PUBLIC ACCOUNTS AND ESTIMATES COMMITTEE

Inquiry into the 2023–24 Financial and Performance Outcomes

Melbourne – Friday 22 November 2024

MEMBERS

Sarah Connolly – Chair
Nicholas McGowan – Deputy Chair
Michael Galea
Mathew Hilakari
Lauren Kathage
Bev McArthur
Danny O'Brien
Aiv Puglielli
Meng Heang Tak

WITNESSES

Professor Euan Wallace, Secretary,

Jodie Geissler, Deputy Secretary, Hospitals and Health Services,

Katherine Whetton, Deputy Secretary, Mental Health and Wellbeing,

Professor Zoe Wainer, Deputy Secretary, Community and Public Health, and

Daen Dorazio, Deputy Secretary, Finance and Support, Department of Health;

Danielle North, Executive Director, Regional Operations, Ambulance Victoria; and

Deanne Leaver, Acting Chief Executive Officer, Victorian Health Building Authority.

The CHAIR: I declare open this hearing of the Public Accounts and Estimates Committee, and I ask that mobile telephones please be turned to silent.

I would like to begin by acknowledging the traditional Aboriginal owners of the land on which we are meeting, and we pay our respects to them, their culture, their elders past, present and future and elders from other communities who may be here today.

On behalf of the Parliament the committee is conducting this Inquiry into the 2023–24 Financial and Performance Outcomes. Its aim is to gauge what the government achieved in 2023–24 compared to what the government planned to achieve.

All evidence taken by the committee is protected by parliamentary privilege; however, any comments repeated outside of this hearing may not be protected by this privilege.

Witnesses will be provided with a proof version of the transcript to check, and verified transcripts, presentations and handouts will be placed on the committee's website.

As Chair I expect that committee members will be respectful towards witnesses, the Victorian community joining the hearing via the live stream and other committee members.

I welcome the Secretary of the Department of Health Professor Euan Wallace – you are very much welcome here – as well as other officers who join him today. Secretary, I invite you to make an opening statement or presentation of no more than 10 minutes, after which time committee members will ask you some questions. Your time starts now.

Euan WALLACE: Chair, thank you. Good morning. Can I too also begin by acknowledging that we meet on the unceded traditional lands of the Wurundjeri Woi Wurrung people and pay my respects to Wurundjeri elders past and present and any other First Nations people with us today.

Visual presentation.

Euan WALLACE: Chair, it is my great privilege to lead the Department of Health. This past year our priority has been building a sustainable health and care system that not only meets the needs of today but ensures a healthier future for Victorians. Our strategic plan sets out the seven key priorities that guide our commitment to building a sustainable health, wellbeing and care system that meets the needs of all Victorians, a system that provides the right care at the right time in the right place. I am incredibly proud of what we have accomplished this past year and energised by what lies ahead.

That is not to say that it is not without its challenges. Our population continues to change, to grow in number and in age. Almost half of all hospital bed days now are occupied by people over the age of 65, and public hospital separations are now 30 per cent higher than they were just a decade ago. We are also seeing a change in the mix of patients accessing health care. In the last decade the proportion of Victorian adults who have at least one chronic condition has been increasing year on year, such that nearly half of our adult population now live with at least one chronic disease. There is a need for us to retool our health care to better meet those needs.

Despite these challenges Australia, and Victoria in particular, have world-class health systems. In the report *Mirror, Mirror*, published by the Commonwealth Fund every three or four years, Australia is ranked first amongst global health systems – first overall, first for health outcomes and first for health equity. Australians have much to be proud of.

Within Australia, using 15 key measures of system performance across domains of availability, affordability, access, equity and health outcomes, the Productivity Commission finds that Victoria is the highest overall performer of all Australian states. Victoria ranks best on key measures of surgical wait times, acute readmissions and measures of harm. Indeed we rank in the top three for every measure except for mental health readmission rates, and that is already being addressed by the reform well underway as part of the response to the royal commission's findings.

The challenge we face is to redesign traditional care systems so that Victorians continue to receive the right care at the right time. To that end we are in the midst of a significant health reform agenda in Victoria. Through the COVID catch-up plan we are building a more capable planned surgical system underpinned by our planned surgery reform blueprint. Nearly 210,000 planned surgeries were performed last financial year, a new record for the state and 10 per cent higher than in previous years. And we have reduced the number of patients waiting for surgery, falling by 20 per cent last year alone. But more importantly we are reducing the time Victorians wait for their surgery. Victoria is the only Australian state where all category 1 patients are treated on time. We are ranked number one for surgical timeliness.

We strengthened our commitment to delivering care closer to home through initiatives such as Better at Home, which has provided now more than a million days of hospital care in the comfort of the patient's own home – 420,000 days last financial year alone – and our 29 priority primary care centres or urgent care centres cared for over 360,000 patients in 2023–24 and are now caring for 7000 patients a week, easing the burden on our emergency departments. And our virtual ED is now the busiest ED in the state, providing care for 700 patients a day and connecting those patients with virtual GPs, virtual paediatricians, virtual specialists or physical care if required.

Delivering on the government's commitment to transform women's health, we have been partnering with BreastScreen to deliver a mobile women's health clinic which will visit the more remote parts of the state. We are deeply committed to improving the lives of Victorian women and girls, and this year we delivered a landmark inquiry into women's pain. The results from the survey of more than 13,000 women and girls made starkly visible the inadequate and often harmful care that so many women and girls have experienced and continue to experience. This has been a necessary step for us towards building a new system that is informed by those who use it.

The Victorian community pharmacists statewide pilot has rapidly established itself in our health and care landscape. More than 700 community pharmacists are now participating, providing accessible, affordable and efficient care to more than 22,000 Victorians and counting – over 10,000 women attending with a UTI and over 6000 women attending for a repeat prescription of the pill.

We are more than three years in now to the largest reform in mental health services in the state's history, and a major component of our reform has been the establishment of course of mental health and wellbeing locals, 15 centres spread across the state that so far have helped more than 12,000 people. These are the front door to our mental health system, offering accessible treatment and support for those who need it without the need for a referral and without costs to the individual at point of care. Our suicide prevention and response strategy focuses not just on preventing lives lost – there were 801 of those last financial year – but on providing holistic, compassionate support for those most at risk. And most recently we have launched a new *Victorian Eating Disorders Strategy*, built on a vision of prevention, early intervention and a recovery-focused approach to eating disorders.

In a pioneering move, Victoria has become the first Australian state to pass dedicated pill-testing legislation, legislation allowing both fixed and mobile testing sites to operate across Victoria. Pill testing at its core is about saving lives, particularly young lives, and changing people's behaviour by giving them access to the information that they are asking for. And then another transformative milestone is the release of our *State Mental Health and Wellbeing Service and Capital Plan*. This plan is a first for Victoria and represents a step towards a new approach for futureproofing our mental health and wellbeing system.

Health infrastructure investment has grown rapidly over the past decade. The current health capital portfolio is valued at more than $15 billion, comprising more than 60 projects. Among the projects completed last year, I would like to particularly highlight the expanded Latrobe Regional Hospital, which my board were very privileged to visit earlier this year. This third stage expanded the maternity unit and delivered three new operating suites, 44 new inpatient beds and new medical and surgical beds that will enable an additional more than 6000 surgeries to be performed each year. This multistage expansion will help to meet the region's increasing and complex health needs and deliver improved health outcomes throughout the Gippsland region. Delivering more connected care is an increasingly pressing need. The health system's plan released earlier this year seeks stronger collaboration and connection between services by creating local health service networks, delivering seamless care planned across the population the LHN serves. We will commence establishing LHSNs by July next year.

A system is nothing without its people, and nowhere is this truer than the health workforce – 150,000 people. To meet and adapt to the challenges of the future we must attract, recruit and retain the absolute best workforce. I am pleased to say that we have seen the biggest yearly workforce growth in the state's history this past year, a record increase of 6.7 per cent in new roles. But we are challenged to make sure the workforce feels valued, fulfilled and able to meet the growing needs of Victorians. We are committed to ensuring that our healthcare sector is well trained, well supported and well resourced. But we cannot do this alone; all levels of government share responsibly for health services in Australia. We need a whole-of-system approach to health care where primary care, community care and hospitals are connected and able to provide optimum models of care for our citizens. We are currently in negotiations with the Commonwealth government and other states and territories for the next round of the national health reform agreement. That should enable our aim for a more connected system with improved access to care and better patient outcomes, delivering the so-called triple aim of better patient experiences and better population health but at lower cost. Chair, thank you.

The CHAIR: Thank you very much, Professor. The first round of questions is going to be asked by Mr O'Brien.

Danny O'BRIEN: Thanks, Chair. Good morning, Secretary and team. Secretary, pages 23 to 34 of the questionnaire list a number of Treasurer's advances, the total amount of which is $1.784 billion. How did the department get forecasting of the cost of the health system so wrong that we needed an additional $1.784 billion so that health services could keep the lights on, pay nurses and doctors and treat patients?

Euan WALLACE: It is about the way that our health system has been funded now for a very long time. If we go back over the BP3 papers for the last half dozen or eight or 10 financial years, you will see that there has always been additional so-called sustainability funding made later on in the financial year, and about $1.4 billion of that additional funding that you refer to, Mr O'Brien, is just that: it is sustainability funding to our hospitals.

Danny O'BRIEN: But the purpose of budgeting is to say, 'We think this is how much it's going to be.' If we knew that last year we had to put in an extra $1.5 billion, why did we not budget for it in the first place?

Euan WALLACE: It is about recognising, particularly during and coming out of COVID, the unstable funding environment and more difficult predictions of funding. We have begun, last year and into this year, fundamental reform to how our hospitals are funded to address just the issue that you raise, actually, about providing clarity, certainty and funding to hospitals at the beginning of a financial year and across the forwards eventually so that they can predict funding with certainty and with clarity.

Danny O'BRIEN: So if that is the case, why then did we have this year's budget and then two months later an extra one and a half billion dollars tipped in by the government?

Euan WALLACE: Following this year's budget we undertook the process that we normally undertake, which is we then go to services to say, 'With this draft budget, what does that look like for your activities?'

Danny O'BRIEN: But the budget that was tabled in the Parliament was not a draft budget; it was the budget.

Euan WALLACE: But the budgets that we then take to individual services –

Danny O'BRIEN: I get that.

Euan WALLACE: around their model draft budgets, which then result in additional funding – and as you know, government has made record investment in the health sector this year.

Danny O'BRIEN: Can you provide a breakdown of the allocation to each health service of the additional $1.7 billion in Treasurer's advances from last year?

Euan WALLACE: Well, the funding is in all of their annual reports, which are –

Danny O'BRIEN: But it will not say how much of that Treasurer's advance went to individual hospitals or health services.

Euan WALLACE: But it will detail their total funding, which is –

Danny O'BRIEN: I know that; I understand that.

Euan WALLACE: a composite of the May budget –

Danny O'BRIEN: But it will not tell us which hospital or health service needed this additional money, and that is what I am asking for. Are you able to provide that notice?

Euan WALLACE: Again, the hospital funding is available in their annual reports.

Danny O'BRIEN: But, Secretary, that is not the question. The annual reports will not say, 'We got $600 million and then in a Treasurer's advance we got another $200 million.' Correct?

Euan WALLACE: Well, they will not see a Treasurer's advance as a mechanism. They see a flow of money –

Danny O'BRIEN: Exactly my point.

Euan WALLACE: But we have always continued to flow moneys across a year to health services. That is how we fund our health services.

Danny O'BRIEN: I understand that. This committee is about the transparency and accountability of the spending of taxpayers money. I am asking you if you could provide me a breakdown of how that Treasurer's advance was –

Euan WALLACE: If I can, I will provide that information.

Danny O'BRIEN: Thank you very much. You stated in a letter to health services boards in May this year:

> Health services will be required to operate within their prescribed budgets for the remainder of 2023–24 and ongoing.

How long is ongoing?

Euan WALLACE: How long is ongoing?

Danny O'BRIEN: Forever?

Bev McARTHUR: Define 'ongoing'.

Euan WALLACE: Well, ideally – again, I have alluded to last year and into this year we have begun some fundamental reform in how health services are funded so that they have better certainty and clarity about their budgets, and so the expectation is –

And again, they have worked extremely hard under extraordinarily volatile environments during COVID, with completely unexpected and unanticipated costs, and it is now time to return to more stable fiscal processes. So that letter really alluded to our expectation that once they are allocated their final budgets, they sign their statement of priorities –

Danny O'BRIEN: That is it.

Euan WALLACE: that they will operate within that funding envelope.

Danny O'BRIEN: That obviously caused – the broad issue, not your letter as such – a political issue for the government. Mildura was going to close their emergency department because of the draft budget that they had got.

Euan WALLACE: Mildura was never going to close their emergency department.

Danny O'BRIEN: No, but it was flagged, whether it –

Euan WALLACE: Not by Mildura.

Danny O'BRIEN: It was reported on the front page of the *Herald Sun*.

Euan WALLACE: Well –

Danny O'BRIEN: Anyway –

Euan WALLACE: No, you have raised the issue. You have raised the issue. Let me be very clear: Mildura Base Hospital never suggested that they were going to close their emergency department.

Danny O'BRIEN: Okay. Nonetheless, there was significant concern in the hospital system. You are aware of that. As a result, have the Premier's office and the Treasurer's office taken control of health department funding from the department?

Euan WALLACE: No. We get a budget from Treasury, and we then allocate that budget out to our health services, as we always have done.

Danny O'BRIEN: Speaking of which, the Minister for Health wrote to the boards on 8 May saying:

> … I am required to set the very clear expectation that the funding provided is to allow you to meet all cash requirements in 2023–24.

But the annual reports show that more than 30 health services did not have cash reserves in 2023–24. Goulburn Valley Health had negative seven days cash reserve, Peter McCallum had 12 hours in cash reserve, Peninsula Health had zero cash in reserve, Austin Health had negative 2.4 days in cash available and a further 28 health services had limited cash reserves. If the health services had no reserves, why was the minister telling them the funding provided was to meet all those cash reserves when it was clear they could not meet the basic necessities of paying their bills?

Euan WALLACE: All health services ended last financial year with available cash – all services. You alluded to 30 services that had an operating deficit, but all services ended the year with available cash.

Danny O'BRIEN: Goulburn Valley had negative seven days; that is not available cash.

Euan WALLACE: Well, Goulburn Valley Health had funding to deliver all of their services and ended the financial year and were able to deliver a financial report as part of their annual report signed off by the Auditor-General.

Danny O'BRIEN: Okay. The Minister had to write to the Treasurer for the Treasurer's advance, and said:

> Without additional funding in June health services will be unable to make payroll payments to employees and will have insufficient operating cash to pay creditors.

For how long were health services operating in deficit?

Euan WALLACE: Again, the services that had an operational deficit had reported that in their annual reports. And again I go back to the processes of funding our services historically, which has led to flows of money across the financial year, which has led to some of the reforms that we have been planning and implementing last year and this year to give much better clarity to services so that they know at the beginning

of a financial year what the funding is and then, through their SOPs, know what their expected expenditures will be. Again, our health services' annual reports detail their end-of-year funding positions.

Danny O'BRIEN: So what was the total shortfall for health services across Victoria at the end of the year?

Euan WALLACE: Are you alluding to the additional funding that was flowed as part of that Treasurer's advance you talked about?

Danny O'BRIEN: Well, there are so many Treasurer's advances, Secretary, it is a little hard to follow. But I am talking about the total shortfall for health services at the end of the financial year, so prior to the $1.5 billion in 2024–25.

Euan WALLACE: Again, that information is available for all services in their annual report.

Danny O'BRIEN: Yes. I am asking if you know what it is collectively?

Euan WALLACE: It is about a billion dollars.

Danny O'BRIEN: If that was the case, again – and maybe that would not have been finally known until after the end of 30 June, but you would have had a pretty good idea – why did we have a budget in 2024–25 and then just two months later have to go back for another $1.5 billion? When the minister had said to the health services board, you had said to the health services board and the Treasurer had said, 'This is it. You're not getting any more,' how did we get that so wrong?

Euan WALLACE: No. Again, when we sat down with our health services around their draft model budgets coming out of the state budget in May and asked what activities and what services they could deliver with these services, that then fed into a conversation about the requirement for additional funding. Again, you have referenced the financial year 2023–24, when additional funding flowed late in the year. This financial year we have focused on providing that information and that funding much earlier so that services have certainty.

Danny O'BRIEN: Okay. To help us understand that, could the department provide to us on notice the initial submissions from the health services to the department of their budgets before the $1.5 billion was announced and then subsequent?

Euan WALLACE: Well, those are planning conversations that we have with health services all the time.

Danny O'BRIEN: Just yes or no would be fine.

Euan WALLACE: Probably. I do not think that information is available in a format that I can provide.

Danny O'BRIEN: The point is we heard $1.7 billion at the end of last year in Treasurer's advances. We then come to August and we get another $1.5 billion. So there is $3 billion of effectively cost overruns of taxpayers money. What I am asking is if you can tell us where the requests were coming from in the health services both before and after that money was made available. Because you are very strong on saying, for example, 'Mildura never said they were shutting their emergency department.' Well, what were the health services talking about that required a revision of $1.5 billion upwards?

Euan WALLACE: Yes. These conversations are about this current financial year rather than last financial year's planning. I have said already that if the information is available, I will provide the additional funding that flowed last financial year to services. The service planning conversations that we have with our 76 services are just that: they are planning conversations that we have in the lead-up to signing their statements of priorities. We do that every year.

Danny O'BRIEN: Okay. I will continue on, Secretary, on health service networks. The expert advisory panel is providing advice to the government on the health services plan. It has obviously been revised after initial discussions or government consideration. Are there lead hospitals in the new plan?

Euan WALLACE: The health services plan – the advice provided by the expert advisory committee lays out a number of recommendations, as you know, and government have chosen to accept those

recommendations through the delivery of local health service networks. Those networks then seek to both plan and deliver services across the population.

Danny O'BRIEN: I understand how it is happening. Are there lead hospitals in the current –

Euan WALLACE: Well, they will vary, right? If you look at the local health service networks for our regions, let us take Gippsland –

Danny O'BRIEN: No, let us do that.

Euan WALLACE: Yes. Then of course LRH in Traralgon is our regional hospital.

Danny O'BRIEN: Yes. That is all I am asking. Will that be the case across the state – that there will be a lead hospital in each network?

Euan WALLACE: I get your question. I am not sure I would phrase it as 'lead hospital'. What I would phrase it as – the recommendations in the health services plan call for role delineation, so care capabilities across the continuum of care, really delivering on the commitment that Victorians can get care as close to home as possible. But if you are in Bairnsdale and you need care that is beyond the capabilities of Bairnsdale hospital, then your care would flow naturally to Traralgon.

Danny O'BRIEN: Of course. But what I am getting at is – and I thought this was a fairly straightforward question –

Euan WALLACE: Yes.

Danny O'BRIEN: we are developing a network plan. Who is it that calls the meeting, for example? Is it LRH? Is it Alfred in south-east? How does it get done? And then who takes control of it?

Euan WALLACE: Well, the governance of the LHSNs is part of the process between now and July. As you know, we have written to health services around the proposed LHSNs. We are going to get that feedback before the end of the year, and then those LHSNs will be finalised – which hospitals are in which LHSNs – and then the governance structures are part of the planning between now and 1 July.

Danny O'BRIEN: Okay, so we do not know whether there will be a lead hospital arrangement for each one?

Euan WALLACE: There will be a tier of hospitals. I think 'lead hospital' is slightly misleading, because it is about ensuring that healthcare needs of the population are appropriately met, being true to the commitment that care is delivered as close to home as possible. So this is not some centripetal form –

Danny O'BRIEN: I am not really talking necessarily about the clinical side of it; I am talking about the administrative side of it. But anyway, can I give you an example? The minister's letter to the board chairs in the Hume region, for example, said that the committee noted that the southern portion of the proposed Hume network has patient flows to Melbourne so there might be a case for those hospitals to be grouped with a metropolitan network. Does that mean Hume might have two lead hospitals – some going to Melbourne and some going to Albury or Goulburn Valley?

Euan WALLACE: Again, the governance of the LHSNs is under development as we speak. But I think what we would expect to see is that the governance is a shared approach to population health planning for the region.

Danny O'BRIEN: Yes, okay.

Euan WALLACE: There will be a higher capability hospital in the region. Hume has two such hospitals – it has got Shepparton and Goulburn Valley Health, and it has got Albury Wodonga.

Danny O'BRIEN: Okay. So 'We don't know the answer' is the answer – whether there are going to be two leads.

Euan WALLACE: No, it is about ensuring that the tier of care capability meets the needs of the population. Each LHSN will have a governance board.

Danny O'BRIEN: Okay. You mentioned Gippsland. Why is Koo Wee Rup health service going to bayside health group rather than to LRH?

Euan WALLACE: Well, as you know, the minister has written to services and we are waiting to hear feedback from services, and that is the bit of work that will be completed between now and the end of the year.

Danny O'BRIEN: Okay. Do you expect more Gippsland hospitals to go towards Melbourne – Bass Coast, Gippsland Southern Health, South Gippsland?

Euan WALLACE: I think it is about ensuring that the final construct of the LHSN best meets the needs for the population.

Danny O'BRIEN: Okay. RCH is lumped in with the Parkville group – Royal Children's with Melbourne Health, Peter Mac and the Royal Women's. Will services such as the Royal Children's Hospital's pathology service be merged with the Royal Melbourne Hospital's pathology service?

Euan WALLACE: Separate to the LHSNs, the state is already on a journey to public pathology reform, and the pathology provision in Parkville will be consolidated into a single pathology provider.

Danny O'BRIEN: All Parkville will be?

Euan WALLACE: Yes.

Danny O'BRIEN: Okay. As part of the plan, Porter Novelli, a public relations firm, was engaged to develop 'communication strategies for each region'. Can a copy of those strategies please be provided to the committee?

Euan WALLACE: We never finalised a strategy, because we engaged Porter Novelli ahead of government's deliberations for consideration of the health services plan. Once government had made decisions around the health services plan, we were then able to have better clarity about what the communication strategy might look like, so the communication strategy has been led out of my own department.

Danny O'BRIEN: So was that work then not used?

Euan WALLACE: No, we obviously used the expertise of Porter Novelli to advise us on approaches to how communications might flow depending on choices.

Danny O'BRIEN: Okay. Nonetheless, can the committee have a copy?

Euan WALLACE: If I have got something I can share, I will share that.

Danny O'BRIEN: Thank you. When will the new Footscray Hospital be completed?

Euan WALLACE: Well, it is on track. I might ask Ms Leaver to give us an update on Footscray Hospital.

Danny O'BRIEN: Perhaps when will it be completed, and when will it be fully operational?

Deanne LEAVER: I am happy to talk to the new Footscray Hospital. The new Footscray Hospital is on track for completion towards the end of next year, so 2025.

Danny O'BRIEN: End of, sorry?

Deanne LEAVER: 2025.

Danny O'BRIEN: End of 2025. And fully operational then?

Euan WALLACE: We will work with Western Health on their commissioning strategies. Obviously moving a hospital all on one day is not something that can occur, so we will work with them to ensure that we can operationalise the building and services can be delivered.

Danny O'BRIEN: So will all beds be open?

Deanne LEAVER: The building itself is more than doubling the capacity of the existing Footscray Hospital, so there will be a staged approach to opening the new Footscray Hospital.

Danny O'BRIEN: How long will that staged approach take? I take it that means not all beds will be open from the start.

Euan WALLACE: I think it is about us working with Western Health around it. Obviously Footscray Hospital is futureproofing the health needs for the west of Melbourne. We will work with Western about what the progressive needs are and progressive commissioning. As Ms Leaver said, the new Footscray Hospital more than doubles the capacity of the existing hospital, so the progressive commissioning of the beds will be made to meet the service needs and activity needs.

Danny O'BRIEN: How many staff will be required to make the new hospital fully operational? Are we doubling the staff numbers?

Euan WALLACE: Again, we are working through those with Western. It is fair to say it is a fairly complex issue, as you might understand. Models of care are changing rapidly, as I alluded to in my introductory comments.

Danny O'BRIEN: I am going to run out of time, Secretary. How many staff will be required to fit out the new hospital?

Euan WALLACE: We do not have a final number yet.

Danny O'BRIEN: Okay. But do you believe you will have the staff to be able to have the beds fully operational?

Euan WALLACE: Yes. Part of the commissioning planning is to work with Western to estimate how much the staff they require and then plan the recruitment and appointment of those staff.

Danny O'BRIEN: Can I ask a final question: when will the full hospital be fully operational?

Euan WALLACE: That will depend on the clinical needs of the population.

Danny O'BRIEN: Okay. Thank you.

The CHAIR: Thank you, Mr O'Brien. We are going to go to Mr Galea.

Michael GALEA: Thank you, Chair. Good morning, Secretary and officials. Thank you for joining us today. Secretary, you mentioned PPCCs in your opening remarks, and I note that in the departmental questionnaire it is also referenced. You spoke about the role that they play, particularly for that non-critical but still nevertheless semi-urgent care. Can you talk to me a little bit more about what has been delivered under this output over the past financial year that we are looking at, in particular reference to any numbers that you have on the usage of these services?

Euan WALLACE: Thank you. The terminology is slightly confusing and confused. As you know, we established the priority primary care centres, PPCCs, during COVID as a particular response to an unmet need, the so-called missing middle between primary care, general practice, and the acute sector, particularly at a time when general practice was particularly challenged by a funding freeze really on Medicare than previously. Like other jurisdictions across the country, we have seen a relentless increase in people attending emergency departments for care that could be provided somewhere else. Emergency departments are very expensive places, and they are quite unpleasant places to spend a lot of time unnecessarily. So we stood those up during COVID. They have been enormously successful. There are now 29 of them. The terminology is slightly confusing because we have been pleased to partner with the Commonwealth, whose preferred branding is

'Medicare urgent care centres', and we are progressively changing our terminology to align with that, so we are now calling them Medicare or urgent care centres. There are 29 of them. The Commonwealth agreed to partner in the first instance on 10 of them, and in their budget this year they have provided additional funding to fund another seven. Of the 29, 17 will now be co-funded between us and the Commonwealth. They are providing what is essentially urgent primary care, which has been the traditional environment for the Commonwealth, but again, recognising the ever-increasing burden on our acute emergency departments, they now are providing that care. They are open 14 hours a day, seven days a week, and they are free, including to those of our citizens who do not have Medicare. They are not an emergency department, so they do not provide emergency responses – they are for cuts and bruises and minor fractures and burns and so on and so forth – but they have been profoundly successful. They are now seeing about 7000 patients a week, and about half of the people who attend them, when we ask them, say that if they had not been there, they would have gone to an emergency department instead, particularly because they are out of hours. Forty per cent of the attendees are children, and 40 per cent of attendees are out of hours. I think they have been a very successful remedy for the so-called missing middle – this difficult access to primary care.

It is interesting – I referenced the Commonwealth Fund's *Mirror, Mirror* report earlier, which ranks Australian health care number one in the nations that they reviewed. We score very poorly for access to health care, and that reflects the principally out-of-pocket costs in the primary care sector: pathology, diagnostic costs and costs in accessing GPs. I think the proportion of people having a bulk-billing GP is commonly in our newspapers. So these priority primary care centres or urgent care centres have been designed to try and meet that growing need. And in the last financial year I think I referenced about 360,000 Victorians used these centres, so extraordinarily successful.

Michael GALEA: And is that an increase on the previous year as well in terms of usage?

Euan WALLACE: It is. It is an increase on previously. I do not have the previous year's numbers in front of me, but it is an increase. And even in this last quarter, so from July to September, there were 98,000 visits, so we are on track –

Michael GALEA: Just in one quarter for this financial year.

Euan WALLACE: Yes, so we are on track to have another bumper year this year. Last year saw an average of 7000 visits a week; this year we are on track for nearly 8000 visits a week.

I think one of the challenges for us – and I alluded to in my last slide actually, in my last comments, about all levels of government having responsibilities to ensure this connected system, and the connected system that we have been trying to build progressively in Victoria needs to connect to primary care. The last thing that was intended by any of this reform was to create a disintegrated care. So the conversations that we have been having with our PHNs, with our general practice colleagues, with our colleges, are about how do we ensure that those primary urgent care needs are well served but do not disrupt the relationships that individuals have with their existing GPs? Our GPs are a critical component of our health system. This is not meant to replace general practice, this is meant to integrate and supplement. So how do we get that right as we continue to develop this? And we would very much like the Commonwealth to fund the residual 12 urgent cares that make up our 29, but I think they are a very important part of our landscape.

Michael GALEA: Thank you. And a good point to note as well of course is that it is not to supplant GPs but rather to expand access and that point where we can actually do a lot more work to improve that access, and that seems to be what the – I will say it now – Medicare urgent care clinics are now doing. It is very interesting as well, and as you say, primary health care is fundamentally a responsibility of the Commonwealth, and we saw a complete vacation of that space, especially during the COVID years, from the former federal government, and that was why Victoria – and indeed I believe New South Wales as well – invested in the PPCC program. It is very good to see now that there is some investment coming from the Commonwealth into this area, which they should be funding. Seventeen out of the 29 are co-funded, which means that 12, or just over 40 per cent, are still solely funded by the Victorian government. That breakdown, is that done at a statewide macro level with funding, or are there specific centres which are co-funded and specific centres which are solely state-funded?

Euan WALLACE: Yes, there are specific centres that are state-funded, and it might be worthwhile just explaining how we initiated this program and funded it. The department worked very closely with our PHNs, and it would have been impossible to deliver this reform without our PHNs. They have been leaders for us in this state in putting these in place. I think in a previous PAEC hearing we talked about where the workforce is coming from. I think Mr O'Brien asked that question about, 'Is this a new workforce?' et cetera. It is actually offering additional employment opportunities for GPs who run their own practice who then may say, 'You know what? I would quite like to do some evening work,' and they can do it in an urgent care centre.

There are 17 that are funded by the Commonwealth and 12 that we wholly fund with that Commonwealth funding. Again, to go back to the GP issue, it is important to recognise that 45 per cent of the referrals come from GPs and emergency departments, so we do have a new health care provision reform that is progressively integrating. We just need to keep that integration front and centre as we further evolve this model of care.

Michael GALEA: Thank you. I am just having a look, but is it publicly listed which centres are Medicare co-funded sites and which are solely state government funded?

Euan WALLACE: No, it is not. I can give you a list of which ones are. I tell you why it is not, because whenever you develop and deliver a new model of care – our healthcare system, as you know, is confusing enough for users already, and when you then deliver a new model of care, we want to deliver it with as much clarity and certainty as possible so that users know, 'I've got this problem. You know what? That is best served by one of the new urgent care centres rather than going to ED.' So we have tried to maintain branding, if you like, to maintain clarity for a population, and we have a 'right care, right place' type of approach. So, what are your care needs? Well, here are your options. And of course, if it is an urgent matter and it is in hours and you can get an appointment with your own GP, you should go to your own GP, because the best doctor for you is your own GP. She knows you, she knows your family, she knows your needs et cetera. But if you cannot get an appointment and you have an urgent need and it is not a matter of emergency care, then the best place for you will either be an urgent care centre or potentially the virtual ED, which will then refer you on to an urgent care centre or another healthcare provision depending on your need.

Michael GALEA: Excellent. Thank you. You make a good point about the need, especially when it is a new service, for it to be as accessible and as clear for people as possible. For the interest of this committee, though, do you have that breakdown of which centre is co-funded and which is –

Euan WALLACE: No, we do not, but we can provide which ones are state-funded and which ones are co-funded with the Commonwealth.

Michael GALEA: That would be terrific, thank you. You touched on workforce as well. I note in the questionnaire it also talks about an initiative for maximising our health workforce, specifically with a target of attracting in 1100 international healthcare workers. The questionnaire shows that that has been achieved. Can you talk to me a little bit more about that output and what the impact those 1100 new healthcare professionals will be?

Euan WALLACE: Yes, and I might ask Ms Geissler to comment. The international recruitment campaign, which again I think we have talked about at this committee in the past, was highly successful, but I might ask Ms Geissler to provide some information on our workforce development.

Michael GALEA: Thank you.

Jodie GEISSLER: Look, it has been an incredibly successful program, the international worker program, and in 2023–24 we absolutely reached our target of 1100 international workers joining our local workforce, and it is a huge achievement actually of all our health services to continue to attract and retain those sorts of workers from around the world. We have also got a lot of activity here in the state that we do to support our workforce. We have actually got 27 different programs underway around attraction and retention. Some of those that were important in the financial year 2023–24: we had 139 post-grad midwifery students employed through the midwifery employment model – that was 94 per cent above our target. In 2023–24 we had 3070 sign-on bonuses paid to nursing and midwifery grads in public health services, which was 12 per cent above our target. We had 375 enrolled to registered nursing transition with scholarships enabled. We had 50 nurse practitioner candidates supported and so on and so on. There was a lot of activity.

I think the only thing that I would add about all of these programs – and of obviously international workers are very important to both metropolitan and rural and regional – is we have a very, very significant emphasis on the distribution of our health workforce across the state, and we have a very significant focus therefore on our rural workforce. We spent half a million dollar in 2023–24 on the Maternity Connect program, which provided clinical placements at Western Health so midwives and nurses can develop their skills; we supported over 585 participants in that program. We have a rural urgent care nurse capability development program which provides professional development, training, information, resources and other supports to nurses employed in rural urgent care centres. Since the financial year 2019–20 the program has educated over 700 nurses. We have the Victorian Rural Generalist Program which delivers end-to-end training to support up to 47 rural generalist doctors a year, and really importantly we have the regional mental health workforce incentive program, which supports workers to relocate to rural areas. Over a hundred grants have been awarded since 2022, so really significant. That is just a snapshot really of the breadth of work we have got underway across the state around our very significant workforce strategy.

Michael GALEA: Thank you. I note that the pandemic catch-up, the COVID catch-up plan, was also talked about in the questionnaire and indeed, Secretary, in your presentation as well. Can you talk to me about the implementation of this initiative?

Euan WALLACE: Yes. Thank you. So from memory the COVID catch-up plan was announced first of all in April two years ago, so April 2022, and it formally concluded at the end of last financial year. It of course has, as you would expect, enduring improvements and reform that will continue to evolve and mature, but it was an investment of $1.5 billion to principally do two things: first, accelerate recovery from COVID – again, we have discussed this in this hearing in past years – through necessarily having to put planned surgery on hold during COVID so that we could enable our hospitals to respond to COVID demand the number of people who went onto our planned surgery waiting lists went up, and they got to a peak of nearly 90,000 during COVID at a peak. So the first thing to do was accelerate recovery from that, try and supercharge our capacity to get through planned surgery, and I referenced in my introduction that last financial year our planned surgical waiting lists fell by 20 per cent. In fact since the beginning of the COVID catch-up plan the planned surgery waiting list has fallen by over 30 per cent. Then the second component of the reform program was to design and implement enduring reform. We knew that our planned surgery system had opportunities for improving efficiency, capacity and effectiveness, so we have done that, and we continue to do that. We continue to connect our services where there are opportunities for patients in the future to choose where they might have their surgery, if they can have it sooner in a different place.

We have accelerated the uptake of same-day surgery. So the proportion of surgeries that are done on the same day and the patient is discharged on the same day is progressively going up. That frees up bed days in our hospitals for capacity, improves patient flow and allows patients in EDs to get a bed where they need a bed faster. We set ourselves a very ambitious target, as you know, of 240,000 additional surgeries. In 2023–24, when you take all of the new bits of the reform program, actually 233,389 Victorians had care under the program. There were the almost 210,000 planned surgeries that I referred to before, but in 2023–24, 1700-odd patients had a non-surgical care pathway that was not available to them before the COVID catch-up plan reforms were put in place, patients who were put on a surgical waiting list and then, on review, let us say for a hip or a knee replacement, for example, through our reform program by a physiotherapist, were actually able to avoid surgery and have the same outcome that the surgery would have intended. So this improved their care, ensuring their experience and the health outcome is improved but, again, at a lesser cost and avoiding surgery.

We did almost 4000 more emergency surgeries in 2023–24 than we did in the previous year, so 100,000 total emergency surgeries. Again, the ability to do that higher number of emergency surgeries is enabled by increasing same-day surgery rates; freeing up beds; creating the so-called rapid access hubs, such as the Frankston centre but all the rapid access hubs that we have created around the state; and progressively trying to ring fence planned surgery from emergency surgery to give those services that are very heavy lifters in the emergency space more access and capacity for emergency surgeries.

We did 18,000 more endoscopies than the before, so almost 150,000 endoscopies total. Again, that was made possible by the reforms that the COVID catch-up plan has progressively put in place under the planned surgery blueprint. So this has been a very purposeful, strategic and, if I may say, relentless piece of work, which was about accelerating catch-up – we have done that, with 30 per cent of patients coming off the list. As said in my introduction, of all states in the country we rank first for surgical access timeliness. The Productivity

Commission in its government services report this year shows time on waiting lists by state and territory, and Victoria is a country mile better than everybody else. Part of that is due to this capacity, efficiency and effectiveness building that the catch-up plan has done.

Michael GALEA: And that is also where, as you mentioned in your presentation, we are the only state where category 1 cases are seen on time. Is that correct?

Euan WALLACE: Indeed, yes. And I think with the planned surgery blueprint that the department launched late last year that we developed with sector – so led by our chief surgical adviser, Professor Ben Thomson, head of surgery at the Royal Melbourne, but also Professor David Watters from Barwon – we are really working with sector, saying 'How do we do this together? How do we build a system that is fit for Victorians, not just for today?' We know we have got all this work to catch up on, but how do we futureproof it for tomorrow to make sure, again, as I referenced in my introduction, that the ever-changing surgical needs of the population are best met, whether it is emergency care, whether it is endoscopy, whether it is actually non-surgical care pathways or whether it is planned surgery?

Michael GALEA: Thank you very much, Secretary. Just to confirm as well, on that question about PPCCs and whether they are federally, co- or state funded, will you be able to get that to us on notice?

Euan WALLACE: We will.

Michael GALEA: Thank you. Thank you, Chair.

The CHAIR: Thank you, Mr Galea. We are going to go straight to Mrs McArthur.

Bev McARTHUR: Thank you, Chair. Thank you, team. Secretary, I refer you to section H of the questionnaire, page 122 and the table 'Reviews/studies/evaluations'. The last column on the right is headed 'Publicly available (Y/N) and URL. If no, why?'

Euan WALLACE: Sorry, which question is this?

Bev McARTHUR: Questionnaire page 122, section H. It is about non-emergency patient transport.

Euan WALLACE: Question 26. These are about the availability of reviews and evaluations et cetera. Which one in particular are you looking at?

Bev McARTHUR: We are looking at section H, page 122, the table 'Reviews/studies/evaluations'. The last column on the right is headed 'Publicly available (Y/N) and URL. If no, why?'

Euan WALLACE: These reviews vary enormously between external reviews and –

Danny O'BRIEN: Sorry, Secretary, the question is specifically about the non-emergency patient transport review.

Euan WALLACE: The non-emergency patient transport review is with government.

Nick McGOWAN: Still.

Bev McARTHUR: Still. That is right. The question indicates that the review is publicly available. You follow the link; there is no report there. Why has it not been made publicly available? How long is the government going to sit on it?

Euan WALLACE: Well, I think that is a matter for government. It is with government for their consideration and decision.

Bev McARTHUR: Why is it not on the department's website?

Euan WALLACE: Because it is still sitting with government.

Bev McARTHUR: So has the government misled the public then – that it is publicly available?

Euan WALLACE: No.

Bev McARTHUR: They have had it since December last year. That is nearly 12 months.

Euan WALLACE: Yes.

Bev McARTHUR: Are you following them up?

Euan WALLACE: I have conversations with my ministers, as you would expect, every week.

Bev McARTHUR: Well, I hope so.

Euan WALLACE: The report is with government still.

Bev McARTHUR: Okay.

David ETTERSHANK: The point remains, Secretary, the questionnaire says, yes, it has been publicly released, and it has not.

Euan WALLACE: It has not.

Bev McARTHUR: Okay, so that is a mistake. Now let us go to the Armstrong Creek ambulance station. I refer to page 66 of 2023–24 budget paper 3 and the line item, 'A new ambulance station for Armstrong Creek'. It was promised prior to the 2022 election, with a $30.4 million spend allocated. No sod has been turned two years later, and the estimated completion date is now 2026–27. Why?

Euan WALLACE: I might ask Ms Leaver to give us an update on our ambulance program. As you know, we have a program of upgrading or building 51 ambulance stations, and the program is all but complete –

Bev McARTHUR: Well, it was promised in the 2022 election. How are you going, Ms Leaver?

Deanne LEAVER: Thank you for that question. The team is working on the Armstrong Creek station. We have been working on identifying a parcel of land that best meets the response times for the ambulance station. We have identified a parcel, and we are working through the acquisition process, which can be quite lengthy. It has a number of component parts. We are working through the design phases, and then we will move into construction.

Bev McARTHUR: How can it possibly take this long?

Deanne LEAVER: One of the challenges with ambulance stations is often identifying, as I said, parcels of land that are suitable in those target zones and that enable us to best meet those response times for ambulance stations or that response time for the paramedics. Certainly we look at all options that are available. We work with other government departments to determine if there is any suitable land.

Bev McARTHUR: Is the planning department holding you up?

Deanne LEAVER: No, we work with those departments.

Bev McARTHUR: You cannot be working terribly well, because it is taking so long.

The CHAIR: Excuse me, Mrs McArthur. You have asked a really good question. Ms Leaver is genuinely trying to answer the question.

Bev McARTHUR: Okay. Well, Ms Leaver, can you tell us why it is costing more than $30 million when other ambulance stations are not allocated anywhere near that level of funding?

Deanne LEAVER: On the costs of stations, our program is a long-standing program. It has been in operation for many, many years now. As with all costs across various construction projects, costs have increased over time, and that includes the TEI increasing over that period of time. We have also standardised designs and really looked at the way ambulance stations are constructed. That is one of the driving factors in terms of the cost.

Euan WALLACE: We should feel very proud of our ambulance program. As I said in my introductory comments –

Bev McARTHUR: Well, perhaps not at $30 million, Secretary – that is the Taj Mahal.

Euan WALLACE: Fifty-one stations, 30 delivered in 2022–23, 12 in 2023–24 and two more since. Six will be completed by the end of next year.

Bev McARTHUR: But not Armstrong Creek. At $30 million it is obviously gold plated, Ms Leaver. Is it?

Euan WALLACE: No. It is appropriately designed. The costs clearly involve land acquisition and construction.

Bev McARTHUR: Is the land that expensive in Armstrong Creek?

Deanne LEAVER: It is not just about buying land, but it is also about service infrastructure. That land has to be serviced and that –

Bev McARTHUR: I am sure we could find some local builders to help you out, Ms Leaver.

Deanne LEAVER: That involves bringing services to site, such as water, electricity and gas, and working with –

Danny O'BRIEN: Gas?

Deanne LEAVER: Sorry, not gas. Water – you are right. You have picked me up on that. It is an all-electric station. So that is water and electricity to site to enable the station to be constructed and to operate.

Bev McARTHUR: Well, how much is the Victorian Health Building Authority – your operation – taking as a percentage off the top?

Deanne LEAVER: Our costs are built into the project cost. Project costs are not just –

Bev McARTHUR: Yes, how much? What is the percentage you are taking?

Deanne LEAVER: The percentage costs will vary depending on the different projects.

Bev McARTHUR: No, but for this project, how much are you taking?

Deanne LEAVER: Our costs are in the order of around 6 per cent.

Bev McARTHUR: How much?

Deanne LEAVER: Six per cent, so very minimal.

Bev McARTHUR: What problems have you identified? The land is not so expensive out there. Everybody has got building problems. What else is getting it to $30 million?

Deanne LEAVER: Costs have a number of factors –

Bev McARTHUR: And what is the average cost of a station, Ms Leaver?

The CHAIR: Excuse me. Mrs McArthur, could you just ask one question at the time. Ms Leaver is genuinely trying to answer you, and this is important evidence that forms part of our inquiry. What is the first question that you need an answer to? Then we will go to your second.

Bev McARTHUR: I will just go straight to: what is the average cost of a regional ambulance station?

Deanne LEAVER: That is a cost that I do not have to hand.

Bev McARTHUR: Would you be able to take it on notice?

Deanne LEAVER: We can certainly look at taking that notice.

Bev McARTHUR: Good. Give us the average cost of our regional ambulance stations.

Euan WALLACE: We can do that. I think one of the complexities of that answer of course will be that 10 of these stations were built and delivered in 2018–19, and then progressively across the years. There have been, as you are aware, across the whole building industry, cost escalations since that time, so what the cost of an ambulance station in 2018–19 was is quite different to what it is in 2024–25.

Bev McARTHUR: Secretary, you cannot possibly tell us that $30 million is a responsible figure. Anyway, Secretary, can you tell us: once it is completed, will it be manned 24/7?

Euan WALLACE: I believe it is a 24/7 station, but I would need to take that on notice I think and find out for you.

Bev McARTHUR: Okay, thank you very much. How many ambulances will be held in this $30 million Taj Mahal?

Deanne LEAVER: We are still working through the scope and designing how many bays will be available within this ambulance branch.

Bev McARTHUR: Would you be able to, when you work through your scope, give us the information of how many ambulances it will accommodate?

Deanne LEAVER: We can do that.

Bev McARTHUR: Thank you very much indeed.

Nick McGOWAN: Secretary, just taking your logic, this was promised in 2022 at $30 million. Now we are some years later, what is the expected budget for Armstrong Creek, given that you have put to us that costs have gone up significantly. Will it still remain at this cost?

Euan WALLACE: In the 2023–24 budget it was $30.4 million for Armstrong Creek. I am just making –

Nick McGOWAN: My simple question is: is this still the budget?

Euan WALLACE: We will work with VHBA and AV to manage the cost for the build and to value manage the cost. We have been allocated $30.4 million for Armstrong Creek. But the point I was making was a broader one, which was that we can provide the average cost to build, but the average cost of a build in 2018–19 is very different to 2024–25.

Nick McGOWAN: But you said they were going up, Mr Secretary, so that is what I am confused about. On one hand you are saying they are going up and on the other hand you are saying we have got a project that was promised in 2022 and some three or four years later it is the same. So why is Armstrong Creek the same but everything else has gone up dramatically? It is your logic, not mine.

Euan WALLACE: No, no. The 10 stations were built in 18–19 –

Nick McGOWAN: 18–19? Not 1819?

Euan WALLACE: 2018–19. The 10 stations that were built in 2018–19 would have had their funding provided in the years prior. The funding for Armstrong's Creek was provided last financial year, 2023–24, at $30.4 million.

Bev McARTHUR: Okay. So how much will it increase by, Ms Leaver? Do you know? Given that costs are going up.

Euan WALLACE: We have been allocated $30 million for Armstrong Creek, and we are working with VHBA and AV to deliver a new ambulance station for that funding.

Bev McARTHUR: You are going to stick to the $30 million?

Euan WALLACE: That is the intent.

Bev McARTHUR: Well, we will look forward to seeing you next hearing. Let us go to performance measures now and the PAEC questionnaire pages 134–136. Secretary, why are you failing to meet all these targets? I mean, the number of patients admitted from the elective surgery waiting list was 209,907, despite targeting 240,000 surgeries. Only 64 per cent of semi-urgent category 2 elective surgery patients were admitted within the clinically recommended 90 days, falling well short of the 83 per cent target. And I can go through a whole lot more.

Euan WALLACE: Let me address the targets that you mentioned. The planned surgery target I alluded to in my answer to Mr Galea around the COVID catch-up plan. Back in early 2022 we set a very ambitious target of 240,000 extra in care provision, and when we take into account all of the additional things that were enabled and made possible by the COVID catch-up plan, 233,000 patients were cared for. Under the strict definition – the business rule, if you like – for planned surgery, we saw just shy of 210,000. But I think it is misleading to say that the 1702 patients who had a non-surgical pathway, which was not open to them before the COVID catch-up plan blueprint and the reforms were put in place, did not receive care. They did receive care. It did not end up in an operation. Thankfully for them they got the same health outcomes, the same benefit intended, but avoided surgery. There were still 1702 patients that received care. With the investments that we have made to our planned surgery capacity – so nearly 200,000 patients – total care was provided to 233,000 patients.

Bev McARTHUR: Secretary, how long do I have to come here and hear that COVID is the continual excuse for everything that is a problem in this government?

Euan WALLACE: No, I did not suggest that. The reasons that the planned surgery reform was initiated, as I said in my answer to Mr Galea, were largely twofold. That government investment was to do two things: first, to accelerate recovery from COVID, when we had to switch off our operating theatres for planned surgery to make capacity in our hospitals for those with COVID. You might recall, back in the days of omicron, we had thousands of patients in hospital. With COVID they needed access to those beds, and necessarily creating space for those beds by switching off or decreasing planned surgery at the time was appropriate. So the first intent of the investment was to accelerate recovery. Our planned surgery waiting list has fallen by 30 per cent. I cannot think of another health system anywhere else in the world that has seen that rate of recovery. Again – these are not my observations – I refer to the Productivity Commission's observations.

Bev McARTHUR: Is that the new Productivity Commission, the most recent one? We do not give that a lot of credit.

Euan WALLACE: Yes, the ROGS this year shows that the waiting time for planned surgery in Victoria is lower than every other jurisdiction in the country. That in part is due to the capabilities we had prepandemic and then the reforms that we put in place as part of this catch-up plan. And then the second thing that that investment was to do was to allow us to undertake the systematic progressive reform to planned surgery capability so that we can futureproof our system, so that when the next pandemic comes – and there will be another pandemic – we will not have to switch off planned surgery the way we have done, because we can do it through ring-fenced rapid access hubs where only planned surgery is done and we can leave our main hospitals then to be able to cope with those other demands.

Bev McARTHUR: Secretary, the proportion of ambulance patient transfers within 40 minutes fell nearly 25 per cent below the target value. Secretary, why are you failing to meet that target?

Euan WALLACE: I might ask Ms Geissler to add. I will just make an introductory comment, and then I do not know whether Mr Crisp or Ms North, who are here from AV, might also help. But as we discussed I think at previous committees, the whole pipeline of emergency care, one component of which is the handover from ambulance to ED, has been a wicked problem – a wicked problem not just for us but for pretty much every advanced healthcare system in the world. We have taken a very systematic improvement approach, and I might ask Ms Geissler for some of the work that addresses this particular bit of the pipeline, which is the handover from AV to ED.

Jodie GEISSLER: I will just comment a little bit on the metrics that you are referencing in terms of handover times. They have actually improved. We have seen 65 per cent of handovers completed in 40 minutes in 2023–24. That was higher than 2022–23. As you know, all category 1 patients continue to be seen

immediately on arrival. Over 70 per cent of patients are seen in the ED within recommended times – that is higher than 2022–23 – and our median wait times in ED at the moment are 15 minutes, which is 4 minutes better than the previous year. A lot of that is due to the significant work that has occurred under the timely emergency care collaborative. We have had a number of health services participating in that, and that continues to grow. It started at 14 health services, and we are moving up to 28 health services.

Between February 2023 and 2024, across those participating sites, we saw some significant results. We reduced the average emergency department length of stay for admitted patients by 55 minutes and non-admitted patients by 14 minutes. We reduced the average time for emergency department arrival to clinical decision to admit by 11 minutes. We have reduced the ambulance handover time by 11 minutes, and we have increased the percentage of patients discharged before 12 pm by 4 per cent. As the Secretary has said, this is a system challenge, so you have to actually approach each part of the hospital – and they all play a role, right from the very front door and the handover and the role of AV, right through to the very back and the discharge of patients in a timely way. The timely emergency care collaborative has been incredibly important in that regard, and that has been largely the work of our hospitals but AV has also been deeply involved in that.

Bev McARTHUR: Great. Thank you very much.

Euan WALLACE: Can I just –

Bev McARTHUR: I would like to move on, Secretary, to electronic medical record systems, please – budget reference 2023–24, budget paper 3, page 54. What is the electronic medical records system that will be rolled out to all Victorian hospitals?

Euan WALLACE: Thank you. Look, there are –

Bev McARTHUR: While you are there, the timeline and projected cost.

Euan WALLACE: There are two bits to that, and much of it is laid out in our digital health roadmap that we published a couple of years ago. There are two bits to it. One is that the individual hospital has an electronic health record – EMR EHR – and with guidance from the department and the eHealth division in the department, broadly the health services have some freedom and some latitude to choose which system. Unlike our counterparts in New South Wales that have decided to go with a whole-of-state system, we have chosen that our health services – and I will come back to some constraints on it – have some choice about their system, because the modern EMR products all have connectivity, which takes us to the second bit of the system.

Again, I think we talked about this at a past hearing – our health information legislation now enables sharing of health information between providers. We have built CareSync, which is the electronic solution to splicing all these EMRs together. It will be rolled out I think in January at the Austin, and then progressively across metro services next year and the year after, and then across the state. It will actually include any health services that do not have an EMR, so small country hospitals that do not have an EMR. Even ahead of them getting an EMR, CareSync will still enable them to access health records of patients that are presenting to them that have presented to a health service that does have an EMR. Again, Austin ED early next year, and then progressively rolled out across metro services first and then regional and rural services 2025–26 and onwards. So there are those two bits – individual EMRs and then CareSync, which will splice them together. I did say there is some constraint, and I think Mr O'Brien asked about LHSNs. The intent will be and there was investment in the budget this year for funding for EMRs at a regional level. So the intent is that within an LHSN those services will all be on the same EMR, and preferably on the same instance of the same EMR, to give more seamless –

Bev McARTHUR: Secretary, New South Wales committed $1 billion – you told us this last year – in 2023–24 to connect all health services. Why is Victoria not matching this investment or rolling out the gold-standard EPIC system?

Euan WALLACE: Well, actually we think our approach is preferable.

Bev McARTHUR: Thank you.

The CHAIR: Thank you, Mrs McArthur. We are going to go straight to Ms Kathage.

Lauren KATHAGE: Thank you so much, Chair. Secretary and officials, thank you for joining us. I want to start by asking about women's health, which is the part of this government's work that I am probably most proud of. Looking at BP3 from 2023–24, it sets out an initiative giving women's health the focus and funding it deserves, which I think we can all agree is a good thing. What activities sit under that, and how are they contributing to better outcomes for women and girls?

Euan WALLACE: Thank you. In the 2023–24 budget there was about $154 million specifically for the focus on women's health, building on an investment in the prior budget of about $87 million. In 2022–23 that was about funding women's health organisations around health promotion and education. In the 2023–24 budget the investment was principally around eight key initiatives. I might just run through those but then ask Professor Wainer, whose portfolio is leading this for us, to give us some further information.

The eight key initiatives were 20 new women's health clinics, including a dedicated Aboriginal women's clinic; a mobile women's health clinic, and I think I referenced that clinic in my introductory comments; the partnership we have with BreastScreen to develop their very trusted brand to expand women's health care; 10,800 more laparoscopies, and we completed, in two targets, 1200 of those in 2023–24; nine new sexual and reproductive health hubs, bringing the total of those to 20; funding to some non-government organisations to establish further women's health and wellbeing supports; further progress on the women's health research institute; establishing the inquiry into pain management that I referenced, and we can give you further information on it; and then some workforce scholarships. So those are the broad areas of focus on that investment, but I might ask Professor Wainer to provide further information.

Zoe WAINER: Thank you, Secretary. I think it is also important to consider that when we talk about women's health we are discussing actually a range of conditions and experiences that directly impact women, both cisgender and transgender women, but may also be relevant and important to transgender men and non-binary people who are assigned female at birth and who may experience similar health issues or gender-based discrepancies in care. When we consider women's health we incorporate both female-specific conditions, whether tied to women's reproduction or some other facet of women's biology, and generally health conditions that may affect women differently or disproportionately, as well as conscious or unconscious bias in the system that also impacts women's health outcomes. Obviously, this can be conditions that pertain generally to females, including contraception, fertility, maternal health and gynaecological oncology. Importantly the women's health program is looking beyond just sexual and reproductive health and considering general health conditions that impact women differently, such as cardiovascular disease, and disproportionately, such as autoimmune disease, migraines and osteoporosis, or which are characterised by gender-based discrepancies in care, which includes medical research design, pain management and mental health.

In terms of the women's health investment to support the health and wellbeing outcomes of all Victorian women and girls, the government invested $153.9 million over four years through, as you said, the 'Giving women's health the focus and funding it deserves' 2023–24 state budget initiative. Through this investment we aim to improve women's health and equity as a fundamental human right to high-quality services and for women to have a choice in selecting a service and making health-related decisions that work best for them. This investment further reinforces Victoria's position as a leader in sex- and gender-centric healthcare. As the Secretary mentioned, it includes the women's health clinics, and we are currently establishing these clinics.

Over the next four years there will be 20 clinics across the state in addition to an Aboriginal women's health clinic and, as the Secretary mentioned, the mobile women's health clinic as well. The first five clinics, launched in April this year, are operational and are gradually expanding their services and hours of operation. The clinics are operating at the Royal Women's Hospital; Peninsula Health in Frankston; Northern Health, Epping; Barwon Health, Geelong; and Grampians Health, which now offers services across Ballarat, Horsham and Stawell. Services offered at the clinics are delivered by a multidisciplinary team of qualified health professionals, including registered nurses, and they are all supported by practice coordinators to promote a smoother consumer experience and a referral pathway. The second tranche of the next five clinics was announced in October and will commence services in early 2025. The second tranche includes Monash Health, Western Health in Sunshine, Eastern Health Blackburn, Central Highlands Rural Health in Kyneton and Goulburn Valley Health in Shepparton. The additional 10 women's health clinics will be rolled out over the next two years.

These clinics are providing inclusive, confidential and safe women's health services without judgement and are ensuring access closer to home, providing a critical service which was not available until now and making it easier for women to access specialist care for sexual and reproductive health needs, medical and surgical abortion care and contraception and conditions such as endometriosis, pelvic pain, polycystic ovarian syndrome, heavy bleeding, incontinence, perimenopause and menopause. As the Secretary also mentioned, we have the Aboriginal women's health clinic, which is a dedicated Aboriginal women's health clinic, and it will be the first in Victoria. We are currently working on establishing that clinic.

In terms of a bit more detail on the mobile women's health clinic, because this is a really important clinic for women in rural and regional areas, it is a nurse-led mobile women's health clinic. It was announced in September and will commence service delivery shortly in regional Victoria onboard BreastScreen Victoria's van, known as Nina, offering girls and women of all ages access to sexual and reproductive health services and breast cancer screening under one roof. The service will focus on servicing Aboriginal and Torres Strait Islander women residing in regional and rural Victoria. Women will be able to receive confidential, safe and free consultations for sexual health testing and treatment, contraception, medical abortion where possible and referral to surgical abortion as well as other local health services available in the community.

The Secretary also mentioned the laparoscopies. We are also significantly increasing the number of laparoscopic surgeries available to improve the diagnosis and treatment of endometriosis and related conditions, which we know can be debilitating and affect one in 10 women. In 2023–24 we delivered over 1200 laparoscopies and are well on track to deliver the target for 2024–25 of an additional 2400.

In terms of the women's sexual and reproductive health hubs, the Victorian government has been a leader in destigmatising women's health conditions and strengthening the sexual and reproductive health of Victorian women, girls and gender-diverse people. The expansion of women's sexual and reproductive health hubs has increased the number of hubs across the state to 20, 12 in regional Victoria and eight in metropolitan Melbourne. Six new hubs have been established this year, joining the current network of 14 hubs in delivering sexual and reproductive nurse-led free or low-cost care, including contraception, medical abortion, referral for surgical abortion and sexual health testing and treatment. New hubs were established in locations of greatest service need, with a focus on establishing services in regional and rural Victoria, including Sunraysia Community Health Services in Mildura, Central Highlands Rural Health service in Kyneton, Nexus Primary Health in Wallan, DPV Health in Broadmeadows, DPV Health Medical Centre in Mill Park and IPC Health in Wyndham Vale. We know that women need and are accessing our services. Between 1 July 2023 and 30 June 2024 a total of 8557 women accessed these services at the hubs.

We continue to support 1800 My Options, which is a phone line and website established in 2018. Funded by the Victorian government, it receives more and more calls every month from women seeking accurate, timely and reliable information and advice on accessing contraception and abortion services. Women's Health Victoria, which operates this service, reported receiving approximately 650 calls per month in 2023–24 from girls and women across all of Victoria. There were 703 calls alone in October this year. 1800 My Options also includes a geomapped database of women's sexual and reproductive health services across Victoria.

We also have the women's health and wellbeing support groups and programs. We have 13 women's health and wellbeing support programs and groups for women which are set up across metro and regional Victoria and led by non-government organisations. These programs vary in their scope in line with local community needs and offer peer-to-peer support, local connections as well as trusted advice and services for women seeking support across all life stages. Groups include support for young mums, women experiencing menopause, women with experience of abortion, women who have experienced trauma, multicultural women and First Nations women.

The groups are critical in improving women's physical and mental health and wellbeing, as well as empowering women and better connecting them to their local community and support networks. For instance, the Gippsland women's health group facilitates a health literacy program for women to support women of all ages. Zoe Support Australia provides support for young mums in Mildura to help them make informed decisions and seek health care. The Mullum Mullum Indigenous Gathering Place provides the Sista's healthy yarning circle to support First Nations women through a trauma-informed lens to achieve improved health and wellbeing. The Wellsprings for Women program provides support for women who are asylum seekers, refugees and from migrant backgrounds with complex needs. The Abortion Project is a face-to-face peer

support group for people with experiences of abortion in North Melbourne, and Women's Health in the South East offers menopause support.

A quote from the women's health support group annual event is, 'Each woman has a specific need, specific knowledge and experience, so we need to work in partnership with them to give them good care.'

Bev McArthur interjected.

The CHAIR: Excuse me. Please continue, Professor.

Zoe WAINER: Thank you, Chair. We also have women's health scholarships. The workforce supporting the hubs and clinics, such as nurses, nurse practitioners, midwives, GPs and allied health professionals are also benefiting from the women's health scholarship program, helping to address existing skills and knowledge shortages when it comes to women's health. More than 150 scholarships were distributed in 2023–24, offering chances to upskill in areas such as IUD insertion, sexual and reproductive health, pelvic physio training, menopause and polycystic ovarian syndrome. The scholarships also fund training to promote cultural safety and remove existing barriers for First Nations women, women from migrant and refugee backgrounds and LGBTIQA+ communities. More scholarships are available in 2024 and 2025. We also have the women's health research institute business case development. As I mentioned earlier, females and women have often been invisible –

Bev McArthur interjected.

The CHAIR: Excuse me, Professor. Is there a point of order, Mrs McArthur?

Bev McARTHUR: Yes, there is, Chair. Professor Wainer has just read nonstop from a document. It would save us all a lot of time and we would get all more interested if you just tabled it.

The CHAIR: That is not a point of order, Mrs McArthur, and you know it. Points of order are not an opportunity to be grandstanding before this committee. Excuse me. Professor Wainer, please continue.

Zoe WAINER: Thank you, Chair. It should therefore not come as a surprise that out of 10 drugs removed in the US between 1997 and 2000 due to life-threatening adverse effects, eight showed greater severity in women. Our understanding of women's health will be improved through our investments into women's health data and research, and we are working on a business case for the first women's health research initiative in Victoria, which will undertake women's biomedical, clinical and health services research. It will look at the impact of sex and gender variables on health outcomes, how we can better draw on the voices and the lived and living experiences of women, as well as enable its translation into policy and practice. We also have the inquiry into women's pain in January 2024. We launched –

Nick McGOWAN: Point of order.

The CHAIR: Excuse me, Professor. Mr McGowan, a point of order.

Nick McGOWAN: Further to member McArthur's point of order, if all witnesses are going to do here today is simply read verbatim, every word, then they can simply table their documents and, as Mrs McArthur said, save this committee a lot of time. This is not in the spirit of the committee, to simply read from a document verbatim. To use notes as an assistance, sometimes to refer to documents, that is fine. But verbatim reading, I would suggest, is not in the spirit of this Public Accounts and Estimates Committee's work.

Lauren KATHAGE: On a point of order, Chair, the Liberal members may not be interested in hearing about women's health improvements in Victoria, but I certainly am. I have appreciated the evidence that has been presented. I have been taking notes for things to follow up in my electorate, for things to learn more about and for things to help the women in my electorate, and I suggest that those over there may like to listen as well because there is a lot to be learned and there is a lot to put on the record.

Bev McARTHUR: Point of order, Chair.

The CHAIR: Mrs McArthur, on the point of order.

Bev McARTHUR: Ms Kathage has suggested we are not interested in women's health. We absolutely are. And to make the point, you can explain exactly why you are shutting down obstetric services at the Camperdown Hospital and women will have to travel long distances to get their care.

The CHAIR: Mrs McArthur, that is not on the point of order, and you know it. There is no point of order. I would say that Professor Wainer has thought about women's health and is giving very comprehensive evidence before this committee.

Bev McArthur interjected.

The CHAIR: Thank you. There is no point of order. Professor Wainer to continue.

Euan WALLACE: Chair –

The CHAIR: I have ruled on the point of order, Secretary. I am happy to continue with Professor Wainer unless there is something –

Bev McArthur interjected.

The CHAIR: Excuse me, Mrs McArthur. It is not an invitation for you to talk.

Euan WALLACE: Chair, I really just wanted to add that this investment by government in women's health is a focus, and it is rich and complex. Professor Wainer I think is just really trying to share with the committee all of the diverse actions that the department has been undertaking on behalf of government in this past financial year.

Lauren KATHAGE: I am ready to go on, Chair.

Bev McARTHUR: Point of order, Chair. The Secretary has just –

The CHAIR: Excuse me, Mrs McArthur. You will wait until you are called. Is this a point of order or is this another piece of commentary?

Bev McARTHUR: It absolutely is, Chair. The Secretary has just suggested Professor Wainer has a lot to tell us. We are grateful for that. But given that she is reading from a very well resourced statement, she could just table it. That would be fantastic. Hansard would not have to take notes.

The CHAIR: Mrs McArthur, I should not have to tell you that I have already ruled on this point of order. We will be moving forward. Professor, please continue.

Zoe WAINER: Thank you, Chair. In terms of the inquiry into women's pain, in January 2024 we launched the inquiry into women's pain, which was the first inquiry ever held in Australia to focus on women's pain conditions and their living and lived experiences of pain and seeking pain care. The inquiry heard from over 13,000 Victorian girls, women, carers and clinicians between January and September 2024 and highlighted that women face real and enduring challenges when seeking care and support for pain.

Lauren KATHAGE: On that, Professor, when I held a women's pain forum in my electorate I heard many experiences from women, and you have just spoken about the challenges that women can face. One of the women shared an experience of having her pain not treated by her doctor – he would not prescribe her any pain medication until she took her husband with her to an appointment. He said to the doctor, 'No, it's true. She really is in a lot of pain,' and then he prescribed her pain medication. A lot of women there spoke about the difficulty with the multiple specialists that they need to see and going back and forth with referrals et cetera. You spoke earlier about the opening of women's health clinics. How are the women's health clinics going to assist women like those who came to my health forum?

Zoe WAINER: Those clinics are designed as multidisciplinary team clinics. It is ensuring that you have all of the clinical team that will be available and may be required to support those women in whatever their health challenges are at that point in time. That may be an obstetrician and gynaecologist for that expertise, but it may also be a physiotherapist that is required, for example, with an expertise in pelvic pain or incontinence. It is really bringing that clinical team together to be wrapped around the women and girls seeking care.

Lauren KATHAGE: We had a women's pelvic specialist physio from our local electorate who came to the forum, and she said she was blown away. She said, 'This is exactly what the women who I look after need.' She sees so many women with conditions after birth and the like, so she was very impressed by what was happening.

You mentioned the Mill Park sexual and reproductive health hub which is being run by DPV – and it was great to be at the opening of that – and Nexus in Wallan. DPV and Nexus are very well known and well-trusted health service providers in my community. Is there a deliberate strategy to use existing networks and strategies in rolling out these sexual and reproductive health hubs?

Zoe WAINER: Absolutely. It is using existing infrastructure capability but also really understanding where the need is. Part of the team's work is really understanding what the local community's need is, and it is actually the local community health providers who really understand their community and their populations and what is needed.

Lauren KATHAGE: And I guess local would understand local referral.

Euan WALLACE: Ms Kathage, you have called out DPV – I should acknowledge that we had our Victorian Public Healthcare Awards this week on Tuesday, and DPV won one of those awards for the work that they have been doing.

Lauren KATHAGE: Yes, they are fantastic in our community. I think the year previous they might have won an award for their cultural navigators as well. I am sure you can imagine it can be quite confronting for women who speak English as a second language to try and understand where to get help, especially for conditions that people might not feel comfortable talking about. That is really fantastic. The inquiry that started this year, where are we up to with that, Professor?

Zoe WAINER: As I mentioned, we have had over 13,000 submissions through that inquiry. We have had many round tables, one of which obviously you participated in, and we are hearing some pretty challenging feedback from lived experience both from women as well as clinicians. One of the quotes I have from the inquiry from 20 August was, 'There is a lot of stigma around pain, and I was treated like a drug addict,' which is exactly what you were referencing from your local member. They also have told us about cases of delayed diagnosis, the high cost of care and the impact that pain can have on the quality of life and relationships with family and friends and carers. We have heard incredibly powerful lived experience from women who feel that their pain is ignored. We have heard women who present to emergency departments with chest pain who are dismissed. I think there is a huge opportunity for the pain inquiry to really dig down and understand what the drivers of that are so that Victorian women and girls receive the care they need.

Lauren KATHAGE: Thank you.

The CHAIR: Thank you, Professor. Thank you, Ms Kathage. The committee is going to take a short break before resuming its consideration of the Department of Health at 11:15 am. I declare this hearing adjourned.

The committee will now resume its consideration of the Department of Health. We go to Mr O'Brien.

Danny O'BRIEN: Thank you, Chair. Secretary, can I move to mental health. In previous hearings we have asked for an updated Royal Commission into Victoria's Mental Health System implementation plan. Could we ask for that again, but on this occasion could we include a summary of progress against all recommendations, a revised implementation date for overdue recommendations and, where relevant, an explanation as to why recommendations are overdue?

Euan WALLACE: We might be able to answer some of those questions for you this morning if you are interested.

Danny O'BRIEN: It is a very long list of recommendations –

Euan WALLACE: It is. Can I say that – and I think the minister may have shared this in the ministerial PAEC earlier in the year – of the 74 recommendations, both interim and final report, we have either started or completed 90 per cent of them.

Danny O'BRIEN: And I do have some specifics I will go to now, but if you could provide that update.

Euan WALLACE: Yes. We can do that.

Danny O'BRIEN: Thank you very much. According to the plan that you provided after the May hearings, three of the nine interim report recommendations remain in progress. That was handed down five years ago, so why are recommendations 5, 6 and 7 not complete?

Euan WALLACE: I might ask Ms Whetton just to give us an update on those. So 5, 6 and 7 – that is, 'Core functions of community mental health', 'Helping people find and access treatment, care and support' and 'Identifying needs and providing initial support in mental health'. Is that right?

Danny O'BRIEN: No. The ones I have got –

Euan WALLACE: Oh, the interim ones.

Danny O'BRIEN: Yes, they are interim. So 5, 6 and 7 –

Euan WALLACE: 'A service designed and delivered by people with lived experience', 'Lived experience workforces' and then 'Workforce readiness'.

Danny O'BRIEN: Correct. Yes.

Euan WALLACE: Apologies.

Katherine WHETTON: Thank you for the question. Recommendation 5 of the interim report was a service designed and delivered by people with lived experience. That is an Australian-first service that would be an alternative to hospital and designed by people with lived experience. The model is being developed with Mind and Alfred Health and with the department, so there has been a big co-design process for what that service looks like and what would be appropriate. The whole idea is that rather than having people going to acute settings in hospitals they would be in a more homelike therapeutic environment. So there is both –

Danny O'BRIEN: I am conscious of my time – sorry, Ms Whetton. I am wanting to know why they have not been delivered.

Katherine WHETTON: It is being delivered. We are looking at where that service would be and then the model of design. Co-design can actually take some time if you are going to do it authentically, so –

Danny O'BRIEN: When do you expect it will be formally delivered?

Katherine WHETTON: I do not have that information to hand, but I would say over the next couple of years we should see it fall into place.

Danny O'BRIEN: Recommendations 6 and 7 relate to workforce delivery and again have not been delivered. How has the failure of delivering those two in particular restricted the delivery of other implementations because of the limited workforce issues?

Euan WALLACE: They are both listed as in progress, and we have talked previously at this hearing about workforce. I think a couple of years ago we talked about JMOs, which had a deadline of 2023, and we have delivered on the JMOs. Then the rest of the workforce, both lived experience workforce and then workforce more broadly – it is a continued journey, right? If you look at the workforce, the FTE in 2023–24 compared to 2022–23, there was a 16 per cent increase. So the rate of workforce expansion – and it varies by, are they doctors, are they registrars et cetera –

Danny O'BRIEN: I am actually going to come to that in a moment.

Euan WALLACE: The rate of workforce expansion broadly in the mental health workforce is running at about 17 per cent compared to the broader health workforce I referenced in my comments, which is about 6.5 or 6.7 per cent. So we are expanding the mental health workforce at double the rate of the non-mental health health workforce and –

Danny O'BRIEN: Sorry, just to get to the number, when will those three recommendations finally be implemented?

Euan WALLACE: Well, the commitment was to double the workforce by 2031, I think. Again, the end date is 2031. That was the commitment of government back in 2022 – to double the workforce. We are growing at, again, about 17 per cent per annum.

Danny O'BRIEN: Okay. Recommendation 29 from the final report was to create Our Agency for people with lived experience of mental ill health. That is overdue. When will it be launched?

Euan WALLACE: I think it was due at the end of this year, and in terms of progress –

Katherine WHETTON: Again, this is one where there is a co-design process, and we are working with our partners SHARC and VMIAC, again, to work up a model. The thing with a lot of the royal commission recommendations is that a lot of these things, whether it is an entity or a new service, have never been delivered before, so we are really starting from scratch for a lot of these things. So again it is a piece of work that is underway.

Danny O'BRIEN: So it will not be operational by the end of this year, I assume?

Katherine WHETTON: Not at this stage.

Danny O'BRIEN: Can you give me a ballpark estimate of when?

Katherine WHETTON: Again, in the coming years.

Danny O'BRIEN: The coming years? Okay. The mental health levy: Secretary, are you able to provide an acquittal of all mental health levy expenditure – sorry, revenue and expenditure?

Euan WALLACE: The revenue is in the budget papers. I think the revenue for 2023–24 was $1.2 billion. Again, I think we have discussed at this hearing and also at the minister's hearing that it is legislated that all of the moneys raised by the levy are spent on mental health, and that has been the case. So if you just compare the output – never mind the capital expenditure for mental health, which has been about $1.7 billion since 2019 – in 2023–24 it was $2.7 billion and if you look at the last year before COVID, when it was stable, or even the 2019–20 year, it was $1.7 billion and the year before that it was $1.6 billion.

All of the moneys raised by the levy are spent on mental health, but we do not apportion – with our mental health funding that we get from Treasury we do not say, 'Well, this money comes from the levy and this money comes from normal appropriations.'

Danny O'BRIEN: It is all just bundled in together?

Euan WALLACE: Yes, because necessarily we are about expanding our mental health activity and mental health capital planning to meet the needs so –

Danny O'BRIEN: So just to be clear, then, can you provide us a breakdown of where the levy spending has gone?

Euan WALLACE: Well, we can tell you where the mental health spending has gone –

Danny O'BRIEN: But not the levy.

Euan WALLACE: and that is in our health service annual report, but again, we do not apportion the mental health levy and other mental health revenue.

Danny O'BRIEN: Separately?

Euan WALLACE: We do not separate them.

Danny O'BRIEN: Okay. Is the expenditure of the levy, though, audited by VAGO or anyone else internally or externally – to be consistent –

Euan WALLACE: That is a question for VAGO. We get funding from Treasury for all of our mental health services, and again, $1.2 billion of that last financial year was raised by the levy.

Danny O'BRIEN: Going to your earlier point that the Act requires all of the levy to be spent on mental health, I guess I am getting to the point of how do we assure the public that that is in fact happening. I know you said it, but, with respect, how is it audited to ensure that is the case?

Euan WALLACE: Well, it is. But if you look at the uplift in funding for mental health services, it broadly reflects the additional funding that comes from the levy.

Danny O'BRIEN: 'Broadly reflects' is one thing. Is it audited?

Euan WALLACE: We do not audit in the department.

Danny O'BRIEN: Okay. Are you aware of cladding services Victoria delivering any programs as outputs of the *Mental Health and Wellbeing Act*?

Euan WALLACE: Say that again?

Danny O'BRIEN: Are you aware of cladding services Victoria delivering programs as outputs of the *Mental Health and Wellbeing Act*?

Euan WALLACE: No.

Danny O'BRIEN: It would not be the case, would it. They received funding from the government to pay their mental health levy, so I just wondered whether maybe they were doing something unusual.

I will move on to workforce, which you touched on. What is the net change in the number of FTE mental health workers by skill category or qualification year by year since 2019? You gave me a figure for the percentage increase I think last year, but I am interested in since 2019.

Euan WALLACE: I will have to give you 2019 and 2020 on notice. I can give you 2021, 2022 and 2023. So total headcount –

Danny O'BRIEN: Yes, I am interested in that, but what I am wanting to know is the net change over the five years, basically.

Euan WALLACE: In front of me I only have going back to 2021, and I apologise, but the total headcount in the mental health and wellbeing workforce in 2021 was 11,343. That is a total FTE of 9867.

Danny O'BRIEN: 9867.

Euan WALLACE: In 2023 it was 11,560. So the growth from 2021 to 2023 is the difference between 9867 and 11,560.

Danny O'BRIEN: Let us forget a headcount; let us just go on FTE. So that second figure is FTE as well?

Euan WALLACE: Yes. That is the specialist public mental health service workforce. We also have a community mental health workforce. We did not collect data for community mental health services back in 2021. We have been collecting that in 2022 and 2023. If we just stick with FTE rather than headcount, the FTE for community mental health services in 2022 was 883, and it was 1088 in 2023.

Danny O'BRIEN: When you say 2023, is that –

Euan WALLACE: Sorry. Apologies. The total FTE in 2022 was 883 and in 2023 it was 1088.

Danny O'BRIEN: Yes. When you are saying 2023 for both of those figures, is that the end of the 2023 financial year or calendar year?

Euan WALLACE: We take the calendar year. These are reported to us at the end of the –

Danny O'BRIEN: End of the calendar year. Okay, that is fine. Are you able to provide the current workforce data, including the number of workers by skill category or qualification, and the number of vacancies? As in, for now or the end of 2024?

Euan WALLACE: The vacancies are managed by individual health services. We do not typically see the vacancies live. In terms of a breakdown of the categories, we have data on –

Danny O'BRIEN: Could you take that on notice?

Euan WALLACE: Yes. We have some data now, if you would like.

Danny O'BRIEN: I am guessing with 11,500 it would take us a while to go through them. Would you be happy to give it on notice? Thank you. Are provisional psychologists eligible mental health workers to deliver the mental health practitioners in school program?

Euan WALLACE: I think the school program is run out of education, not us.

Danny O'BRIEN: I imagine it is. You do not have any involvement directly in it at all?

Euan WALLACE: No.

Danny O'BRIEN: Okay. What number and percentage of junior medical officers undertook a psychiatry rotation in the past year?

Euan WALLACE: The junior medical rotations in 2023–24 was 132 FTE. As you know, they do not spend a whole year – they rotate through. So 132 equivalent –

Danny O'BRIEN: Over the year.

Euan WALLACE: Yes.

Danny O'BRIEN: Do you know the previous year?

Euan WALLACE: It 132 in 2022–23 and it was 29 in 2021–22.

Danny O'BRIEN: That is the –

Euan WALLACE: Sorry, I will run through that again. In 2021–22 it was 29 FTE, in 2022–23 it was 132 FTE and in 2023–24 it was 132 FTE.

Danny O'BRIEN: Sorry, the middle figure again?

Euan WALLACE: 132 – so it is the same for the same two years.

Danny O'BRIEN: So, both years – okay, great.

Euan WALLACE: In addition to that, there is a commitment on psychiatric registrars – 56 psychiatry registrars so far, and we are on track to deliver the 100 positions by 2026 that were committed.

Danny O'BRIEN: Okay. How many fully funded postgraduate mental health nurse scholarships were granted in 2023–24?

Euan WALLACE: That is the mental health and wellbeing workforce scholarship program. It began in 2021. There have been 1100 in total since 2021. This financial year there were 300 available. I do not have the number specifically for 2023–24, but there have been 1100 in total since it began.

Danny O'BRIEN: If you could take it on notice for 2023–24, including how many applied and how many were unsuccessful, that would be great. The mental health and wellbeing workforce strategy ends this year. It was for 2021 to 2024. Can the department provide a report card on progress against the initiatives outlined in the strategy for each year?

Euan WALLACE: We will be evaluating the strategy in due course. I think I referenced it in my introductory comments. At the beginning of this year, in January, we launched a broader healthcare workforce strategy. Our intent would be that our strategies align with each other, and we have an ongoing health workforce strategy that encompasses all the components of our health workforce. It will have a component that specifically calls out mental health.

Danny O'BRIEN: When will that be finalised?

Euan WALLACE: Well, as you said, our current workforce strategy is sunsetting for mental health. Then we will look to roll out and encompass it as a standout component of our broader strategy. We will be evaluating the various initiatives under both strategies to assess their success or otherwise.

Danny O'BRIEN: Two questions: when will the review be complete, and when will you have the new strategy?

Euan WALLACE: I think the review will be a rolling review of various components – so no particular wholesale review of every single aspect. It will be a rolling review of the various components, so you would expect to see some evaluations coming out progressively. In terms of combining the two strategies, I do not have a timeframe for that today.

Danny O'BRIEN: Okay. The new strategy, though –

Euan WALLACE: Yes, I do not have a timeframe for combining both.

Danny O'BRIEN: Okay. Right. Can you provide an update on the rollout plan for mental health locals statewide, including the expected date of operation for each of the ones that were proposed?

Euan WALLACE: We can. I might ask Ms Whetton to give us an update on the locals. They have been enormously successful.

Danny O'BRIEN: There are quite a number of them, though, aren't there?

Euan WALLACE: Yes, and on a visit to Gippsland with the board we visited the mental health local in Latrobe.

Danny O'BRIEN: Probably not the one in Leongatha, though, because I do not think it has happened.

Euan WALLACE: That is right.

Danny O'BRIEN: Could I ask for that to be taken on notice, because there are quite a number of them, I think, aren't there?

Katherine WHETTON: There are 15 that are currently operating. Some started in late 2022; others started towards the end of 2023. Planning continues for the future rollout of the locals.

Danny O'BRIEN: How many more are there?

Katherine WHETTON: The government made a commitment of up to 50.

Danny O'BRIEN: Up to 50. So, the question is: can I get on notice the rollout plan for those?

Katherine WHETTON: The planning work is underway. There is not a finalised plan, as such.

Danny O'BRIEN: Okay. Is there a final date as to when they will all be delivered?

Katherine WHETTON: Not as yet.

Danny O'BRIEN: Okay. I am going to move on. Secretary, the annual report mentions the statewide drug action plan, of which $95 million is allocated. Is there a breakdown of that spending available on what it is actually all going to?

Euan WALLACE: I suppose this is the AOD funding.

Danny O'BRIEN: Yes, the statewide drug action plan.

Euan WALLACE: Oh, the statewide action plan.

Katherine WHETTON: Mr O'Brien, this was the statewide action plan that was launched in April this year. It was $95.1 million, all focused on harm reduction. The breakdown is that there is a community health hub that will be based in the Melbourne CBD.

Danny O'BRIEN: Flinders Street, yes?

Katherine WHETTON: In Flinders Street. And that is an investment of $36.4 million.

Danny O'BRIEN: Is that to fit it out?

Katherine WHETTON: In effect to refurbish it and have it ready for services. There are also wraparound health and support services at that hub, so there will be the services delivered there. There is $9.4 million for that. At that same hub there will also be a hydromorphone trial, the first one in Victoria, and that is an investment of $7.2 million. There is also going to be some intensive case management of people in the CBD, and that is a $1.2 million investment. There is also more outreach being undertaken in the CBD and two other Melbourne locations. There is an investment there of $21.3 million. We are also working right now on boosting pharmacotherapy treatment in up to 30 locations across the state. There is a grants program. Applications are either open right now or have just closed for those for community-based pharmacotherapy.

Danny O'BRIEN: How much is that?

Katherine WHETTON: An investment of $8.4 million. There is also a trial of naloxone dispensing machines that will be rolling out. There is an investment there of $4.4 million. There is also what is going to be called Never Use Alone, an Australian-first overdose prevention and response helpline, with an investment of $3.1 million. And then there is work underway on a Victorian AOD strategy and also the appointment of Victoria's chief addiction medicine adviser, who has just been recently appointed, and that is an investment of $900,000.

Danny O'BRIEN: Okay. Thank you very much. On the same topic, Secretary, how many people have been turned away from a sobering-up centre?

Euan WALLACE: We do not collect those data to report on accurately. I think there has been coverage of an individual, but we do not collect the data on numbers of people.

Danny O'BRIEN: Okay. Do you collect data on how many people have been cared for at a sobering-up centre for longer than 4 hours?

Euan WALLACE: We certainly have data on the number of clients cared for in our sobering-up centres – yes, we do. From November last year until the end of June, so in the last financial year, there were 11,731 outreach services from our services and then 696 attendances at the sobering-up services themselves, so 11,731 outreach and 696 –

Danny O'BRIEN: Do you know how long any of those 696 stayed there?

Euan WALLACE: We do not collect that information.

Danny O'BRIEN: Okay. Thank you.

The CHAIR: Thank you, Mr O'Brien. We are going to go to Mr Hilakari.

Mathew HILAKARI: Thanks, Secretary and officials, for your attendance this morning. I appreciate your answers so far. I am going to take us to the community pharmacist pilot. Minister Thomas and I were at a community pharmacy in Point Cook earlier this year, and Cyrus, who is the community pharmacist there, really loves the program. He told us about how much the community loves and uses the program. I am just hoping you could talk through some of the extra access that Victorians are getting to health care.

Euan WALLACE: Thank you. It is a great program, isn't it? You will forgive me if I say that Scotland has been doing this for nearly 20 years –

Mathew HILAKARI: Do not rub it in.

Euan WALLACE: Look, as you would have seen, it is first and foremost about patient-centred care. It is really about improving access and removing barriers. Government provided $19.9 million for a 12-month pilot, and we have used that money to extend it a bit longer. It started back in October last year, and we developed it very quickly. I might ask Professor Wainer to give us insights into how we did it, but it is fair to say that we leaned very heavily on overseas experience from Scotland, New Zealand and Canada, but also on the early insights that we got from colleagues in Queensland. Queensland have a version of this, and now New South Wales also. They are all slightly different, but we are very grateful to colleagues in Queensland for sharing their insights.

As you know, under the start-up pilot this was about enabling pharmacists under what we call a structured prescribing model to provide treatment for uncomplicated UTIs in women, resupply of the oral contraceptive pill, vaccinations – travel vaccinations but also a small list of others: hepatitis A, hepatitis B, polio and typhoid – and then treatment for mild skin conditions like psoriasis and treatment for shingles, and both of those are just in adults. It has been enormously successful, and again, we thank our colleagues in pharmacy – the pharmacy guild and others – for assisting us in putting this together. As of June this year, over 790 community pharmacists have enrolled and undergone the training that we have provided, and I think, very reassuringly, 27 per cent of those pharmacists are in rural and regional Victoria. That has been really important, because it can be difficult to get access to your GP, particularly out of hours, for a UTI in metro Melbourne. Those challenges are, as you know, magnified the further you get away from postcode 3000, so that 27 per cent of the community pharmacists are in rural and regional Victoria has been very reassuring.

Now over 23,000 services are delivered through those almost 800 pharmacists – 11,000 for women presenting with a UTI. I know there was anxiety expressed from some quarters about the safety of that program, and it is proving very safe. Who would have known that women knew when they had a UTI and that they could be trusted to go to the pharmacist and get the medication? Wonderful. And 6500 women are getting their prescription for the oral contraceptive pill renewed. They are currently doing about 2500 consultations a month, taking the burden off our GPs, who can focus and concentrate on other things that are more complicated.

Before asking Professor Wainer just to tell us about the details of how it was implemented, which she is far more across than I am, can I just share with you some of the data on satisfaction, which are just amazing. Ninety-six per cent of users who have rated the service have said that they are either satisfied or very satisfied – and the majority of that 96 per cent actually were very satisfied – 98.5 per cent said that the services met their healthcare needs and 98 per cent said that they would recommend the service to other people in the future. An extraordinarily successful program; we are very proud of it. I might ask Zoe to give us an update on –

Mathew HILAKARI: Just before we go there – and you might be able to fill me in on some of this information as well – I am interested also in the uptake over time for pharmacists but also users of the program, because I actually think one of the reasons it is not even higher than it is is that recommendation and knowledge through the community have not spread out in such a way that would mean that it is used all the time, even greater than what it already is. Could you talk about some of the uplift in pharmacists – or maybe Professor Wainer – and uplift in users over time? Because I just see it as a program which is going to get more and more and more, subject to funding of course.

Euan WALLACE: Yes. I do not have a trend analysis of the data over time, but you are right. We have still got community pharmacists coming on board. It was 700 at the beginning of the year, 790 mid-year et cetera, et cetera, and the number of users is progressively climbing, not only because the number of pharmacists is increasing but by word of mouth. It goes back to actually the comment I made to Mr Galea's questions earlier around the PPCCs – urgent care centres – about providing clarity to our population: where do I go for what? And this is new, this has only been with us for barely 12 months – just over 12 months. Who knew that I could go to a pharmacist and get antibiotics for a UTI or treatment for my psoriasis or whatever? It will take time, but the numbers are increasing over time

Mathew HILAKARI: Just from your historical experience, what is the scope of services that are provided in Scottish pharmacies?

Euan WALLACE: I think there is scope to increase this. If you look at other healthcare systems round the world – indeed even our northern colleagues in Queensland – I think it is about progressively expanding the scope of care. There are other very stable conditions that lend themselves to pharmacist-led service provision. Remember that our pharmacists are extraordinarily skilled.

Mathew HILAKARI: Great professionals.

Euan WALLACE: Yes, they are a great workforce. Exactly. For things like stable hypertension, so recurrent prescriptions of antihypertensives, and things like chronic obstructive airways disease – pharmacists are beautifully placed using patient-enabled spirometers to track chronic obstructive airways disease, particularly acute deterioration over winter. And these people, when it is not tracked and they have difficulty accessing the family doctor, their disease deteriorates, and then it is too late and they require admission to hospital. Whereas when it is tracked by the pharmacist around the corner, with their own spirometer, then it is something where the pharmacist can say, 'You know what, I think you need to increase your inhaler', or whatever mediation. So those are two conditions, but there are other conditions. There are other broader scopes elsewhere. Canada, Scotland in particular and now the whole of the United Kingdom have broader scopes. I think for us it was about this is being new for Victoria, it is new for our pharmacists. Each of those scopes of practice, so each of those conditions and their medications, require new education, new training and information from pharmacists. It was about us taking things appropriately and safely, because at the end of the day this is about serving the needs of Victorians safety. But I think given the success, and obviously pending future decisions of government, this is a program that looks like it could be expanded.

Mathew HILAKARI: Cyrus, who is one of the local pharmacists, was able to describe his really positive relationship with so many of the patients that he saw, just a trusted relationship. Sometimes we see in GP clinics you are not always seeing the same GP. Whereas often you are seeing the same pharmacist very regularly; it is point of contact within our health system.

Euan WALLACE: Yes, I agree with you. I give my own experience. I get my COVID vaccinations from my local pharmacist. I have been into my pharmacist to get something else, and he has said, 'Hey, Euan, I'm sure you're due a COVID booster'. I say, 'Okay, maybe not today, but I'll book it in.' So you are right. It is exactly the same. Our community pharmacists are trusted care providers, as our family physicians, our family GPs are. It is about keeping care as close to the patient, the user, as possible. Again, it has been very successful.

Mathew HILAKARI: I am happy to hear any more of the data to fill in the blanks from some of our anecdotes for this much-loved program.

Zoe WAINER: Thank you for that opportunity. I can give you the trended data.

Mathew HILAKARI: Wonderful.

Zoe WAINER: When it commenced in October 2023, in the first month it saw 44 people. In the second month, in November, it went up to 632; December, 1135; January, 1320. This trend continued. We then saw in March 2024, 1763, and that has gone up in June to 2558. So we are seeing that ongoing increasing trend. I think, importantly, one of the other data points that we maintain is 'referred to doctors for treatment post that'. That has actually been pretty stable, which is interesting, and it speaks, I think, to –

Mathew HILAKARI: What does that mean, sorry? You will have to explain that to me.

Zoe WAINER: Obviously when the pharmacist, who has had additional training to do this, has any concerns when the person presents to the pharmacy, then they will refer them on to a GP as part of that quality and safety framework.

Mathew HILAKARI: Okay. Great.

Zoe WAINER: I think we have seen that has actually been a really steady rate despite the increase in the number of people presenting to pharmacies, which I think speaks to the maturation of the program and the safety and quality around it as well.

Mathew HILAKARI: And 44 to 2500 over less than a year.

Zoe WAINER: It is pretty impressive.

Mathew HILAKARI: That is a really great uptake. Secretary, I might talk now on regional health care and in particular the Regional Health Infrastructure Fund. I am just hoping you could maybe give a bit of a summary of some of those programs that have been supported, by reference back, of course, to page 62 of the department's questionnaire.

Euan WALLACE: Thank you, and I might ask Ms Leaver to give us an update on RHIF. It has been a very successful program, providing funding for essential infrastructure upgrades in rural and regional Victoria. Deanne, can you give us an update?

Deanne LEAVER: Thank you. The regional health infrastructure program is the largest grant program of its kind in Victorian history. It does have a total investment of $790 million, and last week we did call for submissions from our health agencies for round 9 of the fund. After round 9 there will be a round 10, so there will have been 10 rounds of the fund over the years. The program itself has funded over 670 projects since its inception. The fund really aims to improve the infrastructure, support service capacity, models of care, patient and staff amenity and service efficiency for those rural and regional agencies. The projects include things like expanding capacity, so preparing those health services for bushfire season; infection prevention control; they have compliance types of works; and minor medical equipment. So as you can see, there is a very wide reach of projects that are delivered.

One of the projects from last year's fund was constructing a brand new community health hub at Heathcote Health. Heathcote Health were successful in receiving $6.5 million from the eighth round of what we call the RHIF. This program will then build a standalone community health hub building, and they will also have two additional staffrooms with ensuites that can be accessed through their existing aged care facility. This will enable the health service to provide for the planned growth. It ensures efficiencies through best practice of co-location and integration of community services and enabling the Better at Home program and telehealth expansion. We are really looking forward to this program. Construction is due to commence in the middle of next year.

Mathew HILAKARI: And the round which has just recently opened – when is that due to close?

Deanne LEAVER: That will close in January, so 10 January 2025.

Mathew HILAKARI: Great. So a big shout-out to all health organisations – they should really get a move on.

Deanne LEAVER: Get out there.

Mathew HILAKARI: Get it in before Christmas to the department.

Deanne LEAVER: Get your application in.

Mathew HILAKARI: Fantastic. Secretary, I am just hoping you could talk maybe through some of the other capital projects funded in 2023–24. I know you covered some of those a little bit in your presentation, but particularly those related to regional Victoria.

Euan WALLACE: Sure, and again I must ask Ms Leaver for an update. In the 2023–24 budget there was specific funding for the health infrastructure fund, HIDF, and it was around seven projects. Then in this year's budget there was an additional $1.62 billion specifically for Monash Medical Centre Clayton, Austin and Northern, so not particularly regional. In the original HIDF funding there was course funding for West Gippsland and also Warragul, and again, as I said in my introductory comments, collectively they make up part of the now 68 active projects and a whole capital plan totalling $15.31 billion. But in terms of other broader infrastructure, particularly in regional Victoria, we are very busy in regional Victoria. I might ask Ms Leaver.

Mathew HILAKARI: I am particularly keen to understand what has been delivered for Latrobe Regional Hospital stage 3 and also the Barwon Health clinic facilities relocation.

Deanne LEAVER: Thank you for that. As the Secretary had in his presentation, we did complete stage 3 of the Latrobe Regional Hospital in Traralgon, which opened to patients in March this year, and that hospital project will boost capacities for local families and can connect them to services they need. That project was $223.5 million and delivered three operating suites, 44 inpatient beds and 14 medical surgical beds, and the new operating suites will allow an additional 6200 elective surgeries to go ahead this year. The project itself also expanded its scope to include a $6.5 million six-bed emergency department mental health and alcohol and other drugs hub. The new emergency department hub will mean that people presenting to Latrobe with mental health, alcohol or other drug issues can be fast-tracked to specialists for dedicated care. This will provide them of course with the right care sooner.

The project itself – there are a couple of other call-outs that are beyond just health outcomes. The project utilised innovations in construction such as digital engineering and virtual reality to ensure that we could have design excellence to ensure successful project completion.

Mathew HILAKARI: What does that mean?

Deanne LEAVER: When we design spaces and we bring our user groups together they will often look at a plan, and it can be hard to tell the size of space in the plan, and so with virtual reality we are able to put goggles on and really project ourselves into the emergency department hub to see how it would be, how we would transfer patients, and how that flow would work. This project has also had a positive impact on the local community. Local content was a key strategy, and initially we achieved 70 per cent local labour. Hydraulic and electrical subcontractors all ensured that material was sourced locally where they purchased hydraulic fixtures and general materials from wholesalers.

In conjunction with this, our contractor also prioritised the use of local shipping and freight services and engaged local civil contractors to ensure that the team was spending money within the Latrobe Valley and supporting local companies. Beyond the construction site itself, the contractor was also active in the community, undertaking career talks at local schools and also employing a local female high school student on a part-time basis as a cadet on the project. This student is concurrently undertaking additional tertiary learning through her school and is now undertaking construction and management at university. So you can see our projects do have a reach much beyond the obvious health outcomes of the buildings themselves.

Mathew HILAKARI: And 6200 more surgeries every year – that is just an amazing outcome for that community. I know Mrs McArthur – sorry, she has left – has many times talked about the importance of hiring local businesses, so I am sure she will be extremely pleased with the 70 per cent. That is fantastic. The Barwon Health clinic facilities relocation – can you talk me through what was delivered through that?

Deanne LEAVER: Yes. The Barwon Health project looked to expand its site to include greater reach within its local community. So that project really looked at bringing together services into the one location, and it was very successful with Barwon.

Mathew HILAKARI: Fantastic. I will, Secretary, take you to the Hospital Infrastructure Delivery Fund, which you just mentioned a moment ago, with Austin, Monash and the Northern. I am just hoping you can talk through some of what we expect to deliver through some of these projects, and we may well end up with Ms Leaver again.

Euan WALLACE: I think we probably will. In general, those three projects are about meeting the ever-increasing health needs of Victorians in metro. Austin particularly is about an emergency department upgrade and will see rapid expansion. But I might ask Deanne for the specifics of Austin, Northern and Monash tower.

Deanne LEAVER: Thank you, Secretary. At Monash Medical Centre we are investing $535 million in the tower expansion for the project, so we are building on top of the existing ED that has been recently delivered, and the new multistorey tower will house additional inpatient and intensive care as well as new operating theatres and provide capacity for up to 7500 more surgeries each year. The expanded birthing suites and the maternity inpatient beds will also support around 2400 births annually. So we have seen significant progress on this project, and that includes appointment of a full consultant team, a refresh of the feasibility study and extensive progress around our schematic designs. We are also working through the enabling works package, and we are really hopeful to be able to come back and present more information on that with the committee next year or in due course.

I might quickly then move on to the Austin project, which was funded for $275 million and will expand the capacity of the emergency department. Austin is one of the busiest emergency departments in the state, so increasing the emergency department and short-stay unit capacity will result in timely and equitable access to care. So we are well progressed on early works on that site.

Mathew HILAKARI: How many extra bays? What are we looking at?

Deanne LEAVER: The uplift there is 29.

Mathew HILAKARI: Twenty-nine. What are they at the moment? Do we know?

Deanne LEAVER: I do not have that to hand.

Mathew HILAKARI: That is all right.

Deanne LEAVER: With Austin –

The CHAIR: Thank you very much, Mr Hilakari. We will go straight to Mr Puglielli.

Aiv PUGLIELLI: Thank you, Chair. Good morning. The Centre for Evaluation and Research Evidence finished stakeholder consultations for the five-year review into the operation of the *Voluntary Assisted Dying Act 2017* back in February of this year. Can you confirm that the review will be released this year?

Euan WALLACE: I am not sure about the timeframes of the review being released. CERE, the centre, has completed its review. I anticipate its release soon, but I do not have a specific timeframe for it.

Aiv PUGLIELLI: Can you take it on notice and look into it for me?

Euan WALLACE: Yes. If I can provide you with a date, I will provide you with a date.

Aiv PUGLIELLI: Thank you. That would be wonderful. Has the department advised government to see that review released this year?

Euan WALLACE: Pardon?

Aiv PUGLIELLI: Has the department advised the government that that review should be released this year?

Euan WALLACE: We have not provided specific advice on a release date.

Aiv PUGLIELLI: Okay. Thank you. Just onto the mental health and wellbeing levy; we just touched on it earlier. The levy has been in place for over two years now. Last month the government rejected a PAEC recommendation to report on the specific department outputs and initiatives funded by the levy. Meanwhile, implementation of the royal commission recommendations has slowed considerably. Mental health spending increased by less than half the inflation rate in this year's state budget; it is effectively a cut. Can I just ask: what proportion of all mental health funding in this state is spent on building the infrastructure, and what proportion is spent on services and staffing? Ideally, a percentage would be great.

Euan WALLACE: So what proportion is spent on –

Aiv PUGLIELLI: Spent on new infrastructure –

Euan WALLACE: Yes.

Aiv PUGLIELLI: and then what proportion is spent on services and staffing?

Euan WALLACE: As you know, we would normally proportion those as outputs and assets, so operational and capex. In that question from Mr O'Brien earlier I said that since 2019–20 the government has spent about $1.7 billion on capital, and our current outputs for mental health are about $2.7 billion per annum. But I can give you a specific breakdown for 2023–24 on capital and outputs.

Aiv PUGLIELLI: And ideally since would be great – and if that could be distilled into a percentage, if that is possible, that would be wonderful. Thank you. Just following up one of the other points that was raised: Cladding Safety Victoria's annual report for 2023–24 has got listed a grant income table with a line item named 'Mental health levy grant'. Why is that there?

Euan WALLACE: That is a question for them, I think, rather than for us. We do not put the levy; we are recipients of the income from the levy.

Aiv PUGLIELLI: But there is not a justification you can provide as to why they would have that listed in their annual report?

Euan WALLACE: I think that is for them, to be honest, rather than us.

Danny O'BRIEN: It is a grant, so the question I guess is: has it come from your department?

Euan WALLACE: No.

Aiv PUGLIELLI: Thank you. Just on another matter, in 2021–22, $7.5 million was allocated for designing a model that establishes Ambulance Victoria as the lead responder in mental health-related 000 calls as opposed to police. I understand implementation of that has been delayed. How much funding has been allocated for this task for the period 2023–24 and since?

Euan WALLACE: I might ask Ms Whetton to update us. This is, broadly again, the royal commission recommendations 8, 9 and 10, so crisis response. I might ask Katherine for an update and then provide the funding update.

Katherine WHETTON: I think you asked about investment in 2023–24?

Aiv PUGLIELLI: And since, yes.

Katherine WHETTON: Yes. $7.8 million was provided over two years in the 2023–24 budget, and that was around planning and design for services for people experiencing a mental health crisis. That funding is mostly focused around work to improve mental health triage in health services, some crisis outreach and also, then, design of safe spaces – that was recommendation 9. So it is all in the planning and design phase. Like a question from earlier, they are things that we have not done before; they are very operationally complex and take quite a bit of work to do. You might have seen too that then the 2024–25 budget did have a small investment, but that was around teleprompt, so supporting first responders. So it is still in the realm of those sorts of services, but yes, not around the planning and design.

Aiv PUGLIELLI: Can I just clarify: the $7.5 million for 2023–24, is that further to the 2021–22?

Katherine WHETTON: Yes.

Aiv PUGLIELLI: Thank you, just getting that really clear.

Katherine WHETTON: Yes, they are similar numbers.

Aiv PUGLIELLI: Does the department have a view as to when we can anticipate paramedics being the mental health crisis responders?

Euan WALLACE: We do not have an agreed timeframe yet. It is complex. Planning and training are underway. There are some training changes for Ambulance Victoria staff, as there are for Victoria Police. But also it is about feeding in such reform to not compromise the overall ambulance performance. The work that Ms Geissler alluded to earlier was around initiatives to improve both ambulance and ED – emergency department – emergency responses; we have to consider that at the same time as this new reform. We do not have an agreed timeframe for full implementation yet.

Aiv PUGLIELLI: I appreciate that. For the purpose of the committee and the work we are doing here, even ballpark, like within the next five years, could we expect it to be done?

Euan WALLACE: I would hope so, but again, I do not have an agreed timeframe.

Aiv PUGLIELLI: Thank you. The Dandenong–Cranbourne corridor is home to the largest and fastest growing First Nations communities in Victoria. It coincides also with the largest number of First Nations children in out-of-home care, meaning this community has a distinct need for wraparound social services that can provide culturally safe and meaningful support. Instead for many years now the local Aboriginal health service, the DDACL, has been stranded in a crumbling building – leaky roof, cracked walls, a front door that I am told is too dangerous to use, and no adequate access for patients with disabilities. Some staff have actually reported having to physically lift wheelchairs to get patients through the door. Over the last three years the DDACL has been calling for urgent investment to avoid the very situation that they are now finding themselves in. I understand one of the buildings was recently closed due to asbestos danger from cracked walls. Can the department confirm: did DDACL secure about $200,000 one year to fix a leafy roof that then broke again the next time it rained?

Euan WALLACE: Look, it is an urgent and complex problem, and I was very pleased to visit Aunty Jenny at DDACL earlier this year to see firsthand some of the challenges she and her team were dealing with. You are correct: we did in the 2023–24 metro health service infrastructure fund, so MHIF – the metro equivalent of the rural fund we were talking about a moment ago – provide funding for critical repairs at that Stud Road facility for DDACL, so-called building 1. It is at the front of Stud Road itself; it is a sort of double block that extends back to the street behind. The building behind the front Stud Road building is still operational, but building 1 on Stud Road itself, 62 Stud Road, was closed I think in early August this year because of deterioration.

VBA have been working with VACCHO and us and Aunty Jenny and her team to find other accommodation. We found some accommodation on Thompsons Road in Cranbourne West largely for the staff and services that were displaced out of the Stud Road building. So the clinic in the back building is still working; admin and some of the outreach services that are sort of office administration and coordination and still require desks for staff have moved to Cranbourne. Both we – the department – and VBA have been working with DDACL and other health service partners in the south-east about other possibilities. And we have reached out to the Commonwealth. We think the Commonwealth has a responsibility to support some of the solutions here, given the ACCOs' Commonwealth funding.

Aiv PUGLIELLI: Thank you. Can I also confirm whether the DDACL received $300,000 for a kitchen renovation where, however, the money actually has not been able to be used because builders have refused to fix the kitchen given the structural issues of the building making it too dangerous? That is before they discovered the asbestos. Did that happen?

Euan WALLACE: We provide funding. I do not know if Ms Leaver has the details.

Deanne LEAVER: Yes. We did provide funding to DDACL through the Metropolitan Health Infrastructure Fund. As the Secretary has talked to, the building itself is quite degraded and has a number of risks. That funding was then to identify what types of refurbishment projects would be suitable. Then they have worked with DDACL to be able to re-prioritise that funding to things that are needed. As the Secretary said, they have then moved a portion of their services out to Cranbourne. So it was not specifically for a kitchen; it was for works, and we identified what those works would be.

Aiv PUGLIELLI: Thank you. Just on the interim location you mentioned earlier, when can we expect that to no longer be required?

Euan WALLACE: Again, we are working with them. Ideally, and for very good reason, Aunty Jenny has asked – she would rather have a solution that has all the teams in the one place, so we are trying to work with them and with others on a solution that sees them all in one place. Again, we do not have an agreed timeframe for that, but it is fair to say as soon as possible, really – working very hard to try and deliver that for them as soon as possible.

Aiv PUGLIELLI: Can the department provide the committee with a breakdown of the state's ACCOs that deliver health and wellbeing services with an assessment of whether each of these services requires significant infrastructure upgrades and then ideally an estimated cost of the funding required for each of these upgrades to be completed?

Euan WALLACE: I do not think we have got such an asset catalogue for our ACCOs.

Aiv PUGLIELLI: It might need to be on notice.

Euan WALLACE: I do not think it exists. I mean, again it is fair to say that we have been working very closely with VACCHO on just that – on our ACCO asset assessment process and then prioritisation. But I do not think such an asset list exists currently, so there is nothing for me to provide.

Deanne LEAVER: No. You are correct in that.

Aiv PUGLIELLI: There is no scope for me to ask for it to be looked into a little bit on notice and come back to the committee? Is that –

Euan WALLACE: I will look at what we have got, but again, I do not think we have an ACCO asset assessment list and prioritisation list and cost estimation list. No such list exists. Again, we do work very closely with VACCHO around what their priorities are for community and for ACCOs, but we have not got a collated list of asset assessments.

Aiv PUGLIELLI: Is it possible for you to create one for this committee for its work?

Euan WALLACE: To be honest, it is a large piece of work to sit down with our ACCOs, for VBA to visit all our ACCOs. Again, we are working with VACCHO on what their priorities are, and VBA is focused then on the priorities and cost estimates for those priorities.

Aiv PUGLIELLI: Thank you. Just moving on to the provision of abortion services, can the department provide the committee with a list of public hospitals that have conscientiously objected to the provision of abortion services?

Euan WALLACE: I do not think we have any Victorian public health service that has conscientiously objected to provision of abortion services that I am aware of. I am aware of that matter elsewhere in the country. We have seen as an explicit response to work done by Women's Health Victoria and others, and in our own needs assessment we have been asking our health services to increase provision of surgical termination. Medical termination is more readily accessed through family doctors and others, but in our public health services, Eastern Health, Monash Health et cetera, we have seen a steady increase in surgical abortion service provision. I am not aware of any service conscientiously objecting to the provision of abortion, whether medical or surgical, and to be frank, that would be in conflict with the statement of priorities. We require our public hospitals to provide abortion services.

Aiv PUGLIELLI: I understand the minister recently had a few public hospitals agree to provide these services, and that was reported in media. So perhaps could you look into it on notice and come back to the committee with that list as I have requested? It sounds like evidently there were some instances that occurred.

Euan WALLACE: No, I do not think it was a conscientious objection; I just think they had not provided it before. Again, the abortion black holes, if you like, that Women's Health Victoria and we and others have done – and Professor Wainer may wish to comment – identified areas where access to abortion was less than desired. That then informed conversations we had with health services to say, 'We now ask you to either increase or provide services if services had not been provided before.' I think that where services had not provided abortions before, it was probably largely because in those areas it had been provided in the private sector, and the very rapidly moving landscape of abortion into medical abortion, away from surgical, has changed the viability of some of those private services, which has then either led to or augmented the black hole provision, which has then led to us saying to public hospitals, 'You need to either increase or start providing.' Again, I am not aware of any public hospital not providing services because of conscientious objection, but Professor Wainer may have more information.

Aiv PUGLIELLI: Perhaps I could rephrase the question. Maybe instead of conscientious objection, it is refusing to provide them for any reason.

Euan WALLACE: We can certainly provide it on notice. We will look into it. Again, I am not aware of any.

Aiv PUGLIELLI: Thank you. I understand the TGA made changes in 2023 that would enable more of our health practitioners to prescribe the medical abortion pill MS-2 Step. Since this was announced, can the department provide the committee with data as to how many nurse practitioners are actively prescribing this?

Zoe WAINER: I can take it as a question on notice. We do not have the actual number, but we certainly have seen an increase in nurse practitioners being able to do that, and that is part of our hub work as well.

Aiv PUGLIELLI: On notice is fine.

Euan WALLACE: Again, I think the broader direction the Commonwealth has been travelling in – they made a recent announcement on future changes to Medicare to allow and enable certain nurse practitioners and workforces to access Medicare in a way they have not been able to do before as independent practitioners, which is a good thing. The broader direction of travel is a good direction of travel; these are great initiatives from the Commonwealth. But that may necessarily mean that they progressively step out of the state's jurisdiction of both funding and oversight, so there will be increasing practices of MS-2 Step that we will not have visibility of, which is fine as long as the coverage of abortion services is meeting the needs of Victorian women.

Aiv PUGLIELLI: Thank you. I might just add in for the question on notice: if you could also provide the number of nurse practitioners who have taken up training to do so, and actually if we could throw in endorsed midwives as well to the list, that would be wonderful. Thank you. Actually, I will add one more: if there is any way of geographically placing where these practitioners are, that would be really useful for the committee.

Euan WALLACE: Happy to.

Aiv PUGLIELLI: Awesome, thank you. Just moving onto public dental services, looking at I think budget paper 3, page 226 – so persons treated as opposed to priority and emergency clients treated – if I take away the priority and emergency clients treated target from the total number of persons treated, how many people am I left with? My count has 83,050.

Euan WALLACE: Say that again. If you take away –

Aiv PUGLIELLI: So if you take away the priority emergency clients treated from the total number of persons treated, my figures have that at 83,050. Is that correct?

Euan WALLACE: In 2023–24 the number of persons treated was 286,669, and the priority and emergency clients treated were 219,870.

Aiv PUGLIELLI: Okay. So what is the remaining figure?

Euan WALLACE: Remaining from –

Aiv PUGLIELLI: I may be looking at a different table to you; that is okay. Does the department acknowledge that 1.5 million people are eligible in Victoria to access public dental care?

Euan WALLACE: I do not know the precise number. As you know, the public dental health program is about providing care for all children from zero to 12, for young people from 13 to 17, for adults with healthcare and pension concession cards, and of course all First Nations people. That is what the program is targeted at; that is the population that is targeted. What number those people are I would have to take notice. And as you know, the program is coordinated by Dental Health Services Victoria through their – I think they have got 47 or so providers across community health services et cetera.

Aiv PUGLIELLI: Just looking at the department website, to qualify for an emergency appointment someone must be in severe pain. Is that correct?

Euan WALLACE: I think the eligibility for an emergency appointment – and it is an important point, because the majority of dental health services are delivered to those presenting with an emergency and do not have go on a waiting list. I think those definitions are clinical ones that we do not have input into. These are defined by Dental Health Services Victoria and their clinicians, so they would determine what is an emergency and what is not, and I think that is appropriate.

Aiv PUGLIELLI: It has been put to me that only 7 per cent of the eligible population in Victoria can access the free dental care they are entitled to per year. Does the department have a view to this?

Euan WALLACE: In 2023–24, of those hundreds of thousands of patients that we talked about, 77 per cent of them were not on a waiting list. So those are the ones who were assessed as either emergency or priority clients, and they receive the next available appointment, which I think is appropriate, and then the waiting lists are used – clients who are on the waiting list are those who meet the eligibility criteria for the public dental program who then just require routine dental care. So 70 per cent of people treated, those two numbers that we looked at before – 77 per cent of those people did not go on a waiting list at all. They were treated as an emergency or as a priority client, and again, the eligibility criteria for emergencies I think is a clinical assessment.

Aiv PUGLIELLI: Just moving on to another matter, has the department advised the government to establish more supervised injecting services?

Euan WALLACE: The government has made a decision about maintaining the –

Aiv PUGLIELLI: Has the department advised the government, is my question.

Euan WALLACE: We have conversations with government and ministers all the time about what we do, but they have got a distinct purpose to maintain a single service.

The CHAIR: Thank you, Secretary. We will go back to Mr Hilakari.

Mathew HILAKARI: I might just finish up on the Monash Medical Centre redevelopment. I am very glad I have got an extra few minutes to continue there – Ms Leaver, if you are happy to describe some of those funding priorities.

Deanne LEAVER: Of course, I am happy to do so. The Monash Medical Centre project was one that was funded in the last budget and, as I said to you, is building off the existing emergency department that was completed previously. The centre itself will be a new multistorey tower. It will have additional inpatient and intensive care beds as well as a new operating theatre complex. This will provide for 7500 more surgeries each year. The expanded birthing suites and maternity inpatient beds will also support around 2400 births annually. This work on the centre is progressing well. We are in active user groups with our partners, with Monash Health and all their clinicians and all the user groups as well as the Department of Health, to design the new tower.

Mathew HILAKARI: Fantastic.

Lauren KATHAGE: If I may, Mr Hilakari, we have spoken a bit about the Austin ED but I wanted to ask about the other major community hospital that my constituents access, which is the Northern. The Northern emergency department is well known amongst my community. I had a good experience there a few weeks ago with my daughter, in the children's section. But it definitely needs to be a nicer experience for people who access it. This new ED – what will it mean for people who turn up needing help? What will their experience be like compared to what it is now?

Deanne LEAVER: Thank you for your question. Northern Hospital ED is one of the busiest EDs in the state. It is the Northern Hospital redevelopment project that you are referring to. It was funded in the last budget at $812.5 million – a huge, huge investment – to deliver a new emergency department and inpatient tower.

Any project that occurs inside an operational hospital site is incredibly complex and difficult, and one of the really exciting things about this project is that we are going to relocate the emergency department and the front entrance to Cooper Street. The existing ED will be able to operate without any impact at all during the construction project while the new tower is built.

This hospital site will be developed in two stages. The first stage is building a new ambulatory care building towards the back of the site there, behind the new inpatient tower that we delivered a few years ago, and that will enable us to decant the health services and create that development zone at the front of the site for the new tower. The new tower will increase the number of treatment spaces for emergency patients to almost 200.

Lauren KATHAGE: That is huge – 200.

Deanne LEAVER: Yes, it is a very big project.

Lauren KATHAGE: What is it now?

Deanne LEAVER: I do not have those figures to hand.

Lauren KATHAGE: It is not 200.

Deanne LEAVER: It is definitely not that much.

Lauren KATHAGE: That will be fantastic, and even just to have a fresh new waiting area I think will mean a lot to the community and to my family as well, so that is really great. Thank you.

Michael GALEA: I might jump on that as well and be a little bit parochial and ask about Frankston Hospital, the largest hospital project outside of central Melbourne. It is an incredible facility that is going up there. Ms Leaver, could you give me a quick update on the status of that project and how we are, over the past financial year but also in terms of now, reaching towards the end stages of that rebuild?

Deanne LEAVER: That hospital is amazing. You can see it from every direction when you drive down to Frankston. That is a 12-storey new tower that is being built with new clinical services and main entrance. That project will have 130 more beds, new spaces for mental health and oncology services, 15 new operating theatres and an expanded women's and children's service – new maternity services, obstetrics, paediatric wards, a women's clinic and a special care nursery. We are very excited about the Frankston project as well.

Michael GALEA: Absolutely. I cannot wait to see it fully open. Thank you very much, Ms Leaver. Secretary, can I also ask about another very important part of our healthcare delivery – ambulance services. In my region we had the Clyde North ambulance branch open in this financial year that we are looking at – an already very well utilised branch, I have got to say. We had the official opening just a few months after the practical launch, and in that time it had already done hundreds if not well over 1000 cases. Can you please talk to me, if possible, about that branch in particular but also about the work that has gone on to expand ambulance services to Melbourne's growing suburbs?

Euan WALLACE: I might ask either Mr Crisp or Ms North to give us an update or an expansion. As you know, and as we discussed earlier, government has been on a multi-year project now to either build or upgrade 51 ambulance stations across the state, going back many years, and very excitingly, we are getting to the end of that program. Armstrong Creek, which we talked about earlier in the day, will be the last ambulance station in that build program. In terms of ambulance services themselves, they continue to see year-on-year growth in their activity. Last financial year, 2023–24, I think they did something like 1.1 million road transfers, up by 5 or 6 per cent on the year before, and in the last two years they have been over a million. But I am not sure if Ms North wants to give us an update on the broader changes to increasing ambulance capability and capacity. She is coming to the table.

Euan WALLACE: I appreciate Ms North joining us. Again, in this 2023–24 budget there was $277.8 million further investment for AV, recognising the various components of the care – that they need to increase capacity, the secondary triage services, the medium acuity transport services et cetera, but I might ask Ms North for that information.

Danielle NORTH: Yes, thank you. I am really pleased to share some news in relation to our secondary triage. There are a number of initiatives that we have that are primarily designed to ensure we preserve ambulances for emergencies and to connect the community to the care that they need at the time that they need it. Secondary triage has been in place since 2003 but since that time we have tripled the size of secondary triage. We now have around 250 triage-trained paramedics and nurses, providing care 24 hours a day, seven days a week, to the community. Over the course of 2023–24, the team triaged 341,000 people, which represents 38 per cent of the calls to 000, and approximately 500 patients per day were diverted away from an emergency department and provided care that they needed at the time that they needed it in a safe way. So it is a really significant expansion in secondary triage. It is incredibly important for the community to have the care that they need when they need it, and that does not always mean transport to an emergency department. Importantly, not

only is it the patient experience and the right care, but it actually relieves pressure in the system and allows us to have ambulances available for critical need when it is required.

In addition to that, we have had expansion of our MATS program, which is our medium acuity transport service – a significant investment with 22 MATS crews available across metropolitan Melbourne and regional Victoria. Again, they provide care to the medium acuity patients in the community, again preserving care of acute, priority patients for urgent need when it is required. In the financial year 2023–24, the MATS teams responded to 26,508 cases, 19,000 of those in metro and 7000 of those in rural, but again they are an important part of preserving ambulances for emergencies and meeting the need of the community.

In addition to that is the virtual Victorian –

Mathew HILAKARI: What sort of work do they do, like, in a practical sense? Just by my numbers, there are about a thousand responses per unit per year – what is the sort of work that they actually do in a practical sense? Is it getting people from, say, for example, aged care facilities to health services, or what is the actual –

Danielle NORTH: It may be that. Primarily these are our code 2 and code 3 required patients. These are still patients that require urgent care in the community but not critical care. It might be something like simple fractures. It might be assisting community members off the floor. There are a number of varieties of case types that they respond to. Our MATS teams are staffed by a graduate paramedic and a qualified, experienced paramedic.

Mathew HILAKARI: Great.

Danielle NORTH: It is a really great way to support our graduate intake through the program to give them exposure and support in the community, supported by an experienced paramedic who is with them. But it does take the acuity out. This is not our lights-and-sirens response, but this is our response to community that require timely care in the circumstance that they have – as I said, simple fractures, burns, lacerations, those types of presentations.

Mathew HILAKARI: Thank you, and sorry for interrupting.

Michael GALEA: No, no, no, please. It is a very important subject, and indeed, as you say, having those lower acuity services such as secondary triage, the MATS, helps with the more urgent jobs for the MICA paramedics to be focused on – the really critical jobs for which time is obviously of the essence, I can imagine.

That secondary triage in particular – I know from speaking to paramedics it is one of their biggest concerns, getting that balance right in terms of their being prioritised for those bigger cases. Can you tell me a little bit about how that investment has been made? I know you said the system came in 2003, but with the investment that has recently been made, including in the 2023–24 financial year, how is that now supporting paramedics to focus on the most critical work that they need to be doing?

Danielle NORTH: As I said, around about one in five callers to 000 do not require an ambulance, and over the course of the 2023–24 financial year around about 38 per cent of patients were triaged by secondary triage and connected to alternate service provisions. So they did not require transport to hospital. That is around about 500 patients per day that have not required transport to hospital that have been connected to alternate service care in the community, whether that be a GP, whether that be Royal District Nursing, Victorian virtual ED or a number of other platforms that are available. So it is a significant reduction to allow our paramedics to respond to the critical cases when required.

Euan WALLACE: In the last financial year I think it was about $13.1 million the government invested in the secondary triage process, and as I remember from previous hearings, I think it probably is now world-best: you know, the proportion of calls that can be appropriately triaged to still urgent but non-emergency care to keep our paramedics on the road to deal with the most urgent thousand – more than a thousand – code 1 responses a day now by Ambulance Victoria. It is probably the ambulance equivalent of some of the things we talked about earlier around the integration of right care, right time, right place – you know, primary care, urgent care, ED. This is the ambulance equivalent, making sure that the patients are getting the right care in the right time and the connection between our paramedics and virtual ED as an example. I think it is getting ever more sophisticated and integrated.

Michael GALEA: Yes, thank you, both. Indeed you were saying that it is world's best practice. Have we seen other jurisdictions look to this model and try and learn some lessons off what has been done in Victoria?

Danielle NORTH: Yes, correct. We have. We are world-leading in the program that we deliver through our secondary triage. We do partner and work with our friends in Canada, and I know other areas around Australia are looking at similar models of care to connect patients at the time that they need it with the right care, because as I said, not every patient requires attendance at an emergency department but they do require appropriate care in a timely way.

Michael GALEA: Yes. Thank you very much.

Euan WALLACE: I think the outcome of that, which I alluded to in my interrupted comments is that we have some of the fastest ambulance response times in the country, and it is that hard work that AV do –

Michael GALEA: It is all that small-detail work that goes into making that big number happen, yes.

Euan WALLACE: Yes.

Lauren KATHAGE: Secretary, I would like to ask about maternal and child health. Recently we have been advertising to our community about the consultation that is underway with new Australians about how they would like to see maternal and child health best support them, so I am looking forward to seeing what comes out of that. But in the previous year's budget, the 2023–24 budget, there were more support for mums, dads and babies initiatives there. There are a few things listed there. Does that cover the expanded KISP hours?

Euan WALLACE: Yes, it does. I think in the last budget, the 2023–24 budget, there was $86 million further investment in the support for mums and dads and babies package. And you are right to highlight maternal and child health. It is the envy of the country. Our universal coverage for new parents and their babies is really about supporting new families from birth to school age.

The funding in the last budget was specifically for three broad things: boosting the capacity of universal services, again to respond to growing needs and complexities; further expanding our early parenting centre network and delivering targeted flexible support for mothers, fathers, multicultural communities and Aboriginal families; and then continuation of the Victorian baby bundle, which again we have talked about at this hearing in past years – an amazing bundle that all new parents get of both information and resources that new parents require. There was some funding for Olivia's Place in Narracan and for their nappy collective.

If you stand back from the maternal and child health program, there are four broad elements to it. It has been designed to ensure, again, integrated support for all new families in Victoria. The universal program is delivered, as you know, by local government, and we are very proud of our partnerships with local government; the state government shares funding with local government. That universal thing is around the key age and stage, the KAS, consultations. With the funding in the last budget there are additional consultations. Then there are those enhanced provisions, enhanced supports, for those families that need extra supports or some augmented referral pathways, and there is more time with maternal and child health nurses for them – first-time parent groups, sleeping and settling outreach support and some group sessions.

Then the second bit is what we call the enhanced maternal and child health program. It is, again, delivered by local government, but it is offering additional, targeted support to those most vulnerable families in our community – those where there might be a developmental delay or disability or even mental health challenges in the household or the presence of family violence in the household.

Lauren KATHAGE: It is really important to get off to the right start from the very beginning, with support for the whole family.

Euan WALLACE: Yes, because investment at the beginning – a healthy start to life, investment then – pays dividends for us as a community as the family grows.

Lauren KATHAGE: I did not realise – this is funding the early parenting centres?

Euan WALLACE: There is funding for early parenting centres as part of that support from the mums and dads and babies package. We are expanding, as you know, the early parenting centres around the state.

Lauren KATHAGE: The one that has opened in South Morang is amazing. I did not think I would have the chance to use it, but here we are; I might get a chance yet. I think you have got one in your area as well, don't you, Mr Hilakari?

Mathew HILAKARI: That is right. If we are finished up on there, we have got limited time left, so I am hoping to take us to mental health and the AOD hubs, if that is possible. It is something that I find particularly important. I am just hoping to understand how we are helping people who are presenting to emergency departments with mental health or AOD issues and how we are getting them to specialists and the support and care that they need.

Euan WALLACE: I might ask Ms Whetton about the update on our AOD hubs, which have been these new investments in our EDs, because prior to them people presenting with alcohol –

Mathew HILAKARI: So often –

Euan WALLACE: Yes, and very disruptive. They are very anxious; they are very disruptive. So we have now got these dedicated facilities. I know the minister visited the new Footscray Hospital earlier this week or last week and saw what is planned for there, but Ms Whetton might give us an update on AOD hubs.

Katherine WHETTON: Yes. Certainly. Thanks for the question. It is a pretty exciting part of the reform agenda, and the royal commission recommended there be eight across Victoria. I think by the time we have implemented the ones that are already open and those that will open in the future, there will be more than the royal commission recommended. As the Secretary said, they are really about trying to provide fast-tracked, dedicated care to people who are presenting with mental health and AOD concerns. There are five of the mental health and AOD hubs currently open. They are in Geelong and Sunshine and at St Vincent's Hospital, Monash Medical Centre and the Royal Melbourne Hospital. The Frankston Hospital one we were talking about before will open once the hospital redevelopment is complete. There is also going to be a new hub at the Latrobe Regional Hospital; we have been talking about Latrobe today as well. That will open in early 2025. The new Footscray one is also expected to open when that development is complete.

One of the benefits is allowing people to have that fast-tracked, dedicated care, but it also then relieves pressure generally on emergency departments so that those clinicians can focus on other patients. One of the things that we are seeing is for those services that have a mental health and AOD hub they do see people waiting in the emergency department for less time. We say that for people presenting with mental health and AOD concerns that is really not a great place for them to be, in an emergency department.

Mathew HILAKARI: And in a practical sense, what does it look like? Is it two separate entrances as you get into the waiting room of the emergency department or is that going to be different on each different site?

Katherine WHETTON: It does depend a little bit on the emergency department layout, but just thinking of one, so St Vincent's Hospital. Actually we were referring to the public healthcare awards before. Last year St Vincent's won for excellence in mental health and wellbeing for their hub, and so that is where you are in the broader emergency department, but then you go through this sort of different door, and the difference in the environment is really, really clear. So the hub is a much calmer and quieter environment where people can be seen and just be out of the fray of the broader emergency department.

Mathew HILAKARI: That is terrific, and I look forward to hearing more about them as they open up.

The CHAIR: Thank you very much, Mr Hilakari.

Secretary and officers, thank you very much for taking the time to appear before the committee today. The committee is going to follow up on any questions taken on notice in writing, and responses will be required withing five working days of the committee's request. The committee is going to take a break before beginning its consideration of the Department of Families, Fairness and Housing at 1:30 pm.

I declare this hearing adjourned.

Witnesses withdrew.