PUBLIC ACCOUNTS AND ESTIMATES COMMITTEE

Inquiry into 2019-20 Financial and Performance Outcomes

Melbourne—Monday, 22 February 2021

MEMBERS

Ms Lizzie Blandthorn—Chair
Mr Richard Riordan—Deputy Chair
Mr Sam Hibbins
Mr David Limbrick
Mr Gary Maas
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Ms Pauline Richards
Mr Tim Richardson
Ms Nina Taylor
Ms Bridget Vallence

WITNESSES

Professor Euan Wallace, Secretary, Department of Health;

Ms Sandy Pitcher, Secretary, Department of Families, Fairness and Housing, and

Mr Ben Rimmer, Associate Secretary, Department of Families, Fairness and Housing; Chief Executive Officer, Homes Victoria;

Mr Chris Hotham, Deputy Secretary, Health Infrastructure, and

Mr Greg Stenton, Deputy Secretary, Corporate Services, Department of Health;

Mr Argiri Alisandratos, Deputy Secretary, Children, Families, Communities and Disability, Department of Families, Fairness and Housing;

Ms Chris Asquini, Deputy Secretary, Community Services Operations, Department of Families, Fairness and Housing;

Mr Jeroen Weimar, Deputy Secretary, COVID-19 Response, Department of Health and Department of Families, Fairness and Housing;

Mr Ben Fielding, Deputy Secretary, Commissioning and Service Performance, and

Ms Katherine Whetton, Deputy Secretary, Mental Health, Department of Health;

Ms Eleri Butler, Chief Executive Officer, Family Safety Victoria;

Ms Jacinda de Witts, Deputy Secretary, Regulatory, Risk, Integrity and Legal, and

Ms Kym Arthur, Director, Office of the Secretary, Department of Health; and

Ms Mary Campbell, Director, Office of the Secretary, Department of Families, Fairness and Housing.

The CHAIR: I declare open this hearing of the Public Accounts and Estimates Committee.

On behalf of the Parliament the committee is conducting this Inquiry into the 2019–20 Financial and Performance Outcomes. Its aim is to gauge what the government achieved in 2019–20 compared to what the government planned to achieve.

We note that witnesses and members may remove their masks when speaking to the committee but must replace them afterwards.

Mobile telephones should now be turned to silent.

All evidence taken by this committee is protected by parliamentary privilege. Comments repeated outside this hearing may not be protected by this privilege.

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

For the minute, as we did this morning, we note that the Member for Mordialloc is on paternity leave, and we congratulate him and his wife—and Paisley—on the safe arrival of their second daughter.

We welcome the secretaries of the Department of Health and the Department of Families, Fairness and Housing. We invite you to make a 10-minute presentation, which will be followed by questions from the committee. So thank you for joining us today.

Visual presentation.

Prof. WALLACE: Thanks, Chair, Deputy Chair and members. Let me begin by acknowledging the traditional owners of the lands which we are meeting on today, the Wurundjeri people, and on behalf of us all pay my respects to their elders past and present and to any First Nations people with us this afternoon. Committee, this is a slightly unusual PAEC hearing. You have two departmental secretaries addressing a financial year where there was one department, and to make it even more unusual, neither of the secretaries with you this afternoon were secretaries in the department at the time.

Mr D O'BRIEN: It will still be your fault, though.

Ms VALLENCE: You will have to step up to the plate.

Prof. WALLACE: Both Sandy and I hope to do the performance of the DHHS justice, but if there are items that we do not manage to cover, of course we will take them on notice. The vision of the department is to achieve the best health, wellbeing and safety for all Victorians so they can live a life they value. That actually has not changed with the creation of the two new departments. The department set about delivering this vision through four strategic pillars that are outlined in our annual report: person-centred services and care; local solutions; prevention and earlier intervention; and advancing quality, safety and innovation. Again, those pillars really have not been lost through the two new departments, and I suspect you will hear a bit more about the pillars over this afternoon.

So 2019–20—clearly a year of disruption, and much of the planned work in our four-year strategic plan of the department was disrupted, first by the bushfires and then obviously, second, by COVID. But despite that the department still mostly delivered on its plans, and I think what you will see in the slides in the next 3 or 4 minutes is an agility to deliver as best as possible the commitments and at the same time be able to respond to both the bushfires and COVID.

This slide summarises the $2 billion infrastructure commitment in that year's budget; and then additional funding announced in April 2020 following the interim findings in late November from the royal commission into mental health and the establishment of an administrative office to deliver some of those interim findings; then a further commitment building on the previous year's budget to deliver additional specialist appointments particularly for regional and rural Victorians, again continuing to build on this as close to home as possible; an investment in our school dental program; and then an ongoing boost to regional health infrastructure, supporting some 96 projects across the state.

So I think the department's performance in the 2019–20 year can be best summed up as a mixture of deferred care but successful provision of the most urgent and needed care, and the deferred care was necessary to give space particularly for COVID. So while the numbers of patients admitted from elective surgery waiting lists fell, all category 1 patients, so the most urgent patients, received their surgery within time, and even for category 3 patients—those are patients who need the surgery within 12 months—the performance was among the best the state has ever had. Similarly, while the number of emergency patients treated within the clinically recommended time fell, those in category 1—the most urgent emergency presentations—all received their care in time. I think we can see this story repeated across aged care and other parts of the sector.

I think notably while total hospital separations fell by almost 8 per cent, palliative care separations were increased, and in the 2019–20 budget there was specific funding to improve end-of-life care.

Similarly in the alcohol and drug prevention space, the number of contacts from families fell, but actually direct engagement from clients in our needle and syringe program increased. The proportion of emergency patients with a mental health problem being admitted to hospital actually fell, but again the number of inpatient separations from mental health increased; and not only that, but the new case index increased by over 6 per cent, really indicating that mental health services remained busy and meeting needs.

Similarly, and perhaps not unexpectedly, engagement with our prevention programs—the diabetes and cardiovascular disease prevention program—fell a lot, by 17.9 per cent, but other community outreach services actually met or exceeded targets, including our services to our Aboriginal population and the use of our community referrals through the electronic referral system. Then lastly, I think evidence of the success in community outreach, a recurrent and ongoing trend for the department, is that those Victorians requiring post-acute care, the numbers requiring a readmission to hospital, fell significantly.

In terms of the bushfires, clearly the department played an important supporting role. The preliminary evaluation of additional health burden from the bushfires in the year is more than 330 additional hospitalisations for cardiovascular problems, nearly 600 more for respiratory problems and 400 emergency presentations for acute respiratory, asthma-related issues.

And of course there is the most significant disruption probably in our healthcare system's history, COVID. The department went about a very structured approach to try to manage COVID across the system to create space in anticipation of receiving thousands and thousands of COVID-affected patients—thankfully something that the system did not see. But nonetheless there were these five objectives, really: to create space, to make sure that hospitals were prepared, that we had a system best able to respond and then prevent ongoing viral transmission, and then lastly to recover our society.

The department itself pivoted, and we have talked about this at some of our COVID PAEC hearings. So we had some 2500 staff in our COVID public health division, but at one point as much as 70 per cent of the department's staff were pivoted towards responding to the pandemic, so significant internal changes, and then of course some rapid responses to create new bed capacity in Bendigo and Geelong and the old Peter Mac here in the city. And all the while the normal business-as-usual things about improvement, about quality and safety, about data reporting and of course the beginnings of our new mental health reform agenda were all delivered. And at the same time some highly innovative projects were delivered by the department and the sector—SafeScript. And the success of SafeScript I think is shown by the Victorian coroner's report showing that deaths from prescription medicine have fallen for the first time. Thank you. I might hand to Sandy.

Ms PITCHER: Thank you, Euan. Thank you, Chair. There may be another slide set.

Visual presentation.

Ms PITCHER: Perhaps just while we are setting that up, I would also like to pay my respects to the traditional owners of the land, the Kulin nation, and my respect to elders past, present and emerging.

My name is Sandy Pitcher. I have not met most of you. As Euan said, we are both new secretaries for this set of portfolios, but I have had the benefit of working with many of the people who are here today and having seen their work and riding on the shoulders of their good work. So we do have a number of people here, and it might be useful, Chair, if I for the Hansard let you know who we have, both in this room and in the other room.

So just to my right here we have Ben Rimmer, who is the Associate Secretary of the Department of Families, Fairness and Housing, and Chief Executive Officer of Homes Victoria; Greg Stenton, two over, who is Deputy Secretary of Corporate Services in the Department of Health; we have also Argiri Alisandratos, who is just here, who is the Deputy Secretary of Children, Families, Communities and Disability at the Department of Families, Fairness and Housing; and we also have Chris Hotham, who is the Deputy Secretary of Health Infrastructure. And we have a number of other people in the other room, Chair, that we may need to bring in and out just so the committee has the benefit of their knowledge. So if we could—

Ms VALLENCE: They can sit up the back. It might make it quicker.

Ms PITCHER: Oh, that would be great, I think, if they are able to, just rather than interrupting the session to have people come in and out.

So just taking the opportunity to give you a bit of a run-through of the past 12 months—or the 12 months that the committee is focused on—as Euan said, it was obviously a time of disruption but probably also a real focus on the communities that we all serve in Victoria, and a sense of needing to recognise the importance of quality safety and accessibility of services was really highlighted through the pandemic. We summarise that empathy is at the centre of our efforts to deliver the care, consumers' experience of care and the outcome of the care, and the 2019–20 Victorian state budget really continued a substantial investment to the reform of the services that drive outcomes that we really want to see in our community.

I am sure across the course of today there will be questions that enable us to talk about the Royal Commission into Family Violence, *Roadmap for Reform: Strong Families, Safe Children* and the *Wungurilwil Gapgapduir: Aboriginal Children and Families Agreement Strategic Action Plan*.

So if we just go to the next slide, as Euan spoke about, the bushfires and the pandemic together had a particular impact on the work of the department and the work I think across many of our providers and partners that we work with. But the commitment to working with the community and ensuring community safety was always at the centre.

Many of the performance measures were impacted by the emergency response, and we can go through those in the course of the committee's hearing today—recognising that some of the targets that were set were set before of course the events that began at the start of 2020—but it is really pleasing to see those tangible outcomes for many of our most vulnerable Victorians, particularly in the areas that I am now responsible for. The reforms in child protection, the early intervention and prevention focus across so much of the department's work have really begun to have such a large impact, with fewer reports being received and fewer investigations stemming from reports to the department.

We will speak more about this, but the Child First family services and the Orange Door are two examples of the pathways where we have got other ways that vulnerable children and families can get the support and intervention that they need, and we do recognise as well that the way COVID operated will have necessarily impacted some of those targets. Also worth just a quick mention, our Seniors Card program continues to be a really popular service and outreach with our senior Victorian population.

Just on the next slide, our focus last year continued to be on improving outcomes for children, young people and families experiencing vulnerability, and we have continued to lead on that delivery of the Victorian government's road map for reform, with a strong focus on shifting that child and family system from crisis response to early intervention and prevention. You will see that as a recurring theme throughout the discussions of what we are focused on, because we really want to move the impact of our work and make sure that we are there for families when they first need us, not when the need is so great. We do focus of course on children who cannot live safely at home, and our priority has always been to support them and to continue those consistent relationships with caring adults, enabling them to build the capabilities they need. We will speak more today too about the trials that we have conducted through 2019–20. The KEYS is one example—Keep Embracing Your Success. This model was evaluated in October 2019, and the results really showed a program making strong progress.

If we just skip forward to talking about the implementation of the NDIS, or the national disability insurance scheme, the department has long been part of leading that interface with the services system, child protection and housing. The NDIS—I am sure I do not need tell any of you—has been such a profound change in the way disability services are delivered. We have been transitioning for a number of years, and the department remains very much central to the services that our people in the community with a disability are experiencing, and we have a great focus on inclusion and improvement of quality of life.

I might move to the next slide, as I am conscious of the committee's time. I also want to talk particularly about Victorians having safe and secure housing. The new department has 'Housing' in the title of its name, and safe, stable and secure housing is essential for our long-term health and wellbeing. We are really focused on Victorians experiencing disadvantage and the long-term housing assistance that we can offer in the form of public housing and community housing, but also private rental assistance and even looking to home ownership and renovation assistance. We have got a real commitment across new public housing properties, and we continue our work through Homes Victoria to renew and replace ageing public housing with modern dwellings. There are a lot of investments that we can talk about for the 2019–20 year, and of course there are very large investments coming in the following financial years that were announced in the last budget and that really underscore the importance of this area for us and for all Victorians.

Going to the next slide, advancing Aboriginal self-determination was a huge focus of DHHS in its former life and will continue to be for both departments going forward. If we look at the end of June 2020, 49 per cent of Aboriginal children in our care were being managed by Aboriginal community controlled organisations—we call them ACCOs—with two ACCOs fully authorised to undertake powers and functions usually undertaken by the Secretary, so this move has been increasing over years, and there is quite a strong story for us to talk about in terms of the financial year that the committee is focused on today. The Victorian government has invested $23 million in ACCOs, the Aboriginal community controlled health organisations, to provide culturally safer coronavirus services and public health information to Aboriginal Victorians.

Finally, if we can just talk about family violence reforms, as I have already alluded to, family violence and working towards a Victoria free from family violence is a really important part of the department's work and has been a very strong commitment of the government across successive budgets. The successful primary prevention of family violence, elder abuse and all forms of violence against women is a critical part of our focus. Again, the delivery of the Orange Door and also behavior-change programs for perpetrators are major elements of our efforts to end family violence. There is obviously a whole lot of work that has been done and more to do, and as part of the Dhelk Dja three-year rolling action plan, Family Safety Victoria is establishing Aboriginal access points alongside the Orange Door network to strengthen referral pathways for Aboriginal people impacted by family violence.

There is also a real focus in our 10-year industry plan around the recruitment and attraction campaign for family violence workers and workforce, which was launched in May 2020, and I am happy to talk to the committee more about that work as well. So, Chair, thank you for your indulgence for that opening, and I commend the work of the now two departments, but the former department, to your committee.

The CHAIR: Thank you very much and thank you for those presentations. I will pass the call to Deputy Chair Richard Riordan, MP.

Mr RIORDAN: Thanks, Chair. Thank you for the presentation. We can see why we had to split the departments up; there is a lot to get through, isn't there?

My first question today is for Professor Wallace—the Department of Health's questions. Page 53 of the questionnaire, the Ballarat Health Services redevelopment and expansion—it was said that this was due to be completed in July 2018 and now has a completion date of June 2026. This is an extensive delay for the people of Ballarat. However, the Victorian Health and Human Services Building Authority lists on its website that it is in fact going to be completed in 2027. For a project that is already incredibly late, why is there this inconsistency in completion dates, and can we expect further blowouts or costs from those put in the budget?

Prof. WALLACE: Thank you. Look, I might ask Mr Hotham, who looks after our infrastructure portfolio, to answer.

Mr HOTHAM: Thanks for the question, Mr Riordan. Effectively the revision to the dates in the questionnaire does not relate to an elongation of the project. The July 2018 date was for the business case to be completed. The business case was completed on time. The profile of the project is now out to 2026. As I say, the projected completion is June 2026.

Mr RIORDAN: Right. So the listing of 2027 is not correct in the health authority's—

Mr HOTHAM: That is not the advice that I have had. June 2026 is still our estimated completion date for that project.

Mr RIORDAN: Okay. And is it still on budget?

Mr HOTHAM: It is still on budget.

Mr RIORDAN: Right. How much of the estimated expenditure, per the budget documents we are talking about, has been spent to date? I note you have budgeted more money in subsequent budgets, but how is it tracking to this budget?

Mr HOTHAM: I do not think I have that to hand, Mr Riordan.

Mr RIORDAN: Can you just take that on notice, please?

Mr HOTHAM: I will have to take that on notice, yes.

Mr RIORDAN: Yes, okay. Great. And this is possibly also to you, Mr Hotham, but I will address Professor Wallace, and if necessary—

The Victorian Eye and Ear Hospital redevelopment was due to be completed by the government in December 2018. The 2019–20 budget paper 4 revised that up to December 2021, and page 56 of the questionnaire revised that up further still to June 2022. What is the status of that project, and why are there extending time lines?

Prof. WALLACE: Again, as you know, the build has had significant challenges in the redevelopment, with asbestos et cetera in the early phases, but again I might ask Chris to add detail.

Mr HOTHAM: And the long and the short of it is exactly that, Secretary. As you know, Mr Riordan, that is a somewhat beleaguered project in terms of the time it has taken and the budget costs associated with it, which were due to underlying asbestos issues associated with the project.

Mr RIORDAN: Were these asbestos issues that were not taken into account in the planning?

Mr HOTHAM: That is right; they were not picked up in the original planning.

Mr RIORDAN: Asbestos auditing—isn't that standard practice in public buildings?

Mr HOTHAM: Well, look, it should be. Yes, it should have been properly costed in the business case of 2014. Since we have taken it on and rebaselined it in 2019–20, we have now got a revised project schedule and budget to reset the works to properly account for the works, the decanting and the asbestos issues that were not in the original costings.

Mr RIORDAN: Has all of the asbestos now been removed and dealt with, or is it still an ongoing issue?

Mr HOTHAM: I would have to take that on notice as to where we are at in terms of the full removal of asbestos.

Mr RIORDAN: Okay, if you could please take that on notice.

Prof. WALLACE: I mean, it is fair to say, isn't it, that clearly the challenges met by the building contractors were far greater than ever anticipated, hence the continued re-phasing and re-funding of the project.

Mr RIORDAN: But I understand from Mr Hotham's answer that there was no allowance for asbestos at all.

Prof. WALLACE: Oh, I do not think he said that. We will take on notice exactly what the anticipation was, but—

Mr RIORDAN: Because most commercial leases and tenants in public buildings all have asbestos audits, so either someone forgot to look at it or it was not done at all, I would assume—Mr Hotham, yes?

Mr HOTHAM: The asbestos was not properly accounted for in the original business case.

Mr RIORDAN: So you are saying some of it was accounted for?

Mr HOTHAM: I do not know. I will have to come back to you on that.

Mr RIORDAN: Okay. It would be good to know whether there was, like, zero accounting for it—we just forgot it was there—or whether someone has completely underestimated it.

Mr HOTHAM: Certainly I think it was very much underestimated in the original business case.

Mr RIORDAN: Right. Are there measures in place for the future so that we do not do major hospital upgrades and forget that there is asbestos there?

Mr HOTHAM: Look, we would like to think—because we now have our health capital pipeline that has grown to almost $8 billion, and so has the sophistication of our approach in terms of our business case development and planning—we are certainly going about things in the right way.

Prof. WALLACE: I mean, it is fair to say that that would certainly be the intent. I think when embarking upon a refurbishment program, a rebuilding program, the expectation would be that the building challenges that will be met as part of that program would be anticipated and costed in the—

Mr RIORDAN: Particularly asbestos.

Mr HOTHAM: So I can answer a little bit more to the detail of your question, Mr Riordan. My understanding is the original business case costed asbestos at about $2 million, and it has ended up at about $68 million worth of costs associated—

Mr RIORDAN: Who did the costing? Was that your own internal quantity surveyors?

Mr HOTHAM: It was before my time, a 2014 project, but I could find out exactly how that was costed.

Mr RIORDAN: Because it was done four years earlier than when you actually started—okay. Were there any threats posed to the health of workers and patients at the hospital as a result of the asbestos and the presence of the asbestos beforehand?

Mr HOTHAM: I can answer in broad terms to say that that would have been the number one consideration for our construction workforce. I can come back to you and take on notice the measures that we put in place on site to protect staff.

Mr RIORDAN: I guess I ask the question, Mr Hotham, because there seems to have been a $66 million underestimation of the asbestos problem, so it is not unreasonable to assume that there was perhaps asbestos in far more spots and places, and public places, than what may have otherwise been expected.

Mr HOTHAM: I think, yes, to your question, the discovery of asbestos effectively, if you like, riddled throughout the facility led to a number of very big changes to the development path of that project. That included a number of choices that delayed the program, particularly around that careful juggling act, as it was, to keep some of the site running whilst there was redevelopment. I am happy to come back to you with exactly the safeguards and considerations that were put into staff, but I would not have any concerns, and no concerns have been raised with me, as to the impact on staff or patients from that asbestos.

Mr RIORDAN: All right. Well, while we are on the topic of not being fully aware of dangerous materials in our buildings, flammable cladding: on page 64 of the questionnaire it details that the Royal Melbourne Hospital's critical infrastructure works saw a six-month time line blowout due to additional cladding rectification works. So my question is: has all flammable cladding now been removed from the Royal Melbourne Hospital?

Mr HOTHAM: We will have to take that on notice as well, I think, Mr Riordan. The flammable cladding has obviously been a major priority of ours in terms of identifying its location across facilities in the state. We have done that full audit. We have identified high-risk sites and steps have been taken to remove cladding on those sites. To your question on exactly how far advanced we are at there, I will come back to you on that.

Mr RIORDAN: Okay. Flammable cladding has been quite an issue for quite some time now. Our hospitals have the most vulnerable people in them, so it does seem a bit of a worry you cannot just say, 'Oh no, we've dealt with our hospitals'. Can we take it on notice that there is perhaps a series of other major metropolitan hospitals still with cladding issues?

Mr HOTHAM: No, I do not believe that is a reasonable conclusion. The audit that we have done was very much focused on what the high-risk cladding environments were, and that is to the impact in terms of, say, waiting areas where people are smoking cigarettes and things. It has been an identification of the highest risk facilities and components of those facilities, and the replacement of cladding certainly targeted those areas first. So whilst it will take some years and some effort to continue to retrofit the cladding across a range of buildings, right at the minute I think you can be assured that the high-risk settings have been dealt with.

Mr RIORDAN: Okay, but can you confirm that—all high-risk areas? And assuming you have rated the areas high risk, medium risk, low risk, can you give us a table of what is left in high, medium and low?

Mr HOTHAM: Yes, I am happy to come back to you on the results of the audit.

Mr RIORDAN: In particular if there are any high-risks still left outstanding. And just I guess the follow-up on that, and I guess this is being taken on notice, is which other hospitals have had their high risk removed and are still—by hospital, not just cumulative?

Mr HOTHAM: Sure.

Mr RIORDAN: Right, moving on. The high-value, high-risk services—pages 66 to 71 of the questionnaire list eight high-value, high-risk projects. None of these have publicly available business cases. Why are the business cases not published for these projects?

Mr HOTHAM: The high-value, high-risk process, as you know, involves a lot of commercial IP. In fact one of the reasons that we go down the HVHR or PPP path in some instances is to make the most of the commercial IP of many of our developers. There is transparency around those projects. However, to some degree we are very aware of the intellectual property and capital associated with those partners.

Mr RIORDAN: Right, so there is not a public interest in knowing what the business cases are on things such as building a world-class hospital for Frankston and families, Ballarat Health Services, which we have talked about, the Victorian Heart Hospital, Goulburn Valley Health? We are to take those on trust?

Mr HOTHAM: It is not so much a trust issue; it is of course the commercial-in-confidence nature of it and also cabinet-in-confidence nature, as you would understand, of those final business cases. If there is particular detail on particular projects, I am happy to take that on notice.

Mr RIORDAN: Okay. To the Secretary, I think, Professor Wallace. Page 67 of the questionnaire, 'Building a better hospital for Melbourne's inner west', in preparing this hospital plan for gateway 3, readiness for market, did your gateway review identify any areas of the project that could be subjected to cost overruns and time frame blowouts? You will take that on notice?

Prof. WALLACE: I will, yes.

Mr RIORDAN: Okay, great. Secretary, I refer to the $3.1 million allocated to the commonwealth national partnership agreement expansion of the BreastScreen Australia program—that was on page 49 of the questionnaire. What was the government's forecast for the development of breast cancer in Victorians before the onset of the pandemic? So what was your game plan on that before the advent of COVID?

Prof. WALLACE: In terms of screening?

Mr RIORDAN: Screening. What were your projected numbers?

Prof. WALLACE: The predicted screening numbers were, just bear with me, 267 500 screens. As you know, during the pandemic there was a seven-week freeze on screening, and so 218 129 screens were completed.

Mr RIORDAN: Sorry, how many?

Prof. WALLACE: 218 129. And when the—

Mr RIORDAN: Sorry, is that through to June?

Prof. WALLACE: Yes, through to 30 June. So when the freeze was introduced as part of the whole state response to preparing for the pandemic, it was to achieve a few things. One was to prevent unnecessary movement of peoples across the city and the state but also to create availability of PPE for those who were most at risk. Actually, from recollection, BreastScreen clinicians came to us to us to say we should freeze our services while this was going on, while we were doing our elective surgery freezes in hospital functions. Inevitably some of that freeze led to fewer women being screened than originally planned.

Mr RIORDAN: So based on that, broadly speaking, it was about 50 000 screens fewer to 30 June.

Prof. WALLACE: About 49 000, yes.

Mr RIORDAN: And presumably you did not get an opportunity to catch up in the second half of the year, so what concerns is the department raising with the government about the lack of breast screens? You point out what has caused it. What sort of advice is coming to government about the long-term consequences of—I am going to take a stab in the dark and say it is probably now closer to 100 000 fewer screens, if not more?

Prof. WALLACE: It is an important question. So during the pandemic the department created a clinical leadership expert group, a so-called CLEG, and sitting underneath the CLEG, were a number of expert working

groups—essentially groups of specialist clinicians from different fields advising the department on 'What are the risks now?' and 'What are the risks into the future?'. One of those groups was targeting cancer and in particular raised concerns and did some modelling on 'What is the impact of deferred care, including screening, for future cancer diagnoses?', so not just breast screening but colon cancer, prostate cancer and so on. All of that modelling was provided by the expert groups to the department to then inform the department about what was going to be necessary to catch up. In this year's budget, as you will recall, about $300 million was allocated for surgical catch up and really recognising elective surgeries that were deferred that will still have to be met. Inevitably from the cancer screening programs there will be patients who will come forward who would have come forward during the time that the freezes were on.

Mr RIORDAN: Have you created benchmarks of what your catch up needs to be? Have you set clear goals about how many more extra you have got to do each month to get caught up?

Prof. WALLACE: Broadly we have. It is not entirely straightforward. If you actually take breast cancer, it is a good example. Breast cancer screening programs clearly are critically important for the diagnosis, the detection of cancer, but many of those cancers would not have caused a mortality, would not have caused the death of the woman. So we are picking up not just breast cancer, prostate cancer and so on—we pick up cancers through screening programs that for the individual are probably immaterial to their length of life. So one of the challenges for a modelling group—

Mr RIORDAN: You are not denying the fact that prescreening is of huge value.

Prof. WALLACE: No, not at all, but screening and detection of cancers is not as entirely straightforward as we might think.

Mr RIORDAN: But all the evidence tells us that there is a big advantage to it.

Prof. WALLACE: Look, cancer screening programs are a core component of our health services, but your question was about modelling—in terms of modelling, what do we think the additional surgeries will be? Our cancer expert group is really advising us on: do we think there will be any anticipated additional deaths that would have been prevented otherwise, and if there will be, if they are predicting that, what are the interventions that are required?

Mr RIORDAN: Are you able to provide that modelling to the committee?

Prof. WALLACE: If I have got it, I will provide it.

Mr RIORDAN: Thank you.

The CHAIR: Sorry, Mr Riordan, and sorry to interrupt, but your time has expired. Mr Maas, MP.

Mr MAAS: Thank you, Chair. Thank you, Professor Wallace, and thank you, Ms Pitcher, to both of you and to your teams for being here today. I will start off with Department of Health questions first. I will take you to the questionnaire and page 81, where it was reported that $274 million has been spent on funding Victoria's public health services to cope with the increased demand of the pandemic. Professor Wallace, would you be able to explain how this funding has been able to assist at this time?

Prof. WALLACE: Thank you. As you can imagine, back at the beginning of the pandemic as a system we were looking to overseas for our modellers to try and predict for us what is it that Victorian health services, indeed the whole of Victoria, would face with the pandemic. You might recall that back in March and April last year there were predictions of requiring about 4000 ICU beds and 4000 ventilator spaces. That was a time when we had about 515 ventilators in the state, so funding was rapidly allocated to be able to source staff and equipment and a redesign of our hospitals to allow us to provide up to 4000 ventilator spaces. Thankfully that never eventuated for the state nor indeed for anywhere else in the country, but again we just have to look today to the US, Western Europe, the UK et cetera to see that they are still trying to manage that sort of problem.

The funding was first of all to do that, and there was also funding to repurpose an existing ICU database that is managed by Adult Retrieval Victoria as part of AV—Ambulance Victoria—a database called REACH that was repurposed and is now called CHRIS, where we could see in real time every ICU bed in the state, who was in it and what did they have, particularly did they have a COVID-related illness that put them in an ICU bed. So

successful was CHRIS that the commonwealth has now taken it and it is now used across the whole country, so we can see, whole of nation, all ICU bed utilisation.

We also did a large piece of work around a surge workforce. You might recall there were expressions of interest calls for retired personnel—nurses, midwives, doctors, allied health professionals and people who were not on the registered practitioner registries—to come back onto registry, and AHPRA managed that not just for Victoria but for the whole nation. We used about 25 000 nursing shifts through a nursing agency over a short space of about four months. Broadly it was around retooling our hospitals so that they were ready for receiving patients; sourcing equipment so that if we needed larger numbers of people ventilated that equipment was there; retraining staff, so we had staff training in ICU care and branches of medicine and nursing that they were not currently working in; and then providing additional payments to reduce staff movements, because one of the things that we learned very early on in the pandemic was the ability of staff who may become infected to move between health services. Broadly that is what it was about. It was about preparedness of the system to be able to receive up to, we thought, 4000 patients a day being ventilated.

Mr MAAS: Excellent. Thank you very much. As part of the national partnership on COVID-19 response, can you please report on how that funding has been spent, noting as well the private hospitals agreement that the Victorian government entered into in 2020?

Prof. WALLACE: Actually on my wife's birthday, 13 March last year, at a COAG meeting the first minister signed that national partnership agreement. Broadly the rationale for the NPA COVID-19 response was to provide states and territories some confidence with the commonwealth about shared funding so that they could respond rapidly to health needs. Essentially the commonwealth and all jurisdictions agreed to share the costs of utilising private hospitals to treat COVID. So in April last year we entered, first of all, agreements with our seven large private providers and then subsequently I think 26 other providers. Essentially what the agreement did for us as a state was ensured access to private hospital both resources—beds—but also staff, and many of those private hospital staff actually came in to work in the department in the public health COVID division, the division that Sandy and I worked in for six months, to boost the contact-tracing team. But essentially it was about building a single system, a fully integrated public-private system.

I think one of the key lessons from the pandemic last year was that the public and private systems are better together, and perhaps in hindsight we have not utilised as a state our private hospitals and private providers in quite the way that we might have done. We had access at peak to about 8500 private beds, again, preparing the system for vast numbers of people. Now, those COVID infections never eventuated to the extent, thankfully, that we were planning for, but of course the planning had to be done. However, where the private hospitals did step up in a very substantial way was they were able to take aged-care residents who were COVID infected from our aged care, both private, mostly, and a small number of public aged-care services, so as a system the private hospitals were able to provide care for private aged-care residents who were COVID infected in a manner that had we been trying to negotiate that on the run would have been almost impossible.

Then of course the other important thing is that we were always anticipating coming out the other side. We were always anticipating that there would be surgical catch-up, in answer to Mr Riordan's question in terms of breast cancer screening et cetera. We were always anticipating that there was going to be a need to catch up deferred care, and again, having those hospitals embedded in the system allowed the potential to do that much more quickly than we would do it just in the public system alone.

Mr MAAS: Thanks, Professor Wallace. I just wonder, going forward do you think there is going to be the opportunity for that public and private hospital nexus to continue working, to keep going forward?

Prof. WALLACE: I hope so. I mean, I think there are lots of things from the pandemic that, not that people had not thought about before, but there had not been perhaps the urgency or the need to address. One of them is the relationships between public and private. Now, there are examples pre-pandemic of the public and private working hand in hand, but I think if we have learned anything it is that there is greater opportunity for us to look at how could we do this in a way that best services Victorians. I mean, at the end of the day Victorians just want good health care. Health care is an unwanted intrusion into most of our lives. We do not choose to fall ill, but when we do fall ill or we need a procedure or whatever, we want it done quickly, we want it done as close to home as possible and we want it done by the most skilled staff, and I think partnerships across the public and private sectors allow us to provide that in a more agile manner to our population. Certainly the department will be looking in the future into how do we to sustain those partnerships in a way that best serves our population.

Mr MAAS: Okay, so would you be able to explain how that might be happening into the future?

Prof. WALLACE: Our arrangements with the private hospitals continue, so the National Health Reform Agreement had '2020–25' as an addendum to it, and the commonwealth continues to guarantee funding for Victoria through that addendum and through the NHRA. I think now clearly the system has come out of the pandemic—the pandemic has not gone; the virus is still there, but it has come out of the pandemic and clearly the department is turning its attention very urgently to how do we catch up on the deferred care that we talked about and how do we ensure that our workforces are best enabled. Again, I do not have a specific answer for you, Mr Maas, about the enduring partnerships between public and private, but certainly they are partnerships that the department is interested in.

Mr MAAS: Okay. Thank you. If I could go to ambulance services now, in the questionnaire you have reported that $3.3 million of additional funding in the form of a Treasurer's advance has gone into supporting the ambulance services' response to the COVID pandemic. Could you explain how this funding has helped support the overall response to the pandemic?

Prof. WALLACE: Yes, thank you. Let me just pull it up. The ambulance services were given two advances actually, both of the same value. One was specifically for the Victorian bushfire response and one was specifically for the pandemic. Really this was enabling Ambulance Victoria to arrange a number of things, mostly again to try and ensure that they had the workforce in the right places in the state and in the right numbers to be able to respond to picking up responses to both bushfires and then the pandemic.

So it was around enabling the workforce to backfill staffing arrangements and to fund full shift extensions, on-call or recall payments and some training, and of course there were increased operational costs. So of all of our healthcare workers, our paramedics and other employees of Ambulance Victoria are very much front line. They are the very definition of frontline healthcare workers, and during the height of the pandemic, rightly, they had to assume that every patient they called on was potentially a patient with COVID. So there was training around PPE and infection prevention control practices, there was the provision of that PPE, and the burn rate—the usage rate—of Ambulance Victoria through PPE was necessarily high because they were visiting patients who they had to anticipate had COVID. So that funding was extremely important to enable additional staff, additional shifts, on-call shifts, provision in the right places for the bushfires and then provision in the right places for the pandemic.

And then additionally I mentioned before the repurposed database REACH, now called CHRIS, through ARV. We also provided additional funding to Ambulance Victoria to develop that repurposed database that provides real-time awareness of what patients are in what ICU beds in which hospital and what their condition is—is it a COVID patient or is it a non-COVID patient? And again so successful was ARV with CHRIS that other states and territories have taken it up.

Mr MAAS: Terrific. Thanks very much. I might leave it there, Chair.

The CHAIR: Thank you, Mr Maas. The call is with Mr David Limbrick, MLC.

Mr LIMBRICK: Thank you, Chair. I would just like to start with a simple question, and I could not find it in the budget papers. How much does it cost to split up DHHS? Do we have figures on that yet?

Prof. WALLACE: We do not. So, as you know, the government announced this late last year, the machinery of government changes happened over Christmas and new year and the department split formally into the Department of Health and the Department of Families, Fairness and Housing on 1 February—

Mr LIMBRICK: So there was not any related expenditure in the previous financial year, like preparation?

Prof. WALLACE: No. The announcement was done last year, the planning was done really over the summer, and we went live, if you like, on 1 February. Now, it is an important question, and the other thing is that Sandy and I worked very, very closely for six months at the height of the pandemic in the case and contact-tracing branch of the public health COVID division, and we have a commitment to continue the two departments working very closely together. We clearly have a large number of shared clients, and actually many of the investments that will have health outcomes are actually social investments.

So very purposefully, the machinery of government has been structured so that we continue to have a large amount of shared services—corporate services that Mr Stenton leads, but also data analytic services and so on and so forth. We have done that purposefully to try and keep the departments integrated so that when we are planning investments and improving social and health outcomes they are made at the right place in the journey, but also to reduce costs. So the intent is to minimise the costs as much as possible. But in answer to your question, Mr Limbrick, we will not know the costs until reporting at the end of this financial year.

Mr LIMBRICK: Thank you. And one thing related to that—

Mr STENTON: If I might add, Mr Limbrick—

Mr LIMBRICK: Of course.

Mr STENTON: Euan mentioned the shared corporate functions. We are working quite hard to try and share as much of the back office as possible. There are some additional costs associated with a new secretary—for example, you cannot sort of not pay Sandy—but those costs, in the structuring of the new departments, would generally be absorbed. So in my experience, the expectation is that we would split the departments with the same cost structure. There is some temporary allocation of resources to things like system configuration and just the mechanics of actually moving people from one payroll to another in an entity sense—they are all being paid from the same place. There is a body of work just to split up the organisations, but the mechanics of all the back office is pretty much shared across the departments.

Mr LIMBRICK: Thank you. And one of the costs that I would like to hone in on which was in the budget paper is emergency management. So in the 2019–20 financial year it had just one performance metric in the budget paper, which was the number of people trained in emergency management—expected to train 2000 people. In the next financial year it had a very large drop in its allocated budget due to some of that government machinery being moved to other areas, yet it has still got the same amount of people expected to be trained. So what were those functions that cost 100-odd million dollars that are now being moved somewhere else?

Prof. WALLACE: So the emergency management training of the 2000-odd people are Victorian public service staff in emergency management. The emergency management team branch used to sit in a division called regulation, health protection and emergency management, RHPEM, in the Department of Health and Human Services as part of the machinery of government, and most of that staff actually now sit with Ms Pitcher's department because they are about recovery—so bushfire recovery staff and providing grants to individuals and social supports and so on and so forth. And then there is a small health emergency management team that have remained in Health.

In terms of ongoing provision of emergency management training to staff across the department—and indeed in other departments, because we have a surge workforce across the whole of government departments—if there is an emergency like the bushfires, there are individuals who we call upon, DHHS used to call upon and in the future DFFH will call upon that come from all departments, so that training will continue. I do not know if you want to comment further, but that training will continue. It will be led out of DFFH.

Ms PITCHER: I am happy to continue, just because I do think it is a good example of what both Professor Wallace and Mr Stenton have said about where we are maximising the knowledge we already have in the service and also taking advantage of now having two departments with a more laser-like focus in some of these areas but still making sure that we do not duplicate where we do not need to. So a lot of the emergency management work also involves the very important part of recovery. I think in the COVID response we have seen recovery feel very different to what a bushfire recovery looks like, and we need our service to be able to respond to both bushfire recovery and COVID recovery and whatever the next challenges that are on our horizon come to be.

So in my new department—and this is obviously not for this financial year, but just to give you a sense—we have got a readiness response, an emergency management division that is established, that looks at a whole range of areas but actually also has a particular focus on sensitive settings. So whether they are supported residential services or disability services, and obviously both of our departments still have a very keen interest in aged-care settings and understanding how we train our staff to be really ready to respond both in an emergency sense but also in business as usual.

Mr LIMBRICK: Thank you. On a couple of things about that, with regard to the metrics that are used in the KPIs, one of them that is quite commonly mentioned is 'separations'. Can you explain exactly what a separation is, and does that include when someone maybe passes away under care?

Prof. WALLACE: A separation is actually in the most simplistic terms just a hospital admission, so a person going into hospital and coming out of hospital is a separation. The numbers of separations are really episodes of care, if you like.

Mr LIMBRICK: Right, okay. So one separation is being admitted and then leaving the hospital for whatever reason?

Prof. WALLACE: Yes. Mr Stenton?

Mr STENTON: Mr Limbrick, Euan is right. Separation is a proxy for patients, and it does include deceased and discharged. But the way we count—it is hard to count on the way in because you do not know how long people are going to stay, they get moved around the hospital system. So the method of accounting is on separations, so it includes discharge and morbidity.

Mr LIMBRICK: Okay.

Mr STENTON: Just back to your previous point on the emergency management, you talked about the budget reductions. I understand you talked a lot about the movement of the emergency management workforce. The major change in the budget from 2019–20 to 2020–21 was a transfer of medical research to another department. In that particular output there are a range of things—medical research and emergency management are both in there. The emergency management function for the department is now being split up, but it in fact did not change between budgets, it was a different component of that output.

Mr LIMBRICK: Understood, understood. Another thing in the budget, I think the residential aged-care cost per bed per day actually went down in the 2019–20 financial year and then it went up again—or it is budgeted to go up again—in 2020–21. I was sort of a bit surprised by that. I would have expected that it would have shot up at the start of the pandemic for some reason. What was the explanation for the cost per person per day dropping in the 2019–20 financial year?

Prof. WALLACE: I am not sure. Greg, do you know?

Mr STENTON: Can I take it on notice, Mr Limbrick?

Mr LIMBRICK: Yes, certainly. Yes, that is fine.

Mr STENTON: I think I have an answer, but it is hidden away in here somewhere, so I will come back to it.

Mr LIMBRICK: Yes, no worries.

The CHAIR: Sorry, Mr Limbrick. I think—

Prof. WALLACE: Mr Rimmer? Or Ben Fielding?

The CHAIR: You would like to bring someone else to the table, is that what you are requesting?

Mr LIMBRICK: Okay. Another KPI is the amount of time, if it is admitted within 365 days, 90 days or 30 days. What is the start point for that process when you start counting? How do you figure out, like, 'Bang, we're going to start that the clock now'? What is the trigger for that?

Prof. WALLACE: Good question. There are three categories. Category 1, being the most urgent, has a 30-day limit, category 2 has a 90-day limit and for category 3 it is a year. The category designation is determined by the clinician, so the clinician says, 'This is a category 1, 2 or 3' when they are listing them for their procedure, for their admission.

Mr LIMBRICK: So the procedure is not necessarily linked to a category, it is determined by the—

Prof. WALLACE: It is the disease, yes. So if you have got a bowel cancer that needs taking out, you are category 1. If you have got a knee replacement, then that would not be typically a category 1 procedure. The

clock starts ticking, if you like, in the case of surgery when the surgeon determines the patient is ready for listing, so if she sees the patient in the clinic and says, 'You need a knee replacement and we're ready for the knee replacement'. That is important because in the context of orthopaedics many patients who eventually end up with a knee replacement or a hip replacement actually have a period of physiotherapy. Half of the patients who you think might come forward for a knee or hip replacement actually never end up having one because they get better with intensive physio. So it is really when the surgeon decides the patient is now ready for care is when the clock starts ticking.

Mr LIMBRICK: Thank you. So if I think about the typical process, someone feels ill. They will go to their GP and the GP says, 'You need to go to a specialist'. They will go to the specialist and then the specialist says, 'Look, I think there is something wrong here. You need to see a surgeon'. Then they go to see the surgeon and the surgeon says, 'Yes, you need surgery'. That is when the clock starts ticking?

Prof. WALLACE: Yes.

Mr LIMBRICK: Right. So it is actually a fair way down the process.

Prof. WALLACE: Yes. If it is for a procedure, essentially when the surgeon lists a patient for their operation and it goes on the list is then when the clock starts. You are right, for some the journey might be a long time before they get listed. For others, you would hope with those category 1s, those most urgent, that they whisk through the process very quickly because the GP recognises the problem, refers them to the specialist, the specialist recognises the problem and says, 'Actually we need to operate quickly' and they get listed quickly.

Mr LIMBRICK: Thank you very much. I think I am close to being out of time but that is okay. Thank you.

The CHAIR: Yes. Are you finished?

Prof. WALLACE: Chair, if I might just announce I have got some information for one of Mr Riordan's questions, which is that funding has been put in place for an additional 20 000 breast screens as part of the catch-up.

Mr RIORDAN: So 20 000 out of the nearly 100 000?

Prof. WALLACE: No, no. It was 49 000 that were deferred. Remember, the freeze on the breast screens was just seven weeks, so an additional 20 000 breast screens.

Mr RIORDAN: Thank you.

The CHAIR: Thank you. Mr Danny O'Brien, MP.

Mr D O'BRIEN: Thanks, Chair, and good afternoon, all. Can I just begin, Professor, page 34 of the department's questionnaire response, there is a note there:

> The department was not operating under business-as-usual for the second half of 2019–20 due to the coronavirus … where the implementation of several programs was either postponed or reprioritised.

Could you provide the committee with a list of the projects and programs that were reprioritised, including the dollar value?

Prof. WALLACE: Yes, we could.

Mr D O'BRIEN: Are you happy to take that on notice?

Prof. WALLACE: Oh, no—

Mr STENTON: Mr O'Brien, I think that would be challenging, only in the sense that as Professor Wallace said about 80 per cent of the department was pivoted to coronavirus. So when you say projects, we could probably come back with service-related projects, but there are many projects in the department. In my area, for example, we deferred projects on financial systems implementation and took those staff allocated into other things. So I think it would be challenging to try and understand everything internally, but we certainly could identify projects that were paused while other things occurred.

Mr D O'BRIEN: Yes, well, perhaps as best you can. Perhaps if we look at in particular any projects or programs that were cancelled altogether and/or have not restarted or not continued since.

Prof. WALLACE: I am not aware that we have cancelled anything altogether, and it was actually in my introduction, clearly the approach the department took was to prioritise—what are the things that need done today, done tomorrow both in business-as-usual, if you like, portfolios but also in response to COVID and then what things could we postpone, delay, defer. We have talked about some of that already: the breast screens deferred for seven weeks et cetera. Mr Hotham might want to talk about it because there were a couple of capital projects that we deferred, or do you want them provided—

Mr D O'BRIEN: Yes, otherwise we will be here for my entire time so if we could have them provided on notice, Professor, that would be great.

Could I move to mental health, and again the questionnaire on page 32 refers to the department's role in responding to the interim report of the Royal Commission into Victoria's Mental Health System. As you know, the interim report recommended a mental health tax or levy be implemented. What is the preferred model or a proposed model for a levy being considered, and how will it be applied?

Prof. WALLACE: I think the decision around the responses to the mental health royal commission's findings, interim but the final findings, which I think are due to be handed down next week—those decisions are yet to be made by government. We are yet to formally see the mental health royal commission's findings, and of course there is then going to be a period of time to cost those responses to the recommendations. I am not aware that government has made a decision yet about how it might fund that, whether it is a levy, as you say, or another means.

Mr D O'BRIEN: But the government has accepted all the recommendations. That was one of them.

Prof. WALLACE: The royal commission turned its mind to how would this be paid for. I think that is a decision for Treasury and not for health. Clearly our role in the response both to the interim recommendations but also to the final recommendations when they come next week will be to work with the relevant ministers, with other departments as to how best do we build the mental health system for Victoria for the future? So, again, I think the decisions around how that is then funded is a decision for government that has not yet been announced.

Mr D O'BRIEN: So, to that effect, has your department done any analysis of alternative models than a levy?

Prof. WALLACE: I think that would be for Treasury and Finance to do, not for health.

Mr D O'BRIEN: Okay.

Mr STENTON: Mr O'Brien, if I could: Euan is exactly right. We would cost up. Once we have the recommendations, we would identify cost estimates. They would go to Treasury. But the revenue side of the recommendations sits with the Treasurer.

Mr D O'BRIEN: Okay. So just to clarify: you would expect the Department of Health will see the final report, X number of recommendations, and work out that this is going to cost us $15 billion a year, whatever it might be, and then talk to Treasury about how that actually would be raised?

Mr STENTON: The Treasurer would tell you we are spending department, not a revenue department.

Mr D O'BRIEN: Yes. I am sure.

Prof. WALLACE: It is important, and clearly the response to the royal commission's recommendations—this is not an overnight fix, as you can imagine, Mr O'Brien.

Mr D O'BRIEN: Yes.

Prof. WALLACE: It is a journey for five or 10 years for us as a state to give us a mental health system that we deserve. And, as Mr Stenton says, our role will be to say, 'This is what needs done in response to the

recommendations. Here are some costings', and then work with our colleagues in Treasury and Finance to say, 'Well, how might this be done?'.

Mr D O'BRIEN: So just parallel to that: elsewhere in the questionnaire responses you talk about the stress and anxiety being felt by Victorians, and that obviously is both mental health but also economic, social—all sorts of angles. Have you given any recommendations to your minister about whether a mental health tax should be deferred at this point?

Prof. WALLACE: No, we have not. I mean, again, we have responded to the interim recommendations and established Mental Health Reform Victoria. When we formally respond to the final recommendations, then we will be providing that advice through to the minister.

Mr D O'BRIEN: Okay. Thank you. Can I move on. The Victorian Auditor-General in 2019 undertook a report on child and youth mental health, and one of the findings was that children as young as 13 were being admitted to adult mental health services. Are you able to provide for me for the year 2019–20 but also the prior year the number of people under 18 who had been admitted to an adult facility?

Prof. WALLACE: I do not have those numbers to hand; I do not know if any of my colleagues do. If we have got those numbers, we will provide them.

Mr D O'BRIEN: On notice? That would be great. Likewise the VAGO report recommended that the department develop strategic directions for child, adolescent and youth mental health, which include objectives, outcome measures, targets and an implementation plan. Has that work been completed?

Prof. WALLACE: No. I think is fair to say that work on mental health reform in all of its shapes and sizes has not been completed. Again, one of the priorities for the establishment of the administrative office was to respond to the interim findings in anticipation of much more fulsome findings for the final report, again which we get next week. We are anticipating root-and-branch reform to our mental health system. There are largely three or four—depending on how you cut it—populations that will need to be addressed: children; adolescents—young adults; adults; and then the older person. One of the priorities for the department will be to ensure that the responses that we shape and recommend to the ministers best meet the needs of the royal commission's recommendations.

Mr D O'BRIEN: Professor, sorry. Can I just interrupt you there? I am very aware of the royal commission process. But the concern of many in the mental health field is that we do not just sit back and wait until those recommendations come out. This is a VAGO report from three years ago. Has it not been acted on at all?

Prof. WALLACE: Well, I think the fact that the government commissioned a royal commission in itself is a reflection of the broad acceptance of what the state of Victoria's mental health system was. There was an urgent need for it to be fixed, and we should have a independent commission, a royal commission, to look at it and advise government.

So I think action has been taken. In anticipation of the royal commission's recommendations in December last year, one of the first things I did in this role was to establish a new standalone division of mental health within the department. So previously mental health had been in a very broad acute health care division called health and wellbeing. Recognising that we are going to need to respond across the diversity of those populations to the royal commission's findings, that there was an urgency around it, I created a new division, and Ms Katherine Whetton, who is here, is the deputy secretary of that division. So I do not think it is the right characterisation to say that nothing has been done. I think—

Mr D O'BRIEN: I am talking I guess, Professor, though, the actuality—

Prof. WALLACE: The specific, yes, I appreciate that.

Mr D O'BRIEN: With respect, that is a very bureaucratic answer. We have established a royal commission and we have set up another part of the bureaucracy. The question is: actually how are we dealing with children with mental health issues?

Perhaps I can go on, noting that you will take the data question on notice, and I have another one. Again the mental health services annual report, on page 43, lists how people are referred to mental health services. It

includes obviously emergency departments, acute health, GPs, family et cetera. Given that data is available, could we have, again on notice if you have got it, the time frame for referral of each of those? So broken down by referral type, services referred to and the like?

Prof. WALLACE: I am not sure we will have that data, but if we have it, we will provide it to you.

Mr D O'BRIEN: I am guessing that given we have the data for where the referrals come from—

Prof. WALLACE: Yeah, yeah, I know that.

Mr D O'BRIEN: what I am asking for is then how long it takes for someone to be admitted to a service in that respect.

Prof. WALLACE: Yeah, if we have it, we will provide it, because it requires then date stamping of referrals in a system that then reports referral dates to admission or appointment consultations.

Mr D O'BRIEN: Okay. If you have it, that would be good, and ideally not just the 2019–20, if we could get it for the previous four years. If it is easily accessible, that would be great.

Likewise the annual report refers to the increasing calls to services such as Lifeline and Beyond Blue. Do you have data for the number of calls to those services over the past five years, including up to 2019–20?

Prof. WALLACE: I am not sure, but again, if we have them, we will provide them. We certainly provide funding to those sorts of agencies. But if we have got that information, I will provide it.

Mr D O'BRIEN: I am seeing a shake of the head down the back, but you must have some of it because it is referred to in the annual report. So, again, if I could ask for that, that would be good.

Earlier you referred to the people who came forward and volunteered as health or mental health professionals at the start of the pandemic, and I think the figure of 65 000 people was actually again referred to in the annual report. How many of those 65 000 people who volunteered to provide a surge workforce actually worked more than 8 hours? I think you might have said to Mr Maas before that they covered 25 000 shifts. Was that the right—

Prof. WALLACE: So through one of the nursing agencies, at Torrens, there were 25 000-odd shifts, but the information they have provided would not say how many of those did more than one shift or more than 8 hours.

Mr D O'BRIEN: I take it though that there were clearly nowhere near the 65 000 actually taken up? As in, actually worked frontline roles.

Prof. WALLACE: There are two surge workforces. There was a sort of a rallying cry that the department did with both the lead professional bodies—the ANMF in the case of nursing but also AHPRA. It was a rallying cry: could we mobilise a healthcare workforce—nursing, midwifery, allied, medical, people who perhaps were on maternity leave or retired or whatever—to work in health services in anticipation of what I have already described. And then there was the surge workforce for the department itself. So at the PAEC hearings before, the COVID hearings, we have talked about the 2500 people working in case and contact tracing and an additional three-and-a-bit-thousand from the department pivoting. That 2500-odd workforce that worked in CCOM or contact tracing teams—COVID public health—some of them came from health services, some of them came from that surge workforce and some of them came from industries that were stood down as part of the response to the pandemic—airlines et cetera.

Mr D O'BRIEN: If you are able to provide on notice the people that came through Torrens and what actual work they did, that would be appreciated.

Prof. WALLACE: Yes.

Mr D O'BRIEN: Could I just move on to the medically supervised injecting centre. Can you advise for 2019–20 how many unique clients presented to the centre?

Prof. WALLACE: Let me see if I have got that number.

Mr D O'BRIEN: If you have got it there, I have got a couple of follow-up questions while you are looking, which are: how many of those unique clients requested drug and alcohol treatment and how many of those received drug and alcohol treatment within the public system?

Prof. WALLACE: So I have got—I am not sure if it was 2019–20 or whether it was the 18 months from the start. You remember it opened in June 2018 through to 2020. I have got 4900 users and some—

Mr D O'BRIEN: That is individual users?

Prof. WALLACE: Yes. Some 3800 overdoses managed, 21 deaths prevented.

Mr D O'BRIEN: Do you have any data on how many of those 4900 users sought referral to other drug and alcohol treatment?

Prof. WALLACE: I do not, and I do not think we have those numbers.

Mr D O'BRIEN: Presumably that is part of the assessment of the success of the process.

Prof. WALLACE: It is, but it is not something that—let me take it on notice, but I do not think it is something that is reported to us.

Mr D O'BRIEN: Isn't the idea of it—and certainly it has been portrayed, Secretary, all the way through, by ministers and the Premier—that this is about saving lives but also getting people back on track, getting them referred? If you could take that on notice, and again, just to be clear: how many of those requested drug and alcohol treatment, how many were received into drug and alcohol treatment in the public system and what was the average time to access treatment from referral—if you are able to provide that information?

Can I just go on that issue more broadly, so not related to the medically supervised injecting centre, but the questionnaire again provides average days between screening and commencement of treatment for community and residential-based drug and alcohol treatment. Are you able to provide data regarding the total number of referrals to rehab over the past five years by month, indicating how many people received treatment within three days, within seven days, within 28 days, longer than 28 days but who eventually entered treatment, and then those who withdrew while they were on the waiting list?

Prof. WALLACE: Just so I am clear, what you are asking for is, for the 2019–20 year, by month you are wanting—

Mr D O'BRIEN: People that were referred—

Prof. WALLACE: Referred.

Mr D O'BRIEN: to rehab, so community—

Prof. WALLACE: From the medically supervised—

Mr D O'BRIEN: No.

Prof. WALLACE: No?

Mr D O'BRIEN: Totally separate to that.

Prof. WALLACE: Sorry, apologies.

Mr D O'BRIEN: Just broadly in the community in Victoria.

Prof. WALLACE: Yes.

Mr D O'BRIEN: So those referred to community or residential rehab, ideally for the last five years, but 2019–20 obviously, if you have got it. And can I ask just briefly on the same topic—the Latrobe Valley youth drug rehab facility was announced in the 2018–19 budget, the site was announced for it in March 2019 and the operator was announced in September 2019. But we are here in February 2021, and it is still a paddock. When is that actually going to start?

Prof. WALLACE: We have had a pandemic—seriously.

Mr D O'BRIEN: Well, seriously, but by comparison the Hope Restart Centre in Bairnsdale was announced at the same time. It has been up and running for six months.

Prof. WALLACE: Yes.

Mr D O'BRIEN: Now, it is privately operated; it is government funded but managed by the private sector. I am just wanting to know when it is going to start.

Prof. WALLACE: I am advised the second half of this year.

Mr D O'BRIEN: Second half of this year.

The CHAIR: The member's time has expired. I will pass the call to Ms Pauline Richards, MP.

Ms RICHARDS: Thank you, Professor and Secretary and officials. Professor, I think you can stand down for a couple of minutes. I am going to ask some questions about Families, Fairness and Housing just for a couple of minutes. Secretary, I was interested in reflecting on page 8 of the questionnaire, where you reported that there was $26.9 million funded over 700 000 bed days in the public sector residential aged-care settings, and that was a provision across the state. I am very conscious, as everyone in this room is, that aged care is a commonwealth regulated and funded responsibility, but I am interested in understanding a little bit more about what has happened as part of that response. Could you please explain how this funding helps to provide quality aged care for Victorians?

Ms PITCHER: Thank you, Member. I—

Ms RICHARDS: Sorry, is it Professor Wallace?

Ms PITCHER: I feel bad in doing this, because—

Ms RICHARDS: No, well, I feel bad now too because I might have increased your expectations of a rest.

Prof. WALLACE: I apologise. Could you repeat the question for me? Sorry.

Ms RICHARDS: Sure. So on page 8 of the questionnaire, the report of $26.9 million funded over the 700 000 bed days in the public sector residential aged-care provision across the state, just with that awareness that aged care is a commonwealth responsibility, we would still like to understand how that funding helps provide quality aged care for Victorians.

Prof. WALLACE: Okay, yes. Thank you. So of course we have a reasonable footprint of aged care in the state, about 5600-odd aged-care beds. That is about 12 per cent of the total bed stock in aged care, the rest being funded through the commonwealth. The state's investment in aged care, most of it is taken up by so-called high care supplement. It is about providing, if you like in hospital language, nurse-resident ratios. It is really about providing high-quality care. One of the features of public aged care in respect to private aged care is that the proportion of residents in public aged care with high complex needs is greater, because they are not cost effective in a private setting. So one of the things that government has done is to ensure that there is an appropriate nursing-to-resident ratio. The *Safe Patient Care Act* from five or six years ago essentially lays out what the nursing-to-resident ratio should be: it is 1 to 7 in the morning, it is 1 to 8 in the afternoon, it is 1 to 15 overnight. There is no equivalent at the commonwealth level, and so in a private aged-care setting there is no requirement for designated nursing-to-resident ratios. All that the commonwealth legislation has—and it is governed by an aged-care act from 20 years ago or so—is an appropriate number of adequately trained staff. It is up to the private provider to determine how many nurses or assistants they have.

So I think our public aged-care sector is very well served. It is about a commitment to quality and safety. It is no surprise to you—I was CEO of Safer Care—quality and safety is paramount. We have a quality improvement branch within the department that is specifically dedicated to aged care. They do an amazing job working with our public aged-care providers to ensure that they meet accreditation standards, that they are driving towards improvement goals. But that funding mostly is about ensuring adequate nursing-resident ratios in public, which does not exist in private.

Ms RICHARDS: Thank you, Professor. So leading on from that, I am interested in having an understanding of how the department does ensure that public sector aged-care staff are appropriately qualified and skilled.

Prof. WALLACE: Again, it goes to both numbers of staff—I have talked about the ratios; it goes to who those staff are, what are their training requirements and backgrounds—and then ongoing training. Again, this is a very granular example from the pandemic. One of the key needs that became evident very quickly was that we had a residential aged-care service workforce that was neither used to nor ever had to be highly proficient with PPE usage and wearing, so they needed to be trained, and our acute health services reached in deeply to our aged care, both private and public, to provide training to aged-care staff. Again, that was led out of the aged-care cell, initially within the department, and then of course we were delighted to collaborate with the commonwealth in establishing the Victorian centre for aged care, and so that collaboration then oversaw the provision of training. In exactly the same way that we do for our hospitals, it is about knowing who the workforce needs to be, how many of them, what is the training, ensuring the training is ongoing, and looked after—stewarded, if you like—by our dedicated team within the department, and then obviously working with the providers of training and the employing authorities themselves, the health services themselves.

Ms RICHARDS: Thank you, Professor Wallace. I am interested in understanding how the government supports older people with mental illness through the aged-persons mental health beds. I am interested in getting some insights into that area.

Prof. WALLACE: I think that is probably—still with me. You can learn that our departments are finding their place. Mr Hotham will talk to capital and then I might come back.

Mr HOTHAM: Thank you, Secretary. Look, I guess one thing to profile, Ms Richards, from the 2019–20 budget is the Wantirna facility, effectively a 120-bed new facility run by Eastern Health on the fringes of the Dandenongs there. I guess what that facility represents is really a lifting of the standard for an aged-care facility. It is dignified, it is private—you know, there is that preference on open space. Some of those things I remember talking about in the context of the mental health developments as well, you know, that these are facilities that are doing a lot to support people and provide those really supportive settings. So that has lifted the bar, I guess, in the most recent budget as well. There is funding for a Kingston facility of an additional 150 beds, so I think what you are seeing is more and more an articulation of what good looks like in the public system.

Of course in some of those designs we are looking to learn the lessons of COVID, in terms of touch points, in terms of entrance and in terms of even things like, on a very practical level, voice-activated lifts and things which reduce some of the risk, so I think we are learning all the time, but it really goes to increasing the standard and the bar across many of our facilities.

Ms RICHARDS: Terrific.

Prof. WALLACE: I might ask Mr Fielding also to come and talk to this.

Mr FIELDING: Thanks, Euan. Yes, hi. Thanks for the question. Our PSRAC services provide a wide range of support to people with often very severe psychological needs such as dementia and other mental health issues. They provide a very unique role, and that is one of the reasons we have that service for people who struggle to access mainstream services. The strategy which has recently been developed, which is the modernisation of metro PSRACS, is all about consolidating services where we do not have services at scale, so consolidating those sub-scale services. A good example of that is creating some of the purpose-built facilities, so Berengarra on the St George's site is 30 beds for people with very complex mental health needs who require psychological support, so that is one example, and then we have got the office of the psychiatrist who obviously also provides a lot of on-the-ground, day-to-day support to those kinds of services.

Ms RICHARDS: Terrific. Thank you.

Mr FIELDING: That is okay. I just thought I would add to that.

Ms RICHARDS: Thanks for supplementing the team. You certainly are working as a team this afternoon. I am not going to pose this to anyone in particular; I think I am just going to ask the question and leave it to you all to choose who can best help here. Just moving into the questionnaire again, you have reported that there is $6.6 million of funding that has gone into the recruitment of 44 child protection practitioners. Can you please

explain how the funding of the additional practitioners help to meet government targets, especially around allocation rates and practitioner case loads?

Ms PITCHER: Thank you for the question. As you can see, this is enabling our team to bench, so Chris Asquini is going to be in joining us, who leads so much of our child protection work. But I am just happy to open a bit on talking about our child protection workforce because, as I reflected at the start, as an incoming secretary, being able to see the work that is done in the department has been one of the great honours of the three weeks that I have been in the role. Our child protection workforce is, I think, probably best described and we often refer to it as our real front line. Certainly over 2019–20 the child protection workforce really were still, in the physical community sense, needing to deliver in so many different ways that recognised the paramount safety of the children in our community. They are a very important part of our workforce, and they are a very big part of what will be ongoing in our department. I might see if Ms Asquini wants to go into some of the further details.

Ms ASQUINI: Thank you very much for the question. The 44 child protection positions funded in the 2019–20 budget build on previous years funding—I think overall, probably over a three- or four-year period, something like 660-odd positions—and that has created a range of opportunities, but also some challenges. Child protection, having been a child protection worker myself in the front line, is a very rewarding profession and very challenging as well. The sort of content that the workers need to deal with can really create a number of, as I said, challenges in the context of the abuse and neglect that they need to determine, substantiation of matters or not, and then to support families and children to take appropriate action.

With respect to the challenges that we have had, recruitment continues to be an area that we work on. Much of our recruitment strategy has related to student placements that we have had. We have also had a vocation employment service. We have got what we call our CPP2s, and they are the workforce that basically do a lot of the contact and transport of children, either to schools or to medical appointments or between children and their families, and we use the CPP2s as a bit of a pipeline for us as well in terms of recruitment. The 2019–20 year was a bit of a challenging year because our student placements in fact diminished when the pandemic hit, and so there are aspects of recruitment going into 2020–21 that we will be driving forward with a new recruitment provider, looking at how we use social media differently. Also the other aspect that we have had is a career advancement program. One of the areas that is particularly interesting for us is it is really difficult to get people coming into more senior positions from other jobs, so we have taken the opportunity to grow our own and have a career advancement program that sees our child protection 3s who can become 4s, and 4s who can become 5s. We have got about 100 of those going through that program, and I think they will graduate sometime midyear so that we can progress them into those more senior positions.

Ms RICHARDS: I think, Chair, I have probably just about run out of time. I appreciate your answers.

The CHAIR: Thank you, Ms Richards. I think it might be an appropriate time to take a short 15-minute break, so I will declare the committee adjourned and reconvene at 3.25. Thank you.

I will reopen this hearing of the Public Accounts and Estimates Committee, and the call is with Mr Hibbins, MP.

Mr HIBBINS: Thank you, Chair. And thank you secretaries and your teams for appearing this afternoon before the committee. I want to just ask about, as I was asking the Treasury Secretary, the east–west link property sales that occurred in 2019–20 and whether the office of housing put an expression of interest in for any of the east–west link properties. In particular if I could illustrate the point with 8 Bendigo Street, Collingwood, which was described on the advertising board as 'The entertainer' with a 'designer indoor-outdoor and living and entertainment zone'. Location: it was 'conveniently situated near shops, cafes, transport and the Yarra parklands'. Was an expression of interest put in by the office of housing for this property or any other east–west link properties?

Ms PITCHER: I might hand over to Mr Rimmer.

Mr RIMMER: Thank you, Mr Hibbins, for the question. I do not know whether we put in an expression of interest for that particular property. It sounds like a delightful property.

Mr HIBBINS: For a public housing tenant.

Mr RIMMER: But I am very happy to find that out on notice. I do know that we have been leasing a number of properties in that vicinity and subleasing, I think from memory, to Magpie Nest, if I am remembering correctly. So I know that we are involved in that area still and using some of those properties to provide some good social outcomes, but I am not quite sure whether we put in a bid for that property. But I am very happy to look into that.

Mr HIBBINS: Thank you—for that property and any other former east–west link properties that have either been sold or been prepared for sale. That would benefit the committee. Can I ask more generally: does the office of housing generally put in expressions of interest through the government's land sales program?

Mr RIMMER: That is a great question. The answer to that is that over time it depends on budget allocations for the construction of new developments, because fairly obviously it is not much use investing heavily in land if you do not have the money to construct the housing on top of it. In the context of the Big Housing Build clearly there is significant money now available to increase housing stock—social housing stock and affordable housing stock—and in that regard we are very seriously looking at other government department landholdings where that land is not currently fully utilised. If I may, that is particularly so in regional Victoria. You would be aware that the Big Housing Build has a 25 per cent regional target, and that will require us to own land in regional Victoria that we currently do not or to have land used for social housing in regional Victoria that is currently not used for that purpose.

Mr HIBBINS: Thank you. Is it a cost to the office of housing to purchase land or properties through the government land sales program?

Mr RIMMER: If you do not mind, I might take that question on notice just so that I give you the specific, technically correct answer. It is a complicated area of government financial accounting, and it is not as straightforward as perhaps it might seem at face value, so I might take that on notice.

Mr HIBBINS: Okay. Great. Thank you.

Mr STENTON: If I may, Mr Hibbins.

Mr HIBBINS: Sure.

Mr STENTON: To Ben's point, the director of housing is a public not-for-profit corporation that operates within the department. So it is a separate financial entity, but it receives some of its funding from government—and particularly the big build funding comes in—but then some of its operating funding comes from rental. To the point made by Ben, depending on the nature of the transaction it could be an asset provided to government free of charge, or if the director determines that they want to acquire a property, it would be a cost to their corporation.

Mr HIBBINS: Okay. Great. Thank you. Just now more generally, I am just looking at the annual report, which listed the number of—I think the term they used was—social housing dwellings. Now, the 2019–20 annual report listed 85 111. It stated that was a preliminary result and that an actual end-of-year result would be available by late 2020. Do we have the actual end-of-year result?

Mr RIMMER: We do not, I am afraid, Mr Hibbins. There has been a delay in publishing that result. It is not in the materials that I have in front of me. I am expecting it to be finalised shortly, but it is not currently finalised.

Mr HIBBINS: Okay. What is the reason for it not being finalised?

Mr RIMMER: I do not know, to be honest. There has been a lot of activity in the relevant teams in particular to do with the COVID rental relief grants, and in general there has been pretty heavy demand for housing allocations and people going onto the Victorian Housing Register. So that kind of broad area is under quite a lot of pressure, but I will find the result as soon as I can, and we will publicise that in the normal way.

Mr HIBBINS: And I presume that is the same for the total social housing dwellings acquired during the year?

Mr RIMMER: Yes.

Mr HIBBINS: What about the total number of dwellings that were actually sold during the year? So dwellings that were then—

Mr RIMMER: I think that is part of the same set of calculations.

Mr HIBBINS: Can I ask what the criteria for selling social housing dwellings are?

Mr RIMMER: Sure. There is a technical answer to that that is contained in the policy document, but in a simple sense we sell assets when they are beyond their useful life, when they are for whatever reason not economic to upgrade or further develop. To give a simple example, if there is a set of two or three dwellings side by side that are all very run down and require upgrade, then it may make sense to upgrade the three together and perhaps provide some more medium-density housing—perhaps more one- and two-bedroom stock that better meet the needs of people on the Victorian Housing Register. But if there is just a single dwelling on its own, it may well not be economic to reinvest in that location. We also look quite carefully at the profile of the area and make sure that we are creating good, mixed communities with a range of investment in that area both private and public sector.

Mr HIBBINS: Okay. Thank you. Just finally on this topic, one of the recommendations from our previous outcomes hearings was that the department consider publishing both acquisitions and sales along with the final balance of the number of units.

Mr RIMMER: As part of the BP3 measures?

Mr HIBBINS: Yes.

Mr RIMMER: I am aware of that recommendation. The broader area of BP3 metrics for housing is currently being thought through given the significant investment and change in the role of Homes Victoria and the government investment that is going into it, so I think it is likely that there will need to be some change in that area, but clearly those are decisions for government at the appropriate time, and I am sure that that issue will be in that process. I think in general more transparency about these numbers is good for everyone. In the context of the homelessness parliamentary inquiry there has been a lot of data provided, I think in some cases for the first time by any government over many decades, so I think that goes to the point of transparency that I have made.

Mr HIBBINS: Thank you. In terms of cleaning of public housing estates, is there an overall funding allocation for cleaning of public housing estates?

Mr RIMMER: There is an amount that we have spent on cleaning, which is provided for in our budgets. So for example in the 2019–20 year we spent $12 546 105 on cleaning for the base cleaning contracts.

Mr HIBBINS: In terms of how that is aggregated between estates, are there different contracts for different estates or different regions?

Mr RIMMER: My understanding is that the cleaning standards are uniform. Obviously there will be different standards that apply to a high-rise apartment building compared to a low-rise walk-up compared to single dwellings and different kinds of property, but I think those standards are applied statewide to the different property classes, different asset classes.

Mr HIBBINS: Are you aware of the staffing levels or the contractors that undertake the cleaning in terms of how many staff they employ, whether they are full-time, casual or part-time employees?

Mr RIMMER: I am sure we are aware. I am not currently in possession of that information in front of the committee, Mr Hibbins.

Mr HIBBINS: Would you be able to provide that to the committee?

Mr RIMMER: Of course.

Mr HIBBINS: Thank you. Similarly with security at public housing estates, what is the overall funding provided for security?

Mr RIMMER: The overall—sorry?

Mr HIBBINS: For security, the overall funding for security.

Mr RIMMER: I do not have that information in front of me, but I can provide that. Obviously during the COVID emergency there was significantly increased security for a whole variety of reasons, but for the 2019–20 year, I will have to come back to you with that exact number.

Mr HIBBINS: Okay, thank you. Are you also able to provide the staffing levels provided for security as well?

Mr RIMMER: Sure.

Mr HIBBINS: I guess one of the questions I have about both the cleaning and security—I mean, these are provided by private contractors, correct?

Mr RIMMER: Yes.

Mr HIBBINS: Let us face it, short of a pandemic where you might require more of that, these are pretty steady figures that you are spending on cleaning and security. What benefit is it to actually outsource that to private contractors instead of having the department itself employ staff and manage the cleaning and security?

Mr RIMMER: I think over time successive governments have found that using the market to provide some of these services is a good way of getting better value for the taxpayer investment and making sure that as much of the money that is provided to government as possible is invested in upgrading housing or new housing or the like. It is fair to say that the pandemic did raise some questions around issues like that, and I think it is something that will always be under review. The other aspect of that question is obviously we would like to see more employment of public housing tenants, social housing tenants, as part of contract work across government, but in particular in Homes Victoria and the Department of Families, Fairness and Housing, and I think everyone involved would say that we could do better on that front than we are currently doing.

Mr HIBBINS: Okay, thank you. I would like to find out now about the office of housing and how many complaints were received in the 2019–20 financial year.

Mr RIMMER: I do not think that information is in front of me, unless it is in the annual report and I am forgetting about that note. I think we will have to take that on notice.

Mr HIBBINS: Okay, thank you. And if you could provide a breakdown in terms of just the categories of complaints and then the timeliness of the resolutions as well.

Mr RIMMER: Sure.

Mr HIBBINS: I think that would greatly benefit the committee. Can I ask as well: does the department provide funding directly to residents groups or tenants groups within the states?

Mr RIMMER: Can I take that on notice, Mr Hibbins?

Mr HIBBINS: Sure.

Mr RIMMER: We do provide funding, as you are aware, to the Victorian Public Tenants Association. I think at various points in time we have funded specific residents groups at specific sites, but I am not sure whether that is continuing today, so I would need to check that on notice.

Mr HIBBINS: Would it be fair to say that not all residents actually have access to or are represented by a residents group? There is not an active residents group in all states?

Mr RIMMER: Yes, that would definitely be fair to say.

Mr HIBBINS: Yes, okay. Thank you. I would like to ask now about the public housing renewal program. My understanding is that the Health and Human Services Building Authority at one point had carriage of that program, but then they ceased to have carriage of that program. Is that correct, and why is that so?

Mr RIMMER: That is correct. At various stages in the department's evolution—and Mr Hotham may wish to add more to this—there have been times when the Health and Human Services Building Authority has performed work on behalf of the office of housing, or the housing division, or now Homes Victoria. But that arrangement ceased in mid-2019, perhaps the first quarter of 2019, and since that time all of Homes Victoria's development work and property investment work has been managed directly by Homes Victoria.

Mr HIBBINS: Okay, so from 2019?

Mr RIMMER: Yes.

Mr HOTHAM: I am happy to add to that, if it helps. So as Ben is highlighting, the Victorian Health and Human Services Building Authority did certainly play a role during that period. The reason in some ways that that moved back to the director of housing was more about the kind of interface—that there were a lot of policy questions still to be grounded within the public housing renewal program. Effectively government had a lot more ambition to do more in terms of mixed-use development, in terms of doing better for our most needy clients. With the building authority being a delivery agency, it was not at that point matured for delivery. So it has gone back to housing to effectively make sure that the parameters of the program are really clear—that it is doing as much as it can as a program to get the uplift for, you know, the most needy clients and tenants, as I say. Now that effectively through Homes Vic that delivery capability is being built in-house, we would not expect it to come back to us.

Mr HIBBINS: Okay, thank you. Now, in terms of the Public Housing Renewal program, the original plans for the program would have the non-social-housing dwellings being sold to private owners. Now, the stated arrangement is it would be a rent-to-build arrangement. Just some questions about that: why was that change made? Will the developer maintain the lease on that? And what will determine 'affordable unit'?

Mr RIMMER: Okay, there are a few questions in that. As you would be aware—

The CHAIR: Sorry, Mr Rimmer, perhaps you would like to take those on notice.

Mr HIBBINS: I would appreciate that. Thank you, Chair.

The CHAIR: The call is with Ms Nina Taylor, MLC.

Ms TAYLOR: I would like to explore some of the mental health outcomes. I refer to budget paper 3 of the 2020–21 budget papers, page 230, which shows the total output cost of the mental health portfolio in the 2019–20 financial year was $1.65 billion. I know that this represents an increase on the previous year's actuals. Could you please outline what some of the key achievements in this package were and how they have contributed to improved mental health outcomes for Victorians?

Prof. WALLACE: Thank you. I might also ask Ms Whetton to join us, but the funding in the 2019–20 budget year first of all principally was to meet ongoing mental health demand across the system, and it built on funding for our fixated threat assessment centres and also provided additional funding for worker wellbeing. Then across the year, as you might recall, there were a number of government announcements for additional funding to meet the bushfire response and then obviously COVID.

The principal budget component, if you like, of 2019–20 was also funding for 28 extra beds across the system, and you will recall that some of the interim recommendations from the royal commission recommended additional beds—and again I might ask Ms Whetton just to comment on that in a second—and then during the year there were three parcels of funding announced by government. First, in March 2020 there was a parcel of money—just over $23 million—in specific response to the bushfires, so a mental health and wellbeing response to the bushfires, and in that there was money for GP and community health provision. There was money for practical support, local training, advice to parents, peer group support—so this is in Gippsland and in Corryong—and there was $3 million given to our ACCHOs again to provide support for mental health and wellbeing for our First Nations people. Then in April and May there were two announcements of funding in response to COVID. It is fair to say that the majority of the COVID response actually is in this current financial year—so most of the mental health response to COVID came post June 2020—but in the 2019–20 year there was just over $59 million in funding for improving social connectedness through a number of agencies and then of course in May some funding to meet some of the royal commission's interim recommendations around

workforce, around suicide hubs and around mental health beds in the home. I do not know if Ms Whetton wants to elaborate on any of that.

Ms WHETTON: Thank you, Secretary, and thank you for the question.

Prof. WALLACE: Ms Whetton is the Deputy Secretary of the brand new division for mental health that we established in December.

Ms WHETTON: Thank you, Euan. I might just elaborate a little bit on the April 2020 package that was in support of the COVID response. That had some really critical initiatives in it to support the mental health, wellbeing and social connectedness of Victorians during the pandemic and the first wave. There was $6.7 million that was provided to expand online and phone counselling, and that was through additional funding to online and phone counselling for Beyond Blue, Lifeline, Kids Helpline and SuicideLine Victoria. There was also $7 million to help mental health services deliver supports for people with severe mental illness via phone and video so that they could stay in touch with their services and also to prevent emergency department presentations. There was $6 million provided to fast-track Orygen's online platform, and that was to provide online therapy and peer support for young people, and that has been operating for a while now in supporting those young people. And also $17.8 million to begin the first phase of the rollout of the 179 extra youth and adult acute mental health beds, as the Secretary referred to, that were part of the interim report of the royal commission recommendations.

Maybe just to touch on a couple of the other things that were also in support of COVID, but some progress that has been made in initiatives that were funded in the 2019–20 budget: there was the $23 million for an additional 28 inpatient beds, and so funding has been allocated to health services to enable that. The following services have been funded: Forensicare; Melbourne Health, including Orygen Youth; Mercy Health; Barwon Health; and Monash Health. Also there was $28.7 million allocated to community mental health services, and that has all been allocated across health services to help expansions of services for children, young people, adults and older persons as well.

Ms TAYLOR: Thank you. So when you are thinking about delivering on all these excellent and much-needed initiatives, particularly those involving expanded existing service provision, I think it sort of raises the question about increases needed to our skilled mental health workforce. So on that point, does the department have a strategy for how to address this concern, and if so, can you please elaborate?

Ms WHETTON: So I think, as with some of the earlier questions as well, we are really eagerly awaiting the royal commission final report, because we think that that is going to talk across the whole system, including the need to address workforce pressures. There are some things that we have been doing in the meantime, though. Reflecting some of the recommendations out of the interim report of the royal commission, there was funding of $6.55 million provided in 2019–20, and that was to allow 60 new graduate mental health nurse placements and also more placements through psychiatry—or rotations, rather—for junior doctors. So while smallish numbers in the scheme of things, they are really helping train professionals so that they are on the ground ready to support people.

Prof. WALLACE: I think just to add to what Katherine said, with the rotations of junior doctors in their first two years of training—so-called postgraduate years one and two, or PGY1 and 2—a mental health rotation has never been a requirement in this state. Nor is it a requirement, I believe, anywhere else in the country. There is a commitment now to getting to a place where we can make it, if not a requirement, highly desirable, and we have had conversations with the Australian Medical Council, who are cautious about making any rotations requirements. I think the AMC quite rightly are trying to get to a place where PGY1 and 2 rotations across the nation look very similar. So it does not matter which medical school you graduate from, whether here or interstate, the expectation as a young doctor is your training will be the same in your first years out of med school across the nation. But in Victoria we have specifically said, as Katherine said, we would like our young doctors to have rotations in mental health.

And then the other thing that is picked up in the royal commission's interim report is a recommendation around a workforce with lived experience. So the reform work that is already underway, led by Pam Anders in the administrative office, and work that will now be picked up collaboratively with the department, is about ensuring both recruitment and training of a workforce with lived experience. That was a resoundingly very

clear desire from stakeholders, and so that is something again that the department, with partners, is committed to.

Ms TAYLOR: Thank you. I was pleased to see a modest but vital investment of $3 million for—I am looking both ways because I am not sure where to direct this, but anyway—mental and physical health support of asylum seekers here in Victoria, ensuring their basic medication and mental health needs are met and filling the gap left by a significant federal Liberal government cut. Could you please provide an update on this initiative and how it has helped some of our most vulnerable Victorians?

Prof. WALLACE: I do not have anything. I do not know if Katherine has—

Ms WHETTON: I can give a brief update. Sure. Thanks for the question. So there was $3 million allocated to asylum seekers needing mental and physical support. There are a series of health services being funded to undertake this work. To give some examples: Foundation House has been working with people of refugee backgrounds to help them manage the changing conditions brought around by COVID and also to improve their access to information and services that they need to support their recovery. The Red Cross has mental health supports to provide for asylum seekers, refugees and temporary migrants. Cabrini has also offered asylum seeker health services as part of a COVID response. Orygen, again for young people, has provided supports for international students. And the Asylum Seeker Resource Centre has provided support as well for asylum seekers, refugees and temporary migrants. So some examples there of where that money has gone and what it has achieved.

Ms TAYLOR: Very good. Excellent. Okay, I would like now to move along to page 229 of budget paper 3, and in particular the outcome of 'Occupied sub-acute bed days', which I note shows an increase in the 2019–20 actual compared to target. I understand that the 2019–20 budget invested significantly in critical mental health service demand, including an allocation of $6.6 million at three prevention and recovery care centres across Victoria. Could you please tell us about the benefits of these subacute services and how you were able to overdeliver on the target for occupied subacute bed days?

Prof. WALLACE: I think it goes partly to some of the comments I made in the introduction, which were that during this last year with the pandemic there was a significant flux in demand for mental health, both acute presentations and subacute, but overall the system actually performed well in provision of mental health services. These subacute beds are really around the sort of less urgent provision of care and transition out, and I think again we need to await the findings of the royal commission. But if you look at mental health provision landscapes around the world and the directions in which mental health provision is moving, it is moving away from acute beds into prevention and subacute and community transition. So I think what you are seeing really in the performance numbers is a system that is already heading in that direction and trying to step in ahead of acute crises and acute presentations to our emergency departments and so on and provide more stable, sustained care for those with mental health needs. Katherine, I do not know if you want to add anything to that.

Ms WHETTON: Perhaps just a couple of additional comments that the PARC—the prevention and recovery care—services are now available across Victoria. I think that has contributed to the result. So there was a new Ballarat PARC that was opened in July 2020, which means that now there are 20 of those centres across the state in both metropolitan and regional Victoria. There is also an expansion of the models now, so looking at both young people and women as well. So there are quite specific services for people and they are, as the secretary said, a very important part of the system. Perhaps just to flag too that there is the 20-bed youth PARC service at Parkville that will be able to offer treatment for young Victorians in a home-like environment. I will leave it there. Thanks.

Prof. WALLACE: Just to add to that, as I said in comments I made earlier in the afternoon, it is about the provision of services targeted to populations. I talked about child, adolescent, young adult, adult and aged care, and the PARC centre in Parkville for young adults and children and adolescents, and then again providing care as close to home as possible—the PARCs that are being established across the state in our regional centres so that individuals do not have to travel long distances. It is a very strategic, planned expansion of services to areas of need but also providing this prevention, subacute care, rather than waiting for problems to arise. I suspect that we will see more of that recommended by the royal commission, but again we wait with bated breath until next week.

Ms TAYLOR: Okay. Thank you.

The CHAIR: Thank you, Ms Taylor, and I will pass the call to Ms Bridget Vallence, MP.

Ms VALLENCE: Thank you, Chair. Secretary, again I am not sure who on the panel is best placed to answer this. But in relation to housing, page 37 of the questionnaire—and also the presentation, I noticed—referred to Victorians having suitable and stable housing and of course renewing and replacing ageing public housing. I also noticed, referring to a prior annual report, that in 2018 the estimated useful life of public housing was 60 years and in 2019 that had jumped by 25 years to 85 years. Can you describe the decision around the criteria you used to assess increasing the useful life of public housing and the decision to increase it by a really large 25 years?

Prof. WALLACE: Ms Vallence, I might pass to Mr Rimmer.

Mr RIMMER: And I am going to look hopefully at Greg. I mean, that goes to a matter of technical accounting policy, Ms Vallence. I am not entirely sure I can answer it for you right here, but Greg might have a view.

Ms VALLENCE: Yes, and Mr Stenton, I guess also in respect of the fact that that seems in contrast or inconsistent with the objective of increasing public housing stock and replacing ageing public housing stock.

Mr STENTON: Thank you, Ms Vallence. Ben is correct; this is not unusual. The 2019–20 year was a re-evaluation year. Every four years the accounting standards require us to revalue assets. As part of that we will often look at 'life in use' as opposed to 'useful life', and it is a bit of a nuance. We did the same with hospitals I think about five or six years ago, where the valuer-general and the department will look at what is the actual life in use of an asset and look at revaluing that asset over a longer period, so it is an accounting—

Ms VALLENCE: Yes. It is an accounting treatment.

Mr STENTON: Correct.

Ms VALLENCE: Sure. But in terms of that, that is rather a large jump, and it does seem inconsistent with the department's objectives. As you mentioned in your presentation, I think you were talking proudly about replacing and regenerating that public housing, yet the department has also seen fit to use an accounting methodology to just extend the useful life of these public housing towers by 25 years.

Mr RIMMER: Ms Vallence, I think I can be of assistance. The accounting treatment will be relevant to the depreciation calculations that are obviously essential to the financial reports, but they are not reflective of the policy position of the government or of the operating approach that Homes Victoria takes to the assets. We have quite an elaborate process of working out the asset stance toward every piece of public housing asset that is owned by Homes Victoria and working out where we think that asset is up to—whether or not it is suitable for reinvestment, whether or not it needs an upgrade, whether or not it has just had an upgrade—and we do that obviously on a property-by-property basis. That is quite a separate thing from how it is accounted for and the details of the accounting treatment.

Mr STENTON: The only other thing, I would add the upgrade versus maintenance. Often the upgrade process will extend the useful life of the asset.

Ms VALLENCE: Okay, although your presentation did mention replacing, but anyway I will move on. And what planning—again I would put it through you, Secretary, and whoever is relevant—was undertaken from March 2020 through to June 2020 to mitigate an outbreak of COVID in public housing towers? What planning and what activities were undertaken?

Mr RIMMER: Ms Vallence, I can help with that. There were effectively, if I recall correctly, five main strands to the activity that was underway during that period. The first of those was enhancing cleaning, in particular in the high-rise apartments. The second of those was the provision of information to the community throughout that period and provision of signs and messages in different languages and a range of things to encourage people to utilise appropriate social distancing and the like.

The third of those is that we worked very closely with our colleagues in the public health team to make sure that we and they were working closely on the question of sensitive residential settings because we knew that there was some heightened risk of COVID transmission in more sensitive residential settings such as supported

residential services. Aged care is probably the most obvious example of that, but public housing is also an example of that in some circumstances and some contexts. We were alert to that, and in a very practical sense what that meant is that the public health team had a kind of flag, if there was a case in a public housing property or for that matter in a community housing property, that they needed to alert us.

The fourth element of the strategy was that we did some very explicit work with—you might be aware, there are I think from memory 13—older persons towers, and these are a particularly vulnerable cohort. These are people who are more or less over the age of 60 but who are also eligible for public housing and therefore almost by definition quite low income, often with quite significant pre-existing health conditions, quite frequently with language challenges, language difficulties, in terms of English language and so a cohort that we knew were particularly sensitive to manage in this context. So there were additional services provided into those towers during that period. So I think I have got to four strategies. I cannot remember the fifth.

Ms VALLENCE: Was the fifth anything around locking residents in their public housing towers, perhaps?

Mr RIMMER: There was not planning for that, no.

Ms VALLENCE: Okay. Obviously there was no notice provided, and this committee has heard previously around a lack of communication and a lack of information and information in different languages and so forth. So it is interesting to hear that you had a strategy. Perhaps it may not have been conveyed to the residents. Was there anything around the government's decision to lock down the housing towers without notice, and how does your strategy play into that?

The CHAIR: Ms Vallence, could you please relate your questions back to the performance outcomes?

Ms VALLENCE: Yes, it is. It is in relation to this occurring between March and June 2020.

The CHAIR: But what is your reference? We are talking about the actual financial and performance outcomes that were in the budget.

Ms VALLENCE: That is right—

The CHAIR: Could you relate your question—

Ms VALLENCE: And on many occasions we have heard that the department has had to redeploy and repurpose a lot of its activities to COVID, and this is just one of them.

The CHAIR: Ms Vallence, this committee has conducted a whole inquiry into the government's response to the COVID pandemic, and I feel you are using this opportunity to pursue a separate line of inquiry which you had every right to pursue in the previous lot of hearings related to that inquiry. If you could relate your questions to the financial and performance outcomes for the appropriate budget year, that would be appreciated.

Ms VALLENCE: Well, Chair, we have spent a lot of time actually referring to how departments' budgets have been reprioritised—

The CHAIR: Yes, and as Chair I have been extremely lenient in those questionings, but you are going a step too far, Ms Vallence, and I would ask that you return to the purpose of this inquiry.

Ms VALLENCE: I will move on. Obviously there is a protection racket running on that, because it is a very sensitive topic for the government. Homelessness—

Mr MAAS: On a point of order, Chair, I do note that we are with officials from the public service here. I think any inference that there is some kind of protection racket that is going on, when we have members of the public service, is absolutely out of order. Also I would raise the point that Mr Riordan—

Members interjecting.

Mr MAAS: Excuse me, I am raising my point of order.

The CHAIR: Deputy Chair, Ms Vallence, I am hearing Mr Maas.

Mr RIORDAN: Well, we are hearing time chewing up.

The CHAIR: Well, you are the one eating up the time, Deputy Chair. Mr Maas has the call.

Mr MAAS: Also, Mr Rimmer has very clearly stated that there was no strategy, and yet the line of questioning pursues a line of strategy that the department says did not exist.

The CHAIR: I will uphold the point of order, and I would ask that the member return her questions to the financial and performance outcomes for the financial year 2019–20.

Ms VALLENCE: In reference to page 121 of the questionnaire and your objectives stated there, around supporting homeless people and rough sleepers during the COVID-19 lockdown, I will just run through a couple of examples. There is a serviced apartment building in Kew called Comfy Kew, which was converted into accommodation for homeless people, and the consequence of this has been a lot of disruption to the local community, with police, fire and emergency services attending regularly and apparently an injecting room being set up very nearby in a tent. From my own community, the Lilydale Motor Inn and Yarra Valley motor inn were also used in a similar way—a lot of antisocial behaviour requiring police to attend for monitoring three times day. Why were residents who live near these locations not informed, and why were residents who were in these locations not properly supervised?

Mr RIMMER: Thank you, Ms Vallence, for the question. So when the pandemic first became apparent, in that early period, it became quickly apparent that one of the real challenges was that you cannot safely isolate, you cannot quarantine, you cannot stay home if you do not have a place to call home, even if temporarily. So early on—

Ms VALLENCE: I appreciate that, and I do not disagree. But the question really is around the supervision of those places of accommodation that required a lot of police, you know, attending, and I think fire services also. What about the supervision of those places? And if you need to take that on notice, that is fine.

Mr RIMMER: No, I do not need to take that on notice. That was my next sentence. The supervision arrangements in those—

So it was very difficult to create a safe environment for people who were rough sleeping or homeless. The decision was taken early on that the easiest and most effective way of doing that was to provide emergency accommodation through hotels and serviced apartments and the like. That had an important economic benefit for the hotel sector, as an aside—and that is not the main thrust of the question. For every person who was in emergency accommodation, there was a homelessness agency who was accountable for their stay at that particular emergency accommodation, whether that be in any number of the kind of obvious large providers of homelessness support in the city and indeed around the state.

Ms VALLENCE: But if you take Comfy Kew, for example, it sounds like the delivery of the services from that agency may not have transpired as well as we might have liked. Will that accommodation, Comfy Kew, be shut down now?

Mr RIMMER: I believe that accommodation is no longer taking clients, but I would have to confirm that on notice. But the homelessness agency and my team and Victoria Police worked extremely closely. You mentioned Lilydale; that is certainly one that had come to my attention during the relevant period. There was a lot of close liaison and work to ensure that there was effectively a zero tolerance approach to illegal and antisocial behaviour in hotels and in serviced apartments.

So it is very much the case that we took these issues seriously. The cohort of people who were housed are people who—not everyone—have a range of complexities about their lives, experience of a number of different state government service systems—

Ms VALLENCE: Thank you. It is a challenging situation, but thank you for that. Secretary, the questionnaire at page 183—at June 2020 $2 million was provided as additional funding to residential care services in child protection, and that included additional staffing. How much of the $2 million of that has been allocated to staffing and how many incremental FTE has that been?

Ms PITCHER: I am happy to take that one and maybe Argiri will supplement. So we are looking at the $2 million, and that was provided initially because of the challenges we were having around—

Ms VALLENCE: If you do not have it available, it is really: of that $2 million how much was allocated to staffing and what is the FTE? I am happy to take it on notice if that is something that is—

Ms PITCHER: Yes. I will just check if Argiri has got the exact numbers, otherwise happily.

Mr ALISANDRATOS: Yes. Thanks, Secretary. Most of the funds were allocated directly to community service organisations that were delivering residential care services. I do not have the specific number in front of me of how many personnel, but we can take that away and provide that to you.

Ms VALLENCE: Yes, how much it was for staffing and on personnel. And, look, the Commission for Children and Young People launched an inquiry, an investigation, uncovering the very disturbing reports of children being abducted and groomed by paedophiles while in residential care, noting that these residential care facilities were understaffed. What is the, I guess, assessment of the measures and how that has been addressed?

Mr ALISANDRATOS: There is a range of measures that have been implemented to support children and young people in residential care services, and as you can imagine, at any point in time we have approximately 450 young people in residential care. They are some of the most challenging young people in our system because of the quite significant level of trauma that they have experienced. A range of initiatives have gone to improve the delivery of our residential care services—overnight safety planning, which essentially is about how we support young people to remain at home, to have a plan for them, and additional staffing has been implemented as part of that initiative to support young people and support the workforce to be able to engage with the young people, provide greater levels of supervision and support and ensure that they are safeguarded from being out in the community and being susceptible to exploitation by members of the community. So that work has continued over the last couple of years. We equally are trying to improve the capability of the workforce, ensuring that they have adequate skills capacity to be able to provide greater levels of support.

Ms VALLENCE: And I think that was provided in an earlier answer. In the 2019–20 budget, budget paper 3, page 217, refers to nearly 137 000—

The CHAIR: Sorry, Ms Vallence. Your time has expired. The call is with Ms Pauline Richards, MP.

Ms RICHARDS: Thank you, Chair. I am interested in exploring a little bit more about the rent relief program. In the questionnaire you have reported the Treasurer's advance of $30.5 million for the COVID-19 rent relief program scheme. I am interested in understanding the purpose of the program, and then perhaps if you could also explore a little bit how it has reduced hardship faced by tenants in light of the coronavirus pandemic.

Ms PITCHER: Thanks for that question. It was 15 April 2020 when the government announced the $80 million rent relief grant program, and this actually has been supplemented in September, which I know is outside of the period of this committee, but it is just recognising that the need continued. That totalled $120 million of investment in rent relief after that time. The program is all about providing rent relief payments to Victorians due to the pandemic, and it has been kept open as we know that people still experience this hardship. We are looking at eligible payments of up to $3000 for people, and really the government was looking at all of the different ways that people were being affected by the pandemic. Recognising the importance of keeping people in their homes rather than adding to, I suppose, the challenges we have been reflecting on for homelessness and other things was really paramount. So that was quite an important and big part of our response and, I think we reflected earlier, had quite a level of demand that continued throughout the period.

Ms RICHARDS: Of course we are all very conscious of the financial hardship for many households. Do you have any understanding of if there is a primary reason why people have applied for the rent relief grant and whether you have perhaps a number of renters who have been supported and, even further, do you have some understanding of the average value of the grant? It is kind of a three-pronged—

Ms PITCHER: Yes, sure. Obviously everyone's individual circumstances have their own story to them, but I think if we go to the criteria about the grants it sort of helps tell the story of what challenges people were facing. So to be eligible to be able to receive the grant, you had to log an agreement with Consumer Affairs Victoria. You had to have had your income or your working hours reduced by at least 20 per cent during the pandemic and had to be below $1093 per week, you had to have less than $10 000 in cash and savings and you had to still be paying at least 30 per cent of your income in rent to be eligible. So I think when you look at those

four sort of sets of criteria, you see the picture of who is eligible for it. While something like how much money you have in cash and savings might be a reflection of where you went into the pandemic, having the reduction in working hours criteria and also the level of income that you needed to be earning—they were really demonstrating people whose circumstances had quite materially changed during the pandemic. It was really recognising this was a challenge for, I suppose, not just those tenants—that was really the forefront of the program—but also those landlords and others who are part of the whole social mix that we have in terms of our housing. So in terms of applicants—and I recognise this is going back over the year—at 1 February 2021 more than 23 363 applicants were approved and that was over $73.5 million in grants. And, as I said earlier, we extended the application period for the grant and also the maximum payment. Sorry, I think you asked how much.

Ms RICHARDS: Yes.

Ms PITCHER: Initially $2000 was the amount, but this was increased to $3000, recognising all of those points. And I might just hand to Mr Rimmer for some extra information.

Mr RIMMER: Secretary, just a little bit of, I guess, colour about the application process: by definition, people had to secure agreement from their landlord to a rent reduction prior to applying for the grant amount, and this had the practical effect of telling the landlord a story that it was in their interests—in everyone's interests—to manage their way through this very challenging situation, with a little bit of give and take on all sides, including the government chipping in in terms of some rental relief, in circumstances where perhaps otherwise a landlord may have formed a view that they should just kind of call it quits and behave in a more abrupt fashion. So the arrangements really kind of created the right conversations and the right pathways through the system to manage the way through a very difficult set of circumstances. The teams that have been engaging with this cohort of people have been really struck by the willingness of everyone involved to try and do the right thing with the understanding that tenants in many circumstances actually play an important part in the process, and the whole structure of the arrangement has actually worked very well in practice for people on the ground.

Ms RICHARDS: Thank you, Mr Rimmer. Thank you, Secretary. I am interested in your professional insights into what you think has been the impact of the rent relief grants and the eviction moratorium on homelessness in Victoria, in this context.

Ms PITCHER: I think I will hand to Mr Rimmer just for the experience of time during that period.

Mr RIMMER: I think that along with other measures the eviction moratorium had prevented significant entry into homelessness, but there were other measures used as well for similar purposes. Probably the most important is a program called the private rental assistance program, which received extra funding during the relevant period—and this is really an incredibly important early intervention program. This is people who get behind on their rent who find themselves in very challenging circumstances—perhaps they find themselves needing to rent a new place because of family violence or a relationship breakdown or any other kind of scenario but who cannot get into the rental market or who cannot stay in the rental market without a little bit of assistance. Obviously keeping people connected to a landlord, keeping people connected to stable housing, is, you know, the best preventative medicine for people entering into homelessness, and of course once people are in housing instability that can sometimes lead to further housing instability.

So the rental relief grants, combined with measures in other portfolios about evictions, combined with the private rental assistance program, really prevented significant numbers of people from entering homelessness. Having said that, we are seeing very significant demand for social housing emerging during this period, as evidenced by the Victorian Housing Register, so clearly it has not worked for everyone. There are still people, and increasing numbers of people, who are finding themselves in situations where they need to apply for the Victorian Housing Register and often are getting priority access on the Victorian Housing Register.

Ms RICHARDS: Thank you both. I would now like to move on to an area that is, you know, complex and incredibly difficult, and that is in response to the questionnaire where you identified $1.47 million invested into the sexually abusive behaviour treatment program. I am interested in perhaps having an understanding of what that program is.

Ms PITCHER: Thanks for the question. I can talk about that. As the committee would be aware, the government has made a large commitment and focus on the reduction of family violence, and many programs

have followed from the royal commission that have really identified a whole host of work, including not only early intervention, which has a lot of focus on community-based interventions, but also looking at perpetrator behaviour and perpetrator programs. As you say, these are difficult areas and they are challenging problems to be looking at, but certainly it has been recognised that both men's behaviour change programs for perpetrators of family violence mixed with intensive case management of perpetrators and looking at all of their complex needs, which often looks at other areas, not only of my department now but of Euan's department going forward, and looking at different community-based intervention programs as well, so people who experience violence from diverse communities.

We have the Caring Dads pilot as well, which supports men to improve their parenting and understand impacts of violence, so there are a number of these programs that really work together, so it is all part of very much a joined-up system.

In 2019–20, so the year that we are focused on, we had 4486 men participate in a men's behaviour change program. Our annual target was 4000, so this was a higher number. In that same year we had 1371 case-managed responses to perpetrators, and again that was over our target of 1300 people there. So it is a difficult area, but it is one that we think is really important and particularly part of a system that needs to look at all of the different parts of the violence cycle. We do keep expecting that in some instances the number of people that we will bring into these programs will increase as we are increasing the efforts and energies into identifications of problems, and all of the work that we put into our early intervention will hopefully continue to see us getting to the causes of violence earlier in the cycle.

Ms RICHARDS: Thank you, Secretary. On a broad question related to this program, how do we know that these programs are working?

Ms PITCHER: Well, I mean, this is probably part of the cycle of how we measure not only, as I said, the numbers of people who participate, because again putting more intervention early means that we are going to bring people in at different areas. The year-on-year comparisons tell us part of the story, but they certainly do not tell us everything, and certainly the interventions in each family tell us a story about what is happening in that family but not necessarily the broader context in the community. Really we are needing to look at a whole range of evaluation that takes all of the different parts of the family violence journey in. We have got qualitative and quantitative data that captures that that really looks to seek the impact of our programs, and we are continuing a very strong research program as well as impact measurement through our work.

We do, I think, have particular measures on our Caring Dads behaviour change program, and this is for fathers who have used violence in the past to improve their relationship with their children. There is a particular example there with a cohort-specific trial, because we can tailor the responses that we are doing to those individuals, and we are looking at in those instances perpetrators with cognitive impairment. We have participants from culturally and linguistically diverse communities, Aboriginal communities. We are looking at lesbian, bisexual, transgender and intersex communities, and women who use force all as part of that broader sense. The brokerage funding approach enables that practical assistance so we can measure the impact on those families over time as well as our broader accountability work.

Many of you I think would probably be familiar with the reporting that we do, and this will continue: the *Family Violence Reform Rolling Action Plan*. In fact we have just released the newer rolling action plan in December 2020, but there is a whole part of that reporting about perpetrator accountability. We are committed to publication. We are committed to trying to talk about these issues as much as we can, open that dialogue not only across government but with all of the service centres and communities that work with us in partnership, and that is very much part of the accountability cycle there.

Ms RICHARDS: Thank you very much, Chair. I think I will leave that there.

The CHAIR: Thank you, Ms Richards. That concludes the time we have set aside for consideration this afternoon. We thank you, secretaries, and your officials for appearing before us today.

Prof. WALLACE: Chair, sorry—if it pleases the committee, Mr Limbrick asked a question earlier about the average cost of bed stay in residential care that we have the answer to.

The CHAIR: Absolutely.

Mr STENTON: Thank you, Mr Limbrick. As I understand the question, you were querying the reduction in patient numbers—resident numbers—versus cost. In the budget papers the estimate is based on revenue expected to be received from the state, the commonwealth and individual residents, and in the 2019–20 year that was $433 million. 100 per cent of the state revenue was received, but the commonwealth revenue was down significantly and the revenue from residents was down significantly. So the reduction in revenue was about 12 per cent, but in spite of that the reduction in residents seen was only 1 per cent. So it is a good outcome.

Mr LIMBRICK: That makes sense. Thank you. That explains it.

The CHAIR: Thank you very much, Secretary. We thank you for appearing before the committee today. As I was saying, we will follow up on any questions that were taken on notice and not subsequently answered. Responses will be required within five working days of the committee.

Just because some of the topics we have discussed this afternoon have been a little difficult, I would like to highlight that the phone numbers for Lifeline are 13 11 14 and for Beyond Blue 1300 22 46 36. Thank you for appearing here today. The committee will resume consideration of the financial and performance outcomes tomorrow at 9.30 am. I declare this hearing adjourned.

Committee adjourned.