gov.au
Website: ombudsman.act.gov.au

ACT Civil and Administrative Tribunal (ACAT) review

Under section 84 of the Act, if a decision is made under section 82(1) on an Ombudsman review, you may apply to the ACAT for review of the Ombudsman decision. Further information may be obtained from the ACAT at:

ACT Civil and Administrative Tribunal
Level 4, 1 Moore St
GPO Box 370
Canberra City ACT 2601
Telephone: (02) 6207 1740
http://www.acat.act.gov.au/

Further assistance
Should you have any queries in relation to your request, please do not hesitate to contact the FOI Coordinator on (02) 5124 9831 or email HealthFOI@act.gov.au.

Yours sincerely,

Michael Culhane
Executive Group Manager
Policy, Partnerships and Programs
ACT Health Directorate

27 June 2023

ACT LGBTIQ+ Health Scoping Study Implementation and Costing Report

ACT Health Directorate

Final Report

Disclaimer

Inherent Limitations

This report has been prepared as outlined in the Scope Section. The services provided in connection with this engagement comprise an advisory engagement, which is not subject to assurance or other standards issued by the Australian Auditing and Assurance Standards Board and, consequently no opinions or conclusions intended to convey assurance have been expressed.

No warranty of completeness, accuracy or reliability is given in relation to the statements and representations made by, and the information and documentation provided by the Australian Capital Territory Health Directorate management and personnel / stakeholders consulted as part of the process.

KPMG have indicated within this report the sources of the information provided. We have not sought to independently verify those sources unless otherwise noted within the report.

KPMG is under no obligation in any circumstance to update this report, in either oral or written form, for events occurring after the report has been issued in final form.

The findings in this report have been formed on the above basis.

Third Party Reliance

This report is solely for the purpose set out in the Scope Section and for the ACT Health Directorate's information and is not to be used for any other purpose or distributed to any other party without KPMG's prior written consent.

This report has been prepared at the request of the ACT Health Directorate in accordance with the terms of KPMG's contract dated 14 January 2022. Other than our responsibility to the ACT Health Directorate, neither KPMG nor any member or employee of KPMG undertakes responsibility arising in any way from reliance placed by a third party on this report. Any reliance placed is that party's sole responsibility.

Accessibility

To comply with the ACT Health Directorate's accessibility requirements, two versions of this Report are available: a KPMG-branded PDF version and an unbranded Microsoft Word version. The KPMG-branded PDF version of this Report remains the definitive version of this Report.

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Glossary

The purpose of this section is to provide a glossary of key terms used within the ACT LGBTIQ+ Health Scoping Study Implementation and Costing Report (this report).

Table 1 Key terms

Key Term	Definition
Asset-based and strengths-based	Asset-based and strengths-based, used collectively in this report, means a focus on viewing diversity in thought, culture and traits as positive assets and strengths for the gender-focused model of service.
Community-based	Community-based relates to an activity or initiative focused on or relating to a community which usually takes place and is organised locally.
Community-led	Community-led refers to an approach that is driven by the community themselves, and where it is the community who owns the power and has agency over the process, rather than outside parties, such as non-government organisations (NGOs), government bodies, or clinicians.
An evidence-based gender-focused health service	An evidence-based gender-focused model of service is one in which staff and practitioners combine well-researched interventions with clinical experience, ethics, service user preferences, and culture to inform the delivery of service.
Gender-affirming health care	Gender-affirming health care is health care that attends to transgender (trans) and gender diverse people's physical, mental, and social health needs and wellbeing while respectfully affirming their gender identity.
Informed Consent Model	The Informed Consent Model of care offers a framework and protocol that supports general practitioners (GPs) in commencing and managing hormone treatment for people who are able to consent to their own medical care, without requiring further consultation from a mental health professional or endocrinologist.
Intersectionality	Intersectionality refers to the ways in which different aspects of a person's identity can expose them to overlapping forms of discrimination and marginalisation. Aspects of a person's identity can include social characteristics, such as: identifying as Aboriginal and Torres Strait Islander, gender identity, sexual orientation, disability status, ethnicity, age, and socioeconomic status.
LGBTIQ+	Throughout this report, the term LGBTIQ+ is used to refer to people of diverse genders, sexualities and sex characteristics. This community includes, but is not limited to, people who identify as lesbian, gay, bisexual, transgender, queer, non-binary, asexual, questioning, pansexual, genderfluid, agender, and people who have an intersex variation. This report uses the initialism LGBTIQ+ to align with ACT Government terminology and the terminology used in the Scoping Study.
Outcomes-focused	Outcomes-focused, or outcomes-based, is an approach which is interested in the impact of the service or intervention an activity (or organisation) is seeking to achieve.
Peer	For the purposes of this report and the gender-focused model of service, the term peer is used to refer to someone with trans or gender diverse lived experience as well as shared identities and experiences.

Key Term	Definition
Sistergirls and Brotherboys	Sistergirls and Brotherboys are terms used to describe trans and gender diverse people in some Aboriginal or Torres Strait Islander communities.
Steady state	In hormone therapy, steady state describes an equilibrium that is achieved following repeated and consistent administration of the hormone, in which drug concentrations are stable and consistently stay within therapeutic limits within the body.
Warm referrals	Warm referrals are referrals that support the person to connect to services. Warm referrals can include phoning the service for the person, passing on information to the service with the person's consent and, in some cases where people need more support, helping them to navigate the service system.

Source i: KPMG 2022.

Note to reader:

The initialism LGBTIQ+ has been used to refer to people of diverse genders, sexualities and sex characteristics, including but not limited to people who identify as lesbian, gay, bisexual, trans, queer, asexual, agender, non-binary, gender fluid, pansexual and people who have an intersex variation. It is recognised that the initialism does not capture the full diversity of sexualities, bodies, identities and experiences that exist within the community.

The terms and definitions within this report have been captured to reflect common usage. We recognise that certain words, phrases, and acronyms may vary depending on the language, the community or the environment in which they are used within. The terms should be understood in the stated context to preserve the intended meaning and avoid potential misrepresentation. For the avoidance of doubt, any perceived discomfort experienced due to an error of this nature is the responsibility of the reader.

Executive Summary

Introduction

The ACT Health Directorate's LGBTIQ+ Health Scoping Study (the Scoping Study) looks at the gaps and opportunities for health services for LGBTIQ+ people in the ACT and identifies barriers to seeking care. This report describes the implementation planning aspects and cost estimates for the recommendations identified within the Scoping Study. The report provides:

- Section 1. The LGBTIQ+ Health Scoping Study recommendations - describing the implementation plan and costings for the Scoping Study recommendations excluding recommendation 10, the gender-focused model of service (see Section 2. The gender-focused model of service (recommendation 10)) and recommendation 21 (out of scope).
- Section 2. The gender-focused model of service (recommendation 10) - describing the implementation plan and costings for recommendation 10, the gender-focused model of service. This relates to the establishment of a peer-led, community-based gender-focused health and wellbeing service for trans and gender diverse people in the ACT.
- Appendix A: Approach and cost estimates - describing the approach and detailed cost estimates for the Scoping Study recommendations.
- Appendix B: the gender-focused model of service - describing the approach for co-design and the components of the gender-focused model of service (recommendation 10)
- Appendix C: Workforce Profile - describing the workforce profile for the implementation of the Scoping Study recommendations.

Background

The Capital of Equality Strategy (2019-23) (the Strategy) is the ACT Government's strategy to deliver equitable outcomes for LGBTIQ+ people in the ACT. The Strategy acknowledges the progress made in social inclusion and equality for the LGBTIQ+ community whilst recognising that there is more to do, particularly in addressing the needs of trans and gender diverse people in the ACT.

The Strategy identified that many people in the LGBTIQ+ community feel that their needs go unaddressed when accessing health care services and they often opt out of seeking the care they need. To further understand and address the challenges that the LGBTIQ+ community face in accessing health services, the ACT Health Directorate (ACTHD) undertook the Scoping Study.

The key findings of the Scoping Study identified that the ACT has limited health care professionals who understand LGBTIQ+ health needs and limited availability of information on how to access providers who are knowledgeable about LGBTIQ+ health needs and gender-affirming health care. To address these findings, the Scoping Study made 24 recommendations to improve health outcomes for LGBTIQ+ people in the ACT.

The health needs of the LGBTIQ+ community are diverse and, as noted in the Scoping Study, the historical failure to holistically meet these needs has had an adverse impact on community health outcomes. The implementation of the recommendations from the Scoping Study sets the foundation for better meeting the health and wellbeing needs of the LGBTIQ+ community in the ACT. This is important for progressing the Strategy through three key objectives:

- Fostering understanding and awareness about the health and wellbeing needs of the LGBTIQ+ community (e.g. building capacity among student clinicians about what LGBTIQ+ safe health care looks like) – refer recommendations 1-9.
- Improving services to deliver more inclusive and accessible services through establishing new services where there are service gaps (e.g. the gender-focused model of service) and refining existing service offerings to be more inclusive (e.g. supporting mainstream services to be LGBTIQ+ safe) – refer recommendations 10-18.
- Continuing reforms to have equal rights reflected in law, data and policies (e.g. reliable data collection to understand the health care needs of the LGBTIQ+ community) – refer recommendations 19-24.

Scope

KPMG was engaged to assist the ACTHD with:

- developing a costed implementation plan for the Scoping Study recommendations; and
- facilitating the co-design of a gender-focused model of service with LGBTIQ+ community partners in partnership with Collective Action.

This work was informed through engagement with the LGBTIQ+ community as well as the health and community services working with the LGBTIQ+ sector, with a focus on those working with the trans and gender diverse community.

The following activities were agreed as out of scope for the underpinning analysis of this report.

- Conducting a needs assessment to inform the use of, and demand for, the gender-focused model of service. Service demand for the gender-focused model of service has been described in the Scoping Study and previous reports developed by organisations in the LGBTIQ+ community.
- Recommendation 21 was not included as part of the costing estimates or implementation plan as it relates to deferrable medical interventions for people with variations in sex characteristics (intersex). This recommendation is being led by the ACT Government Office of LGBTIQ+ Affairs.

All the recommendations will be implemented over a five-year time period, with the exception of the gender-focused model of service which is anticipated to require a 10 year implementation period. Figure 1 overleaf summarises the implementation plan for the Scoping Study recommendations.

Figure 1 Implementation plan for the 23 Scoping Study recommendations

	Phase 0-1 Set up & Create the Foundation Year 0-3	Phase 2 Scale Up Years 4 - 6	Phase 3 Transition to Business as Usual Year 7 - 10+
Project management	• Establish the LGBTIQ+ Implementation Team and allocate roles for all recommendations • Develop and implement standard operating procedures (SOPs) and workflows for all recommendations including monitoring and evaluation framework and all relevant documents • Identify and liaise with key ongoing contacts (e.g., Office of LGBTIQ+ Affairs, Education Directorate, Office for Mental Health and Wellbeing, Rainbow Mob, Canberra Health Services (CHS), Sexual Health and Family Planning ACT (SHFPACT), universities)	• Conduct monthly LGBTIQ+ Implementation Team meetings for understanding the progress of the Scoping Study recommendations and any barriers to implementation • Review and refine SOPs, workflows and office management processes • Monitor and evaluate data collected against lead indicators. Refine activities if the recommendations are not being implemented as intended or are not achieving desired impact	• Transition the LGBTIQ+ Implementation Team to a business-as-usual (BAU) function • Refine SOPs, workflows and initiatives based on findings from ongoing monitoring and evaluation
Organisation and governance	• Establish a Health Reference Group (HRG) and Terms of Reference (ToR) • Develop a high-level clinical governance statement of requirement for the gender-focused model of service • Procure service providers for the relevant recommendations (e.g., recommendations 1, 3 and 10) • Review resources on LGBTIQ+ inclusive health services for Aboriginal and Torres Strait Islander people and culturally and linguistically diverse people • Create stakeholder engagement plans, and management and communication strategies for relevant recommendations (e.g., recommendations 9 and 12)	• Facilitate HRG meetings as per ToR • Evaluate the performance of procured providers (e.g., recommendations 1, 3 and 10) • Expand the gender-focused model of service to include specialist services and gender-specific primary health care • Monitor and review the effectiveness of LGBTIQ+ health literacy and promotion strategies (e.g., recommendations 6, 7, 8 and 23)	• Facilitate HRG meetings as per ToR • Establish ongoing governance for the gender-focused model of service as part of a BAU governance approach (rather than project governance) • Monitor and, as needed, review the procured approach and contracting approach for service providers involved in the gender- focused model of service • Continue monitoring and evaluating health outcomes and health care for the LGBTIQ+ community
Infrastructure	• Identify and fit out site locations for the central hub and network sites for the gender-focused model of service • Identify, acquire and establish the appropriate internal operating systems for the relevant recommendations (e.g., software for the ongoing maintenance and refining online resources as per procurement requirements) • Undertake site visits to determine whether public health facilities are adopting more inclusive practices	• Conduct a periodic needs assessment for the gender-focused model of service to understand whether the scope of services or infrastructure needs to change • Monitor and review equipment requirements to align with the scope of services and initiatives continuing after Year 5	• Review and update the infrastructure requirements to ensure that the infrastructure (e.g., hospital sites) is inclusive for the LGBTIQ+ community and that the gender-focused model of service is accessible for a diverse range of trans and gender diverse people
People and workforce	• Develop a workforce plan, including assigning existing resources to the LGBTIQ+ Implementation Team • Recruit to additional roles for all recommendations as required (e.g., policy and information technology (IT) roles for recommendations 5 and 12) • Develop and deliver capacity building initiatives for clinicians and support services (e.g., recommendations 1, 2, 10, 16 and 18)	• Review and update the 'development capability framework' for new clinician/health care workers' profiles to gender-affirming care (i.e., as part of the gender-focused model of service) • Ongoing delivery of capacity building initiatives for clinicians (e.g., recommendations 1, 2 and 18)	• Review and, as required, refine the workforce complement based on findings from ongoing evaluation of the demand for services in the gender-focused model of service • Review and, as required, refine the recruitment and retention strategies to ensure that there is appropriate workforce to support the gender-focused model of service
IT	• Undertake an options analysis to understand equipment requirements (e.g., the gender-focused model of service)	• Monitor data quality for health services across the ACT and perform data cleansing and monitoring of data quality	• Monitor, review and update the online platform and supporting systems

Source ii: KPMG 2022.

Cost estimates for the Scoping Study recommendations

The estimated cost of implementing the Scoping Study recommendations is [redacted] over 10 years. This includes the cost of [redacted] over 10 years for the implementation of the gender-focused model of service and [redacted] over 10 years for the LGBTIQ+ Implementation Team. Note that this cost estimate is based on the preferred option which leverages existing primary health care funding arrangements (i.e. the Medicare Benefits Schedule (MBS)). If new funding arrangements were to be established to fund all aspects of the gender-focused model of service, it would cost an additional [redacted] over 10 years (refer to Table 3 for details). The options are described in further detail in Section 2. The gender-focused model of service (recommendation 10).

Table 2 below describes the cost of implementation of the Scoping Study recommendations, excluding recommendation 21 (out of scope).

Table 2 Cost estimates for the 23 Scoping Study recommendations (millions)

Project Year	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	Total
Financial Year	2023/ 2024	2024/ 2025	2025/ 2026	2026/ 2027	2027/ 2028	2028/ 2029	2029/ 2030	2030/ 2031	2031/ 2032	2032/ 2033	-
Cost estimate	[redacted]										

Source iii: KPMG 2022. Note values will not equal totals due to rounding.

The gender-focused model of service

The Scoping Study included a recommendation to establish a peer-led, community-based gender-focused model of service through a co-design process with the LGBTIQ+ community and NGOs (refer to Appendix B: the gender-focused model of service for more detail regarding the co-design approach). The implementation of the gender-focused model of service is anticipated to occur over 10 years, with the set-up phase requiring at least 12 months. The gender-focused model of service will include:

- a central hub for trans and gender diverse people, and their allies, to access gender-affirming health care, advice and wellbeing supports in the centre of Canberra;
- at least two other network sites in the north and south of Canberra that provide gender-focused health and wellbeing services to improve accessibility of services no matter where people live in the ACT;
- a service delivery and governance approach that includes people with lived experience from the trans and gender diverse community to ensure that the gender-focused model of service is peer-led and community-based;
- a multidisciplinary workforce that includes medical, nursing and allied health clinicians as well as peer support workers; and
- a network of referral pathways that leverages the relationships and rapport that existing safe and inclusive service providers have previously established with trans and gender diverse people in the ACT public and private health care systems.

It is anticipated that the establishment and operationalisation of the gender-focused model of service will leverage the experience and expertise of clinicians who are already working with trans and gender diverse service users in the ACT. During the co-design process, there was some discussion about how best to leverage existing clinical expertise in gender-focused health care in the ACT. Two delivery options were discussed:

1. Having public health care service providers who are experienced in gender-affirming health care delivering services as part of the gender-focused model of service.
2. Having both public and private health care providers who are experienced in gender-affirming health care delivering services as part of the gender-focused model of service.

Some private health care practitioners (e.g. General Practitioners (GPs) and psychologists) have established relationships with the trans and gender diverse community of the ACT as well as having experience in delivering gender-affirming health care. In this context, Option 2 is the preferred option as it draws on a broader pool of workforce who are experienced in gender-affirming care. This option enables a broader suite of services to be offered as part of the gender-focused model of service and leverages existing funding arrangements. The two delivery options are available at Appendix B: the gender-focused model of service.

Cost estimates for the gender-focused model of service

The cost estimates for the gender-focused model of service are shown in Table 3. The estimated cost of establishing and operationalising the gender-focused model of service for Option 1, in which service users are being treated as public patients is [redacted] over 10 years. The estimated cost for Option 2, in which the clinicians exercise their right to private practice and service users are treated as private patients for some services, is [redacted] over 10 years.

Table 3 The gender-focused model of service cost estimates (millions)

Cost estimates	2023/ 2024	2024/ 2025	2025/ 2026	2026/ 2027	2027/ 2028	2028/ 2029	2029/ 2030	2030/ 2031	2031/ 2032	2032/ 2033	Total
Option 1	[redacted]										
Option 2											

Source iv: KPMG 2022. Note values will not equal totals due to rounding.

Section 1. The LGBTIQ+ Health Scoping Study recommendations

1.1 Overview of the Scoping Study recommendations

1.1.1 The LGBTIQ+ Health Scoping Study recommendations

The LGBTIQ+ Health Scoping Study (the Scoping Study) recommendations are listed below. As previously noted, this report describes the implementation aspects and cost estimates for 23 of the Scoping Study recommendations as recommendation 21 is being implemented by the Office of LGBTIQ+ Affairs.

The Scoping Study prioritised the recommendations for implementation as follows:

1. **Critical (C)** recommendations that need to be addressed are: 1, 4, 5, 6, 10, 11, 14, 15, 16, 17, 18, 21 and 24;
2. **Necessary (N)** recommendations that should be addressed following the consideration of critical items are: 2, 3, 7, 8, 13, 19, 20, 22 and 23; and
3. **Important (I)** recommendations that should be addressed on an as-needed basis are: recommendations 9 and 12.

Table 4 List of the Scoping Study recommendations

#	Recommendation	Weighting
1	Education and Training: Work with the Commonwealth and Capital Health Network to identify best-practice training and regular peer-led LGBTIQ+ awareness and clinical training for primary care providers (including General Practitioners (GPs), allied health, specialist services; Winnunga Nimmityjah Aboriginal Health and Community Services; and mental health care service providers to improve understanding of LGBTIQ+ specific health needs.	C
2	Student Outreach: Work with the Canberra based vocational and university sectors to ensure the training for medical, nursing and allied health professionals includes training on best practice gender-affirming health care.	N
3	Safe Schools Initiative: Build upon or support the ongoing implementation of the ACT Government Safe and Inclusive Schools Initiative and provide information on health supports available to parents and students.	N
4	Gender-affirming public health care: Provide training and information on best practice gender-affirming care to publicly funded health service providers.	C
5	Gender-affirming hospital experience: Provide an option for preferred name, gender and pronouns during hospital care, that are visible to patients and hospital staff. Including, for example, on in-patient wristbands, forms and in-room whiteboards.	C
6	Aboriginal and Torres Strait Islander LGBTIQ+ resources: Create LGBTIQ+ health resources for the Aboriginal and Torres Strait Islander community, in collaboration with community and relevant LGBTIQ+ and Aboriginal and Torres Strait Islander community health groups.	C
7	LBTQ+ health resources: Create educational health resources specifically for same sex attracted women and people with a cervix, particularly information on screening services and reproductive health.	N
8	Accessibility of LGBTIQ+ Information for culturally and linguistically diverse (CALD) communities: Create LGBTIQ+ health resources in collaboration with representatives of the community.	N
9	Demonstrating Inclusiveness through Visibility: Promote a visibly welcoming and inclusive environment for patients of publicly funded health services.	I
10	Gender-focused health service: Establish a peer-led community-based gender-focused health and wellbeing service that is co-designed with LGBTIQ+ stakeholders and NGOs.	C

#	Recommendation	Weighting
11	TGD and Intersex Service Provision: Build upon existing clinical services to improve accessibility and provide a holistic health service provision for transgender and intersex people and in particular children, adolescents, and young people.	C
12	ACT public health services Communications and Websites: Reflect LGBTIQ+ people in government advertisements and communications and ensure that websites, communication materials and resources are contemporary, consistent and meet the needs of the LGBTIQ+ community.	I
13	Consumer-facing trans pathway: Explore options for a consumer-facing online pathway for transgender health care in order to support the people who wish to undertake gender transition to navigate the complexities. Support the development of the pathway in collaboration with LGBTIQ+/TGD-specific NGOs and the Capital Health Network.	N
14	Mental Health Support: Compile best practice research and methodology on peer-led counselling and mental health service provisions for intersex, transgender and gender-diverse identifying people, with a particular focus on minors and their families. This work will be used to inform the gender-focused model of service and also the current work being undertaken to create Guidelines for gender-affirming care for mental health care practitioners by the Office of Mental Health and Wellbeing.	C
15	Telehealth-enabled BBV / HIV Testing: Review the availability of STI/BBV testing and potential alternative methods of testing, treatment and awareness, including the potential for telehealth and dried blood spot testing with the aim to reduce transport, cost and stigma barriers associated with attending in-person testing.	C
16	Recognition and support for LGBTIQ+ people experiencing family and domestic violence: Expand the accessibility of clinical and support services for LGBTIQ+ people by ensuring family and domestic violence services are LGBTIQ+ inclusive, in particular promoting an understanding of the needs of lesbian, gay and bisexual identifying people and providing a welcoming environment for all genders.	C
17	Disability and LGBTIQ+: Develop a coordinated response to better identify the needs and supports for LGBTIQ+ people living with disability, including through the development of the ACT Government Disability Health Strategy and other relevant ACT Government strategies.	C
18	Support for local Primary Care Providers (including GPs): Explore opportunities with the Commonwealth Government and Capital Health Network that can assist Primary Care Providers in the ACT to provide services to their LGBTIQ+ clients that are timely, evidence based, and tailored to individual needs.	C
19	Gender Affirmation Surgeries and Procedures: Identify and advocate for the removal of barriers to gender affirmation surgeries and procedures in the ACT due to Commonwealth funding and regulatory arrangements.	N
20	Data Collection: Review the data collection methodologies and frameworks for LGBTIQ+ people at a clinical level, to explore options for recording numbers and care needs of LGBTIQ+ community members, including data that will allow identification of intersectional needs.	N
21	Deferable Medical Intervention for Intersex People: The health experiences of intersex people fall short of reasonable expectations. Further action on deferable medical intervention for intersex people should be a priority and guided by work currently underway in the ACT Government, led by The Chief Minister, Treasury and Economic Development Directorate (CMTEDD).	C
22	Ageing and Palliative Care: Incorporate the health needs of older LGBTIQ+ people in current and future Territory-wide Health Services Plan activities. The ACT Health Directorate (ACTHD) to engage in and support work being undertaken by the CHS around end of life and palliative care planning for LGBTIQ+ people.	N

#	Recommendation	Weighting
23	LGBTIQ+ Health engagement: Continue to consult and engage with the LGBTIQ+ sector, members of the community and service providers on health matters.	N
24	Action Plan: Develop the specific actions to implement the recommendations of this report in consultation with stakeholders and community and set out in future Capital of Equality Action Plans.	C

Source v: ACTHD LGBTIQ+ Health Scoping Study.

1.2 Implementation plan for the Scoping Study

1.2.1 The phased approach for implementation of the Scoping Study recommendations

The implementation plan for the Scoping Study recommendations includes three phases over five years. These phases include Phase 0 – Set Up (Year 1, Months 1 to 12), Phase 1 – Create the Foundation (Years 2 to 3), Phase 2 – Scale Up (Years 4 to 5).

Figure 2 Timeline for three-phased implementation plan of the Scoping Study recommendations

Source vi: KPMG 2022.

The implementation plan has been developed based on the following assumptions:

1. The implementation approach will be coordinated internally by the ACTHD's LGBTIQ+ Implementation Team. This team will oversee the implementation of the Scoping Study recommendations from Year 1 through to Year 5, when many of the activities outlined below become business-as-usual (BAU) functions for the ACT Government and non-government health services. The LGBTIQ+ Implementation Team will also oversee the implementation of the gender-focused model of service from Year 1 to Year 10. The full-time equivalent (FTE) and cost estimates for this team over the 10 year period is available at 1.3 Cost estimates for the Scoping Study and Appendix A: Approach and cost estimates.
2. The implementation approach will be monitored and evaluated across three domains. The monitoring and evaluation framework and domains are available at 1.2 Implementation plan for the Scoping Study.
3. Progress against the implementation plan will be reported in bi-annual updates. This progress reporting will be consolidated by the LGBTIQ+ Implementation. Progress reporting will be shared with the Health Reference Group (HRG) to test and validate the extent to which the Scoping Study recommendations are being effectively and efficiently implemented.
4. The makeup of the LGBTIQ+ Implementation Team has been described in the workforce profile available at Appendix C: Workforce Profile.
5. The HRG will provide advice to the LGBTIQ+ Implementation Team to support implementation of the Scoping Study recommendations in line with community experiences and expectations.
6. The LGBTIQ+ Implementation Team will leverage established relationships with relevant public health services, such the CHS, on an ad hoc basis in the event clinical expertise is required to support the implementation of the Scoping Study recommendations.
7. The implementation plan provides an actionable plan to describe the approach for establishing the co-designed gender-focused model of service. There may be constraints in meeting the infrastructure and workforce requirements described within the gender-focused model of service. There is an ongoing requirement for infrastructure and workforce planning to enable and sustain the proposed gender-focused model of service.

1.2.2 Implementation plan for the Scoping Study recommendations

Table 5 outlines the implementation plan for the Scoping Study recommendations excluding recommendation 10, the gender-focused model of service (see Section 2.2 Implementation plan for the gender-focused model of service) and recommendation 21 (out of scope). The implementation plan has been developed from the perspective of the LGBTIQ+ Implementation Team who will have responsibility for driving the implementation.

Table 5 Implementation plan for the Scoping Study recommendations

#	First 100 days	First 12 months	Year 2	Year 3	Year 4+
Recommendation 1: Education and training	• Identify roles within the LGBTIQ+ Implementation Team responsible for clinical engagement. • Identify and liaise with the relevant contacts for primary care providers receiving LGBTIQ+ awareness and clinical training. This includes GPs, allied health and specialist services; Winnunga Nimmityjah Aboriginal Health and Community Services; and mental health care service providers.	• Procure a training provider to: (i) develop a training package that can be used/adapted for multiple audiences; and (ii) deliver training to allied health, and specialist services; Winnunga Nimmityjah Aboriginal Health and Community Services; and mental health care service providers. • Provide the Capital Health Network with the training materials for their use with GPs.	• Ongoing delivery of training and education to primary care providers.	• Monitor the delivery of face to face and online training through performance indicators as part of established contracts and modify/update as necessary.	• Evaluate the effectiveness of training for primary care providers. • Transition education and training responsibilities for primary care providers to a BAU function.

#	First 100 days	First 12 months	Year 2	Year 3	Year 4+
Recommendation 2: Student outreach	• Identify roles within the LGBTIQ+ Implementation Team responsible for policy and engagement. • Identify relevant contacts (e.g. the CHS, A Gender Agenda (AGA), universities). • Liaise with universities and the vocational sector to understand current training on best practice, gender-affirming health care. These include Australian National University, University of Canberra, University of New South Wales, Charles Sturt and Australian Catholic University.	• The LGBTIQ+ Implementation Team will work with the relevant contacts to identify the vocational and tertiary educational settings that would benefit from training in gender-affirming health care.	• Procure the delivery of clinical skills and lectures by an appropriate public or private health care provider with experience in gender-affirming health care (e.g. the CHS). • Liaise with universities and the vocational sector to ensure that reference materials reflect latest research.	• Monitor delivery of clinical skills and lectures based on performance indicators established within the procurement process. • Liaise with universities to review and update the delivery of clinical skills and lectures based on performance indicators.	• Evaluate the training being delivered in tertiary and vocational settings to understand whether the training is having an impact, and trans and gender diverse people feel comfortable accessing health services.

#	First 100 days	First 12 months	Year 2	Year 3	Year 4+
Recommendation 3: Safe Schools Initiative	• Identify roles within the LGBTIQ+ Implementation Team responsible for overseeing education and training among teachers and school staff. • Identify key contacts within the ACT Education Directorate and Sexual Health and Family Planning ACT (SHFPACT). • Provide support for the continued delivery of the Safe and Inclusive Schools Initiative (currently delivered by SHFPACT and overseen by the ACT Education Directorate) by providing information on LGBTIQ+ health supports available to parents and students.	• Support the expansion of the delivery of the Safe and Inclusive Schools Initiative to all government schools in the ACT.	• Support the delivery of the Safe and Inclusive Schools Initiative to all government schools in the ACT. Consider expanding the initiative to non-government independent schools.	-	• Transition education and training responsibilities to an organisation as a BAU function.

#	First 100 days	First 12 months	Year 2	Year 3	Year 4+
Recommendation 4: Gender-affirming public health care	• Identify roles within the LGBTIQ+ Implementation Team responsible for policy and engagement. • Identify and liaise with the relevant contacts for public health service providers. • Translate the mental health care guidelines for applicability outside of mental health, such as for publicly funded health service providers.	• Support the promotion of the mental health care guidelines for the delivery of care by LGBTIQ+ providers. • Procure a training provider to (i) develop a training package that can be used/adapted for multiple audiences; and (ii) deliver training to public health service provider staff.	• Ongoing delivery of mental health training based on the Guidance to support gender-affirming care for mental health.	• Monitor the delivery of face-to-face and online training through performance indicators as part of established contracts and modify/update as necessary.	• Evaluate the effectiveness of training for primary care providers. • Determine whether further promotion and training for the Guidance to support gender-affirming care for mental health is required. If yes, transition the training and promotion activities to a BAU function.

#	First 100 days	First 12 months	Year 2	Year 3	Year 4+
Recommendation 5: Gender-affirming hospital experience	• Identify roles within the LGBTIQ+ Implementation Team responsible for policy and engagement. • Liaise with the ACT public hospitals to describe opportunities to create a gender-affirming hospital experience. • Identify the number of current hospital resources that will need to be updated to support a gender-affirming hospital experience.	• As part of the Digital Health Record initiative, support ACT public hospitals to provide options for individuals to list their preferred name, gender and pronouns during hospital care. • Undertake site visits to ACT public hospitals and liaise with ACT public hospitals to support them with making the hospital experience gender-affirming.	• Engage with the HRG to understand whether hospital experiences have improved. Identify any further opportunities for improvement. • Support ACT public hospitals to action any feedback from the HRG regarding ways to improve the hospital experience for trans and gender diverse people.	• Ongoing monitoring and evaluation of the hospital experience for trans and gender diverse people. This can occur in consultation with the HRG.	• Prepare to transition the ongoing monitoring and evaluation of the hospital experience for trans and gender diverse people to a BAU continuous improvement initiative for ACT public hospitals.

#	First 100 days	First 12 months	Year 2	Year 3	Year 4+
Recommendation 6: Aboriginal and Torres Strait Islander LGBTIQ+ Resources & Recommendation 7: LBTQ+ health resources	• Identify the roles within the LGBTIQ+ Implementation Team responsible for overseeing the development of resources. • Liaise with community groups to confirm the approach to reviewing, validating, and updating resources available for Aboriginal and Torres Strait Islander people who identify as part of the LGBTIQ+ community and same sex attracted women and people with a cervix (henceforth: these cohorts).	• Develop health resources including a social media strategy and content for these cohorts. • Distribute resources through public health services, NGOs, community service providers and Rainbow Mob. • Procure a translating service to translate the culturally appropriate, online resources.	• Engage with the procured provider for the development and maintenance of culturally appropriate, online resources. This may leverage the establishment of the online information platform in accordance with the options analysis alongside recommendation 13. • Support a review and, if required, update of the culturally appropriate resources. This will involve liaising with representatives from Rainbow Mob to ensure materials are supporting care as planned.	• Ongoing monitoring and evaluation of the impact of the resources to inform any amendments to the resources. This may be achieved through engagement with the HRG. • Support the promotion of resources through the gender-focused model of service (refer to the gender-focused model of service).	• Prepare to transition the periodic review and update of these resources to a BAU function. This BAU function could be delivered by a part of the ACT Government or outsourced to an external provider. If the resources have had minimal changes in the preceding 4-5 years and are proving effective, there may be little effort involved in the ongoing review and update of resources.

#	First 100 days	First 12 months	Year 2	Year 3	Year 4+
Recommendation 8: Accessibility of LGBTIQ+ information for CALD communities	• Identify roles within the LGBTIQ+ Implementation Team responsible for policy and engagement. • Liaise with organisations, such as the Australian GLBTIQ. • Multicultural Council Inc. and Companion House, to support the review and development of LGBTIQ+ health resources for the culturally and linguistically diverse community.	• Perform a needs assessment (including demographic language analysis) to identify the LGBTIQ+ health resources that best meet the needs of the ACT culturally and linguistically diverse community. • Design and develop LGBTIQ+ health resources for culturally and linguistically diverse people who identify as part of the LGBTIQ+ community.	• Procure a translating service to translate health resources into identified languages and amend for different cultural requirements and nuances. • Translate video health resources into identified languages and amend for different cultural requirements. For example, this may include reshooting the video to account for visual representation of various cultural demographics. • Distribute the new resources.	• Support the promotion of health resources to individuals who identify as part of the LGBTIQ+ community and the culturally and linguistically diverse community. • Begin monitoring and evaluating engagement online and in other distribution channels to understand the effectiveness of the resources. • Determine a frequency for the periodic review and update of the resources.	• Prepare to transition the ongoing review and update of the resources to a BAU function. This BAU process could be led by an existing part of the ACT Government that manages the dissemination of translations of public resources, and liaison with the culturally and linguistically diverse community.

#	First 100 days	First 12 months	Year 2	Year 3	Year 4+
Recommendation 9: Demonstrating inclusiveness through visibility	• Identify roles within the LGBTIQ+ Implementation Team responsible for clinical engagement. • Compile a list of public health facilities to be involved in creating a more welcoming and inclusive environment for LGBTIQ+ people. • Identify and engage change champions from each of the public health facilities	• Develop a funding plan for a central area in the CHS to purchase promotional materials • Distribute the promotional materials to the public health facilities to support and coordinate promotional LGBTIQ+ events.	• Monitor the inclusivity of the public health facilities through the number of presentations of LGBTIQ+ service users who report feeling comfortable accessing mainstream health services in the ACT.	• Prepare to imbed the purchase of promotional materials and coordination of LGBTIQ+ events within existing public health funding structures to support transition to a BAU function. This BAU process would be led by the administrative workforce within public health facilities.	• Build promotion of LGBTIQ+ friendly services into public health facility key performance indicators (KPIs) as part of BAU. *Anticipated completion in four years.*
	The implementation plan for recommendation 10: the gender-focused model of service is available at Section 2.2 Implementation plan for the gender-focused model of service.				

#	First 100 days	First 12 months	Year 2	Year 3	Year 4+
Recommendation 11: TGD and Intersex Service Provision	• Identify roles within the LGBTIQ+ • Implementation Team responsible for clinical engagement. • Liaise with the HRG and support the CHS to explore ways in which to improve accessibility for intersex people and transgender children, adolescents and young people. • Liaise with the Office of LGBTIQ+ Affairs, seeking input where appropriate noting their work in intersex protections.	• Support the CHS to identify and implement initiatives to improve accessibility of existing clinical services for transgender and intersex people, specifically children, adolescents and young people.	• Monitor the impact of the initiatives within the CHS to improve the accessibility of clinical services for transgender and intersex people, specifically children, adolescents and young people. • This monitoring can be undertaken in consultation with the HRG and representatives with lived experience.	• Where initiatives have been identified and evaluated as effective in improving the accessibility of clinical services for transgender and intersex people, consider expanding the implementation of these initiatives in public and private health services. • This implementation approach should identify ways to incorporate the initiatives as part of BAU practice for clinicians and health facilities (e.g. as part of the training and resources in recommendations 1, 2 and 3 of the Scoping Study).	• Prepare to transition the ongoing review and update of the initiatives which improve accessibility to a BAU function. This BAU process could include incorporating initiatives that improve accessibility into service agreements with existing public or private health care service providers.

#	First 100 days	First 12 months	Year 2	Year 3	Year 4+
Recommendation 12: ACT public health services communications and websites	• Identify roles within the LGBTIQ+ Implementation Team responsible for internal ACT Government liaison. • Liaise with the CHS and the ACTHD to conduct a review of existing advertisements and communication materials against contemporary and consistent standards of LGBTIQ+ representation. • Seek advice from the Office of LGBTIQ+ Affairs on outcomes of the review and next steps.	• Support the development, with input from the Office of LGBTIQ+ Affairs, of an internal project plan to create content for the CHS and the ACTHD communications, advertisements and websites to reflect LGBTIQ+ people. • Procure an NGO or similar organisation with experience in LGBTIQ+ communications to create the content and host the communications pathway. • Determine a frequency for periodic review and update of the content.	• Periodic review of the content, with input from the Office of LGBTIQ+ Affairs.	• Prepare to transition the ongoing review of the content to a BAU function. This BAU process could be led by an existing part of the ACT • Government that manages the dissemination of government communication materials.	-

#	First 100 days	First 12 months	Year 2	Year 3	Year 4+
Recommendation 13: Consumer-facing trans pathway	• Identify roles within the LGBTIQ+ Implementation Team responsible for IT and communications. • Liaise with LGBTIQ+/ trans and gender diverse specific NGOs, such as Meridian and AGA, and the CHN, to discuss the approach for an options analysis of a consumer facing pathway for transgender diverse care, or an 'online information platform', taking into consideration ways to leverage existing and works-in- progress such as TransHub (ACON).	• Conduct an options analysis to understand the scope and content for the online information platform. This was highlighted as an essential service throughout the co-design process of the gender-focused model of service. Refer to Appendix B: the gender-focused model of service for more detail around stakeholder feedback and expectations of the online information platform.	• Work with the HRG to develop a planned approach to implement recommendation as dictated by the outcome of the options analysis. If deemed necessary, procure a provider to create, host and maintain the online information platform, potentially engaging providers that are currently delivering the existing and works-in-progress, e.g. ACON.	• Delivery of the online information platform as per the planned approach. • Determine a frequency for periodic review and update of the online information platform. • Monitor the impact of the online information platform for improving the accessibility of clinical services for transgender care.	• Transition the ongoing review and update of the online information platform to a BAU function for the relevant NGO.

#	First 100 days	First 12 months	Year 2	Year 3	Year 4+
Recommendation 14: Mental health support	• Identify roles within the LGBTIQ+ Implementation Team responsible for policy and engagement. • Support the Mental Health and Suicide Prevention Division to compile best practice research and methodology on peer-led counselling for intersex, transgender and gender-diverse people, with a particular focus on minors (children and young people) and their families.	• Incorporate the research into future revisions of the Guidance to support gender-affirming care for mental health and ensure all practitioners supporting the gender-focused model of service receive training on the guidance by incorporating it into onboarding and training requirements. • Identify any further work required for the guidance to support the counselling and mental health service offerings within the gender-focused model of service.	*Note: the methodology on peer-led counselling is anticipated to be completed in 12-18 months. This methodology will be leveraged as part of the peer-led component of the gender-focused model of service. This is further described in Section 2.1* Overview of the gender-focused model of service.		

#	First 100 days	First 12 months	Year 2	Year 3	Year 4+
Recommendation 15: Telehealth-enabled BBV / HIV testing	• Identify roles within the LGBTIQ+ Implementation Team responsible for policy and engagement. • Liaise with Meridian and the CHS to determine previous work undertaken to assess viability of alternative methods of testing and treatment. • Complete the review of local demand and availability of sexually transmitted infections (STIs) blood borne viruses (BBV) testing by consulting relevant services, including Meridian, Canberra Sexual Health Clinic (CSHC), and SHFPACT.	• Perform clinical desktop research and a literature review regarding alternative delivery methods, including at-home and telehealth testing. • Liaise with services already providing alternative methods of treatment to determine requirements, including RAPID in Queensland and SAMESH in South Australia.	• Identify equipment required to enable telehealth- enabled BBV/ HIV testing, including within the gender-focused model of service. • Conduct a cost- benefit analysis to identify viable alternative delivery methods. • Prepare paper that summarises the consultations, research and cost-benefit analysis.	-	-

#	First 100 days	First 12 months	Year 2	Year 3	Year 4+
Recommendation 16: Recognition and support for LGBTIQ+ people experiencing family and domestic violence	• Identify roles within the LGBTIQ+ Implementation Team responsible for workforce development and training. • Coordinate with the Office of the Coordinator-General for Family Safety (OCGFS) to identify existing training, literature and works-in-progress.	• Conduct research to determine best practice for LGBTIQ+ accessibility and inclusion within family and domestic violence resources and support services. • Support OCGFS to ensure LGBTIQ+ awareness and inclusion within resources. • Develop resources to support the OCGFS training on LGBTIQ+ awareness and inclusion.	• Support OCGFS to deliver domestic and family violence training that supports LGBTIQ+ awareness and safety.	• Support the delivery of training with OCGFS.	• Prepare to transition the training to become imbedded within BAU functions.

#	First 100 days	First 12 months	Year 2	Year 3	Year 4+
Recommendation 17: Disability and LGBTIQ+	• Identify roles within the LGBTIQ+ Implementation Team responsible for communication and engagement. • Identify internal contacts that are developing the Disability Health Strategy.	• Contribute to and provide support for the development of the Disability Health Strategy. This effort will be concentrated on identifying a mechanism for understanding the needs and supports required for LGBTIQ+ people living with disability. • Share and test the Disability Health Strategy or key ideas with the HRG for validation, advice and input on both the Disability Health Strategy and the mechanism for understanding the lived experience of people with a disability in the LGBTIQ+ community.	• Share advice with the Australian Government on the opportunity to develop a National Disability Insurance Scheme (NDIS) Toolkit to support LGBTIQ+ people with disability. This may be suggesting a feasibility study of what the toolkit could look like.	• Draw insights and recommendations from the Disability Health Strategy and share on the online information platform (developed alongside recommendation 13). This activity may be completed independently by TransHub (ACON) as part of its national expansion. • Monitor advice, guidance and materials from the Australian Government to support LGBTIQ+ people with disability. • If available, distribute any materials and/or advice from the Australian Government to better support the needs and supports for LGBTIQ+ people living with disability.	• Test the progress of the recommendation with the HRG and determine next steps, if required. • Transition roles and responsibilities for the LGBTIQ+ Implementation Team to BAU roles.

#	First 100 days	First 12 months	Year 2	Year 3	Year 4+
Recommendation 18: Support for local Primary Care Providers (including GPs)	• Identify roles within the LGBTIQ+ Implementation Team responsible for policy and evaluating service delivery. • Identify relevant contacts within the Australian Government and CHN that have expertise and understanding of LGBTIQ+ primary health care.	• Establish relationships with the Australian Government. • Support the CHN to perform a needs assessment to understand the capability uplift opportunities for local primary care providers. • Work with the Service User Reference Group (SURG) and HRG to develop a list of policy and service delivery priorities for improving primary care for LGBTIQ+ service users.	• Discuss priorities for improving primary care for LGBTIQ+ service users with the Australian Government contacts. • Influence and advocate for ongoing improvement of the delivery of primary health care to LGBTIQ+ service users. This will include supporting and contributing (where relevant) to the outcomes of the needs assessment and the capability uplift opportunities for local primary care providers. • Leverage training content developed in recommendation 1 to support further capability uplift among primary care providers, in consultation with the CHN.	• Provide support to CHN for the delivery of training to health care providers. • Support the implementation of any Australian Government initiatives relating to primary care to ensure that the policy and funding parameters support an inclusive experience of primary care for LGBTIQ+ service users.	• Support CHN with the implementation of capability uplift of primary care providers for the delivery of appropriate primary health care. For example, the offering of cervical screening to all people with a cervix. • Integrate capability uplift within the gender-focused model of service.

#	First 100 days	First 12 months	Year 2	Year 3	Year 4+
Recommendation 19: Gender affirmation surgeries and procedures	• Identify roles within the LGBTIQ+ Implementation Team responsible for policy, communications and engagement. • Identify contacts within local primary care providers, allied health and ACT public hospitals, and NGOs that can provide advice on the barriers to gender affirmation surgeries and procedures due to Commonwealth funding and regulatory arrangements.	• Confirm the barriers to gender affirmation surgeries and procedures from a Commonwealth policy, funding and regulatory perspective, and identify alternative policies or strategies to remove these barriers. • Identify relevant contacts within the Australian Government that oversee the policy, funding and regulatory environment for gender affirmation surgeries and procedures. • Where barriers have been identified, position as opportunities for the Australian and ACT Governments to address the delivery of more inclusive and effective health care for the trans and gender diverse population. • Leverage the insights from the SURG and HRG to understand the priority opportunities for removing barriers.	• Facilitate an open forum with the identified contacts to present the evidence base for removing barriers to gender affirmation surgeries and procedures, and the alternative policies and regulatory strategies.	• Action priority opportunities to advocate for changes. This may include the submission of a report or recommendations to the Australian Government in relation to funding and regulatory arrangements.	• Support the implementation of changes as part of removing barriers (if required). • Transition roles and responsibilities to a BAU function.

#	First 100 days	First 12 months	Year 2	Year 3	Year 4+
Recommendation 20: Data collection	• Identify roles within the LGBTIQ+ Implementation Team responsible for policy and evaluation of service delivery. • Identify relevant team members within Digital Solutions (Digital Health Record) and the Data Analytics Branch within the ACTHD to guide data collection and better record the type and volume of care needs for LGBTIQ+ community members, including data that will allow identification of intersectional needs. • Leverage existing stakeholder relationships within the Australian Bureau of Statistics (ABS) and Australian Institute of Health and Welfare (AIHW).	• Review current data collection methodologies and frameworks for LGBTIQ+ people at a clinical level. This will be informed by advice from ABS and AIHW contacts and supported by the ACTHD Data Analytics Branch. • Develop a list of opportunities for improving data collection at a clinical level. • Liaise with the ABS and AIHW to understand the progress these organisations are making with improving the data quality around health needs for the LGBTIQ+ community. • Summarise progress with the HRG and test the proposed data quality strategies in order to identify any unintended or negative consequences of the proposed data quality strategies.	• Support Digital Solutions and the Data Analytics Branch to identify potential data collection methods which maintain data quality and enable a better understanding of the health care needs of the LGBTIQ+ community and the intersectionality of community. • Develop an action plan to implement the agreed data quality strategies and data collection methods.	• Support relevant teams to implement the action plan. • Establish a frequency for periodic review of the data quality strategies and data collection methods, to understand whether the data being collected describes the health needs and intersectionality of the LGBTIQ+ community.	• Continue to monitor the implementation of the data collection methods. • Report to the HRG on the progress being made to improve data quality, and relay any feedback or insights to Digital Solutions, the Data Analytics Branch, AIHW and ABS. • Transition roles and responsibilities to a BAU function within the ACTHD so that there is a continuous improvement approach to data quality strategies and data collection methods relating to the health needs of the LGBTIQ+ community.

#	First 100 days	First 12 months	Year 2	Year 3	Year 4+
	Recommendation 21: Deferable medical intervention for intersex people has not been costed as part of this report. This work is underway and has been funded through the 2022-2023 ACT Government Budget.				
Recommendation 22: Ageing and palliative care	• Identify roles within the LGBTIQ+ Implementation Team responsible for policy and clinical engagement. • Identify key contacts within the ACTHD, including those within the Health Service Planning division, the Strategic Policy Division and the CHS.	• Identify opportunities to incorporate the health needs of older LGBTIQ+ individuals as part of the ACT Health Service Plan 2022-2030 in collaboration with representatives from the Health Service Division. • Liaise with representatives from the ACTHD and the CHS in relation to end of life and palliative care planning for LGBTIQ+ people.	• Leverage the insights gained in Year 1 to develop resources to support older LGBTIQ+ individuals make decisions about ageing at home or in residential aged care. • Leverage the insights gained in Year 1 to develop resources to support LGBTIQ+ individuals with advanced care planning and decisions at the end of life. • Ensure that the resources align with the Royal Australian College of General Practitioners (RACGP) aged care clinical guidelines.	• Connect with local NGOs to distribute of the new resources or advice identified from previous phases of work. These NGOs may include, but are not limited to, AGA and Meridian. • If required, establish a frequency for periodic review of the resources to ensure that they align with clinical standards and guidelines, and changes in the needs of older LGBTIQ+ community members.	• If required, facilitate the transition of the maintenance of resources to BAU. This may be either internally within the ACTHD or outsourced through a local service provider.

#	First 100 days	First 12 months	Year 2	Year 3	Year 4+
Recommendation 23: LGBTIQ+ health engagement	• Identify roles within the LGBTIQ+ Implementation Team responsible for communications and engagement. • Re-establish the HRG which was initially formed to oversee the delivery of the Scoping Study. This group will include five community members. The establishment of the HRG must be completed prior to the implementation of the gender-focused model of service.	• Establish an agreed approach with the SURG for seeking advice on how best to implement the Scoping Study recommendations and periodically seeking feedback on the implementation of the Scoping Study recommendations. This approach will describe the reimbursement for SURG members in the event the SURG is accessed for the purpose of supporting the implementation of the Scoping Study recommendations.	• Continue to consult and engage with the LGBTIQ+ sector, members of the community and service providers on health matters. This may be through the HRG and SURG only or also through other mechanisms identified as helpful for incorporating insights from people with lived experience into health policy and service delivery. • Support ongoing HRG meetings.	• Support ongoing HRG meetings. The HRG meetings will be in direct alignment with the meetings for the gender-focused model of service.	• Establish a BAU function for incorporating lived experience into the development of new health policies and services. • Coordinate ongoing HRG meetings as part of the gender-focused model of service.
Recommendation 24: Action Plan	• Endorse and approve the Implementation and Costing Report (this report).	Note: it is anticipated that this report will be endorsed and approved in 100 days.			

Source vii: KPMG 2022.

1.2.3 Ongoing monitoring and evaluating the impact of the Scoping Study recommendations

The ongoing monitoring and evaluation of the Scoping Study recommendations will align with the three objectives of the Strategy, with a particular focus on achieving positive change in the equality of health services. The three domains for monitoring and evaluating the Scoping Study recommendations are described below. A series of lead indicators and measures have been identified for each domain, rather than each recommendation, based on desktop analysis and consideration of what will indicate measurable positive change in each domain. The indicators have been provided overleaf. For each indicator identified, a baseline will need to be captured in Year 1 of the implementation.

The implementation plan describes the key activities that will need to be undertaken to implement the Scoping Study recommendations over a five-year period. It will be important to undertake a periodic process review (e.g. in the second and fourth years) to determine whether these activities have been implemented as intended. The bi-annual progress updates to the HRG will inform this process evaluation. It will also be important to understand the impact that the implementation of the Scoping Study recommendations is having on stakeholders. The lead indicators for understanding the impact are described below.

Domain 1: More inclusive and accessible health services

Inclusivity

- An increase in the number of public health services promoting a visibly welcoming and inclusive environment for the LGBTIQ+ community.
- An increase in the number of LGBTIQ+ identifying service users who report feeling comfortable to access mainstream health services in the ACT.

Accessibility

- An increase in the number of LGBTIQ+ identifying service users who self-refer for STI and BBV testing.
- An increase in the number of LGBTIQ+ identifying service users who are experiencing family or domestic violence and report feeling comfortable to self-refer to appropriate support services.
- An increase in the percentage of service users in the LGBTIQ+ community who self-report:
    - receiving safe and inclusive health care in the public health system; and
    - receiving the information and support they need to improve or maintain their own health and wellbeing.

Reach of health services[1]

- An increase in the number of service users accessing health services in the ACT who identify as part of the LGBTIQ+ community and also as:
    - Aboriginal and Torres Strait Islander
    - A person with a disability
    - Being part of the culturally and linguistically diverse community in the ACT

Domain 2: Fostering awareness in the health care sector

Access to information

- Increase in the number of public health employees attending LGBTIQ+ awareness training (both clinicians and support or administration staff).
- Increase in the number of public health employees reporting an increase in their confidence to deliver inclusive health care or support services for the LGBTIQ+ community.
- Increase in the number of university courses conveners or students reporting that they are more informed following lectures or workshops relating to inclusive health care for LGBTIQ+ people.
- An increase in engagement with social media and online platforms that provide educational LGBTIQ+ health resources.

[1]Appendix B: the gender-focused model of service also provides a specific monitoring and evaluating framework for the gender-focused model of service, which will be established in response to the gender-focused model of service. The monitoring and evaluating framework for the gender-focused model of service aligns with the lead indicators identified in this domain but is more focused on the needs of trans and gender diverse people in the ACT.

Quality of delivery

- An increase in the number of clinicians who report having greater confidence in delivering inclusive health care for LGBTIQ+ community members.

Domain 3: Reforming policy and data collection

Data collection

- The establishment of a consistent data collection methodology and framework for collecting data on the health needs and intersectionality of LGBTIQ+ people in clinical settings.
- An increase in the number of health service settings in which demographic and health needs data for the LGBTIQ+ community is reliably and consistently collected (e.g. public health admitted care, public outpatient care).

Policy and system reform

- An increase in the number of trans and gender diverse people who report having a clear understanding of the options and pathways for gender-affirming surgeries and procedures.
- An increase in the number of elderly people in the LGBTIQ+ community who report receiving inclusive support services.
- An increase in the number of people in the LGBTIQ+ community who report receiving safe and inclusive palliative care (i.e. at home or in residential or admitted care).
- An increase in the number of new policies and programs that are informed by lived experience and engagement with the LGBTIQ+ community.

1.3 Cost estimates for the Scoping Study

1.3.1 Cost estimates for the implementation of the Scoping Study recommendations

The overall cost to implement the Scoping Study recommendations is [redacted] over 10 years. This includes:

- [redacted] over five years to implement the Scoping Study recommendations excluding the gender-focused model of service and recommendation 21 (out of scope);
- [redacted] over 10 years to implement the gender-focused model of service (recommendation 10); and
- [redacted] over 10 years for the LGBTIQ+ Implementation Team.

A description of the co-designed gender-focused model of service and preferred option is available at Section 2. The gender-focused model of service (recommendation 10) and Appendix B: the gender-focused model of service. Table 6 describes the cost of implementation of the Scoping Study recommendations based on the weighting defined within the Scoping Study as well as the cost of the LGBTIQ+ Implementation Team.

Table 6 Cost estimates for Scoping Study recommendation (millions)

Weighting	2023/ 2024	2024/ 2025	2025/ 2026	2026/ 2027	2027/ 2028	2028/ 2029	2029/ 2030	2030/ 2031	2031/ 2032	2032/ 2033	Total
Critical	[redacted]										
Necessary											
Important											
LGBTIQ+ Implementation Team											
Total											

Source viii: KPMG 2022. Note, values will not equal totals due to rounding.

The estimated costs for implementation in Year 6 through to Year 10 are for the ongoing implementation of the gender-focused model of service (Option 2) over a 10 year period. Further information on the delivery options for the gender-focused model of service is available at 2.1 Overview of the gender-focused model of service and Appendix B: the gender-focused model of service).

There are no individual cost estimates for the following recommendations as the activities described within the implementation plan will be implemented by the LGBTIQ+ Implementation Team or activities are already forecast in planned ACTHD programs and initiatives:

- Recommendation 5
- Recommendation 11
- Recommendation 12
- Recommendation 13
- Recommendation 14
- Recommendation 15
- Recommendation 16
- Recommendation 17
- Recommendation 18
- Recommendation 19
- Recommendation 20
- Recommendation 22
- Recommendation 24.

The detailed assumptions and cost estimates are available at Appendix A: Approach and cost estimates.

The LGBTIQ+ Implementation Team

The estimated cost for the LGBTIQ+ Implementation Team is [redacted] over 10 years.

To deliver the Scoping Study recommendations, the LGBTIQ+ Implementation Team will include one Senior Officer Grade B, one Senior Officer Grade C, one Administrative Services Officer Class 6 and one Administrative Services Officer Grade 5. This team will coordinate the implementation of the recommendations over a 10 year period. The FTE estimate for this team was informed by advice from the ACTHD and is available at Appendix C: Workforce Profile.

Recommendation 1 – Education and Training

The estimated total cost for the implementation of this recommendation is [redacted] over five years.

> *Recommendation 1: Work with the Commonwealth and Capital Health Network to identify best-practice training and regular peer-led LGBTIQ+ awareness and clinical training for primary care providers (including GPs), allied health, specialist services; Winnunga Nimmityjah Aboriginal Health and Community Services; and mental health care service providers to improve understanding of LGBTIQ+ specific health needs.*

This recommendation involves all nominated staff completing peer-led LGBTIQ+ awareness and clinical training. This training will comprise a face-to-face component for LGBTIQ+ clinical training and an online component for LGBTIQ+ awareness. It has been assumed that 150 relevant public staff will receive face-to-face training in a single year with all other staff accessing online training. This training would be accessible by public primary care providers, allied health, specialist services, Winnunga Nimmityjah Aboriginal Health and Community Services and mental health staff.

It has been assumed that the LGBTIQ+ Implementation Team will liaise with primary care providers and monitor the delivery of the training.

Recommendation 2 - Student Outreach

The estimated total cost for the implementation of this recommendation is [redacted] over five years.

> *Recommendation 2: Work with the Canberra based vocational and university sectors to ensure the training for medical, nursing and allied health professionals includes training on best practice gender-affirming health care.*

Community stakeholders, including clinical service providers currently delivering vocational training, suggested the delivery of three lectures and three clinical skills workshops is important for the upskilling of allied health, nursing and medical students in inclusive health care. The cost estimates for this recommendation account for the effort to develop, maintain and deliver lectures and clinical skills workshops. An assumption has been made that there are existing relationships with the universities that can be leveraged to deliver training around best practice, gender-affirming health care.

Recommendation 3 - Safe Schools Initiative

The estimated total cost for the implementation of this recommendation is [redacted] over five years. This recommendation supports the ACT Government Safe and Inclusive Schools Initiative.

> *Recommendation 3: Build upon or support the ongoing implementation of the ACT Government Safe and Inclusive Schools initiative and provide information on health supports available to parents and students.*

The estimated cost for implementing this recommendation includes ongoing investment for the Safe and Inclusive Schools Initiative. The Safe and Inclusive Schools Initiative is currently delivered by Sexual Health and Family Planning ACT (SHFPACT) and this initiative focuses on providing information about gender and sexual diversity (and health care options) to teachers and parents so that they are well- placed to discuss gender and sexual identity with children in the school community. The funding for SHFPACT has been based on a historical block funding arrangement. SHFPACT has historically acquitted this funding through the delivery of Safe and Inclusive Schools resources and training at as many schools as the existing funding will allow (approximately 60% of government schools in the ACT). It has been assumed that the cost estimates provided for the pre-service training and resources would support the delivery of this initiative for 100% of government schools.

Recommendation 4 – Gender-affirming public health care

The estimated total cost for the implementation of this recommendation is [redacted] over five years.

Recommendation 4: Gender-affirming public health care: Provide training and information on best practice gender-affirming care to publicly funded health service providers.

The Guidance to support gender-affirming care for mental health has been developed. The estimated cost for implementing this recommendation includes the promotion of the mental health care guidelines and the delivery of training to the mental health sector. The estimated cost also includes the translation of the mental health guidelines for applicability outside mental health, such as publicly funded health service providers, and the subsequent delivery of training based on the revised guidelines.

The assumptions underpinning the estimated cost for the development of content and training delivery are similar to Recommendation 1. Based on the ACTHD guidance, it has been assumed that 150 relevant public health service provider staff will receive face-to-face training in a single year. It has been assumed that all other public health service provider staff will access online training.

It has been assumed that the LGBTIQ+ Implementation Team will liaise with public health service providers and support with the promotion of the use of the mental health guidelines to service providers for the ACT LGBTIQ+ community.

Recommendation 5 – Gender-affirming hospital experience

The estimated cost for the implementation of this recommendation has been included within the cost estimate for the LGBTIQ+ Implementation Team (see *The LGBTIQ+ Implementation*).

Recommendation 5: Provide an option for preferred name, gender and pronouns during hospital care, that are visible to patients and hospital staff. Including, for example, on in-patient wristbands, forms and in-room whiteboards.

It is understood that the implementation of the Digital Health Record will facilitate a gender-affirming hospital experience through the update of options for preferred name, gender and pronouns during hospital care. The implementation of the Digital Health Record is underway. This will not be an ongoing requirement or recurring cost after the system change has been actioned. Changes to ICT have not been costed and are assumed to be incorporated in planned and funded changes to the Digital Health Record in the ACT.

Recommendation 6 – Aboriginal and/or Torres Strait Islander LGBTIQ+ resources

The estimated total cost for the implementation of this recommendation is [redacted] over five years.

Recommendation 6: Create LGBTIQ+ health resources for the Aboriginal and Torres Strait Islander community, in collaboration with community and relevant LGBTIQ+ and Aboriginal and Torres Strait Islander community health groups.

Recommendation 7 – LBTQ+ health resources

The estimated total cost for the implementation of this recommendation is [redacted] over five years.

Recommendation 7: Create educational health resources specifically for same sex attracted women and people with a cervix, particularly information on screening services and reproductive health.

The estimated cost for implementing recommendations 6 and 7 includes website development, social media and traditional media sources, with some staff costs to manage the implementation. The development of Aboriginal and Torres Strait Islander LGBTIQ+ resources may have already commenced through local NGOs. Further validation of the completeness of these resources will be undertaken after the submission of this report. If work is already underway on the Aboriginal and Torres Strait Islander LGBTIQ+ resources then the cost estimates will be proportionately lower, commensurate with the degree of completeness.

Recommendation 8 – Accessibility of LGBTIQ+ Information for CALD communities

The estimated total cost for the implementation of this recommendation is [redacted] over five years.

Recommendation 8: Create LGBTIQ+ health resources for the CALD community, in collaboration with representatives of the community.

The estimated cost of implementing this recommendation includes the translation, update and maintenance of LGBTIQ+ health resources specifically for the culturally and linguistically diverse community in the ACT. This cost estimate is based on the assumption that there will be translation of LGBTIQ+ health resources for up to 20 documents and five videos into 10 different languages. Whilst not being prescriptive, it is acknowledged that other ACT policies, such as the ACT Language Services Policy and the corresponding Canberra Health Services (CHS) - Language Services Procedures, may have an impact on the delivery of this recommendation

(e.g. documentation must be translated to a broad selection of languages). Further detail on the requirements of the ACT Language Services Policy is available at Appendix A: Approach and cost estimates.

Recommendation 9 – Demonstrating Inclusiveness through Visibility

The estimated total cost for the implementation of this recommendation is [redacted] over four years.

> *Recommendation 9: Promote a visibly welcoming and inclusive environment for patients of publicly funded health services.*

The estimated cost of implementing this recommendation includes a pack of promotional material, including stickers, pins, a flag and storefront adhesives, that would be made available to public health services to position themselves as an inclusive service and create a welcoming space for LGBTIQ+ community members. The promotional material was informed by stakeholder consultation.

It has been assumed that up to 20 public health facilities in the ACT will receive a pack of promotional material for up to four years. The promotional material will be purchased centrally, for example by the CHS, and distributed to the facilities simultaneously.

Recommendation 10 – Gender-focused health service

The estimated total cost for the implementation of this recommendation is [redacted] over 10 years for Option 1 and [redacted] over 10 years for Option 2.

> *Recommendation 10: Establish a peer-led community-based gender-focused health and wellbeing service that is co-designed with LGBTIQ+ stakeholders and NGOs.*

The key cost drivers identified included the following:

- Workforce: A range of specialist and administrative staff comprising the hub and HRG are required to deliver and govern the gender-focused model of service.
- Infrastructure and operating costs: The gender-focused model of service will be operated from a facility with five rooms: two consulting rooms, two treatment rooms and an office space occupying a space of approximately 200 square metres. The operating costs include sewage, water and cleaning.
- Referral Services: A number of services will be referred to specialists external to the hub. Referral services include endocrinology, psychiatry, psychology, and breast screening.

The costed timeline of the gender-focused model of service (recommendation 10), is available at 2.3 Cost estimates for the gender-focused model of service, and a high-level summary of the gender-focused model of service is available at 2.1 Overview of the gender-focused model of service The detailed assumptions and cost estimates are available at Appendix A: Approach and cost estimates.

Recommendation 11 – TGD and Intersex Service Provision

Funding for this recommendation was allocated in the 2022-2023 ACT Government Budget regarding Intersex service provision. The estimated cost for implementation support for this recommendation has been included within the cost estimate for the LGBTIQ+ Implementation Team.

> *Recommendation 11: Build upon existing clinical services to improve accessibility and provide a holistic health service provision for transgender and intersex people and in particular children, adolescents, and young people.*

Funding for the transgender service provision will be determined in the first couple of years of implementation and be subject to a future ACT Government Budget. There will be a level of effort required to support the CHS with the implementation of this recommendation. The support from the ACTHD will be provided as part of the LGBTIQ+ Implementation Team.

Recommendation 12 – ACT public health services Communication and Websites

The estimated cost for the implementation of this recommendation has been included within the cost estimate for the LGBTIQ+ Implementation Team (see *The LGBTIQ+ Implementation*).

> *Recommendation 12: Reflect LGBTIQ+ people in government advertisements and communications and ensure that websites, communication materials and resources are contemporary, consistent and meet the needs of the LGBTIQ+ community.*

The estimated cost for the implementation of this recommendation includes the development and update of content, communications and websites. It has been assumed that the LGBTIQ+ Implementation Team will develop and update the materials for this recommendation.

Recommendation 13 – Consumer-facing trans pathway

The estimated cost for the implementation of this recommendation has been included within the cost estimate for the LGBTIQ+ Implementation Team (see *The LGBTIQ+ Implementation*).

> *Recommendation 13: Explore options for a consumer-facing online pathway for transgender health care in order to support the people who wish to undertake gender transition to navigate the complexities. Support the development of the pathway in collaboration with LGBTIQ+/TGD-specific NGOs and the Capital Health Network.*

The estimated cost for the implementation of this recommendation includes conducting an options analysis to understand the scope and content for the online pathway. This was highlighted as an essential service throughout the co-design process of the gender-focused model of service. One example of an option is working with ACON to understand the national expansion of TransHub and how it may be leveraged to enable an online resource to describe and communicate the health and wellbeing services available to the trans and gender diverse community in the ACT.

It may be that when the options analysis is undertaken with community partners and ACON, the ACON online pathway and website is all that is required. Future cost estimates will be developed in the event that are gaps are identified. It has been assumed that the LGBTIQ+ Implementation Team will conduct the options analysis and exploratory activities required for this recommendation.

Recommendation 14 – Mental Health Support

The estimated cost for the implementation of this recommendation has been included within the cost estimate for the LGBTIQ+ Implementation Team (see *The LGBTIQ+ Implementation*).

> *Recommendation 14: Compile best practice research and methodology on peer-led counselling and mental health service provisions for intersex, transgender and gender-diverse identifying people, with a particular focus on minors and their families. This work will be used to inform recommendation 10 and also the current work being undertaken to create Guidelines for gender-affirming care for mental health care practitioners by the Office of Mental Health and Wellbeing.*

The Office for Mental Health and Wellbeing has completed the development of the guidelines for gender-affirming care for mental health care practitioners. This work will be leveraged to compile best practice research and methodology on peer-led counselling and mental health service provision. This work has been assumed to be delivered over an 18-month period.

Recommendation 15 – Telehealth-enabled BBV/HIV testing

The estimated cost for the implementation of this recommendation has been included within the cost estimate for the LGBTIQ+ Implementation Team (see *The LGBTIQ+ Implementation*).

> *Recommendation 15: Review the availability of STI/BBV testing and potential alternative methods of testing, treatment and awareness, including the potential for telehealth and dried blood spot testing with the aim to reduce transport, cost and stigma barriers associated with attending in-person testing.*

The estimated cost for the implementation of this recommendation includes the review of options for alternate methods of testing for STIs and BBV. This will be achieved through the delivery of a research project to understand alternate models of testing for STIs and BBV. An assumption has been made that this project will be delivered over 18 months and be conducted by the LGBTIQ+ Implementation Team. The Scoping Study explicitly mentions a potential role for telehealth and dried blood spot testing within the ACT. The LGBTIQ+ Implementation Team will confirm the type of workforce required to fill this role as part of the research project.

Recommendation 16 – Recognition and support for LGBTIQ+ people experiencing family and domestic violence

The estimated cost for the implementation of this recommendation has been included within the cost estimate for the LGBTIQ+ Implementation Team (see *The LGBTIQ+ Implementation*).

> *Recommendation 16: Expand the accessibility of clinical and support services for LGBTIQ+ people by ensuring family and domestic violence services are LGBTIQ+ inclusive, in particular promoting an understanding of the needs of lesbian, gay and bisexual identifying people and providing a welcoming environment for all genders.*

The estimated cost for the implementation of this recommendation includes the expansion of existing training for Police, legal representatives and individuals who work in the family and domestic violence space to

increase LGBTIQ+ awareness. The Australia National Research Organisation of Women's Safety report suggests that LGBTIQ+ people need to be visible in family and domestic violence awareness campaigns and that most people would identify support services through their social networks.

This recommendation will involve the LGBTIQ+ Implementation Team working with OCGFS to provide content and support the expansion of existing training for LGBTIQ+ inclusive material.

Recommendation 17 – Disability and LGBTIQ+

The estimated cost for the implementation of this recommendation has been included within the cost estimate for the LGBTIQ+ Implementation Team (see *The LGBTIQ+ Implementation*).

> *Recommendation 17: Develop a coordinated response to better identify the needs and supports for LGBTIQ+ people living with disability, including through the development of the ACT Government Disability Health Strategy and other relevant ACT Government strategies.*

The ACT Government is currently developing a Disability Health Strategy. It is assumed that the Disability Health Strategy would be leveraged to identify and support the needs of the LGBTIQ+ people living with a disability. The outputs developed as part of this recommendation will be shared on the online information platform developed alongside recommendation 13.

Recommendation 18 – Support for local Primary Care Providers (including GPs)

The estimated cost for the implementation of this recommendation has been included within the cost estimate for the LGBTIQ+ Implementation Team (see *The LGBTIQ+ Implementation*).

> *Recommendation 18: Explore opportunities with the Commonwealth Government and Capital Health Network that can assist Primary Care Providers in the ACT to provide services to their LGBTIQ+ clients that are timely, evidence based, and tailored to individual needs.*

The estimated cost for the implementation of this recommendation includes consulting with the Australian Government and CHN to identify options for assisting primary care providers in the ACT to provide evidence-based and tailored services to the LGBTIQ+ community. It has been assumed that the LGBTIQ+ Implementation Team will perform the consultation activities for this recommendation. The responsibility of this team will be to influence and advise only. It is assumed that the CHN will resource the needs assessment to understand the capability uplift opportunities for local primary care providers to deliver timely and tailored health care to LGBTIQ+ service users. A range of training costs to support medical students have been accounted for in recommendation 1 and will support the implementation of this recommendation.

Recommendation 19 – Gender Affirmations Surgeries and Procedures

The estimated cost for the implementation of this recommendation has been included within the cost estimate for the LGBTIQ+ Implementation Team (see *The LGBTIQ+ Implementation*).

> *Recommendation 19: Identify and advocate for the removal of barriers to gender affirmation surgeries and procedures in the ACT due to Commonwealth funding and regulatory arrangements.*

The implementation of this recommendation includes a range of advocacy activities for the removal of barriers for gender-affirming surgery. This will also involve advocating for changes on behalf of, and in conjunction with, the LGBTIQ+ community. It has been assumed that the LGBTIQ+ Implementation Team will conduct the advocacy activities for this recommendation.

Recommendation 20 – Data Collection

The estimated cost for the implementation of this recommendation has been included within the cost estimate for the LGBTIQ+ Implementation Team (see *The LGBTIQ+ Implementation*).

> *Recommendation 20: Review the data collection methodologies and frameworks for LGBTIQ+ people at a clinical level, to explore options for recording numbers and care needs of LGBTIQ+ community members, including data that will allow identification of intersectional needs.*

The estimated cost of the implementation of this recommendation includes the review of current data collection methodologies and frameworks for LGBTIQ+ people at a clinical level. It will also involve identification of data quality strategies and data collection methods to better understand the needs of LGBTIQ+ people. It has been assumed that this recommendation will be implemented by the ACTHD Digital Solutions Division leading the Digital Health Record, the Data Analytics Branch, and the LGBTIQ+ Implementation Team.

It is understood that the ACTHD has liaised with the ABS around statistical data collection and will continue engagement to improve the integrity of data collected about the LGBTIQ+ population in the ACT in order to build the evidence base of 'what works well' in safe and inclusive health care. The costs for this recommendation will be absorbed by the LGBTIQ+ Implementation Team.

Recommendation 21 – Deferable Medical Intervention for Intersex People.

This recommendation has not been costed as part of this report. This work is underway and has been funded through the 2022-2023 ACT Government Budget.

> *Recommendation 21: Deferable Medical Intervention for Intersex People: The health experiences of intersex people fall short of reasonable expectations. Further action on deferable medical intervention for intersex people should be a priority and guided by work currently underway in the ACT Government, led by CMTEDD.*

Recommendation 22 – Ageing and Palliative Care

The estimated cost for the implementation of this recommendation has been included within the cost estimate for the LGBTIQ+ Implementation Team (see *The LGBTIQ+ Implementation*).

> *Recommendation 22: Incorporate the health needs of older LGBTIQ+ people in current and future Territory-wide Health Services Plan activities. The ACTHD to engage in and support work being undertaken by the CHS around end of life and palliative care planning for LGBTIQ+ people.*

The implementation of this recommendation includes two key activities:

1. liaising with the Health Service Planning Division to identify opportunities to incorporate the health needs of older LGBTIQ+ individuals for the ACT Health Services Plan 2022-2030; and
2. liaising with the relevant policy area of the ACTHD and with the CHS regarding end of life and palliative care planning for LGBTIQ+ people.

These activities will be performed by the LGBTIQ+ Implementation Team.

Recommendation 23 – LGBTIQ+ Health Engagement

The estimated total cost for the implementation of this recommendation is [redacted] over five years.

> *Recommendation 23: Continue to consult and engage with the LGBTIQ+ sector, members of the community and service providers on health matters.*

The estimated cost for implementing this recommendation includes the continued consultation and engagement with the LGBTIQ+ sector. It is assumed that two governance groups will inform policy development for LGBTIQ+ friendly health care in the ACT. These groups include: the SURG and HRG. The costs for reimbursement of the HRG members have been incorporated within the gender-focused model of service for a period of 10 years. The estimated costs for this recommendation include the reimbursement of SURG members in accordance with the SURG remuneration rates.

Recommendation 24 – Action Plan

There is no estimated cost for the implementation of this recommendation.

> *Recommendation 24: Develop the specific actions to implement the recommendations of this report in consultation with stakeholders and community and set out in future Capital of Equality Action Plans.*

The endorsement of the Implementation and Costing Report (this document) represents the completion of this recommendation.

Section 2. The gender-focused model of service (recommendation 10)

2.1 Overview of the gender-focused model of service

2.1.1 Components of the gender-focused model of service

The Scoping Study included a recommendation to co-design and establish a peer-led, community-based, gender-focused model of service. The implementation and cost estimates for the gender-focused model of service are described in more detail than the other recommendations because it involves establishment of a new, multilateral and multidisciplinary service offering. This section of the report outlines a description of the gender-focused model of service, the implementation plan (see 2.2 Implementation plan for the gender-focused model of service) and the cost estimates (see 2.3 Cost estimates for the gender-focused model of service). The components of the gender-focused model of service are shown below. The co-design process undertaken to identify these components and further detail of the gender-focused model of service is available at Appendix B: the gender-focused model of service.

Table 7 Description of the components of the gender-focused model of service

Component	Description
Overarching characteristics and enablers	During the co-design process a number of characteristics and enablers were identified to support inclusiveness and accessibility.
People and workforce	The gender-focused model of service would require a multidisciplinary clinical and non-clinical workforce complement.
Operating model	The proposed operating model is a hub and network model which is described in more detail overleaf.
Infrastructure	Service users and service providers identified a number of considerations for improving the accessibility and inclusivity of infrastructure for the gender focused model of service.
Types of service	The types of services that were identified for the hub and network sites included gender-focused primary health care, sexual health care and peer support.
Quality of service	Compliance with existing clinical accreditation and practice standards will be required to maintain a quality standard of service.
Service Users and triage criteria	A number of target cohorts were identified for the gender-focused model of service. These cohorts of service users are considered to have current unmet needs for inclusive health care.
Information and technology	To support effective and coordinated support of service users in the trans and gender diverse community, there will need to be an information exchange between the gender-focused model of service and other providers that service users' access (e.g. private GP, disability support service).
Governance	An approach to collaborative governance was identified to enable a community-based, gender-focused model of service. It is anticipated that existing clinical governance arrangements could be leveraged.

Source ix: KPMG 2022.

2.1.2 Characteristics of the gender-focused model of service

During the co-design process, a number of characteristics and enablers were identified as important for establishing an effective and inclusive service. These characteristics and enablers are described below. The characteristics will form an important part of the governance of the gender-focused model of service (details on the proposed governance is available at Appendix B: the gender-focused model of service) and inform the ongoing monitoring of the effectiveness of the gender focused model of service.

2.1.2.1 Key characteristics

The gender-focused model of service will:

- Be peer-led.
- Be community-led and community-based, and include referral pathways to the public health system and to private specialists.
- Be gender-affirming and take an intersectional, whole-of- person approach.
- Be physically and geographically accessible, as well as psychologically and culturally safe, including for young trans and gender diverse individuals, Aboriginal and Torres Strait Islander people, and culturally and linguistically diverse people.
- Prioritise timeliness of intervention, ensuring that this informs all components.
- Use an Informed Consent Model for hormone therapy to ensure person-centred care that is accessible and psychologically safe.
- Be sustainable and able to withstand and evolve in line with changes in a dynamic environment.

2.1.2.2 Key enablers

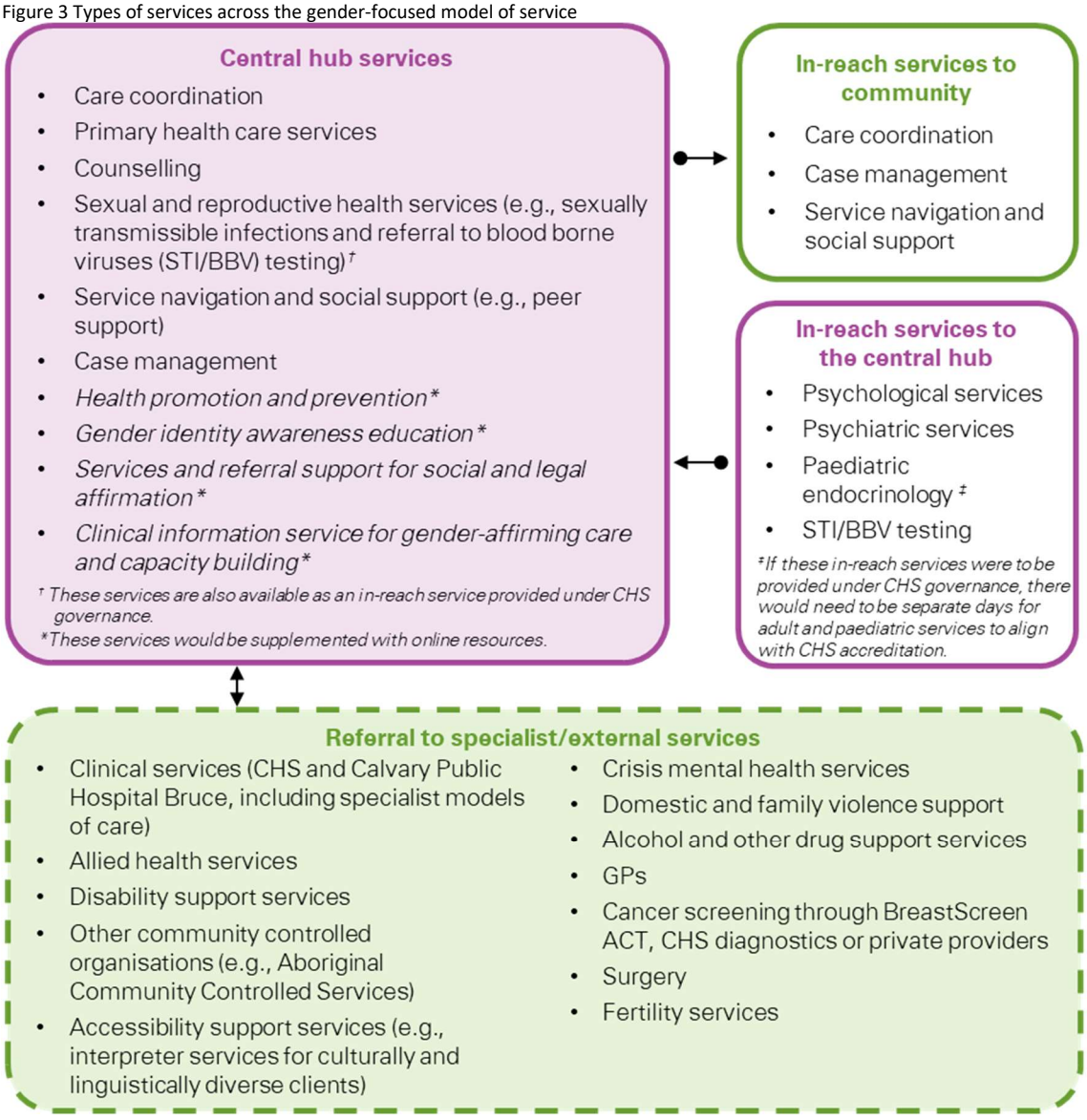
- The model will:
- Incorporate workforce and service planning. This will include analysing, forecasting and planning workforce and service supply and demand to ensure a pipeline of appropriately skilled health care providers for the delivery of sustainable, scalable, and quality gender-affirming care.
- Incorporate learning and development. The model will include an online portal of information for service users and clinicians, as well as initiatives to build the capability of service providers.
- Include measures and indicators that will be monitored to understand the extent to which the gender-focused model of service is safe, effective, efficient and appropriate to meet the needs of trans and gender diverse people.
- Support strong referral pathways that allow warm referral. These pathways will leverage relevant information and communication technology across services to minimise the requirement for service users to re-tell their story.
- Enable service user data and information sharing through robust, gender-affirming online platforms: the online information platform, knowledge management system and clinical information system.

2.1.3 Operating model and types of service

The gender-focused model of service provides clinical and non-clinical support services for trans and gender diverse individuals at all points of their journey. It has been designed to include a multidisciplinary approach to hormone initiation and therapy for young people[21]. The service offering of the gender-focused model will be delivered through:

- a community-based central hub offering psychosocial support, clinical health services, and services that enable service users to navigate and access services;
- in-reach services to community health care centres and in-reach services to the central hub; and
- referral to specialist services.

Figure 3 Types of services across the gender-focused model of service



Source x: KPMG 2022.

[2] This model is based on the Australian Standards of Care and Treatment Guidelines for trans and gender diverse children and adolescents. Accessible at: australian-standards-of-care-and-treatment-guidelines-for-trans-and-gender-diverse-children-and- adolescents.pdf.

2.1.4 Delivery options

It is anticipated that the establishment and operationalisation of the gender-focused model of service will leverage the experience and expertise of clinicians who are already working with trans and gender diverse service users in the ACT. During the co-design process, there was some discussion about how best to leverage existing clinical expertise in gender-affirming health care in the ACT. Two delivery options were discussed:

1. Having public health service providers who are experienced in gender-affirming health care delivering services as part of the gender-focused model of service.
2. Having both public and private health service providers who are experienced in gender-affirming health care delivering services as part of the gender-focused model of service.

There are some private health service practitioners (e.g. GPs and psychologists) who have established relationships with the trans and gender diverse community of the ACT as well as experience in delivering gender-affirming health care. In this context, Option 2 is the preferred option as it draws on a broader pool of workforce experienced in gender-affirming care, thereby enabling a broader suite of services to be offered as part of the gender-focused model of service. Option 2 also leverages existing funding arrangements.

Either option would be funded through a competitive tender process and would be overseen by a collaborative governance model that incorporates the HRG and the SURG. For the two options, there is variability in three components:

1. The level of complexity in the arrangements – Option 1 is less complex as it is a partnership between public health services and NGOs. Option 2 may require a more complex governance arrangement. It may also include more administrative burden as private providers may need to obtain a new provider number from Services Australia for the location of the central hub in the gender-focused model of service. There will also be additional reporting for Medicare Benefits Schedule (MBS) claims, which will be submitted to enable the delivery of bulk-billed services to service users accessing the gender-focused model of service.1 Historically, the inclusion of private providers in government-subsidised, community-based health services in the ACT has resulted in service users who have an ability to pay, trying to access the bulk-billed service rather than attending the private practitioner's usual private clinic. This indicates that Option 2 would require a governance arrangement that supports private practitioners to deliver bulk-billed services to service users as part of the gender-focused model of service, without jeopardising the viability of their private practice.
2. The types of revenue or funding arrangements – Option 1 would draw on ACT Government funding only, whereas there may be opportunities for Option 2 to leverage existing Australian Government funding arrangements for eligible services that are not funded by the ACT Government (e.g. primary health care consultations with a GP may be funded through the MBS3). The cost estimates vary by approximately $1 million over five years. This is described in detail in Section 2.2 Implementation plan for the gender-focused model of service.
3. The breadth of services available – Option 2 may provide a greater breadth of services due to the incorporation of private practitioners. Option 2 may also provide deeper capacity in terms of the number and type of clinicians with experience in gender-affirming care.

In order to identify the preferred option, the options for the gender-focused model of service were assessed against five design principles that were identified during the co-design process. The assessment of the two delivery options against the design principles is available at Appendix B: the gender-focused model of service.

2.2 Implementation plan for the gender-focused model of service

2.2.1 Implementation plan and considerations for the gender-focused model of service

The implementation plan for the gender-focused model of service includes four phases over 10 years. These phases include Phase 0 – Set Up (Year 1, Months 1 to 12), Phase 1 – Create the Foundation (Years 2 to 3), Phase 2 – Scale Up (Years 4 to 6) and Phase 3 – Transition to BAU (Years 7 to 10).

[3] It is noted that, under Section 19(2) of the Health Insurance Act 1973, MBS funding is only payable for services not already funded through other mechanisms by the Australian, ACT or Local Government.

Figure 4 Implementation phases of the gender-focused model of service

Source xi: KPMG 2022.

The implementation of the gender-focused model of service will be guided in alignment with the implementation principles defined in 1.2 Implementation plan for the Scoping Study for the Scoping Study recommendations. Other considerations for the implementation of the gender-focused model of service include:

- A key component of the gender-focused model of service is that it is peer-led and community-based. The use of the HRG will be important for the implementation of the gender-focused model of service to ensure it continues to leverage and be informed by the voice of lived experience through the community, service providers and peers. The HRG will be responsible for providing feedback, guidance and advice into all elements of the implementation of the gender-focused model of service.
- The effort for implementation of the gender-focused model of service will be concentrated within the first two years. This is due to the establishment of the central hub and psychosocial in-reach support services and the effort for the procurement to deliver these services.
- The implementation approach will be guided by the co-design principles identified through the co-design process for development of the gender focused model of service (see Appendix B: the gender-focused model of service for further detail on the approach for the co-design of the gender-focused model of service). This will ensure a community-based and peer-led approach to implementation.

2.2.2 The phased implementation approach for the gender-focused model of service

The proposed phased implementation approach for Option 2 of the gender-focused model of service will allow for the gradual, sustainable capability-building of clinicians and specialists, whilst prioritising the establishment of the central hub and essential service offering as efficiently as possible.

The high-level summary for the phased implementation approach of the gender-focused model of service includes:

Phase 0 - Set Up (Year 1, Months 1 to 12) through:

- Establishing the LGBTIQ+ Implementation Team;
- Determining the procurement approach for service providers; and
- Identifying and establishing working relationships within the ACT Government or externally to facilitate implementation of the gender-focused model of service.

Phase 1 - Create the foundation (Years 2 to 3) through:

- Operationalising a community-based and peer-led central hub;
- Providing a case management and care coordination offering specific to gender-affirming care;
- Implementing an information platform that can support service users and clinicians; and
- Offering increased supply of hormone therapy services (e.g. via sexual health physician or Registered Nurse (RN) at the central hub) and psychosocial supports (e.g. peer support and case management).

Phase 2 - Scale Up (Years 4 to 6) including:

- Scaling up of workforce and capability;
- Contributing to, and supporting the development of, a capacity building program for GPs;
- Offering expanded gender-affirming primary health care in the central hub with the introduction of an RN and GP with Special Interest (GPwSI); and
- Introducing specialists to provide in-reach services to the central hub.

Phase 3 - Transition to BAU (Years 7 to 10+) through:

- Identifying opportunities for continuous improvement through monitoring and evaluation and periodic needs assessment; and
- Transitioning activities to a BAU function.

The detailed implementation plan for the gender-focused model of service is provided overleaf.

Table 8 Phase 0 – Set Up

Theme	Objective	Action	Responsible party	Dependencies	Timeframes
Project Management	Establish the LGBTIQ+ Implementation Team	The establishment of the LGBTIQ+ Implementation Team will include: • defining roles and responsibilities; • identifying/recruiting team members as part of the LGBTIQ+ Implementation Team; and • defining key milestones. *Note: the recruitment for additional team members for the LGBTIQ+ Implementation Team will be captured as part of the workforce plan.*	LGBTIQ+ Implementation Team, Health Policy and Strategy Branch	This objective can be actioned independent of other objectives.	Year 1, Month 1 – 3
Project Management	Develop Standard Operating Procedures (SOPs), workflows and office management processes	These SOPs should leverage existing ACTHD SOPs, Codes of Practice, and policies. This may include, but is not limited to: • defining list of procedural and administrative activities according to remit of responsibilities; • defining and developing SOPs; • defining and developing workflows; and • refining office management processes, such as reporting flows.	LGBTIQ+ Implementation Team	This objective can be actioned independent of other objectives.	Year 1, Month 3 – 9

Theme	Objective	Action	Responsible party	Dependencies	Timeframes
Project Management	Develop a monitoring and evaluation framework	The monitoring and evaluation framework will be developed with advice and input from the HRG. The framework will include: • defining the framework; • developing a program logic; and • determining outcome indicators. The gender-focused model of service will be monitored and evaluated across three criteria including: • improved service integration and coordination of care; • person-centered approach; and • effectiveness of care and support. Example measures and indicators for each criterion have been summarised in Appendix B: the gender-focused model of service of this report. The lead indicators identified for ongoing monitoring and evaluation of the gender-focused model of service align more broadly with the lead indicators identified for monitoring and evaluation of the Scoping Study recommendations. As the gender-focused model of service is a new multilateral service offering which includes government, non-government and private providers, it is proposed that the gender-focused model of service has its own monitoring and evaluation framework. This framework will monitor and evaluate for effectiveness and appropriateness of the gender-focused model of service independent of the monitoring and evaluation framework for the Scoping Study recommendations.	LGBTIQ+ Implementation Team	This objective can be actioned independent of other objectives.	Year 1, Month 3 – 12

Theme	Objective	Action	Responsible party	Dependencies	Timeframes
Organisation and Governance	Develop a high-level clinical governance statement of requirement	Clinical governance will be a requirement for the delivery of clinical services as part of the gender-focused model of service. The gender-focused model of service will leverage existing clinical governance arrangements in the public and / or private sectors. Where health care professionals are funded to deliver services as part of the model, the provider must have their own clinical governance framework. The LGBTIQ+ Implementation Team will develop a high-level clinical governance statement of requirements. This statement of requirements will provide guidance to procured service providers about the ACTHD's expectations for clinical governance as part of the gender-focused model of service. The high-level clinical governance statement of requirements may include: • an outline of commonly referenced quality standards and / or practice guidelines for the scope of services being procured and the target cohort (refer to Appendix B for a description of the service user cohorts); and • a description of the ACTHD's requirements for establishing, reviewing and implementing clinical governance. This may include particular roles and responsibilities, ability to demonstrate alignment with specific quality standards and practice guidelines, measures of success and approaches to continuous quality improvement.	LGBTIQ+ Implementation Team	The development of the framework will depend on how the model is funded.	Year 1, Month 3 – 9

Theme	Objective	Action	Responsible party	Dependencies	Timeframes
Organisation and Governance	Establish the Terms of Reference for the HRG	The Terms of Reference (TOR) will include: background; • role and responsibilities for members of the HRG; • selection process for members of the HRG; • requirements of HRG members; • remuneration and expense policy; and • governance mechanisms, including ways to escalate issues and complaints An example TOR has been provided in Appendix B: the gender-focused model of service.	LGBTIQ+ Implementation Team	This objective can be actioned independent of other objectives.	Year 1, Month 1 – 3
Organisation and Governance	Establish the HRG	Identify the members of the HRG. Further information on the makeup of the HRG has been provided in Appendix B: the gender-focused model of service; Establish the Chair of the HRG by appointment.	LGBTIQ+ Implementation Team	This objective will be dependent on the establishment of the TOR for the HRG.	Year 1, Month 3 – 6
Organisation and Governance	Develop an approach to go to market (i.e. community) for procuring services for the central hub	An approach to market will be developed in accordance with ACT's Government Procurement Regulation 2007. The LGBTIQ+ Implementation Team will need to: • determine scope of services to be procured and the service requirements (e.g. clinical governance); • determine the market approach type (public/limited/selective); and • determine whether to take a phased approach or one-step approach to market (e.g. request for expression of interest, followed by a request for proposals or a request for quote and proposals as part of a single-step approach).	LGBTIQ+ Implementation Team	This objective will be informed by the overarching clinical governance framework and preferred model funding option.	Year 1, Month 9 – 12

Theme	Objective	Action	Responsible party	Dependencies	Timeframes
Organisation and Governance	Commence procurement	This will involve executing the approach to market developed above.	LGBTIQ+ Implementation Team	This objective can be actioned independent of other objectives.	Year 1, Month 12
Infrastructure	Develop an approach to identify community organisations that can operate as network sites for the gender-focused model of service	An approach to market will be developed in accordance with *ACT's Government Procurement Regulation 2007*. The LGBTIQ+ Implementation Team will need to: • engage with the HRG to understand the locational and infrastructure requirements for the network sites (e.g. must be a southside location, must be a northside location, must have an existing relationship with the LGBTIQ+ community); and • determine the market approach type (public/limited/selective) and cadence (i.e. phased approach or one-step approach).	LGBTIQ+ Implementation Team	The objective is dependent on the set up of the HRG.	Year 1, Month 3 – 12
Infrastructure	Undertake an infrastructure needs assessment of the requirements for the central hub	The needs assessment will include: • liaising with HRG and the ACTHD infrastructure planning team on the infrastructure requirements for the central hub and outreach sites (e.g. community centres); • defining the infrastructure requirements including accessibility requirements; • documenting any gaps in the existing infrastructure sites and outreach sites and proposed strategies for mitigating the risks of these gaps or addressing these gaps. The needs assessment will either identify existing infrastructure that can be leveraged, or new infrastructure required to meet the needs of the community. A proposed list of requirements is provided in Appendix B: the gender-focused model of service. These requirements can be used as a starting point for confirming the infrastructure requirements with the HRG.	LGBTIQ+ Implementation Team	The objective is dependent on the set up of the HRG.	Year 1, Month 3 – 12

Theme	Objective	Action	Responsible party	Dependencies	Timeframes
People and Workforce	Validate the FTE assumptions for proposed workforce roles across the central hub and in-reach services	Validation of FTE assumptions can be achieved through testing the FTE with broader stakeholder groups, such as the CHS, Meridian, AGA and other community service providers that may be using more innovative clinical workforce models (e.g. GP private practice, other community health services such as the Junction and Hobart Place GP).	LGBTIQ+ Implementation Team	This objective can be actioned independent of other objectives.	Year 1, Month 1 – 3
People and Workforce	Identify opportunities to increase access of specialist workforce roles to the ACT community	This may involve collaborating with the community and service providers (NGOs or public providers) to identify opportunities to increase access to specialist clinical workforce roles in the ACT community. In the gender-focused model of service, specialist clinical workforce roles may include psychologists (including child psychologists), psychiatrists, paediatricians, adolescent and young adult physicians or endocrinologists (including paediatric endocrinologists). Example opportunities that may increase the accessibility of these roles include: • establishing relationships with interstate specialists who are experienced in gender- affirming care and support them to deliver specialist services in the ACT using telehealth; • establishing relationships with interstate specialists who have experience in gender- affirming health care and enable them to provide telehealth decision support to specialists in the ACT who may have limited experience in gender-affirming health care; and / or setting up a rotation of specialist services from interstate (e.g. once a month).	LGBTIQ+ Implementation Team	This objective will inform the development of the Workforce Plan	Year 1, Month 3 – 6

Theme	Objective	Action	Responsible party	Dependencies	Timeframes
People and Workforce	Develop a workforce plan, including strategies for attraction, retention and recruitment of staff at hub	Developing the workforce plan will include: • drafting position descriptions and scope for the LGBTIQ+ Implementation Team; • drafting position descriptions of key roles in the gender-focused model of service (i.e. a community-based coordinator / practice manager); • drafting position descriptions for clinical roles for the central hub and in-reach services; • determining approach for recruiting additional LGBTIQ+ Implementation Team members; • identifying strategies for the recruitment of specialist clinical workforce roles. In the gender-focused model of service, specialist workforce roles may include psychologists (including child psychologists), psychiatrists, paediatricians, adolescent and young adult physicians or endocrinologists (including paediatric endocrinologists). The workforce plan will describe the key roles for operationalising the gender-focused model of service. As part of the procurement process, the successful provider may identify a more effective or efficient workforce complement to deliver gender-affirming care. Draft descriptions for the roles have been provided in Appendix B: the gender-focused model of service. Noting the difficulties in recruitment for these roles, the workforce plan must identify a range of strategies for the recruitment of clinical workforce roles to facilitate the implementation of the gender-focused model of service. This may include contracting interstate workforce as well as supporting a GP specific capacity building initiative that would be developed in consultation with the CHN, to align with the CHN's professional development agenda for primary health care across the ACT.	LGBTIQ+ Implementation Team	The position descriptions for the LGBTIQ+ Implementation Team will impact all other objectives within Phase 0. Recruitment of new LGBTIQ+ Implementation Team members will impact on the scale of the delivery. The development of the workforce plan will also inform the 'approach to market' for the scope and FTE of services for the gender-focused model of service.	Year 1, Month 3 – 6

Theme	Objective	Action	Responsible party	Dependencies	Timeframes
People and Workforce	Develop communication plan and marketing strategy for the gender-focused model of service	Developing a communication plan and marketing strategy will include: • developing a Stakeholder Engagement Plan; • identifying the target cohorts / stakeholder groups and preferred methods for engagement; • determining marketing communications mix (taking into consideration feedback from stakeholders around social media reach, particularly for Sistergirls and Brotherboys); • engaging with the HRG to validate the communication plan and marketing strategy; and • defining branding elements. Note: the development of the Communication Plan and Marketing Strategy may be completed external to the LGBTIQ+ Implementation Team (i.e. a relevant branch within the ACTHD or an external provider with experience in communications and stakeholder management).	LGBTIQ+ Implementation Team (or a relevant branch within the ACTHD or an external provider)	This objective is dependent on the formation of the HRG.	Year 1, Month 6 – 12
Information and Technology	Develop a *privacy and confidentiality policy* for the gender-focused model of service	Developing a *privacy and confidentiality policy* will require Legal Policy input. This may leverage the HRG for input and advice on the privacy requirements of the service user.	LGBTIQ+ Implementation Team	This objective is dependent on the formation of the HRG.	Year 1, Month 9 – 12

Theme	Objective	Action	Responsible party	Dependencies	Timeframes
Information and Technology	Undertake a needs assessment for the knowledge management system and service user information system	The needs assessment for supporting systems will include: • liaising with HRG and the ACTHD Digital Services Division for the knowledge management system and service user information system for the central hub and outreach sites (e.g. community centres); • defining the system requirements including privacy and confidentiality requirements (where relevant and applicable); and • documenting any gaps in the existing systems and proposed strategies for mitigating the risks of these gaps or addressing these gaps. The needs assessment may be outsourced and completed by an external provider. Further details describing the scope and purpose of the knowledge management system and service user information system has been provided in Appendix B: the gender-focused model of service.	LGBTIQ+ Implementation Team (or a relevant branch within the ACTHD or an external provider)	This objective can be actioned independent of other objectives.	Year 1, Month 6 – 9
Information and Technology	Develop a data quality strategy	The data quality strategy will outline: • what service user data will be collected at the central hub and the appropriate consent process; • how the data will be collected and stored securely; • how data will be de-identified for reporting purposes; and • the type and frequency of reporting from the service provider at the central hub. The type and frequency of reporting from the service provider will be used to inform the 'go to market' and procurement processes.	LGBTIQ+ Implementation Team (with support from the ACTHD Data Analytics Branch)	This objective can be actioned independent of other objectives.	Year 1, Month 3 – 9

Source xii: KPMG 2022.

Table 9 Phase 1 - Create the Foundation

Theme	Objective	Action	Responsible party	Dependencies	Timeframes
Project Management	Conduct monthly LGBTIQ+ Implementation Team meetings for progress of gender-focused model of service and recommendations of the Scoping Study	Monthly LGBTIQ+ Implementation Team meetings will require: • agreeing upon a meeting time and means of engagement (in person or virtual); • developing and forwarding an agenda (including previous meeting's action items); • coordinating logistics (e.g. travel if required); and • minute taking and distribution.	LGBTIQ+ Implementation Team	This objective can be actioned independent of other objectives.	Year 2 – 3
Project Management	Implement Standard Operating Procedures (SOPs) and refine, workflows and office management processes	This will include assigning SOPs and workflows developed in previous phase to appropriate LGBTIQ+ Implementation Team members and service providers to begin actioning in day-to-day operations.	LGBTIQ+ Implementation Team and successful service providers.	This objective can be actioned independent of other objectives.	Year 2 – 3
Organisation and Governance	Implement the clinical governance framework	The implementation of the clinical governance framework will be the responsibility of the contracted service provider(s). A clinical governance framework must be provided to the ACTHD as part of the competitive tender or single select procurement strategies. This framework will need to demonstrate how it aligns with and meets the high-level clinical governance framework developed in Phase 0.	Service provider(s)	This objective is dependent upon the lead service contractor providing a clinical governance framework as part of the procurement process.	Year 1 (prior to commencement of service delivery)

Theme	Objective	Action	Responsible party	Dependencies	Timeframes
Organisation and Governance	Facilitate monthly HRG meetings	Monthly HRG meetings will require: • electing an independent chair; • agreeing the Terms of Reference for decision-making; • agreeing upon a tenure of membership; • agreeing upon a meeting time and means of engagement (in person or virtual); • developing and forwarding an agenda (including previous meeting's action items); • coordinating logistics (e.g. travel if required); and • minute taking and distribution. The LGBTIQ+ Implementation Team will be responsible for providing the key agenda items. Items for discussion may be provided by the SURG, service providers, clinicians or the LGBTIQ+ Implementation Team. Note: these meetings will inform the implementation of the gender-focused model of service as well as the recommendations.	LGBTIQ+ Implementation Team	This objective can be actioned independent of other objectives.	Year 2 – 3

Theme	Objective	Action	Responsible party	Dependencies	Timeframes
Organisation and Governance	Draft contract with successful service provider for the hub	The contract (work order) will likely include (though subject to ACT Government requirements): • scope and requirements of contractor; • reporting and data requirements; and • contract performance indicators or measures. The contract should list the sub-contractors and include their contract details and level of effort.	LGBTIQ+ Implementation Team	This objective is dependent upon the successful identification of a preferred provider that can deliver the desired scope. The preferred provider will be identified as part of the procurement approach in Phase 0.	Year 2
Organisation and Governance	Monitor the triage criteria to effectively manage demand for service users	This will involve capturing data points to understand how demand is being managed by the triage criteria.	Lead service provider and other service providers	This objective may require input from the HRG.	Year 2 – 3
Infrastructure	Identify and establish suitable outreach touchpoints with northside and southside community health care centres for in-reach psychosocial services	This will involve: • executing the approach to market developed in Phase 0; • identifying a preferred supplier / organisation (one on southside and one on northside); and • developing a contract or similar for the delivery of outreach services through the community organisation locations.	LGBTIQ+ Implementation Team / Service providers	This objective is independent of other objectives	Year 2

Theme	Objective	Action	Responsible party	Dependencies	Timeframes
Infrastructure	Establish suitable location for central hub	This will involve leveraging current existing infrastructure within an NGO or the identification and hire of new infrastructure to be coordinated by the ACTHD. This will be informed by the needs assessment conducted in Phase 0 and validated by the HRG.	LGBTIQ+ Implementation Team / Lead contracted service provider	This objective will be dependent on the needs assessment and establishment of the HRG. This objective must be completed prior to the delivery of services as part of the gender-focused model of service.	Year 2
Infrastructure	Develop a periodic needs assessment framework to inform periodic review of the triage of service needs	This will involve determining the timeframe within which a needs assessment is required to be conducted and the ways in which future needs analyses will be used to inform the existing gender-focused model of service. This objective may be conducted internally (within the ACTHD as part of the LGBTIQ+ Implementation Team) or by an external provider. The needs assessment and triage needs will directly inform the future direction of the service model and funding. This assessment must be performed independently of the future service provider.	LGBTIQ+ Implementation Team (or external provider)	This objective can be actioned independent of other objectives.	Year 2

Theme	Objective	Action	Responsible party	Dependencies	Timeframes
People and Workforce	Develop a training and personal development capability framework	The training and personal development capability framework will be developed for and by the LGBTIQ+ Implementation Team. The framework will need to align with ACT Government employee agreement and commitments. The skills may include: • contract performance management; • stakeholder engagement and management; • project management; and • policy development and refinement.	LGBTIQ+ Implementation Team / lead service provider and other successful service providers	This objective may inform the procurement approach and contract drafting for services.	Year 2
People and Workforce	Deliver communication plan and marketing strategy	Execute as per communication plan and marketing strategy developed in Phase 0.	LGBTIQ+ Implementation Team	This objective may require input from the HRG.	Year 2 – 3

Theme	Objective	Action	Responsible party	Dependencies	Timeframes
Information and Technology	Establish Memorandum of Understanding (MoU) or service agreements with the successful service providers to support information sharing as part of the gender-focused model of service	The information sharing needs to occur between the service provider that has been contracted to establish and operate the hub; and service providers in community who are managing the care and support of trans and gender diverse people accessing the hub for gender-affirming care (e.g. mainstream GPs, NDIS providers etc.). The MoU needs to be established to describe: • how information will be shared securely between service providers who opt in to support the gender-focused model of service; • how consent will be sought from service users; • how information will be securely stored and updated following an occasion of service or a change in the service user's details; and • how service providers will be identified for the information sharing arrangement (e.g. perhaps service users identify the providers that they would like to have their information shared with and then those providers are approached to sign the MoU, or perhaps a select number of providers are approached pre-emptively because it is known that they provide care for the trans and gender diverse community).	LGBTIQ+ Implementation Team	This objective will be based on the approach to market and the subsequent successful service provider. The objective will affect and be affected by the clinical governance framework.	Year 2

Theme	Objective	Action	Responsible party	Dependencies	Timeframes
Information and Technology	Implement knowledge management system and service user information system based on needs assessment	Once the needs assessment and options analysis has been completed, the implementation team will need to: • identify the preferred option that best meets the requirements of the gender-focused model of service; • go to market with the scope of the requirements; and • contract an external provider for the implementation of the systems.	LGBTIQ+ Implementation Team to procure external provider	This objective will be informed by the needs assessment performed in Phase 0.	Year 2

Source xiii: KPMG 2022.

Table 10 Phase 2 – Scale Up

Theme	Objective	Action	Responsible party	Dependencies	Timeframes
Organisation and Governance	Conduct monthly LGBTIQ+ Implementation Team meetings for progress of gender-focused model of service and recommendations of the Scoping Study	Monthly LGBTIQ+ Implementation Team meetings will require: • agreeing upon a meeting time and means of engagement (in person or virtual); • developing and forwarding an agenda (including previous meeting's action items); • coordinating logistics (e.g. travel if required); and • minute taking and distribution.	LGBTIQ+ Implementation Team	This objective can be actioned independent of other objectives.	Year 4 – 6
Organisation and Governance	Refine SOPs, workflows and office management processes	The LGBTIQ+ Implementation Team to: • refine list of procedural and administrative activities according to remit of responsibilities; • refine and develop SOPs; • refine and develop workflows; and • refine office management processes, such as roles and responsibilities, and reporting flows.	LGBTIQ+ Implementation Team	This objective can be actioned independent of other objectives.	Year 4 – 6

Theme	Objective	Action	Responsible party	Dependencies	Timeframes
Organisation and Governance	Facilitate monthly HRG meetings	Monthly HRG meetings will require: • electing an independent chair; • agreeing the Terms of Reference for decision-making; • agreeing a tenure of membership; • agreeing a meeting time and means of engagement (in person or virtual); • developing and forwarding an agenda (including previous meeting's action items); • coordinating logistics (e.g. travel if required); and • minute taking and distribution. Note: these meetings will inform the implementation of the gender-focused model of service as well as the recommendations. The LGBTIQ+ Implementation Team will be responsible for providing the key agenda items. Items for discussion may be provided by the SURG, service providers, clinicians or the LGBTIQ+ Implementation Team. Note: the cadence of these meetings may reduce towards the later end of the implementation phase.	LGBTIQ+ Implementation Team	This objective can be actioned independent of other objectives.	Year 4 – 6
Organisation and Governance	Offer expanded specialist services to provide in-reach services to the central hub	This expansion will be achieved through the competitive tender process for the delivery of specialist services as in-reach to the hub.	LGBTIQ+ Implementation Team	This objective will be dependent on the periodic needs assessment.	Year 5
Infrastructure	Fit out the central hub for the delivery of primary care services and specialist services	The fit out of the central hub will be completed by an external provider. The specifications for the fit out must be provided by the service provider for the delivery of primary care and specialist services. The LGBTIQ+ Implementation Team will be responsible for providing oversight and guidance for the accountable service providers.	LGBTIQ+ Implementation Team, service providers and external provider	This objective will depend on the selection of a preferred service provider for the delivery of in-reach specialist services and primary care services.	Year 5

Theme	Objective	Action	Responsible party	Dependencies	Timeframes
Infrastructure	Support relevant service providers with achieving accreditation standards for capability training of GPs	This responsibility sits within the service providers. The LGBTIQ+ Implementation Team may support this process as required.	Service providers	This objective depends on the services procured for the hub, the head contractor and subsequent sub- contractor arrangements.	Year 5
Infrastructure	Conduct a periodic needs assessment to inform service delivery (e.g. in-reach specialist services)	According to timeframe set out in the previous phase, a periodic needs assessment will be conducted. Findings are to be analysed and presented to the HRG for advice regarding ways in which it will inform the existing gender-focused model of service.	LGBTIQ+ Implementation Team / service providers / HRG	This objective can be actioned independent of other objectives.	Year 4
Infrastructure	Ensure relevant service providers hold accreditation standards for the delivery of specialist services	This responsibility sits within the service providers and will be assessed as part of the competitive tender process for the delivery of specialist services.	Service providers	This objective depends on the services procured for the central hub, the head contractor and subsequent sub-contractor arrangements.	Year 5
People and Workforce	Review professional development for central hub roles to provide gender-affirming care.	Review professional development of central hub roles to understand capacity of the system to support gender-affirming care. This will be achieved through service providers providing bi-annual updates on the professional development for workforce roles to increase the capacity of the system to provide gender-affirming care. This would need to be captured as part of the initial and ongoing contracts.	LGBTIQ+ Implementation Team	This objective can be actioned independent of other objectives.	Year 4

Theme	Objective	Action	Responsible party	Dependencies	Timeframes
People and Workforce	Review and refine the triage criteria to effectively manage service demand based on workforce plan	This will involve reviewing the criteria used to prioritise service users at the central hub. By this point in the implementation, the triage criteria will have been in use for 12 months, as part of establishing and operationalising the central hub. The triage criteria will be reviewed at an HRG meeting in combination with demand analysis for the gender-focused model of service (waitlist and wait times for services). The advice from the HRG will be shared with the lead service provider by the LGBTIQ+ Implementation Team. This will inform updates to the triage criteria (if required).	LGBTIQ+ Implementation Team, HRG and lead service provider	This objective can be actioned independent of other objectives.	Year 4
People and Workforce	Recruit specialist service roles based on workforce plan	All recruitment for clinical roles will be completed externally to the ACTHD. The scope and FTE for service delivery will be contracted to preferred suppliers through a competitive tender or single select procurement.	Successful service providers	This objective can be actioned independent of other objectives.	Year 4 - 5
Information and Technology	Monitor data quality	This will involve monitoring the data quality for the gender-focused model of service as described in the Data Quality Strategy. Key activities include: • checking the quality and consistency of data provided in reports from the central hub; • analysing the data to inform briefs to the HRG and the ACTHD executive; and • identifying strategies for informing improvements in the quality, reliability and consistency of data and reporting from the central hub.	LGBTIQ+ Implementation Team	This objective can be actioned independent of other objectives.	Year 4 – 6

Theme	Objective	Action	Responsible party	Dependencies	Timeframes
Information and Technology	Build in GP services and specialist services into the knowledge management system and supporting systems.	Liaison between the service providers of the gender-focused model of service and the external provider for the knowledge management system and clinical information system. This may also involve supporting the relationship between the two providers for ongoing management and updates for the systems to support future delivery.	This will be the responsibility of the external provider who has implemented the knowledge management system and supporting systems.	This objective can be actioned independent of other objectives.	Year 4 - 5

Source xiv: KPMG 2022.

Table 11 Phase 3 - Transition to BAU

Theme	Objective	Action	Responsible party	Dependencies	Timeframes
Project Management	Transition LGBTIQ+ Implementation Team to BAU function	This will involve: • identifying BAU roles for the handover of ongoing activities for implementation; • drafting a Transition Plan (described below); • transitioning activities from the LGBTIQ+ Implementation Team to BAU roles; and • ceasing operation of the LGBTIQ+ Implementation Team. Continue monthly LGBTIQ+ Implementation Team meetings or reduce or cease as needed.	LGBTIQ+ Implementation Team	This objective is dependent on the completion of all implementation objectives.	Year 10
Project Management	Develop Transition Plan for LGBTIQ+ Implementation Team transition to BAU function	This will involve: • defining what 'success' looks like in transition, i.e. what BAU would look like and how it would function; • defining roles and responsibilities within transition; • defining roles and responsibilities for BAU, particularly the role of the HRG; • defining key milestones for transition; and • detailing risk and mitigation strategies within transition.	LGBTIQ+ Implementation Team	The objective can be actioned independent of other objectives.	Year 10
Project Management	Refine SOPs, workflows and office management processes	The LGBTIQ+ Implementation Team to: • refine list of procedural and administrative activities according to remit of responsibilities; • refine and develop SOPs; • refine and develop workflows; and • refine office management processes, such as roles and responsibilities, and reporting flows.	LGBTIQ+ Implementation Team	This objective can be actioned independent of other objectives.	Year 7-9

Theme	Objective	Action	Responsible party	Dependencies	Timeframes
Organisation and Governance	Coordinate bi-annual HRG meetings	Bi-annual HRG meetings will require: • agreeing upon a meeting time and means of engagement (in person or virtual); • developing and forwarding an agenda (including previous meeting's action items); • coordinating logistics (e.g. travel if required); and • minute taking and distribution. The LGBTIQ+ Implementation Team will be responsible for providing the key agenda items. Items for discussion may be provided by the SURG, service providers, clinicians or the LGBTIQ+ Implementation Team.	LGBTIQ+ Implementation Team	This objective can be actioned independent of other objectives.	Year 7 onwards
Organisation and Governance	Establish ongoing governance for the gender-focused model of service	Determine the governance approach for the gender-focused model of service for Year 10 onwards. If the HRG remains an ongoing oversight body, there would need to be consideration around how to maintain it on an ongoing basis. The ongoing operationalisation of the HRG could be determined and captured at a HRG meeting and documented in the Transition Plan.	LGBTIQ+ Implementation Team	This objective is dependent on the completion of all implementation activities as a part of transition to BAU.	Year 10
Organisation and Governance	Manage competitive tender process for service delivery as required	The need to conduct periodic competitive tender processes will be informed by the approach to market, procurement strategies and contract performance management strategies agreed in Phase 0. The tender will be managed based on the ACT Government's Procurement Regulation 2007.	LGBTIQ+ Implementation Team	This objective can be actioned independent of other objectives.	Year 7 onwards

Theme	Objective	Action	Responsible party	Dependencies	Timeframes
Infrastructure	Monitor the use of the central hub and accessibility to ensure it is fit for purpose	This will involve: • reviewing the central hub and network sites against the infrastructure and accessibility requirements identified in Phase 0; • engaging with the HRG to understand if there are any changes to infrastructure and accessibility requirements; and • re-commencing procurement of service and / or hire of venues for service delivery based on updated infrastructure and accessibility requirements.	LGBTIQ+ Implementation Team / HRG	This objective can be actioned independent of other objectives.	Year 7 onwards
People and Workforce	Review and refine the triage criteria to effectively manage demand for the gender-focused model of service.	This will involve reviewing the triage criteria as it has been implemented for the first 12 months of service delivery (i.e. the triage criteria will be reviewed at a HRG meeting in combination with demand analysis for the gender-focused model of service (waitlist and wait times for services). The advice from the HRG will be fed back to the lead service provider by the LGBTIQ+ Implementation Team to update the triage criteria (if required).	LGBTIQ+ Implementation Team, HRG and lead service provider	This objective can be actioned independent of other objectives.	Year 7 onwards
People and Workforce	Review and revise workforce plan	Review the workforce plan developed in Phase 0 to: • compare the workforce FTE with current FTE; • review position descriptions and roles of the LGBTIQ+ Implementation Team for transition to BAU roles; • review progress of the workforce plan addressing the capability uplift of roles for the ongoing delivery of gender-affirming care in the ACT; and • support ongoing pathways to increase the capacity of service delivery through development of workforce.	LGBTIQ+ Implementation Team	This objective can be actioned independent of other objectives.	Year 7 onwards

Theme	Objective	Action	Responsible party	Dependencies	Timeframes
Information and Technology	Perform data cleansing and monitoring of data quality	This will involve collecting and cleansing data to inform a range of activities (e.g. monitoring and evaluation of the service and / or periodic needs assessment). It will also involve monitoring the quality of data. The LGBTIQ+ Implementation Team will need to liaise with the service providers for the gender-focused model of service as well as external providers who manage the knowledge management system and the service user information system to capture key data points.	LGBTIQ+ Implementation Team	This objective can be actioned independent of other objectives.	Year 7 - 10
Information and Technology	Monitor and review the knowledge management system and service user information system, including any supporting programs	This will involve performing a review of the knowledge management system, service user information system and supporting systems to test their ongoing usability in meeting requirements defined in Phase 0.	LGBTIQ+ Implementation Team or external provider. The external provider performing the review must be independent from the providers managing the knowledge management system, service user information system and supporting systems.	This objective can be actioned independent of other objectives.	Year 7

Source xv: KPMG 2022.

2.3 Cost estimates for the gender-focused model of service

2.3.1 Summary of cost estimates for the gender-focused model of service

The cost estimates for the gender-focused model of service are outlined in Table 12. The estimated cost of establishing and operationalising the gender-focused model of service for Option 1 is [redacted] over 10 years. This option involves service users being treated as public patients and all services being funded by the ACT Government. The estimated cost for Option 2 is [redacted] over 10 years. In comparison, this option involves clinicians exercising their right to private practice and claiming MBS rebates for eligible services as full payment for these services (i.e. delivering bulk-billed services). For this reason, the estimated cost of Option 2 is approximately [redacted] less over 10 years.

Table 12 The gender-focused model of service estimates (millions)

Cost estimates	2023/ 2024	2024/ 2025	2025/ 2026	2026/ 2027	2027/ 2028	2028/ 2029	2029/ 2030	2030/ 2031	2031/ 2032	2032/ 2033	Total
Option 1	[redacted]										
Option 2											

Source xvi: KPMG 2022. Note values may not be equal totals due to rounding.

The detailed cost estimates for the gender-focused model of service is available at Appendix A: Approach and cost estimates. The options for the gender-focused model of service were assessed against five design principles that were identified during the co-design process. The assessment of the two delivery options against the design principles is available at Appendix B: the gender-focused model of service.

Appendices

Appendix A: Approach and cost estimates

This appendix describes the approach and detailed cost estimates for the Scoping Study recommendations.

A.1 Approach for developing the cost estimates for the Scoping Study recommendations

The cost estimates for the Scoping Study recommendations were informed by stakeholder consultation and desktop research to estimate the overall cost of implementation over a five-year period, with the exception of the gender-focused model of service (recommendation 10) which was estimated over 10 years. The key cost drivers identified included the following:

1. Workforce: A range of specialist, administrative, operational and policy staff are required to implement and manage the day-to-day components of each recommendation.
2. Technology/digital: Several recommendations require the development of digital offerings for the delivery of services. These platforms also require content to be developed.
3. Training: There is a requirement to upskill staff in a variety of areas to better understand the health care and support needs of the LGBTIQ+ community.

A range of assumptions were made to inform the development of the cost estimates. The key high-level assumptions include:

1. Staff costs have been sourced from *ACT Public Sector Administrative and Related Classifications Enterprise Agreement (2021-2022), Technical and Other Professional Enterprise Agreement (2022 – 2022)* and the *Health Professionals Enterprise Agreement (2021 – 2022)*. It has been assumed that the public sector staff costs will continue to align with these enterprise agreements. Where staff may not be employees of the ACT Government, alternate enterprise agreements have been used, and these agreements have been described where relevant.
2. It is assumed that the Scoping Study will be implemented through workforce planning based on a full-time equivalent (FTE) unit. The assumptions used to estimate the cost of implementing the Scoping Study are therefore described in terms of the FTE estimated to be required for a particular role or activity.
3. A small level cost of miscellaneous expenses has been included for the implementation of recommendations, with the exception of the gender-focused model of service (recommendation 10). The miscellaneous expense item was assumed at a rate of 5% of costs and has been included as a contingency for any unforeseen overhead or incidental expenses that may be incurred during implementation.
4. It is understood that the ACT Health Directorate (ACTHD) has performed a number of consultations with the LGBTIQ+ community and non-government organisations (NGOs) during the development of the Scoping Study. Additional consultation will be achieved through engagement of the Health Reference Group (HRG) and Service User Reference Group (SURG). The costs associated with the consultation of these groups has been captured in the gender-focused model of service (recommendation 10) for the HRG and recommendation 23 for the SURG. Further information on the HRG is available at Appendix B: the gender-focused model of service.
5. The activities assumed to be required to implement each recommendation were identified based on stakeholder consultation and desktop review. The costs of undertaking these activities were estimated based on publicly available data and information (e.g. enterprise agreements and program information for the implementation of similar initiatives). Variations to this timeframe may have a material impact on these estimates.

A.2 Limitations and considerations

The limitations and considerations for the approach to developing the cost estimates have been provided below.

1. The cost estimates for the gender-focused model of service and the Scoping Study recommendations are based on information and insights provided by stakeholders and/or publicly available information. There may be more accurate costing information available through confidential sources (e.g. private providers or government health funding data). If new information or data is made available during the implementation of the gender-focused model of service, the cost estimates will need to be reviewed and refined.
2. The activities described in the cost estimates represent a range of potential activities required to implement each recommendation. Changes to these activities may have a material impact on the cost estimates.
3. There has been limited validation with stakeholders of the cost estimate outputs for a majority of the recommendations. This was due to the challenges in engaging with particular stakeholder groups within the timeframes for the development of the cost estimates. This included various community organisations and health services due to the clinical obligations of staff and the impacts of COVID-19 on the ACT public health system. Further validation of the cost estimates for the Scoping Study recommendations may be required.
4. The implementation plan provides an actionable plan to describe the approach for establishing the co-designed gender-focused model of service. There may be constraints in meeting the infrastructure and workforce requirements described within the gender-focused model of service. There is an ongoing requirement for infrastructure and workforce planning to enable and sustain the proposed gender-focused model of service.

Based on the above limitations and considerations, the costings provided in this report have been developed as ‘high level estimates’ only.

A.3 Assumptions for cost estimates for the Scoping Study recommendations

A range of overarching assumptions were used to inform the development of the cost estimates for the Scoping Study recommendations, excluding recommendation 21 (out of scope). These have been described in Table 13.

Table 13 Summary of overarching cost estimate assumptions for the Scoping Study recommendations

Description	Assumption	Source
Cost Indexation	3.4%	*Australian Institute of Health and Welfare – Health Expenditure Australian 2019-20*
Wage Indexation	2.4%	*Australian Bureau of Statistics – Wage Price Index (Healthcare and social assistance) 2021*
Staff costs – non-health related	-	*ACT Public Sector Administrative and Related Classification Enterprise Agreements (2021-2022)*
Staff costs – non-health related	-	*Technical and Other Professional Enterprise Agreement (2021-2022)*
Staff costs – health related	-	*ACT Health Professional Enterprise Agreement (2021-2022)*
Staff costs – teaching related	-	*Australian National University – Schedule 2, Casual Sessional Academic salary rates*
Uptake of training	40%	*Australian Bureau of Statistics – Work related training and Adult Learning (2021)*
Number of schools in the ACT	136	*Australian Bureau of Statistics – Schools (2021)*

Source xvii: KPMG 2022.

A.4 List of stakeholder consultations

As described in the approach, the cost estimates were informed by stakeholder consultations. The stakeholder groups and purpose for engagement has been described in the table below.

Table 14 Summary of stakeholder consultations

Stakeholders	Description
Capital Health Network • [redacted] Capital Health Network	Consulted [redacted] on Monday, 9 May 2022, to inform the cost estimates and implementation plan for the following recommendations: • Recommendation 1 to provide online LGBTIQ+ awareness and clinical training for General Practitioners (GPs), allied health and specialist services. • Recommendation 4 to provide a gender-affirming hospital experience.
Sexual Health and Family Planning ACT (SHFPACT) • [redacted]	Consulted with [redacted] regarding recommendation 3 Safe and Inclusive Schools Initiative and the activities included in the initiative as well as current funding arrangements which form the basis for the cost estimate. Further consultation was conducted with [redacted] to test the outputs for the following recommendations: • Recommendation 1 to provide online LGBTIQ+ awareness and clinical training for GPs, allied health and specialist services. • Recommendation 2 to work with the Canberra-based vocational and university sectors to ensure the training for medical, nursing and allied health professionals includes training on best practice, gender-affirming health services. • Recommendation 3 to build upon or support the ongoing implementation of the ACT Government Safe and Inclusive Schools Initiative and provide information on health supports available to parents and students. • Recommendation 9 to promote a visibly welcoming and inclusive environment for patients of publicly funded health services.
Canberra Sexual Health Centre • [redacted]	Consulted [redacted] to inform the development of the cost estimates and implementation plan for recommendation 2. This included capturing the underpinning assumptions for the timeframe of content preparation, resources and the delivery of lectures.
Office of LGBTIQ+ Affairs	Consulted with the Office of LGBTIQ+ Affairs to inform the development of the cost estimates and implementation plan for recommendation 9. This engagement provided options for the promotional materials packs.

Source xviii: KPMG 2022.

A.5 Detailed cost estimates for the Scoping Study

The overall cost to implement the Scoping Study recommendations is [redacted] over 10 years. This includes:

- [redacted] over five years to implement the Scoping Study recommendations excluding the gender-focused model of service (recommendation 10) and recommendation 21 (out of scope);
- [redacted] over 10 years to implement the gender-focused model of service (recommendation 10); and
- [redacted] over 10 years for the LGBTIQ+ Implementation Team.

The description of the gender-focused model of service and preferred option is available at Section 2. The gender-focused model of service (recommendation 10) and Appendix B: the gender-focused model of service. Table 15 describes the cost of implementation of the Scoping Study recommendations based on the weighting defined within the Scoping Study and the cost of the LGBTIQ+ Implementation Team.

Table 15 Cost estimates for Scoping Study recommendation (millions)

[redacted]	2023/ 2024	2024/ 2025	2025/ 2026	2026/ 2027	2027/ 2028	2028/ 2029	2029/ 2030	2030/ 2031	2031/ 2032	2032/ 2033	Total
[redacted]											

Source xix: KPMG 2022. Note values will not equal totals due to rounding.

The estimated costs for implementation in Year 6 through to Year 10 are for the ongoing implementation of the gender-focused model of service (recommendation 10) over a 10 year period.

There are no individual cost estimates for the following recommendations as the activities described within the implementation plan will be implemented by the LGBTIQ+ Implementation Team or activities are already forecast in planned ACTHD programs and initiatives:

- Recommendation 5
- Recommendation 11
- Recommendation 12
- Recommendation 13
- Recommendation 14
- Recommendation 15
- Recommendation 16
- Recommendation 17
- Recommendation 18
- Recommendation 19
- Recommendation 20
- Recommendation 22
- Recommendation 24

The FTE and cost estimates for the LGBTIQ+ Implementation Team and detailed cost estimates for the Scoping Study recommendations have been provided within the subsequent pages of this appendix.

The LGBTIQ+ Implementation Team

The estimated cost for the LGBTIQ+ Implementation Team is [redacted] over 10 years.

To deliver the Scoping Study recommendations, the LGBTIQ+ Implementation Team will include one Senior Officer Grade B, one Senior Officer Grade C, one Administrative Services Officer Class 6 and one Administrative Services Officer Grade 5. This team will coordinate and oversee the implementation of the recommendations over a 10 year period. The FTE estimate for this team was informed by advice from the ACTHD.

The detailed cost estimates for the LGBTIQ+ Implementation Team includes superannuation, workers compensation and administration on-costs. The workforce profile for the LGBTIQ+ Implementation Team and the gender-focused model of service (recommendation 10) is available at Appendix C: Workforce Profile.

Table 16 The cost estimates for the LGBTIQ Implementation Team (millions)

[redacted]	2023/ 2024	2024/ 2025	2025/ 2026	2026/ 2027	2027/ 2028	2028/ 2029	2029/ 2030	2030/ 2031	2031/ 2032	2032/ 2033	Total
[redacted]											

Source xx: ACTHD.

Recommendation 1 – Education and Training

The estimated total cost for the implementation of this recommendation is [redacted] over five years.

> *Recommendation 1: Work with the Commonwealth and Capital Health Network to identify best-practice training and regular peer-led LGBTIQ+ awareness and clinical training for primary care providers (including GPs), allied health, specialist services; Winnunga Nimmityjah Aboriginal Health and Community Services; and mental health care service providers to improve understanding of LGBTIQ+ specific health needs.*

This recommendation involves the delivery of LGBTIQ+ awareness and clinical training for primary care providers (including GPs), allied health, specialist services, Winnunga Nimmityjah Aboriginal Health and Community Services and mental health staff.

The LGBTIQ+ awareness and clinical training will comprise a face-to-face component for LGBTIQ+ clinical training and an online component for LGBTIQ+ awareness. Based on the ACTHD guidance, it has been assumed that 150 relevant public staff will receive face-to-face training in a single year. This training would be accessible by public primary care providers, allied health, specialist services, Winnunga Nimmityjah Aboriginal Health and Community Services and mental health staff. It has been assumed that all other relevant staff for these providers will access and participate in online training.

Face-to-face training will not be required beyond Year 5 due to the availability of LGBTIQ+ awareness and clinical skills training within current university curriculum, such as the Australian National University. The training packages will be made available to the Canberra Health Network (CHN) for delivery to staff who provide GP services. This training will also be used to support the implementation of recommendation 18.

The training costs were sourced from groups that provide LGBTIQ+ training to primary care providers. These costs include:

[redacted]

[4] Meridian ACT, accessed 30 September 2022: https://www.meridianact.org.au/

[5] ACON Pride Training, accessed 30 September 2022: https://www.pridetraining.org.au/collections/elearning/products/lgbtq-introduction-elearning

It has been assumed that the LGBTIQ+ Implementation Team will liaise with primary care providers and monitor the delivery of the training.

Table 17 The cost estimates for Recommendation 1

Recommendation 1	2022/23	2023/24	2024/25	2025/26	2026/27
[redacted]					

Source xxi: KPMG 2022.

Recommendation 2 - Student Outreach

The estimated total cost for the implementation of this recommendation is [redacted] over five years.

> *Recommendation 2: Work with the Canberra based vocational and university sectors to ensure the training for medical, nursing and allied health professionals includes training on best practice gender-affirming health care.*

Stakeholders engaged during the co-design process suggested the delivery of three lectures and three clinical skills workshops is important for the upskilling of allied health, nursing and medical students in inclusive health care. The cost estimates include the effort for the development of maintenance and delivery of the lectures and clinical skills workshops.

- It was assumed that three different lectures are required to be developed for inclusive health care. Each lecture is estimated to take approximately 10 hours for a total of 30 hours of effort for three lectures. This was sourced from service providers and stakeholders who are already working in universities to deliver lectures on safe and inclusive health care for the LGBTIQ+ community. Australian National University (ANU) casual sessional academic rates were applied to generate a cost for lecture development:

  [redacted]

- For teaching sessions, costs were based on one hour of preparation and one hour of teaching for the three lectures (six total hours). Casual ANU sessional academic rates were applied to generate a cost for lecture delivery. A similar process was followed for the delivery of the lecture component of the clinical skills lectures.
- Beyond Year 1, a 20-hour annual commitment is required for the maintenance and revision of teaching material.
- It is assumed that there would be two clinical educators and two people with lived experience to deliver each clinical skills workshop. Each person with lived experience would receive a [redacted] in accordance with the ACT Health Consumer, Carer and Community Representative Reimbursement Policy.
- For the clinical skills workshop, it was assumed that there would be a cap to the number of students who could attend each session. It was assumed that a maximum of 50 students could attend a clinical skills workshop, leading to a requirement for nine clinical skills workshops per year. This is based on 100 second year medical students from ANU and 200 students (100 allied health and 100 nursing) from each of the four remaining institutes which is a total of 900 students. It was assumed that 100% of ANU medical students would attend a clinical skills workshop and based on data from the Australian Bureau of Statistics (ABS), 40% of the allied health and nursing students would attend. This is a total attendance of 420 students. Based on the class limit size of 50 students, there would need to be nine clinical workshops, as follows:

  [redacted]

It is assumed that prior engagement has been conducted with the universities and vocational sectors for the delivery of training for best-practice, gender-affirming health care.

Table 18 The cost estimates for Recommendation 2

Recommendation 2	2022/23	2023/24	2024/25	2025/26	2026/27

Source xxii: KPMG 2022.

Recommendation 3 - Safe Schools Initiative

The estimated total cost for the implementation of this recommendation is [redacted] over five years. This recommendation supports the ACT Government Safe and Inclusive Schools Initiative.

> *Recommendation 3: Build upon or support the ongoing implementation of the ACT Government Safe and Inclusive Schools initiative and provide information on health supports available to parents and students.*

The estimated cost for implementing this recommendation includes ongoing investment for the Safe and Inclusive Schools Initiative.

The Safe and Inclusive Schools Initiative is currently delivered by Sexual Health and Family Planning ACT (SHFPACT) and this initiative focuses on providing information about gender and sexual diversity (and health care options) to teachers and parents so that they are well placed to discuss gender and sexual identity with children in the school community. The funding for SHFPACT has been based on a historical block funding arrangement. SHFPACT has historically acquitted this funding through the delivery of Safe and Inclusive Schools resources and training at as many schools as the existing funding will allow (approximately 60% of government schools in the ACT). It has been assumed that the cost estimates provided for the pre-service training and resources would support the delivery of this initiative for 100% of government schools. It was assumed that pre-service teacher training would take place twice per year.

An assumption has been made that the schools in scope for this recommendation are government schools only. This is based on advice from stakeholders consulted as part of estimating the cost of this recommendation, who noted that there has historically been limited engagement by non-government, independent schools in the Safe and Inclusive Schools Initiative in the ACT.

Table 19 The cost estimates for Recommendation 3

Recommendation 3	2022/23	2023/24	2024/25	2025/26	2026/27
[redacted]					

Source xxiii: KPMG 2022.

Recommendation 4 – Gender-affirming public health care

The estimated total cost for the implementation of this recommendation is [redacted] over five years.

> *Recommendation 4: Gender-affirming public health care: Provide training and information on best practice gender-affirming care to publicly funded health service providers.*

The Guidance to support gender-affirming care for mental health has been developed. The estimated cost for implementing this recommendation includes the promotion of the mental health care guidelines and the delivery of training to the mental health sector. The estimated cost also includes the translation of the mental health guidelines for applicability outside mental health, such as publicly funded health service providers, and the subsequent delivery of training based on the revised guidelines.

The assumptions underpinning the estimated cost for the development of content and training delivery are similar to Recommendation 1. Based on the ACTHD guidance, it has been assumed that 150 relevant public health service provider staff will receive face-to-face training in a single year. It has been assumed that all other public health service provider staff will access online training.

Training costs were sourced from groups that provide LGBTIQ+ training to primary care providers. These costs include:

[redacted]

It has been assumed that the LGBTIQ+ Implementation Team will liaise with public health service providers and support with the promotion of the use of the mental health guidelines to service providers for the ACT LGBTIQ+ community.

Table 20 The cost estimates for Recommendation 4

Recommendation 4	2022/23	2023/24	2024/25	2025/26	2026/27
[redacted]					

Source xxiv: KPMG 2022.

[6] Meridian ACT, accessed 30 September 2022: https://www.meridianact.org.au/

[7] ACON Pride Training, accessed 30 September 2022: https://www.pridetraining.org.au/collections/elearning/products/lgbtq-introduction-elearning

Recommendation 5 – Gender-affirming hospital experience

The estimated cost for the implementation of this recommendation has been included within the cost estimate for the LGBTIQ+ Implementation Team (see *The LGBTIQ+ Implementation Team*).

> *Recommendation 5: Provide an option for preferred name, gender and pronouns during hospital care, that are visible to patients and hospital staff. Including, for example, on in-patient wristbands, forms and in-room whiteboards.*

It is understood that the implementation of the Digital Health Record will facilitate a gender-affirming hospital experience through the update of options for preferred name, gender and pronouns during hospital care. The implementation of the Digital Health Record is underway. This will not be an ongoing requirement or recurring cost after the system change has been actioned. Changes to ICT have not been costed and are assumed to be incorporated in planned and funded changes to the Digital Health Record in the ACT.

It has been assumed that the LGBTIQ+ Implementation Team will implement the required activities for this recommendation.

Recommendation 6 – Aboriginal and/or Torres Strait Islander LGBTIQ+ resources

The estimated total cost for the implementation of this recommendation is [redacted] over five years.

> *Recommendation 6: Create LGBTIQ+ health resources for the Aboriginal and Torres Strait Islander community, in collaboration with community and relevant LGBTIQ+ and Aboriginal and Torres Strait Islander community health groups.*

The estimated cost for implementing recommendations 6 and 7 includes website development, social media and traditional media sources, with some staff costs to manage the implementation.

It has been assumed that the LGBTIQ+ Implementation Team will implement the required activities for this recommendation. The development of Aboriginal and Torres Strait Islander LGBTIQ+ resources may have already commenced through local NGOs. Further validation of the completeness of these resources will be undertaken after the submission of this report. If work is already underway on the Aboriginal and Torres Strait Islander LGBTIQ+ resources then the cost estimates will be proportionately lower, commensurate with the degree of completeness.

Table 21 The cost estimates for Recommendation 6

Recommendation 6	2022/23	2023/24	2024/25	2025/26	2026/27
[redacted]					

Source xxv: KPMG 2022.

Recommendation 7 – LBTQ+ health resources

The estimated total cost for the implementation of this recommendation is [redacted] over five years.

> *Recommendation 7: Create educational health resources specifically for same sex attracted women and people with a cervix, particularly information on screening services and reproductive health.*

The estimated cost for implementing recommendations 6 and 7 includes website development, social media and traditional media sources, with some staff costs to manage the implementation. The development of Aboriginal and Torres Strait Islander LGBTIQ+ resources may have already commenced through local NGOs. Further validation of the completeness of these resources will be undertaken after the submission of this report. If work is already underway on the Aboriginal and Torres Strait Islander LGBTIQ+ resources then the cost estimates will be proportionately lower, commensurate with the degree of completeness.

Table 22 The cost estimates for Recommendation 7

Recommendation 7	2022/23	2023/24	2024/25	2025/26	2026/27
[redacted]					

Source xxvi: KMPG 2022.

Recommendation 8 – Accessibility of LGBTIQ+ information for culturally and linguistically diverse communities

The estimated total cost for the implementation of this recommendation is [redacted] over five years.

> *Recommendation 8: Create LGBTIQ+ health resources for the CALD community, in collaboration with representatives of the community.*

The estimated cost of implementing this recommendation includes the translation, update and maintenance of LGBTIQ+ health resources, specifically for the culturally and linguistically diverse community it the ACT. This cost estimate is based on the assumption that there will be translation of LGBTIQ+ health resources for up to 20 documents and five videos into 10 languages. Whilst not being prescriptive, it is acknowledged that other ACT policies, such as the *ACT Language Services Policy* and the corresponding *Canberra Health Services - Language Services Procedures*, may have an impact on the delivery of this recommendation. For example, compliance with the *ACT Language Services Policy* requires:

- increased resources available to those with a first language other than English;
- the use of other services such as interpreters; and
- a broad selection of languages.

It has been assumed that the 20 documents will have no more than 200 words per document and the five videos will be no more than three minutes in length. If this assumption varies (e.g. more complex narratives in the resources or longer word documents), the cost estimates may increase in parallel with the complexity or length of the documentation.

It was assumed that consultation with members from the LGBTIQ+ culturally and linguistically diverse community is required for the development of resources. Consultations have been assumed to occur three times in the first year and once per year thereafter. The cost for consultation is [redacted] in alignment with the ACT Health *Consumer, Carer and Community Representative Reimbursement Policy* and has been absorbed within the costs for the translation of materials.

It has been assumed that the LGBTIQ+ Implementation Team will implement the required activities for this recommendation.

Table 23 The cost estimates for Recommendation 8

Recommendation 8	2022/23	2023/24	2024/25	2025/26	2026/27
[redacted]					

Source xxvii: KMPG 2022.

Recommendation 9 – Demonstrating Inclusiveness through Visibility

The estimated total cost for the implementation of this recommendation is [redacted] over four years.

> *Recommendation 9: Promote a visibly welcoming and inclusive environment for patients of publicly funded health services.*

The estimated cost of implementing this recommendation includes a pack of promotional material, including stickers, pins, a flag and storefront adhesives, that would be made available to public health services to position themselves as an inclusive service and create a welcoming space for LGBTIQ+ community members. The promotional material was informed by stakeholder consultation.

It has been assumed that up to 20 public health facilities in the ACT will receive a pack of promotional material for up to four years. The promotional material will be purchased centrally, for example by the CHS, and distributed to the facilities simultaneously.

The promotional material bundle resources include: 500 stickers, flyers and pins, a rainbow flag and a storefront style adhesive.

[redacted]

A funding envelope for a pack of promotional material will be provided for four years to encourage initial promotion of inclusiveness within the health facilities.

It has been assumed that the LGBTIQ+ Implementation Team will support the implementation of this recommendation.

Table 24 The cost estimates for Recommendation 9

Recommendation 9	2022/23	2023/24	2024/25	2025/26	2026/27
[redacted]					

Source xxviii: KPMG 2022.

Recommendation 10 – Gender-focused health service

The estimated total cost for the implementation of this recommendation is [redacted] over 10 years for Option 1 and [redacted] over 10 years for Option 2.

> *Recommendation 10: Establish a peer-led community-based gender-focused health and wellbeing service that is co-designed with LGBTIQ+ stakeholders and NGOs.*

Based on the co-design process and desktop review of cost proxies, the key cost drivers identified included the following:

- Workforce: A range of specialist and administrative staff comprising the hub and Health Reference Group are required to deliver and govern the gender-focused model of service.
- Infrastructure and operating costs: The gender-focused model of service will be operated from a facility with five rooms: two consulting rooms, two treatment rooms and an office space occupying a space of approximately 200 square metres. The operating costs include sewage, water and cleaning.
- Referral Services: A number of services will be referred to specialists external to the hub. Referral services include endocrinology, psychiatry, psychology, and breast screening.

A range of assumptions were made to inform the development of the costing estimates. These include:

- Staff costs have been sourced from *ACT Public Sector Administrative and Related Classifications Enterprise Agreement (*2021-2022) and the *Health Professionals Enterprise Agreement* (2021-2022). It has been assumed that the public sector staff costs will continue to align with these enterprise agreements. Where staff may not be employees of the ACT Government, alternate enterprise agreements have been used as well as publicly available information.
- It is assumed that the gender focused model of service will be implemented through workforce planning based on an FTE unit. The assumptions used to estimate the cost of implementing the gender-focused model of service are therefore described in terms of the FTE estimated to be required for a particular role. The FTE for workforce roles was informed by Meridian and
  A Gender Agenda (AGA) submission documentation and in consideration of the data available to describe the cohort and demand for services. It has also been validated with data provided by the CHS. It is assumed that each FTE in the hub will receive an allowance for basic first aid and Cardiopulmonary Resuscitation (CPR) training and renewal of these qualifications will occur every three years.
- All staff costs for the gender-focused model of service include superannuation and leave loading. The cost estimates for this recommendation do not include workers' compensation and administration on-costs.
- It is assumed there is a minimal cost associated with the HRG where there may be a small cost associated with reimbursement for community members who are not already receiving payment from the organisation they represent. It has been assumed that up to three community members will require reimbursement bi-annually.
- Two costed options have been developed for the gender-focused model of service. These include the following options:

1. Having public health care service providers who are experienced in gender-affirming health care delivering services as part of the gender-focused model of service. These services would be funded using a service agreement with the ACTHD. Funding for referral services was based on the 2022-23 National Efficient Price (NEP) and would be underpinned by the *National Health Reform Agreement*. Therefore, 45% is funded by Australian Government and 55% is funded by ACT Government.
2. Having both public and private health care providers who are experienced in gender-affirming health care services as part of the gender-focused model of service. For this option, it is assumed that GP and referral services (psychiatry, psychology and endocrinology) would be funded by the MBS with the exception of breast screening. Clinicians will charge for services at a price commensurate with the MBS rebate. The ACT Government would incur a cost for referral services that are not MBS billable. This includes a cost for breast screening which was costed based on analysis from another public breast screening service. It was assumed that 85% (from the Department of Health and Aged Care website) of fees would be subsidised via the MBS, the remaining 15% to be funded by the ACT Government and there would be no out-of-pocket expense.

The detailed calculations for the referral services for the gender-focused model of service are outlined below.

Referral services for the gender-focused model of service

It was assumed that the following referral services form part of the delivery of the gender-focused model of service:

- Adult and Paediatric Endocrinologist;
- Psychiatry;
- Psychology; and
- Breast Screen.

The costs for the above services were based on the NEP determined by the Independent Hospital Pricing Authority and adjusted by the price weighting and CHN adjustment as set out below.

Table 25 The cost estimates for referral services

	Price Weighting	Paediatric Adjustment	Cost per service (adult)	Cost per service (Paediatric)	Referral Service
[redacted]					Endocrinology
					Psychiatry
					Psychology
					Breast Screen

Source xxix: Independent Hospital Pricing Authority 2022.

It was assumed that the frequency of referral services per week is constant throughout the year as set out below. These assumptions were informed by community-based insights from the analysis of Meridian and AGA wait lists for these referral services. Further activity data may be required to estimate the output and understand the MBS item numbers typically used by relevant clinicians working in the ACT under private practice arrangements.

- Adult: four service users per week, total of 192 per year; and
- Children: two service users per week, total of 96 per year.

The roles assumed to be required to establish and operate the gender-focused model of service were identified through the co-design process and desktop review. MBS revenue for the referral services in Option 1 has not been estimated as the scope of work focused on estimating the costs of establishing and operating the service model from the perspective of the ACT Government.

Recommendation 10 – Gender-focused model of service costings

Table 26 The cost estimates for the gender-focused model of service (recommendation 10)

	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32
[redacted]										

Source xxx: KPMG 2022.

Table 27 The cost estimates for the gender-focused model of service (recommendation 10) delivery options

	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32
[redacted]										

Source xxxi: KPMG 2022.

Recommendation 11 – Transgender and Intersex Service Provision

Funding for this recommendation was allocated in the 2022-2023 ACT Government Budget regarding Intersex service provision. The estimated cost for implementation support for this recommendation has been included within the cost for the LGBTIQ+ Implementation Team.

> *Recommendation 11: Build upon existing clinical services to improve accessibility and provide a holistic health service provision for transgender and intersex people and in particular children, adolescents, and young people.*

Funding for the transgender service provision will be determined in the first couple of years of implementation and be subject to a future ACT Government Budget.

There will be a level of effort required to support the CHS with the implementation of this recommendation. The support from the ACTHD will be provided as part of the LGBTIQ+ Implementation Team.

Recommendation 12 – ACT public health services communication and websites

The estimated cost for the implementation of this recommendation has been included within the cost estimate for the LGBTIQ+ Implementation Team (see *The LGBTIQ+ Implementation Team*).

> *Recommendation 12: Reflect LGBTIQ+ people in government advertisements and communications and ensure that websites, communication materials and resources are contemporary, consistent and meet the needs of the LGBTIQ+ community.*

The estimated cost for the implementation of this recommendation includes the development and update of content, communications and websites. It has been assumed that the LGBTIQ+ Implementation Team will develop and update the materials for this recommendation.

Recommendation 13 – Consumer-facing trans pathway

The estimated cost for the implementation of this recommendation has been included within the cost estimate for the LGBTIQ+ Implementation Team (see *The LGBTIQ+ Implementation Team*).

> *Recommendation 13: Explore options for a consumer-facing online pathway for transgender health care in order to support the people who wish to undertake gender transition to navigate the complexities. Support the development of the pathway in collaboration with LGBTIQ+/TGD-specific NGOs and the Capital Health Network.*

The estimated cost for the implementation of this recommendation includes conducting an options analysis to understand the scope and content for the online pathway. This was highlighted as an essential service throughout the co-design process of the gender-focused model of service. One example of an option is working with ACON to understand the national expansion of TransHub and how it may be leveraged to enable an online resource to describe and communicate the health and wellbeing services available to the trans and gender diverse community in the ACT.

It may be that when the options analysis is undertaken with community partners and ACON, the ACON online pathway and website is all that is required. Future cost estimates will be developed in the event that are gaps are identified. It has been assumed that the LGBTIQ+ Implementation Team will conduct the options analysis and exploratory activities required for this recommendation.

Recommendation 14 – Mental Health Support

The estimated cost for the implementation of this recommendation has been included within the cost estimate for the LGBTIQ+ Implementation Team (see *The LGBTIQ+ Implementation Team*).

> *Recommendation 14: Compile best practice research and methodology on peer-led counselling and mental health service provisions for intersex, transgender and gender-diverse identifying people, with a particular focus on minors and their families. This work will be used to inform recommendation 10 and also the current work being undertaken to create Guidelines for gender-affirming care for mental health care practitioners by the Office of Mental Health and Wellbeing.*

The Office for Mental Health and Wellbeing has completed the development of the guidelines for gender-affirming care for mental health care practitioners. This work will be leveraged to compile best practice research and methodology on peer-led counselling and mental health service provision. This work has been assumed to be delivered over an 18-month period.

Recommendation 15 – Telehealth enabled BBV/HIV testing

The estimated cost for the implementation of this recommendation has been included within the cost estimate for the LGBTIQ+ Implementation Team (see *The LGBTIQ+ Implementation Team*).

> *Recommendation 15: Review the availability of STI/BBV testing and potential alternative methods of testing, treatment and awareness, including the potential for telehealth and dried blood spot testing with the aim to reduce transport, cost and stigma barriers associated with attending in-person testing.*

The estimated cost for the implementation of this recommendation includes the review of options for alternate methods of testing for STIs and BBV. This will be achieved through the delivery of a research project to understand alternate models of testing for STIs and BBV. An assumption has been made that delivery of this project will be over 18 months and be conducted by the LGBTIQ+ Implementation Team. The Scoping Study explicitly mentions a potential role for telehealth and dried blood spot testing within the ACT. The LGBTIQ+ Implementation Team will confirm the type of workforce required to fill this role as part of the research project.

Recommendation 16 – Recognition and support for LGBTIQ+ people experiencing family and domestic violence

The estimated cost for the implementation of this recommendation has been included within the cost estimate for the LGBTIQ+ Implementation Team (see *The LGBTIQ+ Implementation Team*).

> *Recommendation 16: Expand the accessibility of clinical and support services for LGBTIQ+ people by ensuring family and domestic violence services are LGBTIQ+ inclusive, in particular promoting an understanding of the needs of lesbian, gay and bisexual identifying people and providing a welcoming environment for all genders.*

The estimated cost for the implementation of this recommendation includes the expansion of existing training for Police, legal representatives and individuals who work in the family and domestic violence space to increase LGBTIQ+ awareness. The Australia National Research Organisation of Women's Safety report suggests that LGBTIQ+ people need to be visible in family and domestic violence awareness campaigns and that most people would identify support services through their social networks.

This recommendation will involve the LGBTIQ+ Implementation Team working with Office of the Coordinator-General for Family Safety (OCGFS) to provide content and support the expansion of existing training for LGBTIQ+ inclusive material.

Recommendation 17 – Disability and LGBTIQ+

The estimated cost for the implementation of this recommendation has been included within the cost estimate for the LGBTIQ+ Implementation Team (see *The LGBTIQ+ Implementation Team*).

> *Recommendation 17: Develop a coordinated response to better identify the needs and supports for LGBTIQ+ people living with disability, including through the development of the ACT Government Disability Health Strategy and other relevant ACT Government strategies.*

The ACT Government is currently developing a Disability Health Strategy. It is assumed that the Disability Health Strategy would be leveraged to identify and support the needs of LGBTIQ+ people living with a disability. The outputs developed as part of this recommendation will be shared on the online information platform developed alongside recommendation 13. The workforce required to identify online resources and other supports for people in the LGBTIQ+ community living with a disability is assumed to be the LGBTIQ+ Implementation Team and the team leading the development of the Disability Health Strategy.

Recommendation 18 – Support for local Primary Care Providers (including GPs)

The estimated cost for the implementation of this recommendation has been included within the cost estimate for the LGBTIQ+ Implementation Team (see *The LGBTIQ+ Implementation Team*).

> *Recommendation 18: Explore opportunities with the Commonwealth Government and Capital Health Network that can assist Primary Care Providers in the ACT to provide services to their LGBTIQ+ clients that are timely, evidence based, and tailored to individual needs.*

The estimated cost for the implementation of this recommendation includes consulting with the Australian Government and CHN to identify options for assisting primary care providers in the ACT to provide evidence-based and tailored services to the LGBTIQ+ community. It has been assumed that the LGBTIQ+ Implementation Team will perform the consultation activities for this recommendation. The responsibility of this team will be to influence and advise only. It is assumed that the CHN will resource the needs assessment to understand the

capability uplift opportunities for local primary care providers to deliver timely and tailored health care to LGBTIQ+ service users. A range of training costs to support medical students have been accounted for in recommendation 1 and will support the implementation of this recommendation.

Recommendation 19 – Gender Affirmations Surgeries and Procedures.

The estimated cost for the implementation of this recommendation has been included within the cost estimate for the LGBTIQ+ Implementation Team (see *The LGBTIQ+ Implementation Team*).

> *Recommendation 19: Identify and advocate for the removal of barriers to gender affirmation surgeries and procedures in the ACT due to Commonwealth funding and regulatory arrangements.*

The implementation of this recommendation includes a range of advocacy activities for the removal of barriers for gender-affirming surgery. This will also involve advocating for changes on behalf of, and in conjunction with, the LGBTIQ+ community.

It has been assumed that the LGBTIQ+ Implementation Team will conduct the advocacy activities for this recommendation

Recommendation 20 – Data Collection

The estimated cost for the implementation of this recommendation has been included within the cost estimate for the LGBTIQ+ Implementation Team (see *The LGBTIQ+ Implementation Team*).

> *Recommendation 20: Review the data collection methodologies and frameworks for LGBTIQ+ people at a clinical level, to explore options for recording numbers and care needs of LGBTIQ+ community members, including data that will allow identification of intersectional needs.*

The estimated cost of the implementation of this recommendation includes the review of current data collection methodologies and frameworks for LGBTIQ+ people at a clinical level. It will also involve identification of data quality strategies and data collection methods to better understand the needs of LGBTIQ+ people. It has been assumed that this recommendation will be implemented by the ACTHD Digital Solutions Division leading the Digital Health Record, the Data Analytics Branch, and the LGBTIQ+ Implementation Team.

It is understood that the ACTHD has liaised with the ABS around statistical data collection and will continue engagement to improve the integrity of data collected about the LGBTIQ+ population in the ACT in order to build the evidence base of 'what works well' in safe and inclusive health care. The costs for this recommendation will be absorbed by the LGBTIQ+ Implementation Team.

Recommendation 21 – Deferable Medical Intervention for Intersex People

This recommendation has not been costed as part of this report. This work is underway and has been funded through the 2022-2023 ACT Government Budget.

> *Recommendation 21: Deferable Medical Intervention for Intersex People: The health experiences of intersex people fall short of reasonable expectations. Further action on deferable medical intervention for intersex people should be a priority and guided by work currently underway in the ACT Government, led by The Chief Minister, Treasury and Economic Development Directorate (CMTEDD).*

Recommendation 22 – Ageing and Palliative Care

The estimated cost for the implementation of this recommendation has been included within the cost estimate for the LGBTIQ+ Implementation Team (see *The LGBTIQ+ Implementation Team*).

> *Recommendation 22: Incorporate the health needs of older LGBTIQ+ people in current and future Territory-wide Health Services Plan activities. The ACTHD to engage in and support work being undertaken by the CHS around end of life and palliative care planning for LGBTIQ+ people.*

The implementation of this recommendation includes two key activities:

- liaising with the Health Service Planning Division to identify opportunities to incorporate the health needs of older LGBTIQ+ individuals for the ACT Health Services Plan 2022-2030; and
- liaising with the relevant policy area of the ACTHD and with the CHS regarding end of life and palliative care planning for LGBTIQ+ people.

These activities will be performed by the LGBTIQ+ Implementation Team.

Recommendation 23 – LGBTIQ+ Health Engagement

The estimated total cost for the implementation of this recommendation is [redacted] over five years.

> *Recommendation 23: Continue to consult and engage with the LGBTIQ+ sector, members of the community and service providers on health matters.*

The estimated cost for implementing this recommendation includes the continued consultation and engagement with the LGBTIQ+ sector. It is assumed that two governance groups will inform policy development for LGBTIQ+ friendly health care in the ACT. These groups include: the Service User Reference Group (SURG) and the HRG. The SURG and HRG will continue to provide advice and input on the provision of services to the LGBTIQ+ community and may provide assistance in the development and design of services and continuous improvement of initiatives. The cost estimates will involve the continued investment into the SURG as well as the re-establishment of the HRG. The HRG was previously established to support the Scoping Study. The costs for reimbursement of the HRG members have been incorporated within the gender-focused model of service (recommendation 10) for a period of 10 years.

The estimated costs for this recommendation include the reimbursement of SURG members in accordance with the SURG remuneration rates[8]. It was assumed that the SURG will be required for one hour on a bi-annual basis to provide advice and input to support the implementation of the Scoping Study recommendations. A small provision for miscellaneous expenses has also been included, which may account for catering, counselling, transport and printing materials.

Table 28 The cost estimates for recommendation 23

Recommendation 23	2022/23	2023/24	2024/25	2025/26	2026/27
[redacted]					

Source xxxii: KPMG 2022.

Recommendation 24 – Action Plan

There is no estimated cost for the implementation of this recommendation.

> *Recommendation 24: Develop the specific actions to implement the recommendations of this report in consultation with stakeholders and community and set out in future Capital of Equality Action Plans.*

The endorsement of the Implementation and Costing Report (this document) represents the completion of this recommendation.

[8] **Meridian ACT, accessed 30 September 2022:** https://www.meridianact.org.au/

Appendix B: the gender-focused model of service

This appendix describes the approach for co-design and the components of the gender-focused model of service.

B.1 Approach for co-design with the LGBTIQ+ community

The purpose of the co-design approach was to develop a community-based, peer-led gender-focused model of service with input from a wide range of LGBTIQ+ stakeholders, public and private health care providers, and NGOs in the ACT.

The co-design process for the gender-focused model of service involved four components:

1. A series of targeted co-design workshops, structured around participant expertise and areas of input, including:
    - one workshop on gender-affirming health care with clinicians and organisations that provide gender-affirming health care and community services to trans and gender diverse people;
    - three workshops with trans and gender diverse service users and parents;
    - one workshop on accessible and inclusive services; and
    - one workshop on referral pathways.
2. Interviews and email correspondence with co-design participants to clarify comments or advice, as required.
3. A summary of the themes captured during the service user workshops played back to service user workshop participants to validate the perspectives and insights gathered.

One validation workshop open to all participants involved in the co-design process (excluding service users) to review and provide feedback on the insights and themes captured, as well as the draft gender-focused model of service.

B.2 Limitations and considerations

The limitations and considerations for the co-design of the gender-focused model of service have been provided below.

- There were challenges in engaging with particular stakeholder groups within the timeframes for the co-design workshops. This included various community organisations and health services due to the clinical obligations of staff and the impacts of COVID-19 on the ACT public health system. The ideas and suggestions from the co-design workshops were tested in a Validation Workshop and during one-on-one consultations with stakeholders who work with the trans and gender diverse community and were unable to attend workshops.
- There is no comprehensive dataset to describe detailed health need of trans and gender diverse people (e.g. the number of people exploring and/or awaiting hormone therapy in different age cohorts, or the number of people in need of gender-affirming mental health services). The data collected by Meridian and AGA was used to understand the current demand and wait for services offered by these organisations to the trans and gender diverse community in the ACT. The co-design process also involved testing assumptions about the volume and type of workforce needed to better meet the estimated unmet demand for gender-affirming health and support services. Further data may be required from other service providers, such as the CHS, to inform the implementation of the gender-focused model of service. Beyond the establishment of the gender-focused model of service, it is recommended that data be captured about the type and volume of services delivered and that a periodic needs assessment be undertaken. This will inform the monitoring and evaluation of the gender-focused model of service and support planned changes to meet any growth in the demand for services.

B.3 Components of the gender-focused model of service

The table below describes the components of the gender-focused model of service.

Table 29 Descriptions of the components of the gender-focused model of service

Component	Description
Overarching characteristics and enablers	During the co-design process, a number of characteristics and enablers were identified to support inclusiveness and accessibility.
People and workforce	The gender-focused model of service would require a multidisciplinary clinical and non-clinical workforce complement.
Operating model	The proposed operating model is a hub and network model which is described in more detail overleaf.
Infrastructure	Service users and service providers identified a number of considerations for improving the accessibility and inclusivity of infrastructure for the gender-focused model of service.
Types of service	The types of services that were identified for the hub and network sites included gender-focused primary health care, sexual health care and peer support.
Quality of service	Compliance with existing clinical accreditation and practice standards will be required to maintain a quality standard of service.
Service Users and triage criteria	A number of target cohorts were identified for the gender-focused model of service. These cohorts of service users are considered to have current unmet needs for inclusive health care.
Information and technology	To support effective and coordinated support of service users in the trans and gender diverse community, there will need to be an information exchange between the gender-focused model of service and other providers that service users access (e.g. private GP, disability support service).
Governance	An approach to collaborative governance was identified to enable a community-based, gender-focused model of service. It is anticipated that existing clinical governance arrangements could be leveraged.

Source xxxiii: KPMG 2022.

B.4 Overarching characteristics and enablers

B.4.1 Key characteristics

The gender-focused model of service will:

- Be peer-led.
- Be community-led and community-based and include referral pathways to the public health system and to private specialists.
- Be gender-affirming and take an intersectional, whole-of- person approach.
- Be physically and geographically accessible, as well as psychologically and culturally safe, including for young trans and gender diverse individuals, Aboriginal and Torres Strait Islander people, and culturally and linguistically diverse people.
- Prioritise timeliness of intervention, ensuring that this informs all components.
- Use an Informed Consent Model for hormone therapy to ensure person-centred care that is accessible and psychologically safe.
- Be sustainable and able to withstand and evolve in line with changes in a dynamic environment.

B.4.2 Key enablers

The model will:

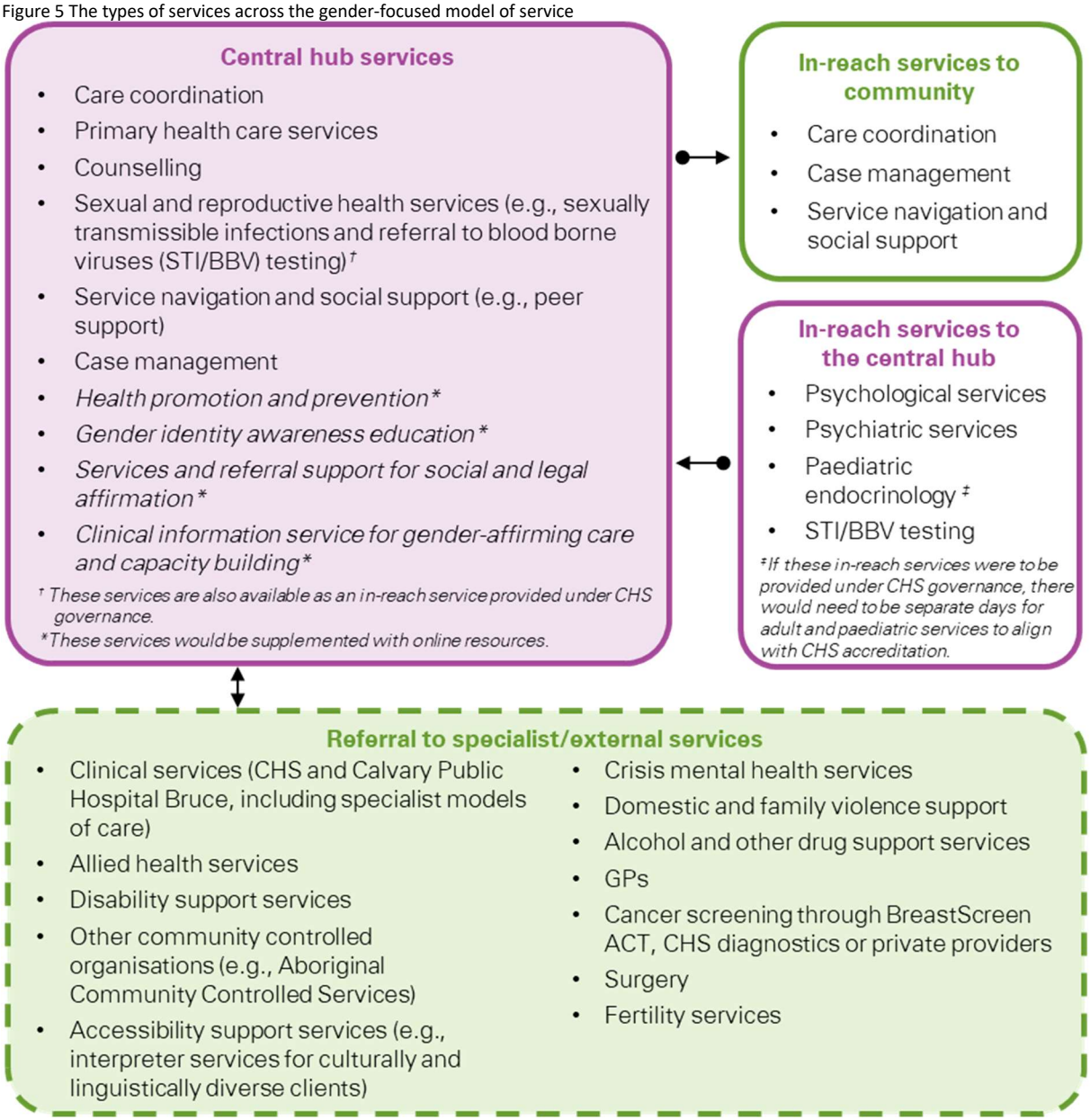
- Incorporate workforce and service planning. This will include analysing, forecasting and planning workforce and service supply and demand to ensure a pipeline of appropriately-skilled health care providers for the delivery of sustainable, scalable, and quality gender-affirming care.
- Incorporate learning and development. The model will include an online portal of information for service users and clinicians, as well as initiatives to build the capability of service providers.
- Include measures and indicators that will be monitored to understand the extent to which the gender-focused model of service is safe, effective, efficient and appropriate to meet the needs of trans and gender diverse people.
- Support strong referral pathways that allow warm referral. These pathways will leverage relevant information and communication technology across services to minimise the requirement for service users to re-tell their story.
- Enable service user data and information sharing through robust, gender-affirming online platforms: the online information platform, knowledge management system and clinical information system.

B.5 Operating model and types of service

The gender-focused model of service provides clinical and non-clinical support services for trans and gender diverse individuals at all points of their journey. It has been designed to include a multidisciplinary approach to hormone initiation and therapy for young people[9]. The service offering of the gender-focused model will be delivered through:

- a community-based central hub offering psychosocial support, clinical health services, and services that enable service users to navigate and access services;
- in-reach services to community health care centres and in-reach services to the central hub; and
- referral to specialist services.

Figure 5 The types of services across the gender-focused model of service



Source xxxiv: KPMG 2022

[9] This is based on the Australian Standards of Care and Treatment Guidelines for trans and gender diverse children and adolescents. Accessible at: australian-standards-of-care-and-treatment-guidelines-for-trans-and-gender-diverse-children-and- adolescents.pdf.

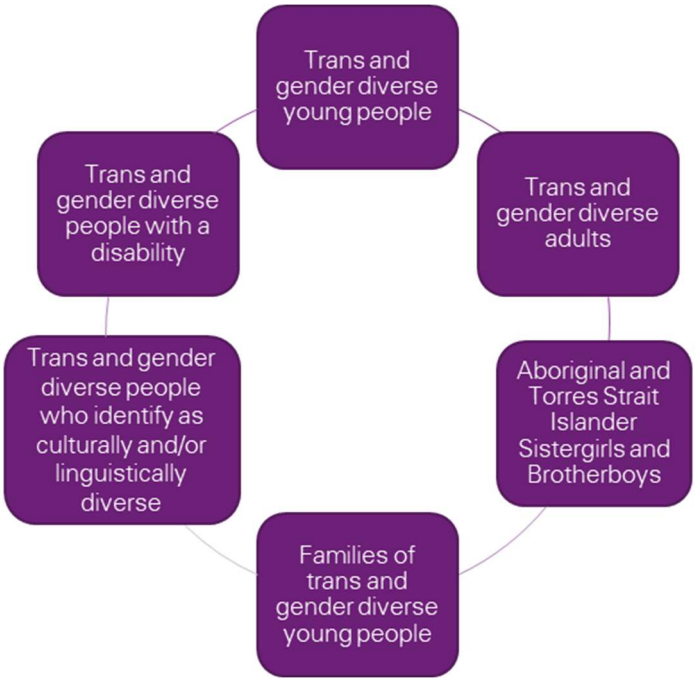
B.6 Service users and triage criteria

B.6.1 Service Users

The gender-focused model of service is also designed to be accessed by those who do not identify as trans or gender diverse themselves but may be seeking information in order to better support those people in their lives who are trans or gender diverse. For example, parents, carers, and guardians of trans or gender diverse young people may wish to access the gender-focused model of service for information or education services. All services are designed to allow trans and gender diverse service users to be accompanied by their carers, support people, or parents and guardians, if they choose.

During the co-design process, the participants identified a number of service user cohorts that should be targeted as part of promoting access to the gender-focused model of service. These service user cohorts are described in Figure 6. It is important to note that they are not mutually exclusive, but that there is significant overlap in trans and gender diverse people who identify with these communities.

Figure 6 The service user cohorts



Source xxxv: KPMG 2022.

The various needs of these cohorts have been considered in all components of the gender-focused model of service. As an example, the central hub will include family and paediatric days for the delivery of services to trans and gender diverse young people to enable easier and safer access for this cohort. This will need to adhere to accreditation standards for service providers (as described in B.10 Quality of service). The key elements to support the accessibility of service user cohorts have been provided in B.9 Infrastructure.

B.6.2 Demand for services

There is comprehensive data collected by service providers to describe the diversity and demography of trans and gender diverse people currently accessing services in the ACT. Data is also collected relating to wait times for particular services (see Table 30). This information has been an important input to the development of the gender-focused model of service.

There is, however, no consistently collected data to describe the volume and type of unmet need for gender-affirming health care in the ACT.

Participants in the co-design process for the gender-focused model of service indicated there is a high level of unmet demand for inclusive health care services, and specifically health care for trans and gender diverse people. This is due to a shortage of health care providers who have experience in delivering gender-affirming health care in the ACT. Participants also noted that this leads to extensive wait times for some services.

Table 30 Current wait times by types of service

Service[1]	Current wait times
Psychological services	6 weeks
Counselling	2 - 3 weeks
Peer navigation	Nil
Sexual health services	4 – 12 weeks[2]
Paediatric Endocrinology	6 – 12+ months[2]

Source xxxvi: Adapted from confidential documentation from Meridian and the AGA Scoping Report. 2021.

[1] The data on wait times and waitlists for the above services have been provided by Meridian and AGA. Other services to be included in the model may also experience long wait times, however this data was unable to be sourced.

[2]These wait times are for all cohorts seeking these services; appointments for trans and gender diverse people at these services are captured within the general workload, so it is not possible to identify the wait times specifically for trans and gender diverse people.

The wait times shown in Table 30 and the qualitative feedback from participants in the co-design process signal the importance of implementing the other recommendations in the Scoping Study in parallel to establishing the gender-focused model of service. It is critical that there is capacity development among new and existing clinicians in how to deliver gender-affirming health care (refer to recommendations 1 and 2), as well as greater access to gender-focused health services.

It will also be important for the gender-focused model of service to monitor the ongoing health needs and demand for services among the trans and gender diverse community. This will be enabled through ongoing data collection and periodic needs assessments to inform service delivery. Further detail on the process for data capture and periodic needs assessment has been outlined in B.11 Information and technology.

B.6.3 Entry options for service users

The gender-focused model of service will be accessible to service users through a range of entry pathways. This may include, but is not limited to, self-referral from the online pathway or supporting website, referral from another provider, referral from a clinician or physical drop-in.

B.6.4 Triage criteria

During the co-design process, some community-based service providers indicated that consideration would need to be given to how to prioritise service users if the demand for the gender-focused model of service exceeded the supply of services. As part of the co-design process, triage criteria were developed to describe priority cohorts.

Trans and gender diverse people who are in circumstances that align with the following criteria should be prioritised for access to the gender-focused model of service:

- people at the start of their journey;
- people with complex needs10 or chronic health conditions, requiring multiple services;
- people with time-sensitive needs (e.g. young people seeking puberty blockers, older trans and gender diverse individuals);
- people who face other risk factors, such as having no social support, employment, family support, community connection or those experiencing homelessness;
- people who are unable to access alternative services without assistance due to access barriers, such as service users with disabilities;
- people in crises, such as people experiencing domestic violence or moderate to acute mental health illnesses; and/or
- people with low income, where it is possible to be assessed.

The triage criteria will support a formalised process for identifying the service users most in need of care and ensuring they can access gender-affirming health care in a timely way.

B.6.5 Application of the triage criteria

A holistic approach will be used to apply the triage criteria in order to avoid barriers to access and give regard to the unique circumstances of each service user. For example, some members of the trans and gender diverse community may have family members with the financial means to pay for private health care. However, if these family members are unsupportive of gender-affirming health care, the service user may not be able to access these finances and pay for private services. This would mean that the service user should still be considered for priority access to the gender-focused model of service.

Participants in the co-design process signalled the need for:

- a clinical and psychosocial lens in applying the criteria (e.g. having the criteria applied by a nurse and/or social worker during initial consultation with the service);
- a consistent and agreed approach to assessing service users with these criteria, as part of the implementation of the gender-focused model of service; and
- a higher emphasis on individuals at the start of their gender-affirming journey as many service users may satisfy at least one of the triage criteria.

[10] a person with 'complex needs' is someone with two or more needs affecting their physical, mental, social or financial wellbeing.

B.6.6 Case management

The triage of service users will be undertaken by a clinical care coordinator. The triage will be followed by an initial needs assessment by a case manager and the development of a support plan. Service users who are in circumstances that align with two or more of the triage criteria will be offered ongoing case management. The case manager will work with these eligible service users to develop a support plan for their service needs. Further information on the workforce roles is available at B.8 People and workforce.

Participants in the co-design noted the importance of ensuring that a peer is the first touch point within the gender-focused model of service and that this connection between peer and service user is maintained. An option for future sustainability of the model is to upskill peer roles to triage service users based on agreed criteria. Whilst the responsibility of formal and clinical triaging will remain with the clinical care coordinator, peers may support the clinical care coordinator with an initial needs assessment to maintain connection with the service user.

B.7 Governance

B.7.1 Guiding governance principles

The guiding principles for implementing the governance of the gender-focused model of service include:

- The gender-focused model of service must be peer-led, inclusive and evidence-based.
- The service delivery and monitoring and evaluation of the gender-focused model of service must be asset-based and strengths-focused.
- The service delivery and decision-making for the gender-focused model of service must take care to do no harm.
- The service delivery and decision-making for the gender-focused model of service must commit to the valuing of local expertise and relationships.

Based on these guiding principles, the governance structure within the gender-focused model of service will:

- Include a procurement approach that is outcomes-focused. The procurement process may involve a mix of competitive tender and single-select procurement strategies and will incorporate outcomes-based performance measures.
- Be a requirement for the delivery of clinical services. It is anticipated that the existing clinical governance arrangements will be leveraged by public and private providers delivering services. This means that each service provider engaged to deliver services must have their own clinical governance framework. This must also include certificates of currency, such as indemnity insurance and liability insurance.
- Enable a community-based and peer-led model. Collaborative governance will bring multiple stakeholders together as partners to participate in facilitated discussion and consensus-oriented decision-making.
- Contain a monitoring and evaluation component which will be the collective responsibility of service providers. The monitoring and evaluation will include measures and indicators that support an understanding of the safety, effectiveness and efficiency of the gender-focused model of service. This will form the baseline for ongoing research around 'what works well' (see B.14 Monitoring and evaluation).
- Be a periodic needs assessment to inform funding, service planning and decisions about which services may be added (or removed). The needs assessment will consider population health and wellbeing needs and the qualitative and quantitative data collected for monitoring and evaluation, including input from service users (e.g. Service User Reference Group (SURG)). This approach will ensure that any services not currently in-scope are considered for future inclusion, and decisions about the scope of services are informed by evidence.
- Utilise an Informed Consent Model to underpin the delivery of gender-affirming care, specifically the initiation and management of hormones for those under the age of consent.

B.7.2 Health Reference Group (HRG)

The HRG was initially established to support the development of the Scoping Study. In the context of the gender-focused model of service, the HRG's primary role would be to provide advice to the LGBTIQ+ Implementation Team and, where required, to the preferred provider on the establishment, ongoing operation and evaluation of the service.[11] It is recommended that the HRG have representation from a range of groups implementing the gender-focused model of service. This may include clinicians, government commissioners, service providers, peers and service users, via the SURG. A Chair will be appointed from the ACTHD. A diverse membership will ensure the views of community members and people with lived experience will be given high regard when facilitating consensus among clinical and non-clinical stakeholders.

The example Terms of Reference for the HRG include:

- Each member of the HRG will represent a cohort that is implementing and delivering the gender-focused model of service (e.g. clinicians).
- The membership will be determined based on the stakeholder organisations submitting an expression of interest to the Chair and putting forward their preferred delegate. Where there is disagreement on the preferred delegate, the successful delegate must be voted in by the stakeholders within the relevant organisation.

[11] This process is similar to existing models of care. For example, Townsville Health Service receives feedback from First Nations peoples through their First Nations Advisory Group, to then be reported to the Board via an advisory note.

- The delegate must have sufficient time to be able to commit to one-hour-long monthly meetings, particularly in the first 300 days of establishing the gender-focused model of service.
- The delegate must have sufficient seniority to make governance decisions about the gender-focused model of service within the monthly meetings.
- The delegate will be informed of any specific roles and duties upon their appointment to the HRG.
- The delegate will receive remuneration to compensate for their time (one hour monthly meetings) if their primary role is not situated within the ACTHD or any public health care structures within the ACT and if they are non-salaried workers. For example, peers would be eligible for compensation, while a public health physician under the employment of the CHS would not.
- The HRG will ensure there are at least two peers at any one time in the group. This is to ensure that no one peer is representing the community by themselves and to enable the HRG to reflect the diversity of the trans and gender diverse community.
- The HRG will establish mechanisms by which the ACTHD and any public health provider can escalate issues or points of discussion with the HRG. For items to be resolved, it will be raised in the meeting and not delayed. Where there may be a significant list of items, out of session meetings may be required. Discussion items may include change of service provider, change of scope, dismissal of a clinician for not aligning with the principles of the model, etc.

B.7.3 Informed Consent Model

The Informed Consent Model is currently used in similar models of care (e.g. Equinox Gender Diverse Health Centre) and supports greater accessibility, clinical and psychological safety for service users accessing services. The Informed Consent Model will underpin delivery of gender-affirming care for the gender-focused model of service.

The gender-focused model of service will align with the Australian Informed Consent Standards of Care for Gender Affirming Hormone Therapy.[12] This document includes the guidelines and templates for clinicians to follow in using the Informed Consent Model when commencing and managing gender- affirming hormone therapy for their patients. This process may be completed in one or two appointments, or may require more, depending on patient needs and clinician confidence. Other mechanisms to best offer support and information as part of the gender-focused model of service include:

- resources, such as infographics and videos, with information pertaining to accessing hormone therapy in plain English for service users;
- education and resources for clinicians, such as GPs, about how the Informed Consent Model works and how they can improve access to hormone therapy for their service users; and
- training of clinical roles, such as GPs, to provide hormone therapy.

The legal/consent requirements for young people under the age of 18 within the Informed Consent Model must be considered. Current law requires a young person's clinicians to ascertain whether or not the parents or legal guardians consent to the proposed treatment before a young person can access either pubertal suppression or hormone treatment. Where there is no dispute from parents, the young person or the medical practitioner, the clinician may proceed on the basis of:

- the young person's consent, where competent to consent; or
- parental consent, where the young person is not competent to consent.

Where there is a dispute as to either competence, diagnosis or treatment, court authorisation prior to commencement of treatment is required.[13]

B.7.4 Support for children and young people without parental consent

In the event that a child or young person who identifies as trans or gender diverse has limited family or parental support or is in out-of-home care, there may be challenges associated with seeking parental consent,

[12] Australian Standards of Care and Treatment Guidelines for trans and gender diverse children and adolescents. The Royal Children's Hospital Melbourne. Accessible at: https://www.rch.org.au/uploadedFiles/Main/Content/adolescent-medicine/australian- standards-of-care-and-treatment-guidelines-for-trans-and-gender-diverse-children-and-adolescents.pdf

[13] Australian Informed Consent Standards of Care for Gender-affirming Hormone Therapy. AusPath. Accessible at: https://auspath.org.au/wp-content/uploads/2022/05/AusPATH_Informed-Consent-Guidelines_DIGITAL.pdf

particularly if the child or young person is seeking to medically transition (i.e. an initiation of puberty blockers or hormone therapy). Here, consent may be provided by:

- a guardian, where the guardian is available within the state of care;
- options via the ACT Civil and Administrative Tribunal; and
- alternative options accessed through Legal Aid ACT Youth Law Centre or similar organisations, such as LawMail that provide free legal services for young people aged 12 to 25 years.

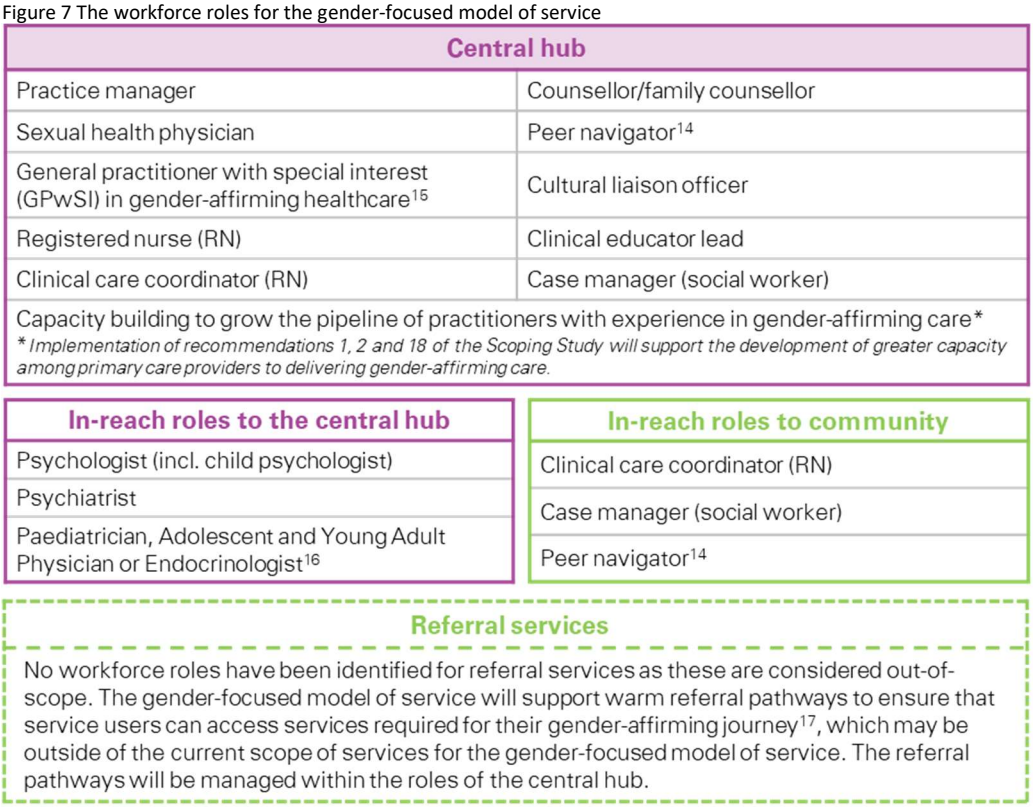
The peer support services available through the model of service will be critical to supporting young people who identify as trans or gender diverse to access the legal services or support they may need. Peer support is also critical for helping the young person to identify and develop a network of support while they wait for legal consent or to 'age-in' to being independent and able to legally consent on their own behalf.

B.8 People and workforce

B.8.1 Workforce roles in the model

A description of the type of workforce roles required to deliver the services have been described in the figure below.

Figure 7 The workforce roles for the gender-focused model of service



Source xxxvii: KPMG 2022.

[14] Peer navigators would be included as identified roles to reflect the intersectionality of the trans and gender diverse community.

[15]The GPwSI will build capability of local GPs through referring service users back to their usual community GP once they have received gender-affirming care or are comfortable to do so.

[16]Any paediatricians, adolescent and young adult physicians and endocrinologists engaged would be experienced in the care of trans and gender diverse adolescents and young adults. These roles are intended to align with the Australian Standards of Care and Treatment Guidelines for trans and gender diverse children and adolescents and will need to be adjusted once the new guidelines are published.

[17] The gender-focused model of service will ensure warm referrals are appropriately prioritised against other referrals one time within the service. The model will also ensure that ongoing support will be provided to service users by peer navigators and other similar roles throughout the warm referral process.

Table 31 Workforce roles and descriptions

Role	Proposed Definition
Practice manager	This role would perform the practice management tasks and act as a coordinator for all roles.
Sexual health physician	This role would be responsible for providing sexual health services, screening and education. This role would support service users with hormone therapy, administration and management, including Pharmaceutical Benefits Scheme subsidised testosterone.
GPwSI in gender-affirming care	This role would be responsible for providing gender-affirming primary care services, assessment, screening and education, as well as mental health care plans and supporting capability building of GPs. Capability uplift to community GPs will be achieved through referring service users back to their community GP once gender-affirming care has been provided or the service user is comfortable to do so. This ensures that community GPs will have increased exposure to service users who require gender-affirming care and greater understanding of available referral pathways for services.
Registered nurse (RN)	This role would assess medical, psychosocial and cultural needs, administer hormones and medication, contribute to care plans, and collaborate with specialists, where required. This role would also provide education to enable service users to make informed decisions regarding treatment and provide referrals to community-based groups and organisations. The RN will support the sexual health physician and GPwSI in gender-affirming care.
Clinical care coordinator	This role would triage service users following a needs assessment with the case manager. This role would work with service users to coordinate a multidisciplinary clinical care plan based on the service user's needs for medical transition, and direct patients to appropriate services in a timely manner.
Case manager (social worker)	This role would undertake a preliminary needs assessment with the service user (and their parent, carer, guardian or advocate). This role would develop a support plan for accessing services that service users with complex needs may require (e.g. referral to relevant employment and housing services) and to enable social and legal transition.
Counsellor	This role would provide individual and family counselling for service users exploring gender identity or transition.
Peer navigator[18]	This role would support trans or gender diverse people looking for information about social, legal and medical transition and available services. The peer navigator will also provide peer support to people accessing the service. This may be in peer support sessions or supporting service users to attend their appointments. The peer navigator would also identify where there is a need for interpreter services.
Cultural liaison officer[19]	This role would be responsible for facilitating safe and culturally appropriate interaction with the central hub. Whilst this is one role, there could be multiple cultural liaison staff to support service access for trans and gender diverse people from a range of cultures. The cultural liaison position would not replace the need to have identified positions in the peer navigator role for priority population groups (e.g. Sistergirls and Brotherboys). The cultural liaison officer would also identify where there is a need for interpreter services.

[18] Peer navigators and cultural liaison officers would be included as identified roles to reflect the intersectionality of the trans and gender diverse community.

[19] Ibid.

Clinical educator lead	This role would provide materials, resources and training for capacity building to grow the pipeline of GPs and RNs with experience in gender-affirming care.

Source xxxviii: KPMG 2022.

B.8.2 A peer-led model

A key characteristic of the model is that it will be peer-led. In this way, the role of the peer plays a critical part in the gender-focused model of service. The key considerations for a peer-led, gender-focused model of service include:

- a service user's first interaction with the model will be someone with lived experience (i.e. a peer);
- staff who identify as trans and gender diverse should be prioritised in all roles within the gender-focused model of service, where possible, noting that there may be challenges in recruiting trans and gender diverse staff, especially for clinical roles; and
- resourcing for roles, particularly for peers, must reflect the intersectionality of the trans and gender diverse community, where possible. This is critical to support individuals from the key service groups not only access the gender-focused model of service but to feel comfortable and safe whilst doing so.

B.8.3 The scope of practice for peers

The identification of core competencies and scope of practice for the workforce is essential in creating a consistent framework for the role of a peer. This framework should:

- establish the definition of peer workers;
- establish the scope of practice for the role of a peer. This may include (but is not limited to) peer support, advocacy and representation; and
- identify and define support mechanisms for peer workers.

B.8.4 Supporting individuals who identify as a Sistergirl or Brotherboy

During engagement with Aboriginal and Torres Strait Islander Sistergirls and Brotherboys, the following key themes were identified:

- the model must provide group and/or mob support that enables Sistergirls and Brotherboys to be brought together and connect in a safe space; and
- the model must support Sistergirls and Brotherboys to access services. Sistergirls and Brotherboys may face challenges attending booked appointments as they may clash with meeting family or cultural needs.

Based on these themes, the following activities have been incorporated as part of the peer and cultural liaison officer roles:

- The delivery of group and/or mob support sessions at the central hub and northside and southside community centre in-reach locations. This would be a total of three group support sessions across the model at the same time each week to facilitate a culturally safe entry point and environment for Sistergirls and Brotherboys seeking 0to access services. This will be coordinated by the cultural liaison officer and a relevant peer.
- Support for Sistergirls and Brotherboys to access services on a walk-in basis. For example, in the instance there was a late cancellation, the cultural liaison officer and/or relevant peer may be able to provide advice on individuals in urgent need of care who can be available for the appointment. This approach provides flexibility for those individuals who are unable to commit to booked appointments due to family and community requirements. The peer and cultural liaison officer must have strong community connections to identify relevant individuals and manage the substitution of appointments.

It is recommended that the criteria and implementation of walk-in management be validated as part of implementation, noting that high demand for services may limit accessibility options and conflict with the application of the triage criteria.

B.8.5 Example of a clinic plan template

Within the central hub, the workforce roles will range from part time to full time. This will

be dependent on the service need. A high-level example of a clinic plan template for the central hub, in-reach support services to the community and in-reach specialist services to the central hub is summarised in the table below.

This is an example only and there may be additional workforce roles considered within the rotation of specialist services (i.e. psychologist and psychiatrist). The estimated FTE for the workforce roles was developed based on submission documents provided by Meridian and AGA. The proposed clinical FTE aligns with workforce data provided by the CHS.

The FTE of the workforce roles will be further tested and validated during the implementation of the gender-focused model of service.

Table 32 Example clinic plan template

Delivery Model	Workforce Role	FTE	Clinic Plan
Central hub	Practice Manager	1	Full-time role
	Administration officer	1	Full-time role
	Sexual Health Physician	0.4	A sexual health physician and RN will deliver services for adults on Mondays and Tuesdays.
	Registered Nurse	0.4	
	General Practitioner	0.4	A GP will deliver services for adults on Wednesdays and Thursdays supported by a RN.
	Registered Nurse	0.4	
	Counsellor/family counsellor	1	A counsellor will be available for half a day on Wednesdays and Fridays to support individual and family/couple counselling services.
	Peer navigator	1	One full-time role. This may scale up? during implementation. The peer navigator will travel with the case manager and clinical care coordinator for one day as part of in-reach to community.
	Cultural liaison officer	1	Full-time role
Central hub and in-reach support services to the community	Case Manager	1	A case manager and clinical care coordinator will spend four days within the central hub and one day as part of in-reach to community. The approach to identify the locations will be established during implementation.
	Clinical Care Coordinator	1	
In-reach specialist services to the central hub	Paediatric endocrinologist	0.2	There will be a paediatric day on Fridays with family only appointments.
	Paediatrician	0.2	

Source xxxix: Adapted from the Meridian and AGA submissions and in consideration of the data available to describe the cohort and demand for services as of June 2022.

B.9 Infrastructure

B.9.1 Central hub

The core infrastructure for the gender-focused model of service is the physical central entry point (the central hub). The key infrastructure requirements for the central hub include the following:

- The central hub must be a safe, gender-affirming space, specifically for trans and gender diverse people. This includes having a neutral external façade in such a way that it maintains the privacy of service users, while also ensuring that the central hub is visually welcoming inside.
- The central hub will begin with two consultation rooms, to increase to four rooms or subject to demand over the 10 years of model implementation, for the delivery of psychosocial and support services as well as the delivery of in-reach specialist services. For the delivery of in-reach support services to the community, the gender-focused model of service must have access to a 'shop front' or community health hub that can provide up to two consultation rooms. These alternative rooms must provide geographic reach of the hubs and facilitate service users to access these services who may otherwise be unable to do so.
- The central hub must be in a location that considers transport for services. For example, it must be in close proximity to a hospital or community health hubs, be accessible by public transport, and must be located in a well-lit and safe area. The close proximity to hospital or health hubs facilitates greater access to referral or external services delivered outside of the central hub.
- The central hub must have enabling equipment and infrastructure to support the delivery of telehealth consultations.

B.9.2 Accessibility

To enable access for all service user cohorts (as discussed in Service users and triage criteria), the gender-focused model of service must ensure accessibility of:

- Facilities including:
    - Enabling access to all spaces and buildings for people with all access needs.
    - Having access to quiet, sensory-regulating rooms.
    - Offering service navigation and coordination in-reach services at community health care centres in a northside and southside location. Both locations must be accessible via public transport.
- Services including:
    - Offering a family and paediatric day for the delivery of services to trans and gender diverse children and young people to adhere to accreditation requirements. This also enables easier and safer access for this service cohort.
    - Providing translation and interpreting services. This will be achieved through the national free Translating and Interpreting Service (TIS), offering both over the telephone or in-person support. These services can be pre-booked by the health care provider. These services would also be supported by translated information sheets and online information.
    - Facilitating the engagement of support people, carers, and families within sessions, where requested by the service user.
    - Offering group and/or mob support sessions at the central hub and northside and southside community centre in-reach locations (as discussed in People and workforce).
    - Supporting trans and gender diverse service users to access services on a walk-in basis when needed. This will be open to all service users as needed, however it was identified in stakeholder consultations as being especially important for Sistergirls and Brotherboys who may require greater flexibility in receiving support (as discussed in People and workforce).
- Information including:
    - Supporting the distribution of information through community spaces accessed by people of all different backgrounds.
    - Supporting the provision of detailed information about the services, supports, and the facilities on the online platform, including information on how to access the service and what a service user can expect to experience once there. This online platform is further discussed in Information and Technology.

- Enabling inclusive and gender-affirming data collection (including having a service user-facing function so that service users can easily control and update their information). All forms and data collection processes in the gender-focused model of service are recommended to be screen-reader friendly and easily translatable.

B.10 Quality of service

To support the delivery of quality and effective services, the gender-focused model of service will align with the following standards:

Quality standards and accreditation for health services, including:

- the National Safety and Quality Health Service Standards;
- EQuIP6 Healthcare Support Services;
- Accreditation for General Practice;
- Royal Australasian College of Physicians accreditation for training of physicians and specialists;
- the National Standards for Mental Health Services; and
- RACGP Standards for general practices.

Accreditation standards for practitioners, including:

- Aboriginal and Torres Strait Islander Health Practice Board of Australia;
- Medical Board of Australia;
- Nursing and Midwifery Board of Australia; and
- any other relevant practitioner board overseen by the Australian Health Practitioner Regulation Agency.

Practice standards and relevant credentials for practitioners, including:

- Standards for General Practices (5th Edition);
- relevant Royal Australasian College of Physicians accreditations (for endocrinology as an example);
- nurse practitioner standards for practice;
- Australian Association of Social Workers Practice Standards; and
- national codes and standards relevant to psychiatry practice and mental health services in Australia and New Zealand.

To further support the delivery of quality and effective services, the gender-focused model of service will adhere to clinical guidelines developed for trans and gender diverse care. These include:

- Australian Standards of Care and Treatment Guidelines, for trans and gender diverse children and adolescents (AusPATH); and
- World Professional Association for Transgender Health (WPATH) Standards (the Standards of Care Version 7 – which have been endorsed for use in Australia by AusPATH).

B.11 Information and technology

The gender-focused model of service will consider the information and technology component in two parts:

1. the collection and use of information; and
2. online information platform/s to support both service users and clinicians.

B.11.1 The collection and use of information

- The gender-focused model of service will require information sharing in a safe and secure way, between medical services and community-based services. This will be enabled through the establishment of information sharing guidelines and memorandums of understanding or service agreements to support sharing information between public health providers, community-based service providers and private providers.
- The mechanisms through which information will be collected and used will be through a 'knowledge management system' and a 'clinical information system'.
    - The knowledge management system will be an internal system which stores all information pertaining to trans and gender diverse health or wellbeing care, including (but not limited to) transgender care pathways and treatment guidelines and reference materials for clinicians. The knowledge management system will be used to inform the public facing online information platform (refer overleaf).
    - The clinical information system will store and manage all service user related data and information. The privacy and security of this data and information is critical to protect the confidentiality of service users. The data capture for this system must be trans and gender diverse friendly (e.g. using gender-inclusive language (parent/guardian, etc.) and including non-binary genders) This may include employment of, or engagement with, liaison staff to facilitate communication between services.
- The gender-focused model of service will require a standardised referral form. This will ensure that the burden of information collection is minimised for people who are new to the gender-focused model of service. This will also ensure that the minimum standard of information is collected at intake and that service providers have sufficient information to make decisions about prioritising support services and care.
- Due to the relatively small population of trans and gender diverse individuals in the ACT, there is a risk that de-identified data may be able to be identifiable if captured at a detailed level. The gender-focused model of service will consider and use the minimum viable de-identified dataset for monitoring and evaluation purposes to mitigate this risk.
- The gender-focused model of service will require provisions to ensure the privacy and security of service users' information, both online and within the physical service. This will be a critical element to data collection of service users and the considerations of who and how this information is shared with other service providers. For example, not all clinical services require access to information relating to service users who have accessed gender-affirming care. It must be shared on either an as-needed basis or with consent from the service user.
- The gender-focused model of service will consider ways in which to leverage existing platforms and works-in-progress, such as TransHub or CHN's HealthPathways.

B.11.2 Online information platforms for service users and clinicians

The co-design process revealed the importance of an online platform for service users to:

- describe what it looks and feels like to access the central hub and face-to-face services;
- provide information about the types of details that service users will need to provide to access services; and
- describe the type of services available to trans and gender diverse people in the ACT, including health promotion and prevention, gender identity awareness education and services, and referral support for social and legal affirmation.

Service users emphasised the importance of having both online and face-to-face options for accessing resources and information about gender-affirming health care.

During engagement with Aboriginal and Torres Strait Islander Sistergirls and Brotherboys, it was noted that there is a high prevalence of social media usage within the community. This should be used as an opportunity for increasing the reach of the gender-focused model of service through culturally safe information-sharing avenues and storytelling, supported by the cultural liaison officer and peers.

The co-design process also indicated that an online platform would be helpful for clinicians to understand:

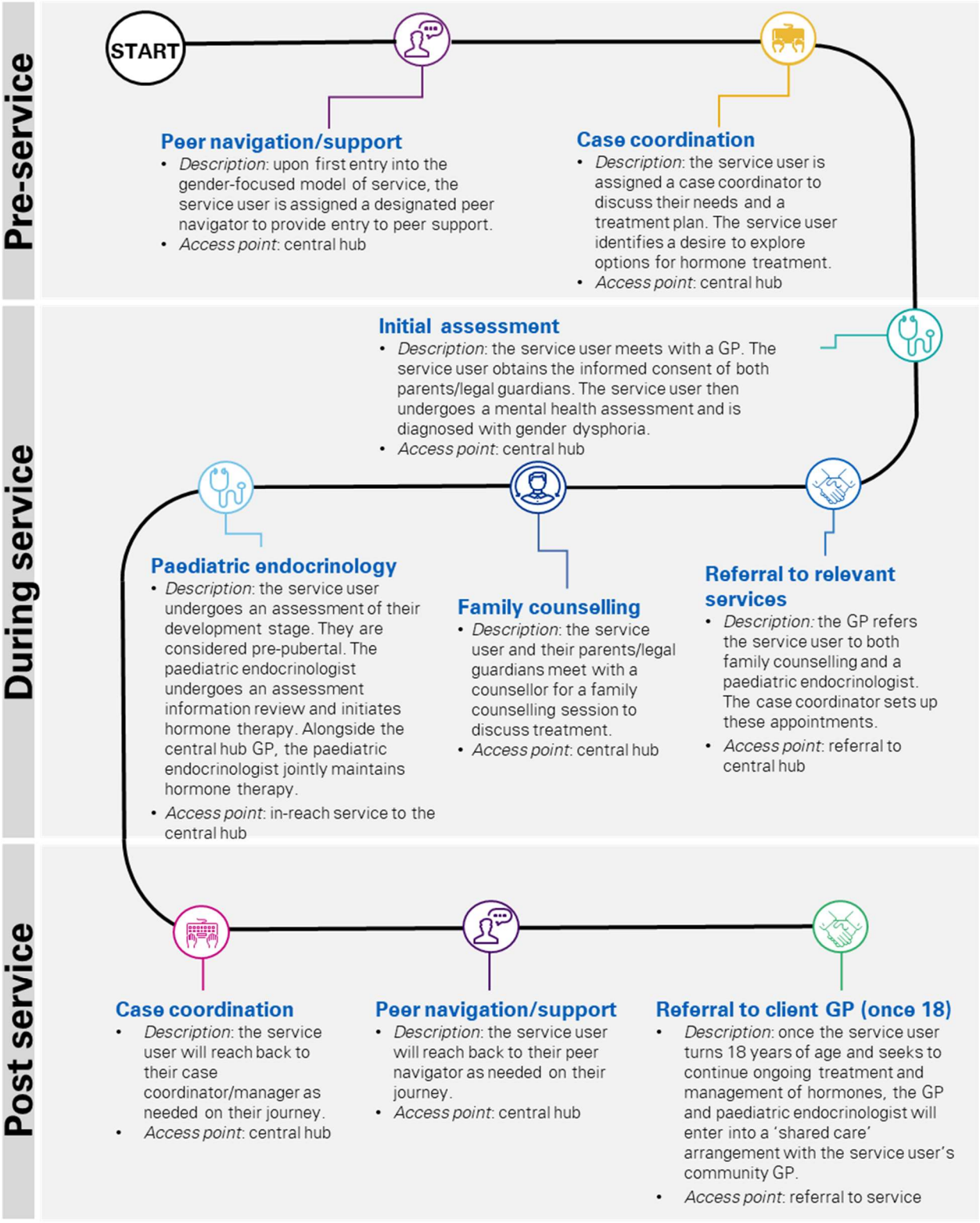
- the types of gender-affirming services available in the ACT;
- the location and referral details for clinicians with experience in delivering health care to trans and gender diverse people; and
- how best to deliver gender-affirming health care. This information would complement the implementation of recommendations 1, 2 and 18 of the Scoping Study to support the development of greater capacity among primary care providers to deliver gender-affirming care.

The development of the online information platform/s will be independent of the gender-focused model of service. The assessment of whether one or two online platforms will be required for service users and clinicians will be determined as part of the options analysis conducted for recommendation 13.

B.12 Example Service User Pathway

This diagram below provides an example of a possible service user's interaction with the gender-focused model of service. The service user is aged under 16 years and has family support.

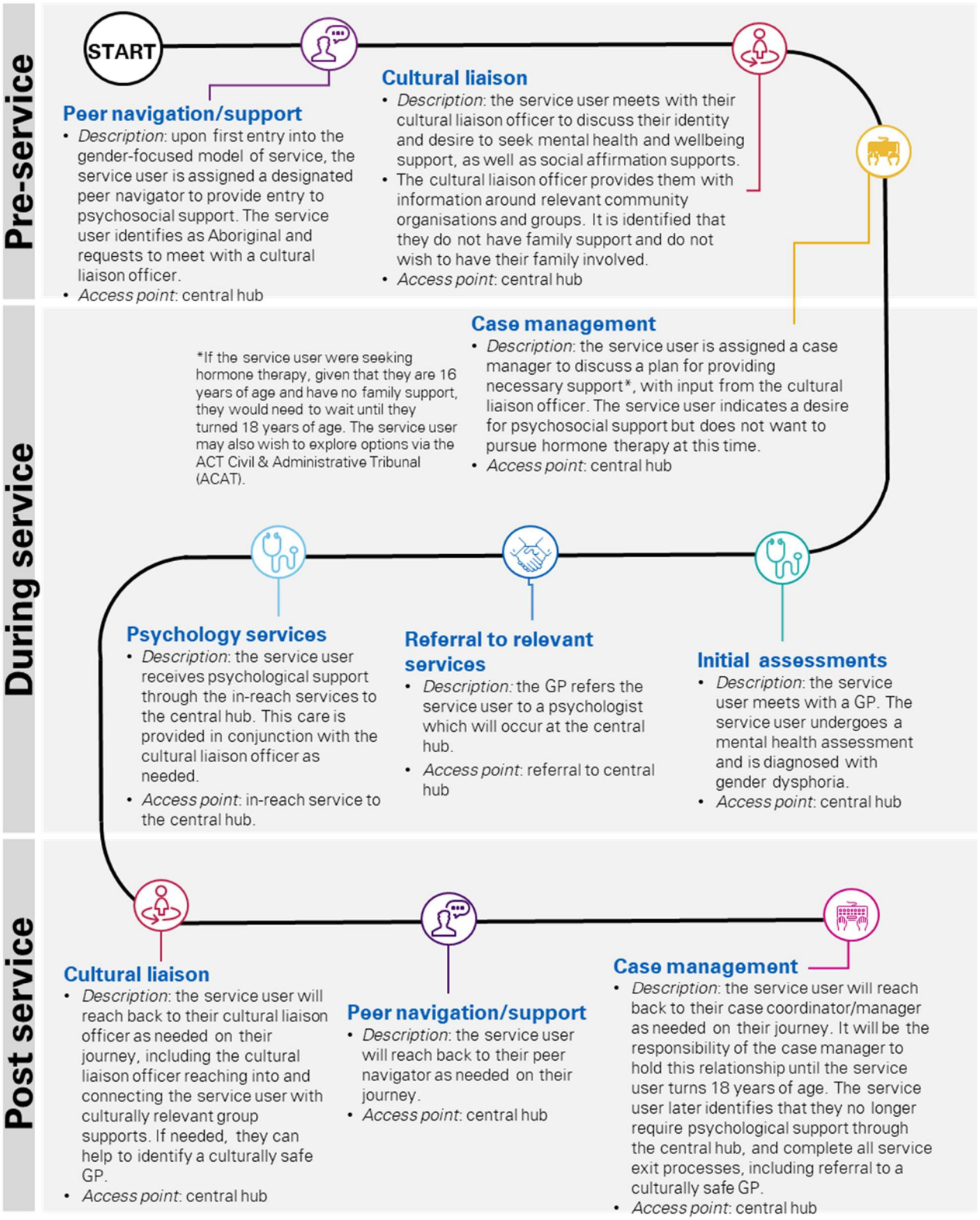
Figure 8 Example of service user interaction (under the age of 16) with the gender-focused model of service



Source xl: KPMG 2022.

This diagram below provides another example of a service user interaction. The service user is a 16 year-old Aboriginal Sistergirl or Brotherboy, who does not have family support.

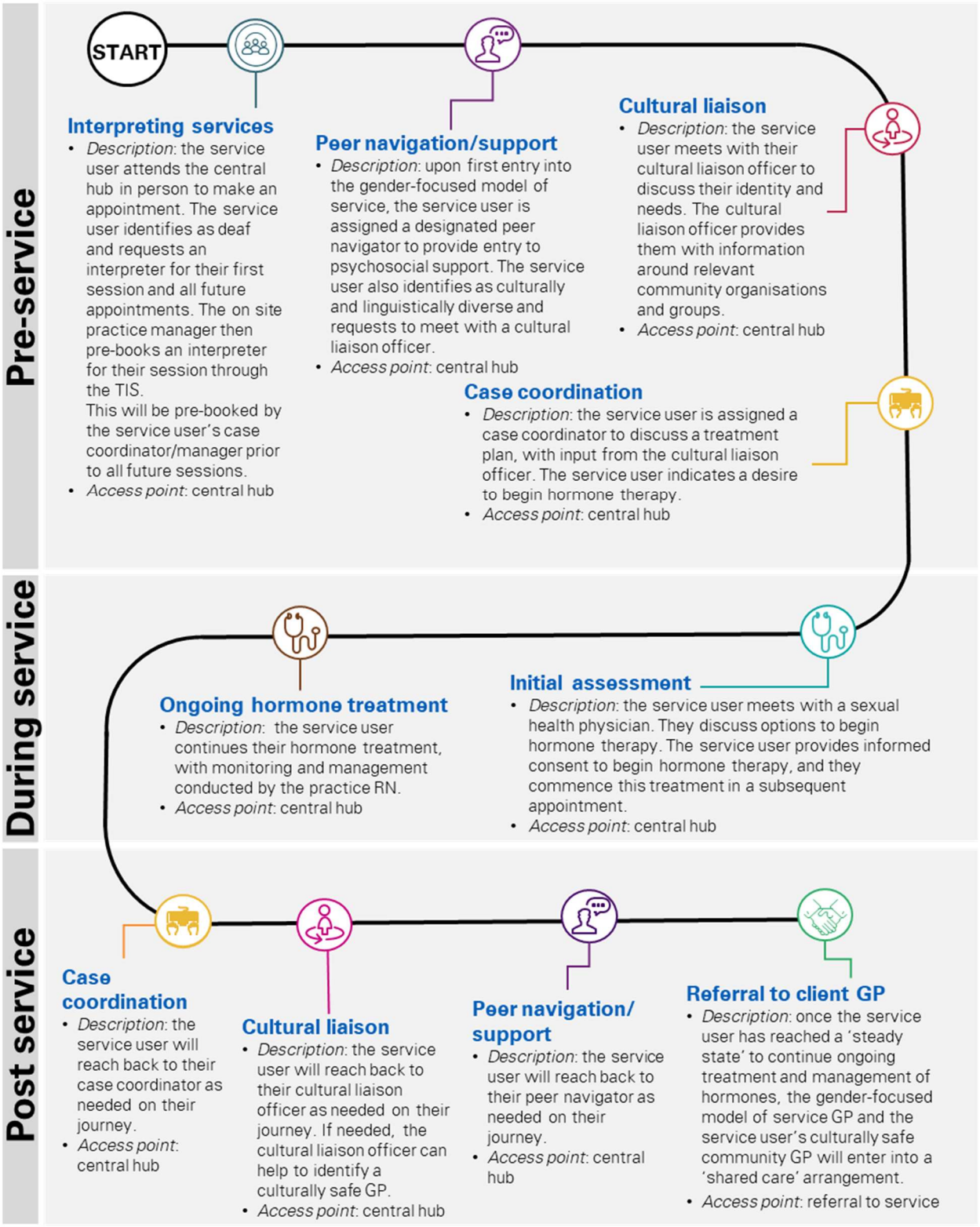
Figure 9 Example of service user interaction (aged 16) with the gender-focused model of service



Source xli: KPMG 2022.

The service user in this example is aged in their mid-30s, is deaf, and identifies as culturally and linguistically diverse.

Figure 10 Example of service user interaction (adult) with the gender-focused model of service



Source xlii: KPMG 2022.

B.13 Delivery options

During the co-design process, there was some discussion about how best to leverage existing clinical expertise in gender-affirming health care in the ACT. Two delivery options were discussed:

1. Having public health service providers who are experienced in gender-affirming health care delivering services as part of the gender-focused model of service.
2. Having both public and private health service providers who are experienced in gender-affirming health care delivering services as part of the gender-focused model of service.

There are some private health service practitioners (e.g. GPs and psychologists) who have established relationships with the trans and gender diverse community of the ACT as well as experience in delivering gender-affirming health care. In this context, Option 2 is the preferred option as it draws on a broader pool of workforce experienced in gender-affirming care, thereby enabling a broader suite of services to be offered as part of the gender-focused model of service. Option 2 also leverages existing funding arrangements.

Either option would be funded through a competitive tender process and would be overseen by a collaborative governance model that incorporates the HRG and the SURG. For the two options, there is variability in three components:

- The level of complexity in the arrangements – Option 1 is less complex as it is a partnership between public health services and NGOs. Option 2 may require a more complex governance arrangement. It may also include more administrative burden as private providers may need to obtain a new provider number from Services Australia for the location of the central hub in the gender-focused model of service. There will also be additional reporting for Medicare Benefits Schedule (MBS) claims, which will be submitted to enable the delivery of bulk-billed services to service users accessing the gender-focused model of service.1 Historically, the inclusion of private providers in government-subsidised, community-based health services in the ACT has resulted in service users who have an ability to pay, trying to access the bulk-billed service rather than attending the private practitioner's usual private clinic. This indicates that Option 2 would require a governance arrangement that supports private practitioners to deliver bulk-billed services to service users as part of the gender-focused model of service, without jeopardising the viability of their private practice.
- The types of revenue or funding arrangements – Option 1 would draw on ACT Government funding only, whereas there may be opportunities for Option 2 to leverage existing Australian Government funding arrangements for eligible services that are not funded by the ACT Government (e.g. primary health care consultations with a GP may be funded through the MBS20). The cost estimates vary by approximately $1 million over five years. This is described in detail in Section 2.2 Implementation plan for the gender-focused model of service.
- The breadth of services available – Option 2 may provide a greater breadth of services due to the incorporation of private practitioners. Option 2 may also provide deeper capacity in terms of the number and type of clinicians with experience in gender-affirming care.

B.13.1 Assessment of the delivery options

The options for the gender-focused model of service were developed and assessed against five design principles to ensure that they aligned with the following:

- Safe – the model is safe, inclusive and welcoming for all trans and gender diverse people and allows service users to focus on their specific needs and situation in their gender-affirming journey.
- Effective - the model enables the delivery of appropriate health care in the right place and at the right time to improve health outcomes for trans and gender diverse people in the ACT.
- Efficient - the model leverages existing health funding arrangements and enables an early intervention approach for trans and gender diverse people, to reduce the risk of acute presentations thereby decreasing the cost to public health care.
- Sustainable - the model enables the strengthening of the health system for the delivery of gender-affirming care.
- Accessible - the model enables choice around how, where and when people can access the gender-focused model of service.

The options were assessed through the considering the extent to which each option met the criteria and achieves the objectives of the design principles.

[20] It is noted that, under Section 19(2) of the Health Insurance Act 1973, MBS funding is only payable for services not already funded through other mechanisms by the Australian, ACT or Local Government.

Option 2 is the preferred option as it draws on a broader pool of workforce who are experienced in gender-affirming care (i.e. including private practitioners), thereby enabling a broader suite of services to be offered as part of the gender-focused model of service. Option 2 also leverages existing funding arrangements. Refer to the assessment of the two options overleaf.

B.13.2 Model options assessment

Table 33 Option 1 assessment for funding the gender-focused model of service

Option 1 Assessment	Option 1: Community, NGO and public health provider service delivery
Design Principle	Community and NGOs and public health providers.
Funding Approach	The funding approach for the model option has been described as part of the approach for the cost estimates of the gender-focused model of service.
Safe **Rating: high**	Option 1 has been assessed as highly aligned to this design principle. The gender-focused model of service will be delivered from a central hub as well as at sites on the northside and southside of the ACT. These sites will be designed to be physically and geographically accessible, as well as psychologically and culturally safe for people in the trans and gender diverse community.
Effective **Rating: moderate**	Option 1 has been assessed as moderately aligned to this design principle. This option will leverage the knowledge, skill and experience of clinicians currently practicing transgender health care in the public health system in the ACT. In contrast to Option 2, this option will not leverage the expertise of the private health system which may limit the suite of services and experience in gender-affirming care available as part of the gender-focused model of service.
Efficient (value for money) **Rating: moderate**	**Option 1 has been assessed as moderately aligned to this design principle. Option 1 will** leverage the planning, policy development and funding from the ACTHD for the gender-focused **model of service. Whilst value for money can be achieved with Option 1 through procuring cost-effective services, it does not leverage existing funding arrangements** (e.g. MBS). As such, this option has been assessed as moderately aligned rather than highly **aligned.**
Sustainable **Rating: moderate**	Option 1 has been assessed as moderately aligned to this design principle. This option supports a sustainable gender-focused model of service by building capacity in mainstream clinicians to better meet the needs of the trans and gender diverse community, in a community setting. It could be more sustainable to include private clinicians in the service delivery and capacity building (refer to Option 2). This could incentivise a broader range of clinicians to learn about gender-affirming care across both public and private health care in the ACT.
Accessible **Rating: high**	Option 1 has been assessed as highly aligned to this design principle. This option will provide choice to service users about where they access services and whether they access services in the central hub or in outreach sites, or within public and private practice. The suite of services to be accessed at the central hub and outreach sites should be the same across both options. The difference is in what kind of clinicians are delivering the service and making it accessible (i.e. public health clinicians only or private clinicians as well [refer to Option 2]).
Risks	There is a risk that service users in the trans and gender diverse community may want to have all their primary health care needs met through the gender-focused model of service. To maintain the sustainability of the model, a mitigation strategy could be to support service users with accessing gender-affirming primary health care through mainstream GPs for common illnesses (e.g. colds and infections) and accessing the gender-focused model of service for gender-specific health care needs only.

Source xliii: KPMG 2022.

Rating Legend:

An assessment of low indicates that this option does not align with the design principle (refer to previous page).

An assessment of moderate indicates that this option partially aligns with the design principle.

An assessment of high indicates that this option aligns fully with the design principle.

Table 34 Option 2 assessment for funding the gender-focused model of service

Option 1 Assessment	Option 2: Public and private service delivery
Description	Community and NGOs, public health providers and private health providers.
Funding Approach	The funding approach for the model option has been described as part of the approach for the cost estimates of the gender-focused model of service.
Safe Rating: high	Option 2 has been assessed as highly aligned to this design principle. Similar to Option 1, the gender-focused model of service will be delivered from a central hub as well as at sites on the northside and southside of the ACT. These sites will be designed to be physically and geographically accessible, as well as psychologically and culturally safe for people in the trans and gender diverse community.
Effective Rating: high	Option 2 has been assessed as highly aligned to this design principle. This option will leverage the knowledge, skills and experience of clinicians currently providing trans and gender diverse health care in the public and private health systems in the ACT.
Efficient (value for money) Rating: moderate	Option 2 has been assessed as moderately aligned to this design principle. Option 2 will leverage the planning, policy development and funding from the ACTHD for the gender-focused model of service and also existing funding arrangements for clinicians exercising their right to private practice (i.e. MBS).
Sustainable Rating: high	Option 2 has been assessed as highly aligned to this design principle. This option supports a sustainable gender-focused model of service by building capacity in mainstream clinicians across both public and private practice in the ACT.
Accessible Rating: high	Option 2 has been assessed as highly aligned to this design principle. This option will provide choice to service users about where they access services and whether they access services in the central hub or in outreach sites, or within public and private practice.
Risks	Similar to Option 1, there is a risk that service users in the trans and gender diverse community may want to have all their primary health care needs met through the gender-focused model of service. To maintain the sustainability of the model, a mitigation strategy could be to support service users with accessing gender-affirming primary health care through mainstream GPs for common illnesses (e.g. colds and infections) and accessing the gender-focused model of service for gender-affirming health care needs only.

Source xliv: KPMG 2022.

Rating Legend:

An assessment of low indicates that this option does not align with the design principle (refer to previous page).

An assessment of moderate indicates that this option partially aligns with the design principle.

An assessment of high indicates that this option aligns fully with the design principle.

B.14 Monitoring and evaluation

It is proposed that the monitoring and ongoing evaluation of the gender-focused model of service occurs with reference to the three domains that were commonly discussed during the co-design process. These domains are outlined below. A series of measures and indicators for each domain have been identified based on what some health care providers delivering gender-affirming care are already monitoring in order to understand the effectiveness of their services.

To inform the ongoing review and refinement of the gender-focused model of service, the data for each measure must be collected from Phase 1 onwards. This data could be captured in the knowledge management system (e.g. the type and volume of referrals) and also in periodic surveys of service users and partner organisations. The HRG may periodically refine the type and volume of measures and indicators that are used to understand how the gender-focused model of service is achieving positive change across the three domains. Note that a subset of these indicators have been included in the overarching measures and indicators for the evaluation of the Scoping Study recommendations.

Domain 1: Service user-centred approach

Access to information and care

- An increase in the percentage of service users who self-report receiving:
    - Culturally safe and gender-affirming care
    - The information, support and resources needed to improve or maintain their health and wellbeing

Service user satisfaction

- An increase in the percentage of service users who:
    - Report confidence in using services
    - Report improved health or wellbeing
    - Rate their overall health and mental health as very good or excellent
    - Demonstrate improvements in mental health through screening tools

Reach of the gender-focused model of service

- An increase in the number of service users accessing services who identify as:
    - Trans or gender diverse
    - Aboriginal and Torres Strait Islander
    - People with disability
- Culturally and linguistically diverse
- Families of trans and gender diverse people

Domain 2: Improved service integration and coordination of care

Patient journey

- A reduction in the number of service users waiting for more than six weeks[21] to access a service.
- A decrease in the length of wait time for services.
- Duration of the care journey from start to end – this is a measure to be monitored and to aid in understanding how long, on average, a service user may need to maintain an ongoing relationship with the gender-focused model of service for gender-affirming care.

Integrated care

- An increase in the number of partnerships with health care providers and specialists.
- An increase in the number of partners that report having an effective and collaborative service delivery partnership.
- An increase in the number of warm referrals that service users act on and attend.
- An increase in the number of case conferences between service providers.
- An increase in the number of partners that report having effective and helpful case conferencing to inform their support of service users.

[21] The Australian Institute of Health and Welfare MyHospitals platform indicates that Australians are waiting, on average, approximately six weeks for elective procedures and some specialist consultations. For this indicator, a period of longer than six weeks is assumed to be a 'long' wait for a service.

- An increase in the number of shared service users between services at the start and end of a care pathway.

Domain 3: Effectiveness of care and support

Improvements in social determinants of health

- An increase in the number of service users who report:
    - increased social connection and inclusion
    - greater autonomy in how they access health care
    - increased health literacy
    - increased self-acceptance
    - a reduction in the use of drugs, alcohol, or smoking
    - fewer acute mental health occasions of service
    - having stable housing and/or stable employment

Staff development

- An increase in the opportunities for capability strengthening of clinical staff for the delivery of specialist trans and gender diverse care.
- Increased participation in specialist trans and gender diverse care training by clinicians.
- An increase in the number of mainstream clinicians who report having greater confidence in delivering gender-affirming care.

Appendix C: Workforce Profile

C.1 The workforce profile for the implementation of the Scoping Study recommendations

This appendix outlines the workforce profile for the implementation of the Scoping Study recommendations. The workforce profile has been set out by the LGBTIQ+ Implementation Team and the gender-focused model of service workforce roles.

Table 35 Workforce requirements for the implementation of the Scoping Study Recommendations

Workforce roles	No. of proposed FTE
LGBTIQ+ Implementation Team	**4**
Senior Officer Grade B	1
Senior Officer Grade C	1
Administrative Services Officer Grade 6	1
Administrative Services Officer Class 5	1
Gender-focused model of service	**9.7**
Sexual health physician CMO2	0.4
Sexual health registered nurse RN Level 2, Yr2	0.4
Clinical care coordinator RN Level 2, Yr4	1
Case manager (social worker) Level 3.3	1
Counsellor / family counsellor Level 2.1	1
Peer navigator Level 2.6	2
Cultural liaison worker Level 2.1	0.5
General practitioner CMO2	2
Paediatrician specialist band 3	0.2
Paediatric endocrinologist snr specialist	0.2
Coordinator role HP 2.2	1
Total FTE	**13.7**

Source xlv: KPMG 2022.