PUBLIC ACCOUNTS AND ESTIMATES COMMITTEE

Inquiry into the 2021–22 and 2022–23 Financial and Performance Outcomes

Melbourne – Friday 24 November 2023

MEMBERS

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

WITNESSES

Professor Euan Wallace, Secretary,

Professor Zoe Wainer, Deputy Secretary, Public Health,

Katherine Whetton, Deputy Secretary, Mental Health and Wellbeing,

Jodie Geissler, Deputy Secretary, Commissioning and System Improvement,

Chris Hotham, Deputy Secretary, Health Infrastructure,

Daen Dorazio, Deputy Secretary, Corporate Services,

Jane Miller, Chief Executive Officer, Ambulance Victoria,

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

Jodie Gervasoni, Acting Chief Executive Officer, Victorian Health Building Authority, Department of Health.

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

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

On behalf of the Parliament, the committee is conducting this Inquiry into the 2021–22 and 2022–23 Financial and Performance Outcomes. Its aim is to gauge what the government achieved in both years compared to what the government planned to achieve.

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

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

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

I welcome the Secretary of the Department of Health Professor Euan Wallace – welcome – as well as other officials joining him today. Secretary, I am going to invite you to make an opening statement or presentation of no more than 10 minutes, after which time we will ask some questions. Your time starts now.

Euan WALLACE: Chair, thank you. Good morning, committee. Thanks for your time this morning. It is my pleasure as Secretary of the Department of Health to give you a very short summary of the department's activities over the two years, in front of the committee this morning, but also to give you a sense of the broad direction of travel that the department and government are on in terms of healthcare provision and a sense of the future.

Can I also begin by acknowledging the traditional owners of country across Victoria. I pay my respects to them, their culture and their elders past and present and acknowledge all Aboriginal and Torres Strait Islander peoples and their ongoing connection to country, culture and community.

Visual presentation.

Euan WALLACE: Chair, the vision of the department is that Victorians are the healthiest people in the world, and we have seven priorities – almost signposts, if you like – for the road to that destination. These priorities we have had in place now for two years. First and foremost, they are about keeping Victorians healthy and safe in the community. This is about progressive investment into prevention and early intervention. People

would rather not get sick in the first place, but if they do, then we should capture the diseases and illnesses as early as possible. We are very proud of our hospitals in Victoria, but if we were honest, Victorians would rather not be in them. They would rather have the health care that they need in the community and, if at all possible, in the home. One of our priorities is a commitment to doing that increasingly.

Victoria already has one of the best healthcare systems not just in Australia but actually in the world, and indeed Melbourne is the only Australian city in Medbelle's top 10 health cities in the world, competing with Berlin, Boston, London and Tokyo. That is not an accident. We are part of an ecosystem of a continuous learning system, and we look forward to continuing to improve in our care for Victorians and their outcomes. We have a particular focus on improving Aboriginal health and wellbeing. There are four key health outcomes in Closing the Gap. We are making progress on two, but there is much to do still.

Over the last couple of years, principally but not uniquely through our health service partnerships, we have been working with our health services around closer collaborations. Chair, it is not that we are against healthy competition – there is a fruitful tension there – but all too often competition between health services in the past has gotten in the way of care provision. Working with our health services through our partnerships we are building, if you like, care corridors for a seamless transition of escalating care for Victorians when they need it.

There is no health care without a healthcare workforce, and the workforce in our industry, more than any other industry, has been hit hard by pandemic, partly of course because they were at the centre of the pandemic, keeping Victorians safe, but also because, like all other industries, we had an interruption to international recruitment. The department is very focused on working in partnership with our health services around growing, sustaining and retaining a healthy workforce. Then collectively, it is about the department's focus on building a safe and sustainable – sustainable both from an environmental aspect and also from a physical aspect – health, wellbeing and care system that will continue to evolve and change to meet the ever changing needs of Victorians. Chair, this is not about more of the same, this is about continued adaptation and improvement.

I have got a few slides just on achievements over the two years in question, and I will start of course with the pandemic. The department was at the centre of the pandemic response for the state, keeping Victorians safe and healthy. Of all the things the department do, I want to highlight the state-run COVID vaccination program that, in record time, once COVID vaccines were made available to the state by the Commonwealth, ensured that almost 95 per cent of eligible Victorians had two or more COVID vaccines.

Like all jurisdictions, both nationally and internationally, we have come out of the pandemic with a significant backlog of deferred care. Since April last year we have had a focus on planned surgery recovery and reform. I am very pleased that Minister Thomas a few weeks ago formally launched our surgical blueprint that will see 240,000 planned surgeries a year being done in the state. That is a 20 per cent uplift on the best performance ever in this state. And it is not just about volume, it is about where those surgeries will happen, with increasing utilisation of what we have called 'rapid access hubs' – dedicated planned surgery facilities. Two of those of course have transitioned from the private sector, one in Frankston and one at Blackburn. But it is also how we do our surgeries, so lifting the proportion of surgeries that are same day, returning Victorians after their surgery to their home, where they would rather be, as quickly as possible, freeing up beds and improving patient flow. Then there is how surgery is done: the so-called HIT lists or high-intensity lists, where services will have maybe a week or a few days concentrating on a particular surgical craft – getting through orthopaedics, getting through gynaecology et cetera, et cetera, improving efficiency and effectiveness.

Then we are focused on expanding services to continue to ease the ever-growing pressures on our emergency services, both Ambulance Victoria and our EDs, through initiatives like the Victorian virtual ED – the world-leading secondary triage processes that Ambulance Victoria have been putting in place over the last few years – recruiting more staff and particularly paramedics, and putting in place primary care rescue packages, like our GP respiratory clinics that we stood up during COVID to replace what was market failure in primary care for urgent need.

I have talked in one of our priorities about care closer to home already. We opened in record time 28, soon to be 29, priority primary care centres – and there are now 6000 Victorians using those every week – and expanded our Better at Home program. Chair, since Better at Home started a little over two years ago 400,000 hospital bed days have been saved. So that is 400,000 nights a Victorian patient has had her or his head on their pillow rather than on a pillow stamped with 'Warragul Linen Services'.

We have a focus of course on workforce, and over the last four years we have added thousands of skilled professionals to the healthcare workforce, including recruiting more than 2100 international nurses, midwives, doctors and allied health physicians.

Two and half years in now, we continue on what is a decade journey to reform our broken mental health system. We have made strong headway on more than 90 per cent of the royal commission's recommendations, and more recently we have a reinvigorated focus on women's health, meeting the needs of the majority of our population that in past years has not been adequately met.

A summary, Chair, would not be complete without just touching on our infrastructure project – $15 billion of health infrastructure in the pipeline, the largest capital pipeline in the state's history. We completed 23 projects in 2021–22 and 2022–23, of course including Australia's only standalone dedicated heart hospital, the Victorian Heart Hospital in Clayton, and we continued with significant progress against other major projects, such as the award-winning Footscray Hospital. What is ahead of us is we will start work on Melton hospital next year and planning and development for what will be Australia's largest health infrastructure project, the Parkville redevelopment, while we continue seven other major hospital upgrades, continuing to expand our emergency departments and of course continued next stages of modernising our public sector aged care facilities.

Chair, it has always been the department's focus to keep Victorians healthy and safe during the pandemic, whatever the next phases of the pandemic may bring us, but as I said in the beginning, increasingly focusing on prevention and early intervention to keep Victorians as healthy as possible, such as the Smile Squad, such as increasing cancer screening programs, such as increasing early intervention and prevention in the mental health space such as what we delivered through our mental health locals. We will remain focused on the ongoing challenges of access to health care – particularly in primary care, and work with our Commonwealth colleagues – and also on the pressures that our emergency departments and ambulance services continue to face. Chair, ultimately this is about a journey of better collaboration to deliver better health outcomes for Victorians and better care as close to home as possible. This is not more of the same; this is about continued evolution to meet the ever changing needs of our population. Thank you.

The CHAIR: Thank you, Secretary. Talking about that continued evolution, the first round of questions will go to Mr O'Brien.

Danny O'BRIEN: I am not quite sure what that means, Chair, but anyway – I will take it as a compliment. Secretary, good morning, and good morning, team. The department's annual report for last year states that 2016 health professionals were recruited from overseas as part of the international recruitment drive. How many of the 2016 were nurses?

Euan WALLACE: So it is now more than 2016. I think it is above 2100 that have been recruited. The breakdown – I might ask Ms Geissler if we have got a detailed breakdown. The other stand-out feature of that recruitment program was a purposeful recruitment to rural and regional Victoria.

Danny O'BRIEN: I will come to that.

Jodie GEISSLER: I will have to get back to you, but I should be able to get back to you in the course of this hearing.

Danny O'BRIEN: On the breakdown?

Jodie GEISSLER: Yes.

Danny O'BRIEN: I am after how many are nurses and how many are midwives. I would be interested to know whether we know how many of them have stayed in the system, how many are left. Do you have that data, do you know?

Euan WALLACE: How many have stayed?

Danny O'BRIEN: Yes.

Euan WALLACE: Part of the recruitment package requires them to stay with us for two years, I think – as part of the package.

Danny O'BRIEN: Two years – and there are, what, financial penalties or something if they leave?

Euan WALLACE: Yes, and there are sequenced incentives.

Danny O'BRIEN: And payments, yes. I am not sure whether you have breakdown of the experience level of the nurses recruited from overseas.

Euan WALLACE: Not in terms of professional experience – no, we do not. I mean, they will all meet Australian standards.

Danny O'BRIEN: Of course, but I mean, I guess, the level that they are all at as it applies to Victorian and Australian codes.

Euan WALLACE: No, we will not. I mean, again, they will all meet Australian nursing, midwifery, medical standards. They are all accredited by the relevant board, whether it is the nursing and midwifery board, the medical board or any of the allied health boards. So they are required to meet Australian standards, to be registered practitioners with Ahpra. But in terms of the years of experience we will not have that breakdown.

Danny O'BRIEN: Okay. I assume they are all still working in the public health system?

Euan WALLACE: Yes.

Danny O'BRIEN: Okay. Secretary, are all legislated nurse-to-patient ratios being met in Victorian public hospitals?

Euan WALLACE: I think over the years we are talking about – as you know, during the pandemic, we worked with industrial partners, ANMF principally, but other health unions too when we needed to flex those ratios, and we worked very collaboratively with Lisa Fitzpatrick and her team. You might recall during COVID we had those health system response ratings: green, amber, red. During red, one of the triggers and one of the facilities that red afforded us was then conversations, service by service. During code brown in January last year, system wide, it allowed a facility to, if you like, adapt those nurse-to-patient ratios. So we are now in amber –

Danny O'BRIEN: Is 'circumvented' a better word, perhaps?

Euan WALLACE: So we are now in amber, and our nurse-to-patient ratios are all being met.

Danny O'BRIEN: Right. But in the case of a code brown or a code red, they can be circumvented – is that what you are saying?

Euan WALLACE: Yes, they can. Obviously what it does is trigger then conversations both with our code – stage red would have us have a conversation with health services and industrial partners. And again lessons from the pandemic were that the whole state is not typically affected uniformly, so where there are bits of the state that are not affected, they would maintain ratios. Where hospitals were particularly hit hard with hospitalisations – and you might remember in January last year we had some 1200 COVID hospitalisations at a particular point in time – where those services are particularly hit hard, then there is flexibility about ratios, but always with a commitment to returning to ratios as quickly as possible.

Danny O'BRIEN: Does the government intend to introduce nurse–patient ratios in the private system as well?

Euan WALLACE: The regulations for private hospitals and private health services are currently under review. They are due for review I think late next year or early 2025, so we are deep in consultation with stakeholders now. We have been meeting with industry partners; we have been meeting with private health services and private providers. I think as we review regulations – safety and quality outcomes from our private sector compared to our public sector – we will consider those issues. The determinations of those have not been made.

Danny O'BRIEN: So it is on the table but not yet decided?

Euan WALLACE: I think a sensible conversation as we review licensing regulations would be: 'We've got these features in public and these features in private. Are they best serving what we want?' I think ultimately it is not about making both sectors identical, it is about making both sectors deliver the best health outcomes and best health provision possible. There are some important differences between the private and public sectors.

Danny O'BRIEN: Indeed. Moving on, these are broad questions, not just about the recruitment from overseas. Do you have data on how many nurses left the Victorian public health system and retired in 2022?

Euan WALLACE: We have got overall rates. Pre pandemic we had recruitment rates – exit and replacement rates – of about 7 to 8 per cent across the industry. Post pandemic, if there is such a thing as post pandemic – so in the year 2022, let us call that peri pandemic – that increased to about 12 to 13 per cent.

Danny O'BRIEN: Of retirements?

Euan WALLACE: Over that calendar year. We have about 40,000, 50,000 nurses in the public system, so that gives you a sense. There are about 5000, 5500 needing to be recruited over a calendar year whereas historically it had been in the region of 3000, 3500. Again, one of the focuses I commented on in my introductory comments – one of the focuses of our workforce strategy – is about improving retention. We are already seeing some innovative models of that. If I look to, for example, the virtual ED run out of Northern Hospital in Epping, the retention of their ED nursing staff at Northern is better than average for the state. There are complex reasons for that, but I think one of the contributors will be that they have been able to offer their ED staff a day or a couple of days in the virtual environment as well as three days in the physical environment.

Danny O'BRIEN: Sorry, Secretary, I am conscious of my time. Did you have an actual figure, Ms Geissler?

Jodie GEISSLER: They are coming through.

Danny O'BRIEN: They are coming through. Likewise, I am interested – and it goes to the Secretary's point – in how many nurses have reduced their hours from full time to part time. Do you have that sort of data?

Euan WALLACE: We do not hold that data. Obviously those data are held – remember that the employers are the individual health services. Data of fractional appointments and changes in fractional appointments are not held centrally by the department. We do hold total FTE data.

Danny O'BRIEN: Okay. For that total FTE and the data that Ms Geissler is getting, could we provide a breakdown for metro and rural and regional areas if that is possible? That would be great. Just moving on to nursing student clinical placements, the questionnaire on page 16 shows that the actual number of additional placements was 73 per cent of the 200,000-day target. When will the government meet the target of 200,000 additional clinical placement days in the public system?

Euan WALLACE: I may ask Ms Geissler if she wanted to –

Jodie GEISSLER: The budget figure for the 200,000 additional student placement days is $13.2 million. That is the correct cross-reference, I think.

Danny O'BRIEN: You are talking the figures, the dollars?

Jodie GEISSLER: Yes.

Danny O'BRIEN: I believe so, yes. I am interested in the actual days delivered; that is probably the key question.

Jodie GEISSLER: Over 70 per cent of the additional days were delivered – 146,585 days. This was impacted by the pandemic. The clinical placements were impacted by the pandemic. They are heavily reliant on supervision being available, and that was difficult, as you can imagine, during the –

Danny O'BRIEN: So the question is: when will we get to the 200,000 target?

Jodie GEISSLER: Sure. I will ask if there has been some modelling on that.

Danny O'BRIEN: Okay. Some more data questions: are you able to provide how many undergraduate nursing students there were in Victoria for the two years in question and what is expected for this year, if you have got it?

Euan WALLACE: Again I do not have those to hand. Obviously they are held by our tertiary providers, but we will provide what we can.

Danny O'BRIEN: Okay. Do you also have attrition rates of student nurses for the two years?

Euan WALLACE: During their undergraduate training?

Danny O'BRIEN: Yes.

Euan WALLACE: I am not sure we will have those data actually.

Danny O'BRIEN: Okay. If you can check, that would be good.

Euan WALLACE: So obviously we have graduation data from our nursing and midwifery schools.

Danny O'BRIEN: Can I ask how many compliance checks there are for undergraduate nurses – how many they are required to undertake as part of their training?

Euan WALLACE: What do you mean by compliance checks?

Danny O'BRIEN: Well, things like working with children checks and that sort of stuff that forms a compliance check.

Euan WALLACE: There are two sets of compliance checks as I understand it. Obviously there are checks as a student, whether it is an undergraduate or postgraduate healthcare course, such as hepatitis B vaccination is a requirement for our healthcare students. And then there will be checks for them as they come in to the workforce as students working in the workforce, and those checks will be aligned with the checks of the employer – working with children, police.

Danny O'BRIEN: So police check, international police check, working with children, NDIS screening check, immunisation, serology and compliance –

Euan WALLACE: So they will all differ by what discipline they are in and what provider they are working for.

Danny O'BRIEN: Do you know what the out-of-pocket costs for student nurses to undertake all of those are, and do they get any support for those?

Euan WALLACE: Again, I think the checks that they require will differ by what they are doing – what clinical activity they are doing – and what their providers are. So the cost will differ. Whether they get assistance with those costs we will take on notice.

Danny O'BRIEN: Okay. Thank you. Can I move to the priority primary care centres you mentioned. The government's media release from 3 January this year indicated that:

> Many of the clinics are operating seven days a week and up to 16 hours a day …

Can I ask: are all 27 of the PPCCs fully staffed 16 hours a day, seven days a week?

Euan WALLACE: So now 28 and soon to be 29 – they will vary. So their opening hours and the facilities will vary. As I said in my introductory comments, they have been a stand-out success for the state. We have stepped into a space that has traditionally been the space of the Commonwealth, and we have all read – it is writ large – around –

Danny O'BRIEN: I appreciate that, Secretary –

Euan WALLACE: No, no, but it is about access challenges, out-of-pocket costs. So these are free at point of care, free diagnostics –

Danny O'BRIEN: Yes, yes, I understand what they are about, Secretary. I just want to know how many are operating 16 hours a day, fully staffed, seven days a week.

Euan WALLACE: Well, again, they will vary. We will get that information for you.

Danny O'BRIEN: If you would not mind.

Euan WALLACE: And again, as I said in my introductory comments, about 6000 Victorians use these every week now, and there have been something like 160,000 visits total since we stood them up in August last year.

Danny O'BRIEN: So again I assume you will have to check this, but how many doctors are employed in each of the facilities, and how many are full-time and how many are part-time?

Euan WALLACE: So they are a mixed model. Remember that we have built these in collaboration with our primary healthcare networks, our PHNs, aligned with general practices where they exist but also aligned with our major metro EDs in particular, because the principal function of them is to offload work – category 4, 5 work in particular – from our EDs. So I think we will not have and neither will they have information on full-time, part-time because they are working in a hybrid model. They work partly in the GP practice and then partly in the priority primary care centre.

My own family having been a user of one of the PPCCs – the PPCC in Commercial Road in Prahran – my sense is that we will have doctors working there allied to their practice but doctors who may work elsewhere and using sessionals. So there will be a hybrid model, and the employers are of course not the department but through the host general practice.

Danny O'BRIEN: Okay. That goes to the next question. Where have the GPs come from?

Euan WALLACE: From our existing services. So this is about creating an environment where our GPs can work additional hours, whereas previously they were not able to.

Danny O'BRIEN: So they have not been new recruits from overseas, new graduates, interstate?

Euan WALLACE: We have not recruited specifically internationally to them. Principally general practices in Australia are private businesses, small businesses, and general practices will recruit their own GPs. Partners will recruit their own GPs. So we have not been recruiting GPs to the system for our PPCCs. We have built the PPCCs in collaboration with our PHNs. The PHNs and the host general practice would then staff. Have GPs come from elsewhere in the country? It is possible, but we would not have the information. That information would be held by PHNs.

Danny O'BRIEN: You said, though, that effectively predominantly they are existing GPs working additional hours.

Euan WALLACE: I think so. And the reason I say that –

Danny O'BRIEN: What sort of percentage of that –

Euan WALLACE: Well, I do not know. We will not have that information. But the reason I say that is that we stood these up extremely quickly. They were not dependent on recruiting staff from elsewhere in the country or internationally. It was about mobilising personnel that already existed who, for whatever reason, were not working those additional hours. Government has created an environment where the primary care workforce has wanted to work additional hours and provide these services.

Danny O'BRIEN: It is ironic that my next question has a quote from the then acting Minister for Health that says these facilities are:

> … ultimately taking pressure off our hardworking doctors and nurses.

In fact we are actually asking them to work more hours, it would appear.

Euan WALLACE: No, no, I think that is a mischaracterisation.

Danny O'BRIEN: All right. Anyway –

Euan WALLACE: No, no. Let me answer the question because you have asked it.

Danny O'BRIEN: No, it was not actually a question. It was a statement.

Euan WALLACE: It was, I think, and I do not want to put words in the acting health minister's mouth, but I suspect he was –

Danny O'BRIEN: He was referring to hospitals.

Euan WALLACE: Yes.

Danny O'BRIEN: Which is what the question is: he also said that they are helping reduce waiting times in our EDs. Again – I assume this will be on notice – can I have the reduction in wait times for EDs at a number of hospitals? I can give you a list if you like, or if you have got it for all the EDs in the state – is that possible?

Jodie GEISSLER: Well, I can give you a little bit of data around how many people would have presented to EDs if these had not been available.

Danny O'BRIEN: Sure.

Jodie GEISSLER: Survey data indicates that approximately 53 per cent of patients would have attended in an emergency department if a priority primary care centre had not been available.

Danny O'BRIEN: Okay. So presumably the other 47 per cent would have gone to their GP.

Euan WALLACE: If they could have got into their GP.

Danny O'BRIEN: Which goes to the next question – there are lovely segues happening here this morning. On the HotDoc webpage for the Glen Waverley PPCC, patients are warned when booking an appointment that:

> This clinic is specifically for urgent care for injuries and illnesses. Not a replacement for your regular General Practitioner.

The Premier keeps saying that in fact that is what this is. We are stepping into the GP space because the Commonwealth has failed, basically. The message from the Glen Waverley centre suggests that is not the case, is it?

Euan WALLACE: No, so I think, as you know, it is not a simple ecosystem. I think we have seen changes in healthcare access and utilisation over the last 20 years, like actually most of the Western world has, that have seen the provision of general practice services less accessible than they were. When we were children, our GPs would have been available 24 hours and come to our home. That is a very unusual model now. This is about providing primary care in an urgent setting. This is not about replacing the services where people have an established relationship and a trusted relationship with their GP. They are going for anti-hypertensive medication or follow-up care et cetera et cetera. This is about respiratory infections, UTIs. It is about –

Danny O'BRIEN: So when the Premier said:

> This is the fundamental issue – we are making sure Victorians can access GP services.

That is not really what it is about.

Euan WALLACE: Well, no, it is because that urgent care out of hours or in hours was one of the very things that, again, when were children, general practice provided. For lots of understandable reasons, they no longer provide it in the way that they used to. So how do we replace that? In our system, like elsewhere in Australia, like actually elsewhere in the Western world, sadly, those urgent primary care needs have been increasingly met by emergency departments. Emergency departments are not the right place. So it is about

providing the care needs for people. It is not that Victorians are turning up to the wrong place. It is about providing the care that they need. And that is what the PPCCs are doing.

Danny O'BRIEN: Can I move on to planned surgery. The questionnaire on page 30 talks about the COVID catch-up plan, and you mentioned it in your opening comments. In providing after-hours surgeries on the so-called Super Saturdays, are there additional costs compared with doing surgeries during the week, and what is that cost?

Euan WALLACE: Yes, there are. The planned surgery recovery and reform program, I think, is a stand-out success for the state. I might ask Ms Geissler to add to comments I might make. As you know, back in April last year we set a very ambitious target of 240,000. That 20 per cent uplift in activity, as I sort of touched upon in my introductory comments, will be met through a myriad of different initiatives –

Danny O'BRIEN: Sorry, Secretary –

Euan WALLACE: sorry – one of which is weekend lists and evening lists. Like any weekend work, they come at additional salary costs for the individuals – the nurses, the perioperative technicians. Our Saturday list is moderately more expensive than a Monday morning list.

Danny O'BRIEN: Can you tell me what additional costs have been borne to deliver that?

Euan WALLACE: Well, the investment in the whole program, as you know, is $1.5 billion. We do not have a specific breakdown for services for a Saturday list.

Jodie GEISSLER: Yes. They will vary by service is the reality. Service by service, there will be different arrangements struck locally.

Danny O'BRIEN: So it is absorbed within the total of the $1.5 billion.

Jodie GEISSLER: Mr O'Brien, I can provide you with a little bit of the workforce data if that is useful now.

Danny O'BRIEN: I have just got one more question and then we might come to it. Are there any public lists being cancelled on weekdays to accommodate weekends instead?

Euan WALLACE: No.

Danny O'BRIEN: Absolutely 100 per cent certain?

Euan WALLACE: Yes, absolutely. This is about increasing capacity, not reducing capacity. I have seen some commentary on that very question. It is misinformed.

Danny O'BRIEN: Okay. Thank you. If you have got that data, I have got 7 seconds left, Ms Geissler.

Jodie GEISSLER: Sure. We have recruited 26 midwives and 1017 nurses as part of the international program in 2022–23.

Danny O'BRIEN: Thank you. And if you could come back to us with the rest of it, that would be great.

The CHAIR: Thank you, Mr O'Brien. We will be moving on to Mr Galea.

Michael GALEA: Thank you, Chair. Good morning, Secretary and officials. Thank you for joining us. Much as I would love to talk about priority primary care centres as well – because I know how successful they have been and how great they have been for my community in the south-east, especially with the Narre Warren one, which has been up and running for a while now too – I would actually like to direct you, Secretary, to the questionnaire for the Department of Health, specifically question 30, which is in regard to the performance measure targets and objective indicators. Now, I note that there is quite a significant number – a very large number – of these performance measure targets which have not been met over the 2021–22 and 2022–23 financial years. Why?

Euan WALLACE: Thank you. I am just getting the questionnaire. As I do that, I will maybe just say there clearly have been some very challenging years for health for lots of reasons, and I think many of those challenges are evident in many of these performance measures. It might be useful as a bit of background because the performance measures exist in multiple places. In BP3, they exist obviously in the questionnaire and response to the committee's information needs, but they also exist in our annual report. And as you compare BP3, the questionnaire and the annual report, there are some subtle differences. In BP3, the department's performance measures are in broadly three clusters – health, mental health and Ambulance Victoria – whereas in our annual report they are in clinical services, aged care, mental health and ambulance services.

We obviously pay a great deal of attention to our performance measures. I might ask Ms Geissler just to supplement some of my comments in a moment, particularly around surgery and perhaps ED. When the department is looking at our performance across a year and the performance of the sector across a year, we broadly look at activity, quality and workforce. We have now about 200, 201 measures in 2022–23, slightly more than the year before, and as you have said, we delivered on just over half of those and did not achieve just under half. The majority where we did not achieve were about activity, and I think the explanations of why we did not get to activity – and actually Mr O'Brien asked about the 200,000 student placements, which is an expression of activity. The reasons in 2021–22 are a wee bit different to those in 2022–23. In 2021–22 it was mostly COVID, so it was mostly lockdowns and mostly cessations of surgeries and closure of clinics et cetera. In 2022–23, while still dealing with significant COVID challenges – we had omicron, remember, in the first quarter of 2022–23 – the activity challenges were ones of recovery and then workforce, and we have touched upon workforce already. Most of our non-delivery of activity targets was around workforce challenges – retention, recruitment and replacement of workforce, and we have gone to some of those, and in a moment if we get time, we might get to workforce also.

Quality – if I can go to quality, because at the end of the day Victorians care that the care they receive is high quality and safe. In health we met 68 per cent, 70 per cent of our quality targets; in aged care, 75; in mental health, about half; and in ambulance, almost 80 per cent. The key failings in health were around readmissions – so unplanned readmissions of patients having hip replacements, tonsils, those who have had acute myocardial infarction. These are people who have come in, either with a condition or for a procedure, who have been discharged and then unexpectedly readmitted. We see that as a failing of quality, so we have not met those targets. Safer Care Victoria, the state's lead healthcare quality and safety improvement agency, are leading pieces of work through their clinical networks, cardiovascular continuing care network and paediatric learning network to drive down those readmissions – to find out the conditions that are leading to unplanned readmission and then working with services, working with patients and working with families. The other cluster of quality measures that we did not meet relate to category 3 and category 2 surgeries being delivered on time – and I might ask Ms Geissler to talk to what we are doing about surgery – and then of course ED waiting time and ED experience, but maybe we will talk about planned surgery and what we are doing with those measures, and then time allowing we can come back to ED. I can pick that up and then look at the other things.

Michael GALEA: Thank you.

Jodie GEISSLER: I am very happy to talk about the improvement plans that are underway around surgeries. As the Secretary referenced, the $1.5 billion COVID catch-up plan announced in April 2022 is the state's largest ever investment in a surgical plan, and it is focused on improving performance against planned surgery targets. The key goal, as expressed by the Secretary, of the plan is 40,000 more operations each year from 2023–24 compared to prepandemic levels – that is 240,000 operations a year. The plan is designed to create enduring system reform that will provide Victorians with timely access to surgery, irrespective of where they live and what their surgical needs are. The plan is really multifaceted – and very deliberately multifaceted – with initiatives designed to maximise public activity, maximise private activity, support rapid expansion of the workforce, increase efficiency and effectiveness of surgery and support local delivery of reform.

Practical examples of what this investment is delivering include patient support units in health services to provide rapid assessment, management and communication with patients on the planned surgery waitlist. This may include offering alternative or complementary treatments such as physiotherapy. As of June this year, these patient support units have contacted over 44,000 patients.

We have also established rapid access hubs. Four of those have opened: Northern Health, Broadmeadows; Alfred Health, Sandringham; St Vincent's on the park; and Werribee Mercy. The remaining four hubs will open later this year. To maximise public activities we have seen extended theatre lists put in place, with twilight and weekend sessions available, as Mr O'Brien referenced, for people to get their surgery out of hours; increasing, where appropriate, same-day surgeries; and a Surgical Equipment Innovation Fund to upgrade, modernise and replace surgical equipment. Investment has also been made in two new public surgical centres at Frankston and Blackburn, and we are maximising private hospital capacity, with partnerships in place between our public hospitals and private providers to promote timely care.

Since the plan commenced in April 2022, there has been progressive improvement in the volumes of planned surgery delivered and the waitlist, including a 19 per cent increase in planned surgery volumes – that is 9068 – in the quarter ending 30 June 2023, compared to the corresponding period in 2022. 50,881 planned surgeries delivered in the quarter ending June 2023 is the fourth-highest quarterly activity on record, with the records going back to 2012. There has been a waitlist reduction of 17,112 patients – 21 per cent – since March 2022. The reduction in the waitlist of 14,677 patients in 2022–23 was also the largest annual decrease on record. We are seeing improvements in the median wait time for category 2 and category 3 patients between this most recent quarter and the same quarter the year before, and an overall improvement in terms of the percentage of patients treated in the recommended time.

Really importantly, a lot of work is being done to continue this performance improvement in an enduring way. We continue to think about the future. To keep this momentum of the program going, more than $80 million has been allocated to upskill over 1000 nurses and theatre and sterilisation technicians, supporting the training of an additional 400 peri-operative nurses, and to recruit a further 2000 highly skilled healthcare workers from overseas. We have also very deliberately made investments in rural and regional Victoria as a key part of the plan. Totalling $75.3 million, it comprises: additional activity funding of a rapid access hub in Geelong, due to be delivered in the coming months; delivering innovation teams in each rural and regional health service partnership, five in total; planned surgery patient support units; and money under the Surgical Equipment Innovation Fund. It is a huge, ambitious program, but it is well underway and making really good progress. I am very happy to talk about emergency departments.

Euan WALLACE: I think the other bit of our quality measures relate to ED not uniquely but also mental health. I will maybe just quickly touch briefly on ED and ask Ms Geissler to supplement, and also Mr Hotham can talk to you about the capital investments we have made in ED. Managing ED workload is very complex. Ultimately, it is about solving what is a pipeline of care – it is about reducing the inflow of patients. We have talked a bit about PPCCs already – about whose care needs are better delivered somewhere else; their care needs are not best served in an ED. It is about increasing the capacity of our EDs, and it is about increasing bed access in our hospitals for those who are in ED who need to be admitted. The solutions to our ED performance measures will require work in those three buckets in the pipeline.

In terms of connecting patients to the right care, so avoiding ED when they do not need to come to an ED – they are better served elsewhere – we have talked about PPCCs already. As you know, we established the Victorian virtual ED in Northern. It is now seeing somewhere between 600 and 1000 patients a day, and the majority of those – 70 per cent of those – never require physical care at an ED. They either have their care needs provided entirely by their virtual consultation or their virtual consultation refers them on to their own general practitioner or other care providers – so diverting care away from our ED.

The virtual ED also provides an escalation source for our paramedics. Again, there were 2500 visits, if you like, from our paramedics in July this year. So our paramedics are calling virtual ED – they attend a patient at home, or wherever, realise as a skilled health practitioner that the patient actually probably does not need to physically transfer to hospital, to an ED, but they need some sort of care, so they call into virtual ED. Again, the majority – almost 80 per cent – of those patients referred by their paramedics to virtual ED did not require transfer to an emergency department. Most recently, our virtual ED at Northern have expanded their paediatric services, so they now have a network of paediatric specialists in the virtual environment, providing the urgent care, the needed care, to children that their parents are seeking.

During the pandemic, like most jurisdictions in Australia, Victoria established a rather sophisticated residential aged care in-reach program where we connected both public and private aged care services with public hospitals, where public hospitals were providing medical care into the aged care facility. We have continued

that program, and that is diverting patients – which goes to my comments about prevention and early intervention – and preventing those patients from turning up unnecessarily at an ED, because they can get the care that they need in the home.

Then there are some other innovative programs. I think of a program I visited down at Peninsula a couple of months ago, where they have patients with chronic heart failure who weigh themselves every day. If you have got heart failure and you are deteriorating, then you will retain fluid and your weight will go up. They have a call service, and they have skilled staff who phone them every day and say, 'What's your weight today?' Maybe actually that is something I need. If their weight is going up, they then refer them on to a physician – virtually – who adjusts their medication, and it avoids hospitalisation. So all of those complex programs are connecting Victorians to the care that they need in a much better environment, rather than them deteriorating and going to ED.

Part of the pipeline of course is increasing ED capacity. I might ask Mr Hotham to tell – we have had an extensive and elaborate capital program over a number of years now in ED expansion.

Chris HOTHAM: Yes, I am very happy to touch on that. Before I go to the expansion itself, there are also a number of augmentations to our emergency departments that are now more in line with contemporary models of care. I particularly talk about the paediatric zones that we are creating in our EDs and the mental health and AOD hubs which are designed to create better flow within ED in those facilities. So there is expansion, but the model is improving as well.

Over the period of these two financial years that we are considering there was $439 million to expand capacity of hospital emergency departments across the state. In these two financial years we completed a number of works, including the Northern, Casey and Werribee Hospital modular expansions, which opened in mid-2022; the Wonthaggi expansion of stage 1, completed in November 2022; and we also had the Monash Medical Centre completed in March 2022. Beyond that, in these two financial years we kicked into a number of works, including ED expansion at Casey and Werribee and the paediatric emergency departments which I touched on. They are in University Hospital Geelong, in Casey and in Frankston and are being planned for Northern, Maroondah and the Austin. We are investing in and delivering an expansion at Swan Hill, in the emergency department there. So you can feel the growing capacity within the system. Most of those are particular dedicated emergency department works. It is also worth noting of course that our bigger capital program is now running at around $15 billion with a number of those major tertiary hospitals. Of course they all come with new EDs and new ED expansion. So new Bendigo; Goulburn Valley Health; the Shepparton redevelopment; Footscray, which the Secretary touched on; Warrnambool; and Melton will all come with that additional capacity.

Euan WALLACE: So those are the first two buckets, and then the last bucket, which I think actually is among the most important, is about patient flow bed access. Often when health systems look at ED pressures, they think of the solutions being in ED. You get a sense that there are some solutions in ED – making sure that we have got capacity – but actually the solutions lie in ensuring that there is flow of patients who require admission into our hospitals, and we have got two particular programs for addressing that. One is Better at Home and one is a timely emergency care collaborative. I might just ask Ms Geissler to talk about them.

Jodie GEISSLER: Yes, sure. In terms of Better at Home, $698 million over four years was invested in 2022–23. Really that supports the delivery of more acute rehabilitation, geriatric evaluation and management, health independence programs and specialist clinic services at home. This program currently helps more than 15,000 Victorians each year to receive home-based care. These services freed up 374,000 hospital days, so it is making a really significant impact. But in addition to community care, as the Secretary has referenced, when people need acute care we need to look at how best to progress that care – ambulance to emergency department, emergency department to ward where necessary, ward to home or to community services. $9.6 million was announced in July 2022 to support a two-year initiative called the Timely Emergency Care Collaborative. It is a partnership with Ambulance Victoria, 14 of our health services and the Institute for Healthcare Improvement. Health services are testing over 150 clinician-led ideas to improve flow in their local hospitals, and we are seeing some results as a consequence of that investment: emergency department length of stay for admitted patients has started to trend below the mean, and we are seeing reduced inpatient length of stay. We have seen improvement in handover times and some improvement in 24-hour breaches. The

partnership really is an example of how the system works together in the best interests of the patients that require emergency care.

Euan WALLACE: I think the last bucket of quality measures that we have not met around mental health I mentioned – many of those measures are brand new. They are measures that we brought on over the last two years and investments in mental health reform in response to the royal commission. But some of those particular performance measures are mental health and ED, and I might ask Ms Whetton just to describe a couple of the initiatives that we have put in place.

Katherine WHETTON: Thank you, Secretary. One of the performance measures that has not been met in 2021–22 and 2022–23 was the emergency patients being admitted to a mental health bed within 8 hours. This is something the royal commission found was a real challenge across the system – that there is an undersupply of beds across the system and often the emergency departments are the entry point to the mental health system. A couple of things that have been worked on since the royal commission that go to that performance measure are new beds – so the government committed to 179 new inpatient beds in response to the royal commission – and a lot of those beds are now coming online, so there is somewhere for those emergency patients to be admitted, beyond the emergency department.

Also, as Mr Hotham mentioned, we have got mental health and AOD hubs in emergency departments, and that is about having those people who do present to an emergency department in a mental health crisis or with an AOD concern get specialist help straightaway in a more calm environment. We have got a few of those now up and running. In fact St Vincent's Melbourne recently won the Excellence in Mental Health and Wellbeing award at the Victorian public health care awards for having halved the wait times for those patients who arrive at emergency departments with mental health and AOD needs.

Euan WALLACE: I hope that gives you a sense that we take our performance measures extremely seriously. It is some of the work that the board spends most of its time on as we look at how we solve the care needs of our population.

Michael GALEA: Thank you, Secretary and all officials. It is certainly very reassuring and very exciting as well, actually – some of the things that are happening. Some of those figures, especially with the virtual ED in particular, were quite remarkable. I could talk for much more time, but my time is up, so thank you very much.

The CHAIR: Thank you. We will go back to Mr O'Brien.

Danny O'BRIEN: Thank you, Chair. Secretary, you talked about Blackburn and Frankston hospitals before. Can you tell me what each has delivered in terms of surgery since opening in October last year?

Euan WALLACE: Yes. I might ask Ms Geissler to give us – if we have got specific numbers from Frankston. Before going to those, the intent for Frankston will be that it will deliver between 8000 and 10,000 more. That is the destination point. Blackburn –

Danny O'BRIEN: Right. What has it actually done?

Euan WALLACE: Well, we will get to that in a second. We are adding an additional theatre to Blackburn. Blackburn is not currently operating today. We have closed it for adding an additional theatre. However –

Danny O'BRIEN: At all?

Euan WALLACE: Well, in collaboration with Eastern Health, who are operating Blackburn, we have moved the additional surgeries that Blackburn would have done to other campuses. So they still see an activity uplift – they are doing surgeries at Maroondah, Angliss et cetera – but they are not doing them at Blackburn. Blackburn is scheduled to open early next year, and –

Danny O'BRIEN: But it has been doing surgeries?

Euan WALLACE: It has been, but we have now closed it to add an –

Danny O'BRIEN: Yes. I understand.

Euan WALLACE: The site plan requires us to close it to add the additional theatre.

Jodie GEISSLER: Two theatres, actually. So as the Secretary said, the Frankston and Blackburn public surgical centres opened in September 2022 and October 2022 respectively. As of 30 June 2023, Frankston has completed 2599 surgeries and Blackburn 877, for a total of 3476 combined. It is really important while the capital works are underway at Blackburn and while it is closed for a short period, to add two theatres to make it four theatres onsite.

Danny O'BRIEN: You have had to close the other two while you are doing that? Yes.

Jodie GEISSLER: Eastern Health is absorbing the additional patient throughput that would have happened on that site in their other campuses. While it is disappointing to have a shutdown, it will be great to have two additional theatres, and it is good that the patients will continue to be seen elsewhere at Eastern Health.

Danny O'BRIEN: I think there are more up-to-date figures from VAHI which indicate that between the two over the 12 months they delivered 4783 surgeries, whereas the government promised they would do 14,700 per year. Extrapolating out, the government also promised 240,000 additional surgeries by next year. Has the department then revised down its estimate of surgeries that will be completed, given these targets have not been met, at least in the first year?

Euan WALLACE: Our goal is still 240,000.

Danny O'BRIEN: So you have not changed it?

Euan WALLACE: Well, that is where we need to get to. If you do the mapping and the modelling – these are planned surgeries, remember. In addition to these 240,000, there are emergency surgeries. In order to meet the population's needs, our modelling shows that we need 240,000 surgeries ongoing. Our population continues to grow. So that is the destination. You correctly said that when we built this program in April last year, when we began it, the intent was to deliver 240,000 surgeries by the end of this current financial year. I do not think we will hit that target, but we will get to those volumes next calendar year.

Danny O'BRIEN: Do you know what you will hit this year?

Euan WALLACE: We will do more surgeries than we have ever done in the state's history.

Danny O'BRIEN: That is not the question, Secretary.

Euan WALLACE: I know.

Danny O'BRIEN: If you do not know, that is fine. I will move on.

Euan WALLACE: Obviously the numbers are fluid. They are ever changing because we are ever increasing. We will get well above 200,000 surgeries this year. I am hoping we will get north of 210,000, and we may get to 220,000. We may even get beyond that, Mr O'Brien, but it is about progressively building capacity and bringing that capacity on stream.

Danny O'BRIEN: The latest figure shows 68,941 Victorians still waiting for planned surgery. One of the bugbears as a country MP is that you cannot get figures for many of our hospitals – places like Mildura and Bairnsdale. What is then the true number of people waiting for planned surgeries across the state, given that that data is not publicly available?

Euan WALLACE: There are two bits to that question, I think. The first is what I think is a fixation with waitlists, which is misplaced. It is not about waiting lists, it is about waiting time. We could have a million people on a waiting list. If we were doing 500,000 surgeries a year –

Danny O'BRIEN: That is not a particularly good picture, though, Secretary.

Euan WALLACE: No, no, but if we were doing 500,000 surgeries a year, having a million people on waiting lists would be irrelevant because you would get your surgeries done on time. It is about waiting time.

Of course we will continue to report waiting lists, but actually what matters to the patient, to the Victorian who is on a list, is –

Danny O'BRIEN: The individual.

Euan WALLACE: when they will get their surgery.

Danny O'BRIEN: But of course the more people that are on the list, given the resources we have got now, the longer it will it be for each of those people.

Euan WALLACE: Well, yes. That is true, but our lists are coming down. We have taken 16,000 off the list over the last 12 months. That is the biggest decrease in the waiting list in the state's history. To go to your point about Mildura and elsewhere, we have two systems. We have a system called ESIS which our major hospitals are on. These are patients typically – not uniquely but typically – who are seen as outpatients in the hospital. They see a surgeon, and then she puts the patient on the waiting list. Those lists are visible; those are the lists that are always published. Then there are so-called non-ESIS lists. These are lists held by individual surgeons in their rooms. So when she sees a patient in her rooms, she puts it on her list, because she is the surgeon providing the surgery at Mildura or Maryborough or wherever. Part of the planned surgery recovery reform program is to progressively make those non-ESIS lists visible, and so we will add them to ESIS.

Danny O'BRIEN: Will that include Mildura's and Bairnsdale's?

Euan WALLACE: Yes, it will. In time, it will.

Danny O'BRIEN: Can you give me a time line of when?

Euan WALLACE: No, because it is very complicated. It is much more complicated than you would think. For example, we are working with Grampians, who have brought Horsham and Stawell into their health service, and we are working with them on how we might do this most efficiently. The reason I started with it not really being about waitlists – it is about wait time – is not to be precious. As we bring non-ESIS lists, lists that are currently sitting in drawers of private surgeons, into public visibility, our waitlists will go up, but our capacity will go up.

Danny O'BRIEN: On that point, can I ask whether you can confirm that when certain category 1 patients cannot have their surgery performed within the 30-day limit to make them still a 30-day category 1 patient, they are often recategorised as a 3A?

Euan WALLACE: No.

Danny O'BRIEN: It does not happen?

Euan WALLACE: We have essentially 100 per cent. I think there were half a dozen category 1 patients total last financial year that were not done in 30 days, and they were done at 31–32 days. Recategorisation of patients – down-categorising from cat 1 to cat 3 or cat 2 – does not happen. Remember the categorisations happen by the surgeon.

Danny O'BRIEN: Exactly. Thank you. You mentioned 16,000 off the waiting list.

Euan WALLACE: Yes.

Danny O'BRIEN: How many of those actually were patients that died before they could have surgery?

Euan WALLACE: There are always patients on the waiting list.

Danny O'BRIEN: Of course.

Euan WALLACE: The number of patients in the last financial year –

Danny O'BRIEN: We are asking Ms Geissler a lot of data questions. I wonder whether she has got the answer to that.

Euan WALLACE: We do have that number.

Jodie GEISSLER: The number being – you are asking about the number of deaths on the waiting list, or are you asking –

Danny O'BRIEN: Ideally for the reporting period, the last two financial years – how many people were removed from the waiting list because they died?

Jodie GEISSLER: I guess the first thing we have got to say about that is that figures cannot be taken as an indication that a patient's wait for planned surgery resulted in their death.

Danny O'BRIEN: No, no. I am not suggesting it was.

Jodie GEISSLER: That is right.

Danny O'BRIEN: Naturally people who are sick are going to die from time to time.

Jodie GEISSLER: Yes, but it is an important clarification because it might be misconstrued. In 2022–23, 1395 people are recorded as being removed from the waiting list by reason of death. In the most recent quarter this number was 351.

Danny O'BRIEN: Sorry, 3 –

Jodie GEISSLER: 351.

Danny O'BRIEN: As in, to now, effectively?

Jodie GEISSLER: Yes, the most recent quarter.

Danny O'BRIEN: Have you got 2021–22?

Jodie GEISSLER: I do not, not on me today.

Danny O'BRIEN: Could you provide that on notice perhaps? Thank you.

Euan WALLACE: Our sense is that those numbers are reasonably stable proportionate to the waiting list size. I think – again, a point I have made before – that the decrease of 16,000-odd from the list is the largest decrease we have seen.

Danny O'BRIEN: Just to clarify, would those numbers be included in the 16?

Euan WALLACE: They will.

Danny O'BRIEN: Yes, okay. Just on palliative care, Secretary, there was $32.4 million in the budget in 2022–23 for 'strengthening palliative care in the community'. Could you tell me how much of that allocated funding has actually been provided and spent?

Jodie GEISSLER: According to the notes I have here, the funding went to direct care service providers with the aim of improving access in Victorians' palliative and end-of-life outcomes. I have got no indication that the funding was not provided.

Danny O'BRIEN: Okay. So that is being rolled out as planned per the budget?

Jodie GEISSLER: Yes, and the 2022–23 state budget included $32.431 million over two years.

Danny O'BRIEN: How much of that was Commonwealth funding, if any?

Jodie GEISSLER: Good question. I would have to get back to you.

Danny O'BRIEN: If you would not mind, that would be good. It does say 'attracts Commonwealth funding' in the budget papers. So if you could give me an idea of how much that was.

Jodie GEISSLER: Yes.

Danny O'BRIEN: And perhaps this is a question for the Secretary. Palliative Care Victoria has indicated that the sector needs an additional $122 million in funding by 2025. Is the department planning for additional funding in that respect?

Euan WALLACE: We are certainly having conversations with stakeholders and the sector more broadly around palliative care needs, and it goes to one of my points in the introductory comments, which was around whether we can provide increasing care at home and in community. So if you take a survey of Victorians with palliative care needs, the majority say they would rather have those needs met at home – they would rather die at home. As you know, currently we are no different to most other like jurisdictions: sadly, the majority of Victorians who wish to die at home actually end up dying in hospital. So we are having conversations, we are having planning discussions with stakeholders, with the sector. As our population gets older and older, then it is not surprising that palliative care needs will continue to increase, and we will plan accordingly.

Danny O'BRIEN: Okay. Can I move on to Smile Squad, which I know the government loves talking about. Can I ask how many children are missing out on follow-up dental care with their local dentist as a result of the Smile Squad program claiming the Australian child dental benefits schedule funding for eligible students?

Euan WALLACE: Well, Smile Squad we do like talking about, because it is a stand-out success for us. I might ask Ms Geissler to just summarise where we are at, but we are treating more children –

Danny O'BRIEN: I will come to the numbers, Secretary, but if I can just get an answer to the question.

Euan WALLACE: So your question is: how many children are missing out –

Danny O'BRIEN: On follow-up dental care because their federal voucher, if you like, has already been used up by the Smile Squad.

Euan WALLACE: Well, I guess I am not sure I understand the question. There were some 7000-odd children that had treatment with Smile Squad last year. If they have had treatment with Smile Squad, will they need treatment with another provider?

Danny O'BRIEN: No, they might need follow-up treatment; that is the question. I guess the question is getting at: is Smile Squad using the Australian child dental benefits schedule funding and therefore not available for students outside the Smile Squad program?

Euan WALLACE: I think it is about providing dental care for those that need it most using available funding streams. As you know, in Smile Squad there are two components. There is the dental assessment and examination, and some 30,000-odd kids have had that last year. Then there are those that need treatment, about 7000, and the expectation is that they have treatment. If they need treatment, they will have treatment with Smile Squad. They will not miss out on treatment at all.

Danny O'BRIEN: Okay. So you get an assessment as part of Smile Squad that you need three fillings and a couple of teeth taken out. Smile Squad will do that as well?

Euan WALLACE: They will, and it is up to the parents and the child. If they say, 'Well, I now need something; I'd rather go to my own dentist,' then they are free to go to their own dentist.

Danny O'BRIEN: Yes, of course. At the hearings in June the minister said at the end of this year every government school will have received a visit from Smile Squad. I think we are a fair way off. Can you give me an update as to how many schools have been visited now?

Jodie GEISSLER: We are not actually too far off. The number of students examined by Smile Squad – let us just start with the number of students, because the performance metrics there are quite staggering. We have far exceeded the target, as has the number of students receiving treatment by Smile Squad, which builds on your previous question about them going on to get specialist care. 31,844 students were examined by Smile Squad against a target of 10,000. The target for the number of schools visited, as you say, in 2022–23 was 200; 177 schools were visited. The reason for that is –

Danny O'BRIEN: 177 have been done?

Jodie GEISSLER: Yes. The reason for this included clinical workforce shortages, which I will talk about in a second, but also schools prioritising resumption of learning in the classroom. You can understand there is a lot of activity in our schools. But in terms of workforce and how we are ensuring we have the necessary pipeline so that we can keep going out to schools – as many as possible – the 2022–23 budget provided $3 million to recruit 100 new dental assistants. That is forward planning to ensure that more schools can be visited.

Danny O'BRIEN: How many have we got of those 300?

Jodie GEISSLER: I will have to get back to you.

Danny O'BRIEN: Thank you – if you could take that on notice. Of the 177, are you projecting you will get to 200? You have about four weeks to go.

Jodie GEISSLER: Well, that was the target in 2022–23, so we are hopeful, of course, that we will continue to revisit the program and ensure that we can get to as many schools as we possibly can.

Danny O'BRIEN: Okay. Has every child in the schools visited had a physical dental check by a qualified dental professional?

Euan WALLACE: It is offered, so obviously one cannot obligate. It is about offering children at the school and their parents – and of course some parents will choose for their children to have the dental care with their own private dentist, and that is perfectly appropriate.

Danny O'BRIEN: The distinction I am making here, though – and I understand that response – is between a full check-up versus a dental information pack being provided.

Euan WALLACE: Yes. Kids get a pack, and then when the Smile Squad visit – and obviously we work very closely with our colleagues in the Department of Education, who work with school principals and school staff. So as we are scheduling visits of Smile Squad to a school, information will go to parents – 'Here are the year levels' – and those parents who want their child examined and then potentially treated will have access to that.

Nick McGOWAN: Just on the 31,800 et cetera, that was by a qualified dental professional. Is that correct?

Euan WALLACE: Yes.

Nick McGOWAN: The 31,000?

Jodie GEISSLER: Yes. The examination has to –

Nick McGOWAN: As Danny said, it is not just a kid – not someone who is an assistant.

Jodie GEISSLER: An examination can only occur by a qualified professional, yes. But Mr O'Brien, can I just tell you that 64 of the 100 assistants have been recruited today.

Danny O'BRIEN: Sixty-four?

Jodie GEISSLER: Yes, but we are on track.

Danny O'BRIEN: Sorry, didn't you say 300 assistants?

Jodie GEISSLER: No, I said 100. Apologies, I might have said 300, but I meant to say 100.

Danny O'BRIEN: Right. So that was the funding from the 2022–23 budget?

Jodie GEISSLER: The 2022–23 budget, yes.

Danny O'BRIEN: In 2021 the government said that free dental treatment would be provided to 200,000 students. What are we up to in total? You mentioned 31,000 this year.

Jodie GEISSLER: Yes, against a target of 10,000.

Danny O'BRIEN: That is 2022–23?

Jodie GEISSLER: That is correct.

Danny O'BRIEN: What was 2021–22?

Euan WALLACE: The numbers were not collected then.

Jodie GEISSLER: Yes, that was not a BP3 measure in the previous year.

Danny O'BRIEN: The numbers were not collected?

Euan WALLACE: It was not a BP3 measure.

Danny O'BRIEN: Okay. That is important to the committee, but when the minister says 200,000 surely we know how many actually got treated.

Euan WALLACE: Well, over the life of the program, so again –

Danny O'BRIEN: That is what I am asking.

Euan WALLACE: Yes. We will see if we have got numbers for 2021–22.

Danny O'BRIEN: That would be great, thank you. Can I move on to ambulance services, Secretary. The medical director of Ambulance Victoria Dr David Anderson said on ABC radio this week that 40 per cent of ambulance calls to 000 go to secondary triage. In 2022–23 how many patients were unable to get an ambulance because there were none available and subsequently their condition deteriorated before they got to hospital?

Euan WALLACE: I might ask Ms Miller, who is CEO of Ambulance Victoria and who is here, to come to the table. While she is doing that – I think I alluded to this in my introductory comments – the Ambulance Victoria secondary triage system, a world-leading system, has grown secondary triage from about 7 per cent to now 20 per cent or around 20 per cent, not 40 per cent. But then to go to your question, which is how many patients –

Danny O'BRIEN: How many patients were unable to get an ambulance because there were none available and subsequently their condition deteriorated before they could get to hospital?

Jane MILLER: I think that is best represented in terms of our response times. I cannot give you the particular number around the number of patients that did not get an ambulance in the context that we do continue to respond to all patients in the community. But as you know and as the Secretary has outlined, we make sure that we are prioritising our resources for those with life-threatening conditions that need an urgent response. Our response times for 2021–22 for code 1 emergencies, which are the most urgent, was 67.5 per cent. In 2022–23 it was 62.8 per cent. I would also state that were also record demands across some of those quarters.

Danny O'BRIEN: Of course. Do you know what it is at the moment for the current year?

Jane MILLER: For the first quarter of this year, which is our fourth busiest quarter ever, it was 66 per cent.

Euan WALLACE: Can I just supplement that. If I understand your question, if a Victorian has called an ambulance and an ambulance was not available in time and their health deteriorated such that they never made it to hospital, that would be a sentinel event and the –

Danny O'BRIEN: Which is exactly what I was going to ask. How many sentinel events were there as a result of that and how many people died?

Euan WALLACE: There were 10 sentinel events in 2020–21 related to Ambulance Victoria and there were 10 in 2021–22.

Danny O'BRIEN: Ten in both years?

Euan WALLACE: Yes.

Danny O'BRIEN: How many of those died, can you tell me?

Euan WALLACE: All 10 of these people died.

Danny O'BRIEN: Right. Okay.

Euan WALLACE: And as you know, the sentinel event program – the current sentinel event program I built when I was COC for care. About 78 per cent of sentinel events are sentinel events because the patient died.

Danny O'BRIEN: Dr Anderson also said that around 100 taxis a day are being used to take patients to hospital. I remember being told a few years ago, 'Well, that's just temporary and it's only for emergencies.' Is that now becoming the norm?

Jane MILLER: We have used taxis for less urgent connection to care for more than six years. Our secondary triage team in 2022–23 organised 18,998 taxis.

Danny O'BRIEN: 18,000?

Jane MILLER: 18,998 taxis for patients where clinically appropriate, avoiding an emergency ambulance dispatch.

Danny O'BRIEN: That was what year, sorry?

Jane MILLER: 2022–23.

Danny O'BRIEN: Thank you.

The CHAIR: Thank you, Mr O'Brien. We will now go to Mr Tak.

Meng Heang TAK: Thank you, Chair. Secretary, through you, I refer to the Department of Health questionnaire response, pages 9 and 10, under 'Responding to community-based healthcare demand'. Can you explain how investments to increase HPV vaccinations in vulnerable populations have contributed to our goal of eliminating cervical cancer in Victoria?

Euan WALLACE: Thank you. I might ask Professor Wainer to give you details about that question. But before she does that, as a clinician I am an obstetrician gynaecologist. When I was in training, as part of the training in specialist gynaecology, I spent six months in gynae oncology – the specialty – treating women with cervical cancer, and on a daily basis I saw women in their 20s and 30s dying of this horrid, horrid disease, undergoing just the most dreadful surgeries. It is amazing now, 25–30 years on, to think that we are staring down eradication of this dreadful condition, which is just testament to brilliant medical research, some of it done by Ian Frazer here in Australia in Queensland, also a Scottish graduate. But I might ask Professor Wainer to give you an answer to your specific question.

Zoe WAINER: Thank you for the question. Thank you, Secretary. We are committed to reducing the impact of cancer on the Victorian community by improving prevention, screening and early detection of cancer under the *Victorian Cancer Plan 2020–2024*, in addition to the development of the next Victorian Cancer Plan 2024–28. Australia's world leading screening program, combining a human papilloma virus vaccination program, means that we are on track to be the first country in the world to eliminate cervical cancer as a public health concern. The *Victorian Cancer Plan 2020–2024* sets the ambitious target for Victoria to reach this goal by 2030.

The 2023–24 investment in prevention and early intervention of chronic and preventable health conditions will increase primary care workforce capacity to detect and treat skin cancers as well, and also to refer to specialist care more broadly. That investment obviously aims to reduce the skin cancer incidence and mortality as well.

In terms of HPV vaccinations specifically, in September 2021, $1.229 million was provided through the equitable cancer prevention and care budget bid to fund local council immunisation services, to develop and implement catch-up strategies to increase HPV vaccination rates in secondary school students. Funding was provided to 77 councils, with payments made based on the number of secondary schools within the LGAs.

In December 2022 $0.3 million was provided by the screening and cancer prevention team of the Department of Health to deliver activities to increase HPV vaccination in priority cohorts. This included $37,785 provided to the Cancer Council Victoria to pilot strategies to increase HPV vaccination in young people with a disability. Resources were developed to support parents, teachers and local council immunisation providers and made available in June 2023. $262,215 was provided to the Victorian Aboriginal Community Controlled Health Organisation, or VACCHO, to deliver a program to increase HPV vaccination coverage in Aboriginal adolescents. This project included grants to 11 organisations to deliver catch-up immunisation and provide health promotion activities.

To go to the cervical cancer elimination element that the Secretary also touched on, the Department of Health is committed to strengthening prevention and early detection to improve cancer outcomes for all Victorians as set out under our *Victorian Cancer Plan*, as mentioned. Data from the *Victorian Cancer Plan* monitoring and evaluation framework progress report shows that Victoria is on path to be the first jurisdiction in the world to eliminate cervical cancer as a public health problem. The World Health Organization target for elimination is four new cases per 100,000. In 2021 Victoria had an incidence of six new cases per 100,000.

Euan WALLACE: The other bit of the program Professor Wainer has described is that over the last year or so how cervical screening is done has changed. It changed to self-testing. Women can now do the test themselves. They do not have to attend a healthcare professional to have a Pap smear. That was always the most awkward entry point to the system – says he as a man, who has never had one done. That is really important, because particularly women from CALD communities now can self-test. So when we look at the increase in cervical screening uptake, the difference is greatest in those communities than other communities, just reflecting this access issue. As Professor Wainer says, we are on an extraordinary pathway, and to think in my lifetime we will see eradication of this disease is outstanding.

Meng Heang TAK: So can I just confirm, Professor – thank you, Secretary: is Victoria on track to meet our target in terms of eliminating cervical cancer as a public health problem?

Zoe WAINER: We are on track, and as the Secretary said, that cervical screening self-collection has been a significant game changer as well. In the 12 months since the introduction of universal self-collection, which was 1 July 2022, there has been a 20-fold increase in the number of self-collected cervical screening tests in Victoria. Victoria has achieved the *Victorian Cancer Plan 2020–2024* goal to screen 10,000 under-screened women by self-collection, with over 11,000 under-screened women completing this by the end of 2022. While most self-collected tests were in women who were on time for their screening, proportionately self-collection uptake has been the highest in the under-screened population, which is really important, as the Secretary mentioned – which is 24 per cent of the total HPV tests in that cohort, compared to women who were on time for screening, being 15 per cent of HPV tests in that cohort. Self-collection uptake has been higher in the lower socio-economic status areas in Victoria where 20 per cent of total HPV tests were self-collected from July 2022 to September 2023, compared to areas with a higher socio-economic status, where 16 per cent of total HPV tests self-collected from July 2022 to September 2023.

Meng Heang TAK: Thank you. What other initiatives are contributing to the prevention and detection of early common cancers affecting women, and how has this been implemented?

Zoe WAINER: Thank you for the question. Secretary, are you happy to –

Euan WALLACE: Yes. I mean, obviously we are very proud of the work that BreastScreen Victoria does for us in screening for breast cancer, the other major currently accessible cancer of women that we can get at through screening and early intervention. The other cancers, endometrial and ovarian cancers, are much less accessible than cervical and breast. Professor Wainer may want to talk to the initiatives that we have had in breast cancer screening. Remember at a previous hearing of this committee we were talking about the seven-week pause that we had in BreastScreen Victoria's activities during the pandemic. We estimated at that time about 30,000 Victorian women had had their care deferred. In order to meet that, government invested

specifically to increase BreastScreen Victoria capacity, but I might ask Professor Wainer to give us some details.

Meng Heang TAK: Thank you.

Zoe WAINER: Thank you, Secretary. I think, importantly, the HPV vaccine is also for men, but obviously the disease impacts women.

In 2023 the Victorian government committed $20 million over four years to expand breast screening services in Victoria and screen an additional 36,136 eligible Victorians per year by 2026–27. The Victorian government has committed under the Victorian cancer screening framework a significant investment over four years to deliver targeted engagement and delivery of cancer screening activities and to enhance Victoria's monitoring and evaluation of these programs through improved data and reporting processes. In 2022–23 the Victorian government extended funding for BreastScreen Victoria to improve access to culturally and linguistically diverse women by implementing in-language evidence-based activities to lapsed clients who were overdue for screening. This encouraged over 1700 women to re-engage with the BreastScreen program.

In 2022–23 the Victorian government contributed funds towards Cancer Council Victoria's statewide bowel screening program. The campaign adopts an always-on approach to build a sustained narrative over an extended period of time throughout 2023 and complements other cancer screening and bowel screening initiatives running. In 2022–23 the Victorian government funded the Cancer Council Victoria to design and deliver an early detection campaign, which launched in May 2023. This campaign aimed to increase awareness of participation in cancer screening broadly, attending health checks and practising early detection health behaviours to ensure diagnosis of cancer at the earliest stage.

In October 2021 of the 42 breast screen clinics in operation in Victoria, the majority, being 23, had a wait time of more than 10 weeks, as impacted by the pandemic. However, due to the expansion of the services and the opening of new clinics in areas of high demand, in November 2022 of the 48 clinics now operating none had a wait time of greater than 10 weeks, with the majority, 25 clinics, having a wait time of between two to four weeks. Sorry, correction – it is 2023 that there are now 48 clinics operating.

Euan WALLACE: I think it goes back to the point I was making earlier to Mr O'Brien, it is the wait time that is important, and I think we are on track now. Our target for breast screens this year is 267,000. We are on track based on quarter one's results to get to about 285,000 breast screens in the state.

Just in closing – and I mentioned in passing ovarian and endometrial cancer – ovarian cancer is really the next Everest for us to climb in women's cancers and cancer prevention or cancer detection. It is a hidden cancer because of course ovaries are inside the abdominal cavity. It is very difficult to screen imaging, but places like the Hudson Institute at Monash University are leading work globally on the development of ovarian cancer screening blood tests that we can do to try and get early markers of ovarian cancer. Then work is being done through the Peter Mac, the Royal Women's, the Olivia Newton-John Cancer Research Institute and others around improving cancer therapies for ovarian cancer. Today the majority of women with ovarian cancer present with very advanced disease – stage 3 and stage 4. The five-year survival rate for women with stage 4 ovarian cancer is profoundly low. So it is important that as scientists, such as those at the Hudson, develop new screening tests, our clinicians, clinician scientists and oncologists are developing better and better therapies so that those women who will still present late have better survival rates. But you know, there is breast cancer and cervical cancer, and then, as I said, the next Everest for us has to be ovarian cancer. We have to crack that.

Meng Heang TAK: Thank you, Secretary. I am still interested in cervical cancer and prevention screening. We heard about the women in diverse communities and low socio-economic areas. What sort of initiatives have been carried out to promote awareness in these areas?

Zoe WAINER: Are you happy for me to take that?

Euan WALLACE: Okay.

Zoe WAINER: Thank you for the question. Obviously, as I have mentioned, Australia now has a national strategy to eliminate cervical cancer as a public health problem, making us one of the first countries in the world to achieve this status. I think importantly it highlights, as you have raised, the equitable resource

distribution that we need to ensure we achieve through strategic planning and implementation of vaccination programs to reduce vaccine-preventable diseases for at-risk populations. These at-risk populations include First Nations people, culturally and linguistically diverse people, people with disabilities, pregnant individuals and those with medical conditions or barriers to health care access. Victoria has already invested heavily in equitable HPV vaccination programs.

In September 2022, $1.229 million was provided through the equitable cancer prevention and care budget bid to fund local council immunisation services to develop and implement catch-up strategies to increase the HPV vaccination rates in secondary school students. Funding, as I have mentioned previously, was also provided to 77 councils, with payments made based on the number of secondary schools within their LGA. As mentioned and detailed, $37,785 was provided to the Cancer Council specifically for young people with a disability and more than $260,000 was provided to the Victorian Aboriginal Community Controlled Health Organisation to deliver the program to increase HPV for Aboriginal adolescents in particular.

Euan WALLACE: I think one of the other things I would add actually is that obviously, as you know, during the pandemic we as a department learned lots of lessons about engagement with community, particularly recent migrant communities who may be less trusting of government departments than people who are born here. Through the pandemic we established really important and enduring relationships with community leaders in the diverse communities that we have, particularly recent migrant and refugee migrant communities, and I referenced our COVID vaccine program earlier in my introductory comments. We are very proud of the 95 per cent coverage of eligible Victorians, but we are actually even prouder of the equity measure. Every Australian jurisdiction did really well with COVID vaccination, but of all jurisdictions, on the measures of equity, uptake of the COVID vaccine in Victoria was outstanding. That was no accident. I think Mrs McArthur asked me a question at a previous hearing about operation mocha. You might remember. It was a very bespoke cafe-based COVID vaccine program to get at a community that we knew we had difficulty getting at. Those really important lessons we are now increasingly applying to a broader portfolio. So as Professor Wainer said: where are the inequities in health delivery, health provision and health outcomes, and how do we correct those inequities?

Meng Heang TAK: Thank you. There was such good campaign awareness at the time. We are looking forward to hearing maybe in the next PAEC meeting about this very important topic. Moving on to the Ambulance Victoria workforce, Secretary, I refer you to budget paper 3 of the 2021–22 state budget, page 62.

Euan WALLACE: Sorry, budget paper 3 –

Meng Heang TAK: Budget paper 3 of 2021–22, page 62, speaks to the funding provided to boost Ambulance Victoria operational resources. That is including new funding for the 117 paramedics in addition to the paramedics and support staff to be recruited as part of the ambulance demand initiative. How has the initiative attracted new recruits?

Euan WALLACE: Thank you. I might ask Ms Miller, CEO of Ambulance Victoria, to give you more detail than I can instantly access. But let me just say first of all that even prior to 2021–22 and 2022–23 there has been very purposeful, sustained investment in our AV workforce both in terms of numbers but also in terms of additional training once they are in place. Indeed over the last decade the Ambulance Victoria workforce has increased by about 50 per cent – well ahead of jurisdictions elsewhere but, importantly, actually ahead of other components of our health workforce. I think our nurses have grown by 34 or 35 per cent, our allied health by 38 per cent and our doctors by 40 per cent. I think the increase in the AV workforce by 50 per cent over a decade is a reflection of that sustained, purposeful investment. We now have more ambulance workers per head of population than the national average, so we have got 58.5 ambulance workforce personnel per 100,000 population. The national average is 53, and New South Wales is 45.

But to go to your specific question around budget paper 3 and that investment of $204 million for 117 additional paramedics, I might ask Jane to comment.

Meng Heang TAK: Thank you.

Jane MILLER: Certainly. Thank you, Secretary. As the Secretary said, we have the largest operational staff of any Australian ambulance service following consecutive years of record recruitment, and through that we continue to lead the way in patient care, including delivering the nation's best cardiac arrest survival rates. We

fast-tracked the recruitment of 358 paramedics in 2022–23, and in 2021–22, the year that you are focusing on, we recruited 716 paramedics. That includes the cohort of 117. As we continue to focus on meeting the demand of our community and ensuring that we have ambulances on the roads to patients that need them, even this financial year Ambulance Victoria has already recruited 178 new paramedics.

Meng Heang TAK: Thank you for the status. What has been the overall growth of the paramedic workforce?

Jane MILLER: Let me get my figures on that. The growth in percentage terms of our on-road paramedics from 2014–15, about 10 years ago, is 45 per cent. From 2021–22 to the current year it is 3 per cent. So we are continuing to grow year on year.

Meng Heang TAK: Thanks.

Euan WALLACE: The other thing I would add is that – and I think I alluded to this earlier – it is not just about numbers, it is also about roles. So the other thing that Ambulance Victoria has been doing is to expand the capability and scope of our paramedics. I referenced the paramedics phoning virtual ED and actually delivering the health care themselves. We are so far away from – if you think that our ambulance services two decades ago used to be about putting people in a van and taking them to hospital, these are now skilled, regulated healthcare workers that are providing care onsite.

Meng Heang TAK: Thank you, Secretary. Thank you, Chair.

The CHAIR: Thank you, Mr Tak. The committee is going to take a very short break and resume the hearing at 11:15 am. I declare this hearing adjourned.

The committee will now resume its consideration of the Department of Health. Secretary, I believe there is something you wish to say.

Euan WALLACE: Thanks, Chair. We do have answers to the questions that Mr O'Brien asked us earlier. If it pleases the committee, we can share those.

The CHAIR: Thank you.

Jodie GEISSLER: So you asked how many nurses retired in financial year 2022–23 and for a breakdown of how many were rural and regional. Whilst we do not have oversight of the reasons behind staff movements, in the 2022 calendar year 9520 nurses left the profession –

Danny O'BRIEN: Sorry, 9000 –

Jodie GEISSLER: 9520, of which 1174 were aged 65 or over and were likely retiring.

Danny O'BRIEN: Yes.

Jodie GEISSLER: In 2021, 7067 nurses left, including 1084 aged 65 and over. In terms of rural and regional breakdown, in 2022 the total, as I said, was 9520 and 3115 of those were regional. In 2021 – of the total 7067 – 2357 were regional.

Danny O'BRIEN: 2357.

Jodie GEISSLER: That is correct.

Danny O'BRIEN: Thank you very much.

Jodie GEISSLER: The second question you asked was: how many undergrad nursing students did we have in financial year 2022 and financial year 2023? In 2021 Victoria had 16,675 undergraduate student nurses. While we do not receive, as the department, student outcome data, based on historical student numbers and Ahpra registration rates it is projected that on average approximately 17 per cent of nursing students withdraw from their course. In terms of a breakdown of the nursing workforce across metropolitan and regional locations, let us start with metropolitan in 2021 – 75,352. 30,664 of those were regional, rural. In 2022 there were 76,617 metropolitan in total, and rural was 31,299.

How many healthcare workers have left the workforce in terms of resignations? They made up approximately 8 per cent of the total workforce in 2021, up from about 7.3 per cent in the previous year. Between 2019 and 2021 the proportion of nurses who resigned from the health service increased; however, there was also an increase in the supply of nurses during that period. For doctors and other clinicians the data does not indicate higher rates of resignation than in previous years.

You asked about compliance checks.

Danny O'BRIEN: Sorry, just on those ones, that was 2019 to 2021. What about 2021 to 2023?

Jodie GEISSLER: I will have to get back to you on that.

Danny O'BRIEN: Sure.

Jodie GEISSLER: Yes. In terms of compliance checks, we do not subsidise checks, but we are funding the 'making it free' initiative, which provides scholarships for undergraduate nurses and midwives, which reduces financial disincentives. Safer Care Victoria is working on a central portal over the next two years to improve the efficiencies and minimise the financial burden on individual nurses and midwives who need to provide that sort of information.

You asked about priority primary care clinics being open six days a week. The times and days that each of those centres is open are publicly available on the department's website. Hours and times do vary from the 16 hours, seven days due to workforce availability at times.

Palliative care: how much did the Commonwealth contribute to this? The 2022–23 budget commitment was for $32.4 million over two years. The total Commonwealth commitment over the two years was $13.355 million. In 2022–23 the Commonwealth's contribution was $7.678 million and Victoria's was $10.744 million. And in 2023–24 the Commonwealth's contribution was $5.677 million and Victoria's was $8.332 million.

In terms of schools visited by Smile Squad –

Danny O'BRIEN: Righto. Keep going.

Jodie GEISSLER: the number of students who received treatment in the calendar year 2021 was 11,244 and in calendar year 2022 it was 31,844, and results are reported by calendar year to reflect the school year. And then finally you asked about additional specialist services and what has been established in terms of children receiving dental care. The Royal Dental Hospital of Melbourne has been established as a primary specialised hub, with new regional services being established in Bendigo, Latrobe and Barwon – plus six additional satellite clinics operated by private dental specialists.

Danny O'BRIEN: Okay. Thank you very much. Excellent.

The CHAIR: Thank you. We will now go to Mr McGowan.

Nick McGOWAN: Just on that figure there you gave for the treatment – 31,834, was it?

Jodie GEISSLER: Yes. Sorry, my computer has just frozen.

Nick McGOWAN: For 2022?

Jodie GEISSLER: Yes, I think so, yes.

Nick McGOWAN: Because that is very similar to the examined, is that correct?

Jodie GEISSLER: Yes.

Nick McGOWAN: Because the examined was 31,844. It sounds like it is the same thing. It is a large number –

Jodie GEISSLER: It sounds like the same thing, yes.

Nick McGOWAN: It does. It sounds a large number to have treated and examined – that does not seem to be plausible.

Jodie GEISSLER: I am sorry, my computer has frozen, so it is going to be hard to pull up.

Nick McGOWAN: I thought the number of treated was in the order of 10,000 – or 7000 I think it was.

Euan WALLACE: Well, in the financial year 2022–23 treatment was 7759 I think; and examined, 31,844.

Nick McGOWAN: So that figure we have just received would not be correct, then, in terms of treated?

Euan WALLACE: It is probably –

Nick McGOWAN: Examined.

Euan WALLACE: Yes, it is the same. It is probably the definition of 'treatment' as an examination of treatment.

Nick McGOWAN: If you could just come back to us on that.

Jodie GEISSLER: We can, and it might also come down to the calendar years – apologies. We will come back, yes.

Nick McGOWAN: But even calendar years – financial years – still would not tally, I would not have thought. But if you could come back to us, that would be great. Just on non-emergency patient transport: obviously there are only six months to go now until the contracts all expire, and obviously the sector is very concerned – in fact I am very concerned, and most Victorians should be concerned. What are the intentions? Let me be more specific: are you going to advise the current service providers of their future? Because obviously they have large workforces and significant funds invested. When can they expect to hear from the department?

Euan WALLACE: Again, I might ask Ms Miller if she wants to add anything, but as you know, we have a review of non-emergency patient transport underway at the moment, and that review is due to report at the end of this year.

Danny O'BRIEN: That is the Steve McGhie review?

Euan WALLACE: Yes.

Nick McGOWAN: I get the review, but in all reality even if you get a review, it could take two years to consider the review. These people have staff, they have Christmas, they have six months to go – surely they need some sort of sense of where their future lies? These are tens if not hundreds of thousands of employees – Victorians – who are now hanging in the balance. What is the plan?

Jane MILLER: As I understand it, the review will be delivered to government towards the end of this calendar year. Notwithstanding, we continue to engage with a number of providers to deliver non-emergency patient transport services. We have got them contracted to the end of this financial year, and we have just gone out to them with a request to extend with new contracts beyond that period so that there is ongoing stability of service delivery while that review is provided and implemented by the government.

Nick McGOWAN: Just to pick you up on that. The extension – when is the extension until? Is it another financial year after the expiry of this one?

Jane MILLER: Let me check the figures on that. I think it is 15 months, but let me check the figures on that.

Nick McGOWAN: Fifteen months from the start of the next financial year?

Jane MILLER: From the start of the next financial year, yes.

Nick McGOWAN: Okay. Well, that gets us somewhere at least. Mr Secretary, did you want to add something?

Euan WALLACE: Well, just that obviously the department is most interested in this part of healthcare provision, but we support Ambulance Victoria and HealthShare in terms of contracting with providers. We encourage contracts to be extended, as Ms Miller has just described, as we prepare to receive the review and then work through with government the findings of the review. The department itself, as you would expect for proper integrity and probity reasons, is not involved in those contracts.

Nick McGOWAN: No. Okay. Very quickly, on Ambulance Victoria: when was the last staff satisfaction survey that was completed? Do we have an idea when that was?

Jane MILLER: We have just participated in this year's people matters survey. That closed on 17 November. The one prior to that was in 2022.

Nick McGOWAN: Will you make that public? The results from that survey?

Jane MILLER: We will absolutely share those results with our workforce, and the results will be provided through the Victorian Public Sector Commission as well.

Nick McGOWAN: I suppose I am being more selfish. Will you provide those to the committee as well?

Jane MILLER: I have no problem sharing those with the committee. We will share them with our workforce, and we will use those to improve our services.

Nick McGOWAN: Fantastic. That would be great. When would that be? Do you know, roughly?

Jane MILLER: We will be receiving those results from the Victorian Public Sector Commission. I believe they will be provided in the next couple of months – early new calendar year at the latest.

Nick McGOWAN: Okay. So let us say before Easter?

Jane MILLER: That is my understanding, but we are obviously needing those results to be provided to us by the VPSC.

Nick McGOWAN: That would be great. I was somewhat shocked at the 1395, I think it was, Victorians who died on the waiting list in 2022–23, if I heard correctly. Is the department investigating those deaths to ensure that – of course as we do not want and as you have alluded to in your answer – there is not a situation where they are dying as a consequence of waiting?

Euan WALLACE: If a Victorian dies as a result of either perceived or actual healthcare failure, then by definition that would be a sentinel event, and the expectation would be that health services report the sentinel event through to Safer Care Victoria that curates that program. The health service then reviews the sentinel event, depending on the nature of the sentinel event, typically using root cause analysis methodology.

Nick McGOWAN: So there will be an investigation into those numbers?

Euan WALLACE: Well, if – and it goes to Ms Geissler's comment, that I do not think the committee nor anyone else should misconstrue, that 1300 patients, Victorians, on a waiting list who –

Nick McGOWAN: We will not misconstrue them until we know what the cause of death is, of course.

Euan WALLACE: Yes. And so that will be the for the health –

Nick McGOWAN: But that is key for us to know. Okay. So let us try and do that.

Euan WALLACE: service to determine whether they thought that was a sentinel event or not, and then report and investigate appropriately.

Nick McGOWAN: Okay. Secretary, ambulance response times for code 1 emergencies in the last quarter were only 66 per cent within 15 minutes. That is well below the target of 85 per cent, it is quite shocking, really. Why has this figure remained at much the same level as the 12 months previous?

Euan WALLACE: Yes, and again I might ask Ms Miller to supplement my answer. It is a reflection of significant volume challenge for the sector, as Ms Miller reported earlier to the committee. I think the last quarter we had was the fourth busiest quarter ever, so we are seeing volumes of calls to Ambulance Victoria continue a trend continuing to increase over time. It is also around case complexity, so again not unique to Ambulance Victoria. We have also seen in our emergency departments but also our hospitals more broadly, partly due to deferred care but partly due to an ageing, more complex population, that care takes longer. And as Ms Geissler described with the Timely Emergency Care Collaborative, this pipeline of improvement solutions to help manage Ambulance Victoria response times and ED flow and patient flow; if our EDs cannot flow patients through to our hospitals, then they find it more challenging to take the next set of patients that arrive.

Jane, I might ask if you have got anything else to add. I also say that, before Jane steps in, this is not unique to Victoria. While our response times are in the last quarter 66 per cent, similar response times in New South Wales were below 50 and into the 30s.

Nick McGOWAN: We are not aiming for that, are we?

Euan WALLACE: We are aiming for our target, which is 85 per cent.

Nick McGOWAN: Bravo.

Jane MILLER: Yes, indeed. It is important to recognise the impact of COVID-19 across Australia and indeed the world significantly impacted the demand and our ability to respond. We have seen record demand, so whilst our performance was strong on code 1 responses time prior to the pandemic, we have since seen record demand. October to December 2022 was the biggest quarter in AV's history with more than 100,000 cases for the first time ever, so that understandably impacted response times. We have had some relief but demand does remain high; July to September saw ambulance called to 96,594 cases of code 1, which is 2002 more than a year ago, so that was our fourth busiest quarter ever. There is a huge 23.6 per cent increase from 78,132 code 1 cases five years ago, before the pandemic.

Despite this, ambulances are arriving at lights and sirens cases on average 23 seconds faster than a year ago, and 52 seconds faster than the previous quarter. From July to September, paramedics across Victoria responded to 66 per cent of code 1 cases within the statewide target of 15 minutes, up from 61.7 per cent for the previous three months and up from 64.3 per cent a year ago. As a result, the statewide average response time to code 1 emergencies dropped to 15 minutes and 12 seconds.

I would also reflect some of the comments made by the Secretary earlier that we are always focusing on right treatment, right place, right time and making sure that where we are needing a lights-and-sirens response, we are mobilising that resource. But for less urgent, less time-critical responses we are utilising our secondary triage team, we are connecting patients to health care through virtual ED and indeed other service pathways. So this remains a very big focus for Ambulance Victoria, but we are committed to continuing to improve our response times.

Euan WALLACE: Mr McGowan, can I add –

Nick McGOWAN: I will come back to you in a second, sorry. I just do not have a lot of time. On the NEPT, will the contract extensions apply to all the current providers?

Jane MILLER: That will be a process that will go through those providers. They have been given the opportunity to engage in that process.

Nick McGOWAN: Okay, thank you. Jodie, just to follow you up too on the sentinel matters, can you tell us how many of those related to children? That is, those under 18 years of age.

Euan WALLACE: This is sentinel events to do with the total sentinel event program?

Nick McGOWAN: Both the total sentinel program but also those who were waiting on a waiting list, so those two figures. I understand you might need to take that on notice.

Danny O'BRIEN: You said before there were 10 in each of the –

Euan WALLACE: Those were AV sentinel events. Remember we talked about 10 in 2021–22 and 2020–21? Those were 10 Ambulance Victoria sentinel events.

Danny O'BRIEN: I think the question is –

Euan WALLACE: I do not think any of those were children, from memory. I would have to come back and confirm that with you.

Nick McGOWAN: If you could check that, but I was also asking specifically –

Danny O'BRIEN: Generally.

Nick McGOWAN: correct, generally – of the 1300 or so that passed away waiting on the waiting lists, whether any of those were children as well. That would be useful, thank you.

On a different matter, the Lay report – Mr Secretary, are you able to provide a copy of that to us, please? Ken Lay's report.

Euan WALLACE: Ken Lay's report is with government.

Danny O'BRIEN: Not with you? Have you read it?

Euan WALLACE: I have, but it is with government.

Nick McGOWAN: Please tell us about it.

Euan WALLACE: I think in due course government will make its decisions informed by that report.

Nick McGOWAN: There is nothing at all you can share with us about the second location for an injecting room?

Euan WALLACE: Not today.

Nick McGOWAN: Tomorrow?

Euan WALLACE: Not tomorrow.

Danny O'BRIEN: You are coming back tomorrow.

Nick McGOWAN: Coming back tomorrow, exactly. On a personal matter for my electorate in Ringwood at Maroondah Hospital – 2018, that is nearly, what is it, too many years ago now – they were promised a dedicated emergency department for the children. Some 20,000 children in the region – Croydon, Warrandyte, Ringwood – we are still waiting and people are incredibly frustrated. But I do know at the last election we were promised a brand new hospital, and there was a nice contingency in there too. I think from memory it was like $150 million to $1.04 billion, so they are factoring in the cost blowout; so efficient is this government now, it can actually factor that in. So when can we see something at Maroondah Hospital, either in terms of the children's emergency department that was promised years ago and never delivered and/or the commencement? I heard there is a reference before to the planning of the hospital. That gives me no confidence at all given that we are now waiting locally for close to a decade.

Euan WALLACE: I might ask Mr Hotham to give us some details. As you know, the Maroondah Hospital is one of our seven major capital projects that was announced in the last budget.

Nick McGOWAN: Secretary, it was also one of the five emergency children's departments announced in 2018 which never happened.

Euan WALLACE: Indeed, and we will come back to that. I do wish to just correct your characterisation of cost blowouts. In the health –

Nick McGOWAN: No, what I said was in the commitment the government gave, they said it was $850 million to $1.05 billion. They actually gave a scope in terms of what they would promise.

Euan WALLACE: I think that is appropriate, because obviously environments change, but in the health portfolio we have a track record of delivering our projects on time and on budget.

Nick McGOWAN: Not in Maroondah.

The CHAIR: Mr McGowan, may I remind you the Secretary is trying to answer the question.

Nick McGOWAN: I am not holding you responsible, I am holding your minister responsible. Please, enlighten us.

Euan WALLACE: Maybe Mr Hotham could just talk to the Maroondah build.

Chris HOTHAM: I guess to zoom out, Mr McGowan, on your question about the new Maroondah Hospital and the most recent series of election commitments and projects, as you know – and we discussed some of that earlier in the year – there is $320 million set aside for the development and delivery of all of those. They are significant tertiary hospitals; they take time to deliver. If I look at some of the biggest investments in the state over time – Joan Kirner, VCCC – these hospitals take time to come to fruition. We are working that very carefully through in terms of the needs of your community. The paediatric EDs, the commitment that you referred to, is now being encompassed within that wider build, an important –

Nick McGOWAN: You are kidding, right? It was promised in 2018.

Chris HOTHAM: It has been, in a way, I guess, superseded by the larger developments. So that will still be –

Nick McGOWAN: Six years later we still do not have an ED for the children in our region in Ringwood, in Warrandyte, in Croydon and the surrounding districts. I just do not fathom – you are the bureaucrats; you are the Secretary. Successive governments now have made these commitments and have failed to deliver, and I do not know whether it is a failure of advice and policy and implementation, which is yourselves, or just the political failure to actually do what they have said they would do and give you people the resources and the money you need. I do not know what it is. Can you enlighten me?

Euan WALLACE: I think, as Mr Hotham has described, the original commitment for a paediatric ED in Maroondah has appropriately been subsumed by the much more expansive plans for a new hospital there.

Nick McGOWAN: But that did not come until later – years later. How is that possible? It does not even make sense. You know that, Secretary. Was there ever money for the actual ED, the children's ED in Maroondah, in the first place, that you are aware of in your budget?

Chris HOTHAM: Yes, it was absolutely budgeted.

Nick McGOWAN: So where did the money go?

Chris HOTHAM: It will be folded into the new redevelopment.

Nick McGOWAN: What do you mean folded? It has been there since 2018. How many times are you going to fold money?

Chris HOTHAM: I guess if –

Nick McGOWAN: I do not know. You should know.

Chris HOTHAM: We have a significant –

The CHAIR: Mr McGowan! Please wait, Mr Hotham. Mr McGowan, you know that these witnesses are trying to answer your question. Can you please allow them and afford them the courtesy to answer your question one at a time? Thank you. Mr Hotham.

Chris HOTHAM: Thank you. If I step back on the paediatric ED commitment, that commitment was to new paediatric EDs in Geelong, in Maroondah, as we are saying, in Frankston, in Casey and northern. As you say, it was a 2018 commitment. We have planned these; we have carefully designed the builds. But as for your community, as the potential and now the commitment to a much larger redevelopment for that hospital comes online, and that is something that we are now working very strongly to deliver, it is important that we bring that existing commitment into the fold of the wider hospital. That is an efficient use of the money. Otherwise we are looking at potentially an add-on or a tack-on to the rather larger redevelopment, so this –

Nick McGOWAN: Okay, well, I have little time. Just let me remind you of the press release of 12 November 2018, and it says:

> An emergency department Maroondah kids and their families can count on.

That is a joke. Clearly that is a joke, but I am going to move on.

Chris HOTHAM: It is still part, Mr McGowan, of the development.

Nick McGOWAN: Secretary, the *Health Legislation Amendment (Information Sharing) Act* was supposed to be implemented as of 7 February next year. Is there any budget for that mega database?

Euan WALLACE: Is it?

Nick McGOWAN: Is there any budget for that mega database in your department?

Euan WALLACE: We obviously have a budget for ICT projects across the sector.

Nick McGOWAN: This is a massive database that includes every Victorian's public health record.

Euan WALLACE: We do not currently have a budget to deliver that.

Nick McGOWAN: How are you going to deliver it?

Euan WALLACE: It is about a pathway to data provision information sharing. The legislation – important legislation, landmark legislation – was an enabling piece of legislation to allow health information to be shared across providers in our jurisdiction.

Nick McGOWAN: Starting when?

Euan WALLACE: Well, health information is already shared, as you know, between providers and –

Nick McGOWAN: Yes, but the minister stood in the chamber and told me that it would be kicking off in February next year.

Euan WALLACE: Well, health information is –

Nick McGOWAN: So you have no budget for it. Have you outsourced any of these services to be able to actually pull this information together or design the system?

Euan WALLACE: No, the investment in ICT in our sector over the last –

Nick McGOWAN: But there is no investment in this project.

Euan WALLACE: But it is about connecting healthcare providers –

Nick McGOWAN: Not without money.

Euan WALLACE: to allow them to share information.

Nick McGOWAN: But you are running the database. You are the department responsible for it. That is what the minister has told us. You are telling me you have no money to set up this mega database, which is supposed to be up and going by February next year, to share and improve the services and the health outcomes of all Victorians. This is the fanfare the government gave us months ago.

Euan WALLACE: No, again, the legislation was about enabling the sharing of health information between providers in the best service of the patient. That is a continued journey that we are already on, that our health providers are already sharing information, whether it is through My Health Record, whether it is about better integration of the electronic medical records between our health services. Irrespective of the vendor, whether it is Epic or –

Nick McGOWAN: Okay. I am not sure we are getting anywhere here, Mr Secretary.

Euan WALLACE: Pardon?

Nick McGOWAN: The community hospital promised in 2021 – has that been delivered in Eltham? How far off are we with that?

Euan WALLACE: As you know, we have a community hospital program for 10 community hospitals. I will ask Mr Hotham just to update us on where we are at, but that was a –

Nick McGOWAN: Do we have a location for that hospital?

Chris HOTHAM: As you would know, Mr McGowan, in Eltham we had a location, and the local council voted against the original acquisition of that site. We are working through I believe with the department of transport the acquisition of a site in Eltham. Design is certainly complete for that site. It will be part of 405 Ryans Road in Diamond Creek. That is the site that we are working to for the Eltham hospital. We have got the demolition permit now received by council. The department of transport, which I mentioned, is currently reviewing the easement to the north-west, and traffic, road safety and parking around that site are now being looked at very carefully. As part of the design process, we also looking with ecological experts and landscape architects to get the best design for that space.

Nick McGOWAN: Secretary, are you able to provide the number of patients presenting to EDs requiring mental health inpatient beds and waiting for more than 4 hours, 24 hours and 48 hours respectively?

Euan WALLACE: Yes, we are able to provide the –

Nick McGOWAN: And could you do that by location over the past five years? Is that possible?

Euan WALLACE: By all of our hospitals?

Nick McGOWAN: Sure.

Euan WALLACE: Yes, if we have got those data, we can provide them.

Nick McGOWAN: Okay. And are you able to provide an update to the 20 recommendations made in the VAGO report for child and youth mental health –

The CHAIR: Apologies, Mr McGowan. You are out of time.

Nick McGOWAN: I am happy to take an answer on that one – an update of the recommendations.

The CHAIR: Mr McGowan, you are out of time. We are going straight to Mr Hilakari.

Mathew HILAKARI: Thank you, Secretary and officials, for your attendance today. I want to just take us to early parenting centres. I think it is a really joyful time often, the birth of a child, but then it presents some challenges almost straightaway – or straightaway actually – particularly around feeding, sleeping, those basics that ensure that the family unit is working well and happy and producing a wonderful child. I will take us back to page 92 of the health questionnaire, which outlines five new early parenting centres and two upgraded ones. The intent was to have them operational in October 2023 to March 2024. I am just hoping you can talk through some of those locations and where we are up to on them. I recently attended the Werribee Tweddle centre on

the opening there. It was a really great day. Actually the Premier was there and the Minister for Health to open it, and I know for my own community – the community I represent – it is going to be a really great service. So I am really keen to understand where we are going on that.

Euan WALLACE: Thank you. I might ask Mr Hotham to supplement my answer with some details about capital. But, look, I agree with you. I think the investment in our early parenting centres is part of a much broader pipeline of work about the best start to life possible for new Victorians. Our total investment in our early parenting centres has been about $165 million. There was an $123 million I think in the 2019–20 budget and then an additional $25 million in the 2022–23 budget for an EPC in Shepparton. Then in our most recent budget, this year's budget, just over $70.5 million for a new EPC in Northcote and also our state's first First Peoples EPC, which will be led by First Peoples' Health in Frankston.

I agree with you; I think EPCs are about providing free primary health service, specialist support and flexible, targeted services for children – and their families – aged from birth to four years of age. It is about sleep and settling behaviours. It is about assisting with what can be sometimes difficult early childhood behaviours – the troublesome twos and so on – but also assisting the parent and the child in their overall health and wellbeing. Mr Hotham will give us an update on the five new and then the two upgraded – Noble Park and Footscray. Wyndham I think is already open, but Mr Hotham will give us an update on those.

The other thing that we have done is fund the Queen Elizabeth Centre. Monash University's Professor Helen Skouteris, at Monash and the Alfred, has developed an early parenting centre outcomes framework for us. With 100 key stakeholders and lots of input they have developed this framework that maps the indicators and measures that we and the sector themselves will use across the EPC – so, are they being successful? Broadly there are domains for health and wellbeing, and there are domains for connectedness, growth and learning. I think we will use that framework, as the sector will, to be able to in future years assess the success of our EPC program. But Chris, I am wondering if you can give us an update on those.

Chris HOTHAM: Yes, thank you. Yes, I am very happy to, Mr Hilakari. And just perhaps before I go through the progress on particular sites, I will just bring the capital side of this to life, as the Secretary has talked about the service really oriented at those very important early years. In terms of the builds themselves, we are talking about facilities that have residential family units. They have day-stay places. They have shared kitchen and dining areas and multipurpose rooms. There are playgrounds, indoor and outdoor play areas, and obviously the administration and staff area. So they are a really bespoke service and a template that we are now rolling out, with the addition of the nine, across 11 locations.

Wyndham was the first of the nine new parenting centres. There are nine new and two upgrades. Wyndham was the first of the nine EPCs to open its doors, in October, last month. Casey and Whittlesea have reached completion. Whittlesea will open its doors later this year and Casey in February 2024. Construction is then underway on three in three regional locations, which are expected to be complete also late this year – Geelong, Bendigo and Ballarat. The site at Hastings has been announced, and construction is expected to commence there in 2024. And then in terms of the newer additions to the program, a land search is currently underway in Shepparton, with construction expected to be complete there in 2025, and planning is underway for our newest addition there in Northcote as part of the recent budget. So they are the nine new, and then there are two upgrades and extensions in Footscray and Noble Park. Construction is underway there and expected to be completed in 2024. So hopefully that gives you a sense of progress but also of the flavour and the kind of design of the redevelopments.

Mathew HILAKARI: Great.

Euan WALLACE: And once they are delivered, that will see an additional 5000 families have –

Mathew HILAKARI: You have hit my next question on the head – keep going.

Euan WALLACE: Oh, okay. Well, again, it is about providing for increasing needs and providing for 5000 additional families. I think we have touched upon this in a previous question this morning, but we are a very multicultural population. It is part of the richness of our population, but it also means that many of our young families are displaced from the traditional family and the extended family. Their own parents are overseas and in some situations cannot get here to support new parents, a new mother or a new father. And I

think, clearly, the intent of our EPCs – not uniquely – is to provide that support that the extended family might have done in past generations.

Mathew HILAKARI: Is that being promoted from birth at hospitals? How is the information getting through? Is it through maternal and child health centres? I should say that you have made each of us very happy here with Noble Park all the way through the locations in Whittlesea and Casey and of course in Wyndham with Werribee. And Werribee Mercy is one of those great hospitals that has seen, I understand, more than 100 babies every week – 120 to 130 is what I have been told are being born. But I am really keen to understand: is it from birth? Is it through the maternal child health centres? Is it just a whole range of services that are driving people to these places?

Euan WALLACE: It is an important question, and it goes to, again, one of the comments I made in the introductory comments this morning about collaboration and not competition. One of the challenges for us, our healthcare environment, has been we have had islands of health service provision which, when you stand back from them all, you see, well, actually we have got provision of all of the health care needs for our population, but from a user's perspective it is this staccato service. You have brilliant maternity care, you have your baby and the hospital then connects you with maternal and child health largely provided, as you know, by local government – brilliant service, triply qualified health practitioners – but there has not been the connectedness, I think, that we would all want to see. So I think one of the continued evolutions of our health and social care system is to make those better connections. Of course there are referrals from maternal and child health, there are referrals from family doctors, there are self-referrals, referrals from all directions, but again it goes to the challenge of perhaps non-English-speaking Victorians or Victorians from overseas who are not familiar with health care and social care provision. How do we make it more accessible, more connected? I think actually the government's recent establishment of a children's portfolio under Minister Blandthorn is an opportunity for us to better connect health and social care across the continuum. You know, we are all born, and there is a nice starting point for services – maternal and child health, early parenting centres et cetera et cetera and how we do that. I think that is an important question, because it is a challenge and it is something that I think collectively our department and our sister departments are focused on.

Mathew HILAKARI: Great. And I might just keep us on infrastructure for the moment, talking about the Footscray Hospital. I refer to page 112 of the questionnaire. I note that the TEI of the Footscray Hospital has increased from the original amount, so I am keen to understand what has occurred in those circumstances. I often look at the maps of hospitals across Victoria, and I do look to the western suburbs as being a significant wedge which misses some of those hospitals. But this is of course a huge hospital that is being built, one of the biggest across the state, so it is going to be really valuable for us in the western suburbs. So I am just keen to understand what those changes are and what the reason for it is.

Euan WALLACE: And again, I might ask Mr Hotham to give us the detail. We are very excited about the new Footscray Hospital, as you can imagine. Western Health is one of the fastest growing health services in our state. We are particularly excited at the dual footprint of Western Health there and Victoria University, with a connecting corridor to keep research and education as close to the healthcare workforce as possible, and our partnership with VU is a very strong one. In terms of the increased scope and therefore increased TEI, I might ask Mr Hotham to comment.

Chris HOTHAM: Thank you, very happy to go here. It was our biggest project up until the announcement of the RMH Arden project and a huge contribution to that community, as you are suggesting. The change in TEI is effectively a result of the PPP model. Just let me step that out for the benefit of the committee. It was announced in the 2019–20 budget at $1.495 billion, as you have said, and that sum represented the state's capital expenditure. The announcement also included confirmation that we were expecting to deliver the hospital as a PPP. That, as you would understand, involves bringing together private consortia to design, construct, finance and maintain the new hospital over a lifetime of 25 years. In March 2021 following extensive tender the PPP model was confirmed to represent the best value for money and was approved by government, with Plenary Health consortia our constructor partner. So then the changing figure that you see in the 2022–23 budget, where the TEI increased by $503.605 million to $1.999 billion, just shy of $2 billion, is reflective of that PPP structure. That figure is inclusive of 25 years of operational and life-cycle costs, including capital upgrades across the tenure of the concession, and this figure represents financial contribution from all project partners. Importantly, I think really importantly, there is no additional cost to taxpayers over the whole project term in that change in TEI. But for this project, and to the project partners – and the Secretary touched on VU –

the increased TEI also included $72 million for an education and research space for VU and a pedestrian footbridge that connects VU to the Footscray Park campus, and that additional cost was entirely funded by Victoria University.

Mathew HILAKARI: Okay. Do we know how much that one cost? Sorry, I just missed that on the way through.

Chris HOTHAM: $72 million was their contribution – Victoria Uni's contribution.

Mathew HILAKARI: And I guess that is important for Victoria University, because obviously it is a pathway for their students to go straight into a hospital to learn there, study there and to go on to work there – we hope – and make that really important contribution.

Chris HOTHAM: Absolutely. I mean, they are very focused on, as you say, those education and training partnerships. They are partnerships that will exist and keep growing between government, our construction partners and VU. VU will have dedicated education and research facilities at the hospital, and that footbridge is a very symbolic link of how important that is.

Mathew HILAKARI: Will they be on both sides of the road there? Is that the intent?

Chris HOTHAM: I believe so.

Euan WALLACE: In a past life I ran a clinical training program on the site of a clinical hospital. I think having students live and breathe the clinical workspace from the very beginning of their entry to their studies is really important. Of course VU are also the largest provider of paramedic training in the state. You may recall in a previous budget the government invested in a new paramedic training facility. I think it is just about that continued partnership build between healthcare provision and providers and tertiary education providers. We have had discussions earlier this morning around some of the challenges of recruiting the workforce. There is nothing quite as exciting as young students coming into a hospital, particularly a brand new hospital, such as Footscray will be when it is built.

Mathew HILAKARI: I would be keen to understand if that actually produces a better rate of completion of courses as well. When people go straight in and have some experience of the job, they get a pretty good idea pretty quickly if that is the sort of job for them. So I think that is a really good thing to be so enmeshed in each other.

I might just ask about the 25-year model. You mentioned no additional cost. What are the protections to the taxpayer for no additional cost in the future of this project for the next quarter of a century?

Chris HOTHAM: Yes, absolutely. Perhaps to answer in the general and the specific, we have got the PPP model now running across a number of projects in our pipeline. In terms of those in delivery, Footscray, Frankston and Melton are all PPP structures. But in terms of fully operational ones, there are five additional, fully operational PPPs – VCCC, Bendigo, Casey, the Royal Children's and the Royal Women's. It is not a model that is fit for purpose in all settings, but certainly in some of these more complex projects, where they need the innovation and the leverage of other partners, it has certainly become a path well trodden.

In the general, before coming to the specific, the PPP does bring innovation to the fore. It is a competitive tender process, which really provides a significant incentive for all entities to bring some of that innovation, whether that is in the design phase, construction, operation or even through procurement. As your question goes to, Mr Hilakari, this is about the whole-of-life outcome. What the PPP structure does is optimise the whole-of-life maintenance outcomes across the facility. Effectively, it is incentivising the ongoing maintenance. At the 25-year mark the facilities will look much as they did when they were handed over on day one. So it is really important in terms of the sustainability of the system.

When you say protections for the Victorian taxpayer, if you like, the PPP model gives time certainty. Private finance creates significant incentives for all players to hit the marks and to hit the delivery marks on time and on budget. It also is a good model and a useful model in terms of creating the most robust risk regime for us in terms of managing it. You know, as events and various things will unfold over the course of these projects, it allows us to make sure that the private sector is effectively bearing a good portion of those risks.

In the specific, in Footscray, it is one thing to talk about innovation and scope and things, but to make that really tangible for the committee, we have talked about the education and research space delivered for VU. There is additional car parking delivered under the PPP model. There is additional shell space for just shy of 60 points of care. It is futureproofing some of the growth of the hospital. There are additional measures to help achieve long-term sustainability in the facility. Then there have been lots of value creation and capture opportunities for all of the ancillary services you would expect, so child care, retail, a retail pharmacy and allied health services. All of those players and services are coming together to activate the precinct. I think, like many of our PPPs, this model lends itself to that precinct-wide activation. It is more than just a hospital, it is a real service to the community, as your question goes to.

Mathew HILAKARI: I know that is pretty important. When you walk out the door of a hospital, you are usually going to be going to a pharmacy straightaway. I imagine you might be able to talk to the total number of staff at the hospital at a certain point in time, when it reaches its full completion – but I imagine they are going to need a cup of coffee at some point; you know, we cannot work on water alone. Just in terms of any future upgrades to the hospital or changing needs of patients, has that been written into those agreements? I am interested also in the practical life of the hospital as well. If we are talking about a quarter-of-a-century PPP, what are we looking at?

Euan WALLACE: Again – and Chris has alluded to some of it – we are futureproofing the hospital, but maybe to give the committee and the Victorian community some reassurance I will point to the five existing PPPs that we have got. Again, as Mr Hotham has said, the PPP model, the approach, is not fit for all purposes. It is about very specific, typically large, projects. We have got Peter Mac. The Bendigo hospital is a PPP. The Casey Hospital expansion was a PPP. Royal Children's was a PPP, and our most mature PPP, which is now 23 years old, is the Royal Women's Hospital.

Mathew HILAKARI: That is a good example.

Euan WALLACE: And I think if you walk into the Royal Women's Hospital today, it still feels like a very new hospital. I think that is a reflection of this model, where the private provider, built into the 25-year contract, is responsible for the upkeep and maintenance of the infrastructure, facilities and fabric of the hospital. Chris, I do not know if you want to add anything?

Chris HOTHAM: Look, I think only in terms of your question, Mr Hilakari, about the long-term sustainability of the system. You talked about the west. This is one of the things that we have taken the time to get right in terms of the network of hospitals for that region. We have now got Footscray; Sunshine; Melton, we have touched on, coming online; and Werribee. So we absolutely look at demand and service provision across a network of public hospitals to make sure this is right-sized. But as you can hear from some of the additional scope, we have also built in that space for growth as our population changes and demographic changes emerge.

Mathew HILAKARI: Thank you.

Euan WALLACE: Chair, if I may, I misspoke. I should have said that the Royal Women's Hospital is 18 years into its PPP, not 23. Apologies.

The CHAIR: Thank you for correcting that, Secretary. We will go to Ms Sandell.

Ellen SANDELL: Thank you – my turn. Good morning, everyone. I wanted to ask about AOD services, specifically naloxone. As people would be aware, naloxone is a life-saving drug given in the case of opioid overdose, so you might liken it to an EpiPen or even a fire extinguisher. We have got AOD workers and drug users on the streets of Melbourne now who just simply cannot get their hands on naloxone at the moment. I will ask about supply issues in a moment, but can I just confirm that Victoria is currently receiving funding from the Commonwealth under the take-home naloxone program?

Katherine WHETTON: Yes, we do.

Ellen SANDELL: Yes. The Commonwealth take-home scheme is legislated to make naloxone available to 'anyone at risk of, or who is likely to be able to assist, an opioid overdose.' When you look at the Victorian regulations, which I think, Secretary, you are responsible for, they are currently worded to be slightly more restrictive than that, so there is actually a list of who can carry naloxone, as I understand it. Could you please

clarify exactly who can dispense and obtain naloxone? Specifically, can it actually be obtained by drug users, their peers or their family?

Katherine WHETTON: There is an existing Commonwealth-based naloxone program, so people can access that with a prescription over the counter from a pharmacy. There are 823 community pharmacies in Victoria that are currently registered to supply free naloxone as part of that national program. Between 1 July 2022 and 31 October this year we have had 467 active community pharmacies across Australia supplying up to nearly 60,000 units of naloxone. So that is the Commonwealth program. There is also a take-home naloxone program that is about to commence in Victoria. It actually commences next week, and that is expanding the access to free naloxone. So there will be more organisations that will be able to supply naloxone to consumers and their families, carers and supporters, as you were asking about – other people can now access that. They will be able to access that through either an intranasal spray or prefilled syringes. When we start that program from next week, needle and syringe program providers at 52 sites across Victoria will have that available.

Ellen SANDELL: Just to clarify, those are the distribution guidelines. They have been in draft form since October 2022. So you are saying next week they will be finalised and it will be clear that NSP workers can distribute?

Katherine WHETTON: We are expecting to commence that from next week. So it might be a bit of a staged start in terms of supply – as you mentioned before, there are some supply challenges the moment. But the program itself will commence.

Ellen SANDELL: From next week – excellent. Good to hear. Can I just confirm, do you see any barriers in terms of the list? Under the *Drugs, Poisons and Controlled Substances Act* there is actually a list under the regulations of who can carry naloxone. So currently, for example, police are not on that list and drug users are not on that list. Do you see that that has been a barrier? We are hearing that from AOD workers – they are saying, 'We are not actually on that authorised list, and the list might need to change.'

Katherine WHETTON: I might need to come back to you on that one.

Euan WALLACE: As you know, the intent of these programs is about keeping Victorians safe. It is harm reduction. If there is a need to review the regulations – that I am responsible for; you are quite correct – then I think we would be open to reviewing them and reassessing whether the list is overly restrictive or not.

Ellen SANDELL: Okay, wonderful. Thank you. I think AOD workers would say that it is, I guess, just unclear that there is a mismatch between what the Commonwealth program says, which is essentially that anyone who is likely to come across an overdose should be able to carry naloxone, and what the Victorian regulations say, which is a much more prescriptive list. Has there been any discussion between the health department and VicPol about police carrying naloxone? There was a trial in WA that was, as far as I am aware, wildly successful in terms of police carrying naloxone.

Euan WALLACE: I have not had a conversation in the three years I have been in this role. I have not had a conversation with VicPol, no.

Ellen SANDELL: Okay. Thank you. In terms of supply issues, can you speak to any work the department is doing to relieve the supply issues?

Katherine WHETTON: We are very aware that there are supply shortages the moment. We think that the ampoule formulation now has stabilised, so we think that that will be the primary formulation that is available at the commencement of the program, but we are working closely with suppliers to try and get access to it.

Ellen SANDELL: Thank you. It has become apparent in my conversations with AOD workers – obviously my electorate is Melbourne, and the highest overdose number is in the city – AOD workers have approached me, saying that they do not feel like there is a clear line of communication with the department about naloxone and it is creating a lot of confusion. Can you confirm that the department could arrange a briefing with AOD workers from the City of Melbourne to deal with some of that confusion?

Katherine WHETTON: We actually either have scheduled or are in the process of scheduling a session, I think for next week.

Ellen SANDELL: Great. Excellent, thank you. Good to get that on the record. Obviously people are nervous about fentanyl hitting the streets. Can you speak to any work the department has done both in terms of detections of fentanyl on the streets and then response or preparation for once fentanyl hits?

Euan WALLACE: I might ask Ms Whetton to provide the detail on that. We are certainly aware of it. Particularly with fentanyl, we are aware of changes in the US and we are preparing for responses here more locally. We have certainly had a number of conversations now with providers around what an appropriate and needed response would be as a state. But Katherine might have more specifics.

Ellen SANDELL: And specifically around: have there been any concerning detections?

Katherine WHETTON: Not that I am aware of, but just if I can talk to work that the department does do on surveillance of emerging drugs, we monitor for any emerging drugs that are among patients presenting with severe or unusual drug toxicity to hospital emergency departments. We also analyse discarded injecting equipment for microscopic drug residue, which could involve fentanyl. We also work with service providers and partners to issue public drug alerts when we become aware of that.

Ellen SANDELL: So there has been no detection of fentanyl? We have heard that there have been some low-level detections of fentanyl, for example, lacing heroin, at the moment, but it has not reached a very concerning level. I am just wondering if the department is detecting any.

Katherine WHETTON: I have heard that anecdotally as well but not coming through in any data that I have seen.

Ellen SANDELL: Not in any data, okay. Thank you. I will just move on to public dental wait times. In June at the PAEC hearings you indicated that the average wait time across Victoria for public dental care was 14.8 months. I am wondering if there is a more updated figure for the last quarter.

Euan WALLACE: For general – was it denture, or –

Ellen SANDELL: Dental, just public dental.

Euan WALLACE: We split it by general care and also by denture care, so at the end of 2022–23 the wait time was 16.9 months. It is now 16.4. For denture care, it was 16.1; it is now 13.8.

Ellen SANDELL: Okay, great. Thank you. I would like to ask about access to termination services. There is performance data published in the budget regarding many services provided by public health services – so the number of knee replacements, for example – but not published data on surgical terminations of pregnancy. Is that data collected?

Euan WALLACE: We do collect data on surgical terminations. As you know, the pregnancy termination landscape is ever changing, and the majority of pregnancy terminations have always been first trimester. A very large proportion of those are now done medically, and we do not record those numbers. Surgical terminations we do record. I do not know if Professor Wainer wants to add anything. I mean, as you know, and as I alluded to in my introductory comments, one of our focuses now is on women's health and the provision of sexual and reproductive services in particular. Zoe, do you want to –

Zoe WAINER: Thank you, Secretary. Could you just restate the question?

Ellen SANDELL: I am just wondering if you have data on the number of surgical terminations provided by public health services and where that data is published.

Zoe WAINER: I would need to come back to you as a question on notice, if that is okay.

Ellen SANDELL: Okay, thank you. I appreciate that. Do you have data on which LGAs currently have no access to surgical termination?

Euan WALLACE: As you know, the VAGO report made comment on 17 LGAs with less than adequate access. We are now working with the sector, including those LGAs, around how we improve access for those services.

Ellen SANDELL: At PAEC I asked the minister which LGAs do not have access to termination services. We were given an answer subsequently that said, 'Look at the women's health atlas.' The data on the women's health atlas is from 2021, so I am just wondering – and that is just around the number of GP prescribers and pharmacist dispensers – is there a lag in that data? Does the department have data that is more up to date than that to help? I am getting at how we are identifying areas that have essentially no access to termination.

Euan WALLACE: It goes to a bit of the response a moment ago around the ever-changing needs and therefore provision of, particularly, pregnancy termination, but not uniquely pregnancy termination – also broader sexual and reproductive health needs and access, the contraceptive pill et cetera. We currently have underway a program of work, triggered really in part by the VAGO report, around better understanding the needs and provision of sexual and reproductive health care, particularly but not uniquely for women across the state, where there may be gaps in provision and how those gaps will be closed. Included in that are a number of conversations with public health services about the provision of both medical and surgical termination. As you know, surgical termination in particular in this state historically has been largely serviced by the private sector. But over the last five years or so the private sector has progressively exited provision because of course as women sensibly choose to have medical termination rather than surgical, it is a business model that is no longer sustainable for them. Therefore again we are working with health services to both map need and provision so that we can ensure that where there are gaps in provision of surgical pregnancy termination those gaps are filled.

The other thing I should say of course is our pharmacist-led prescribing pilot is live, and repeat contraceptive pill prescriptions, as part of that pharmacist-led prescribing, are there purposefully to increase access to contraception.

Ellen SANDELL: I appreciate that. Is it a matter that because it is a space that has pharmacists, GPs and public health services that it is difficult to collect the data? You say a piece of work is now being done to help map and understand the landscape of why people do not have access to termination. Is that because the data is just difficult to access or because the department is not collecting it? I am just trying to understand what the barriers are to it happening before that.

Euan WALLACE: I do not think there are barriers per se. I think it is complex for the reasons we have been discussing. We have got a needs environment that is changing rapidly and a service provider environment that is equally changing rapidly. Again we have had in our state the provision of what a decade or so ago was essentially uniquely surgical termination of pregnancy which was largely, not uniquely but largely, provided by the private sector, and that is changing. As that is changing, it is creating gaps of service which we need to understand as a department and work with our health services on. Services who in the past may not have provided surgical termination are now providing surgical termination. As part of that evolution and change we need to understand if the provision is adequate or not, and where there are gaps – and VAGO have suggested that there are gaps – then we need to be aware of those.

Ellen SANDELL: Thank you. Continuing on this theme, one of the findings of the 2023 VAGO report into sexual and reproductive health was that the department does not know if its hubs have improved access to sexual and reproductive health services. There also seem to be some curious elements of this data. For example, the audit showed that in Gippsland only seven IUD insertions were undertaken at that hub over three years. That seems like an extraordinarily low number. Do we know why that is?

Euan WALLACE: We do not, unless Professor Wainer knows. We accepted VAGO's recommendations in their report, as you know. I think what VAGO pointed to was that government made an investment in sexual and reproductive hubs. As a department, how do you know those hubs have been successful in meeting the needs? Just establishing the hubs is not sufficient; we have to know what the service provision is. And they indicated some gaps in the department's data collection, which we are now correcting with the hubs. Why would a particular hub in Traralgon insert very few IUDs? I do not know the answer to your question, but it may well be that the service provision is adequately provided through well-trained GPs or other providers locally or it may be that we have a population that is choosing alternate methods, perhaps in part due to information provision differences. I think understanding variation in healthcare provision and need across the state is critically important for us to be able to provide adequate care.

Ellen SANDELL: There were some other elements of the report that no doubt you have looked at that were also quite curious. For example, in Monash – no service provision for medical terminations at all. The Monash hub provided 18 STI treatments in 2021–22. In comparison, Bendigo provided almost 4000 STI treatments. They seem like huge discrepancies. Why is this?

Euan WALLACE: Again, I think the answers will be complex, but in part it is about who is providing the care. To go to your point about STIs, are we saying that the incidence of STIs varies enormously to that extent? Of course they do not.

Ellen SANDELL: Are they reporting their data differently, or no?

Euan WALLACE: No, I think it is about having multiple care providers. We of course have got Melbourne sexual health clinic servicing a large population in our city, so where are people choosing to have their care? STIs are really good example: if you live in one part of the city, it is not uncommon for individual men or women to choose to have their STI care somewhere else in the city, if there is another provider. If you live in a regional city and there is only one provider, you are going to go to that provider. So I think it is about ensuring that the overall sexual and reproductive health needs of the population are served.

Ellen SANDELL: So that is being looked into now?

Euan WALLACE: Yes.

Ellen SANDELL: Was any of that taken into account when the locations of the sexual health hubs were being decided?

Euan WALLACE: The original hubs were planned to be in locations where the assessment at that time identified need, yes.

Ellen SANDELL: And was that assessment publicly available?

Euan WALLACE: I cannot recall.

Ellen SANDELL: Okay. Can you get back to me about how that assessment was made?

Euan WALLACE: I will.

Ellen SANDELL: Okay, thank you. Moving on to a different topic now, I would like to talk about tobacco. I think we have all seen the growth in the black market in tobacco and e-cigarette products recently, e-cigarette products being marketed to children and teenagers and also sellers openly advertising illegal products. Does the department know how many tobacco and e-cigarette retailers there are in Victoria?

Euan WALLACE: Currently, we do not have a licensing scheme in Victoria, so we do not have a register of vendors. We do have, as you know, a program of visits by authorised officers to those who do sell. As you will be aware, the Commonwealth is working very closely with states and territories around changes to e-cigarette regulation. E-cigarettes, again, were introduced as a potential therapy to have smokers come off cigarettes, with rather flimsy evidence that they are effective. Big tobacco knew exactly what it was doing when it introduced e-cigarettes. They are vendors of death, and the Commonwealth has taken appropriate action in collaboration with states and territories to really address what is one of the most significant public health risks to our population. The –

Ellen SANDELL: Yet as you point out, we are the only state or territory that does not have a licensing scheme. Are there any discussions or plans within the department to have a licensing scheme?

Euan WALLACE: Yes, there are discussions currently underway about: would a licensing scheme assist both us and the Commonwealth in the regulatory and legislative changes that they are foreshadowing?

Ellen SANDELL: You mentioned that there is a program of monitoring test purchases, for example. I think in 2021–22 there were just over 3000 visits to tobacco and e-cigarette retailers. Do we know how many of those nearly 4000 visits found illegal activity?

Euan WALLACE: Yes, we do. We have got the outcomes for 2022–23. They are just being verified now, but I can give you the outcomes of 2021–22. So in 2021–22 I think there were 6952 monitoring visits. The target was 3500, but there were 6952. Of those, 566 resulted in a verbal warning, 191 in a written warning, 44 fines were issued and there was one prosecution. Again, the numbers for 2022–23 are just undergoing final validation.

Ellen SANDELL: Do we know how those visits are selected? Is it tip-offs? Is it random?

Euan WALLACE: This is our agreement with MAV and participating councils. It is their EHOs that do these test purchases and monitoring visits. I do not have insight into how local councils choose which outlets they visit.

Ellen SANDELL: Okay. I think my time is probably up, is it?

The CHAIR: Thank you, Ms Sandell. We will go straight to Ms Kathage.

Lauren KATHAGE: Thank you, Chair. Secretary, officials, I would like to speak about mental health. The 2021–22 budget included an initiative around new local services for adults and older adults in their communities – this walk-in, dial-in model without need for a GP. I am very happy that one of the first tranches is in my area in City of Whittlesea with a great partnership there: Neami, Drummond Street, Uniting Vic and the Victorian Aboriginal Health Service – quite a combo. My area has long advocated for mental health services. We have people in the northern part of my electorate who are still impacted today by Black Saturday. It is an ongoing trauma, so mental health services are something that people have always been asking for. This hub model was one of the recommendations of the mental health royal commission. Are you able to update us on implementation of the balance of the recommendations?

Euan WALLACE: We can. I might ask Ms Whetton to give us an update on the hubs, the locals, and then we can broadly go to the recommendations. I think to go to your question, again I alluded to in my introductory comments the department progressively investing in prevention and early intervention, and nowhere is it more true than in mental health. I think the royal commission, as you correctly alluded to, identified that there were not sufficient early community-based intervention and supports available for mental health. One of the things that we have learned as a department out of emergencies like Black Saturday and the floods more recently is that while we provide mental health supports in association with our sister departments as part of the emergency response, actually the needs for those mental health supports have a very, very long tail and often the mental health needs do not surface until 12, 18 months later. But Ms Whetton might go to an update for you.

Katherine WHETTON: Thank you, Secretary. The royal commission found, as the Secretary was saying, just how much care needs to be provided in the community so you do not have people presenting to emergency departments, like we talked about earlier. So the mental health and wellbeing locals are an entirely new service stream that have come out of the royal commission, and government – it was in the 2021–22 budget – invested $263 million to establish the first of those local services. A really important thing about these is that they operate on a 'how we can help' philosophy, which is something that the royal commission found has not been a feature of some of our mental health systems and services in the past. As I think you might have reflected earlier, it is a free service and you do not need a referral from a GP to access them.

Now, you mentioned before some of the first ones. The first six of those locals started operating in October of last year, and each of them is taking a scaled approach. A lot of them are now accepting walk-ins and doing face-to-face appointments. We do also have another nine locations that will be opening from mid December this year, which is very exciting, and they will be in Orbost, Bairnsdale, Bendigo, Echuca, Dandenong, Shepparton, Melton, Mildura and Lilydale. So far from the services that we have had in place we have reached more than 3500 people, which is fantastic, and in October this year we have got almost 1400 active registered consumers who are using those services.

We have also been undertaking an early evaluation of the services so that we can keep improving as we roll out additional ones, and I should mention that the government commitment is to roll out 50 of these local services by the end of 2026. One of the things that the early findings of an evaluation has found so far is that that intended 'how we can help' philosophy is really consistent in the model of care, but also the idea of not having to have a referral has been a significant shift from the way previous services have been delivered.

Lauren KATHAGE: This multidisciplinary model – who is making up the staff there? What are the different disciplines that are provided through the hub model?

Katherine WHETTON: I can give a couple of examples. There are both clinical and non-clinical workers who work in those local services, so you have disciplines like psychiatrists, psychologists and nurses. But we will also have lived experience workers, so peer workers who can support those people coming into the service, and it is really who can best support the needs of the person who is accessing that service.

Lauren KATHAGE: This committee has recently conducted an inquiry into gambling harm, and one of the things that we heard from witnesses in our hearings was the need for gambling support to be integrated with other services. I do not know whether your early evaluations will consider potentially looking at the ability of the hubs to service those, and I guess there was an ongoing discussion in the hearings around where gambling sits – is it a justice department sort of issue or a health department sort of issue?

Euan WALLACE: Age-old question. I think there is no question that there are adverse health outcomes for a small but significant number of people who gamble. The gambling alerts on betting advertising on our television and social media are a reflection of that. We would think that there is certainly a role for the department to be offering advice on the provision of mental health supports and other health supports for those whom gambling is causing health harm. But there is no question that there are health outcomes from gambling for a small but significant number of people.

Lauren KATHAGE: I think one of the stark pieces of evidence we heard in that is that of women whose partners have a gambling addiction who experience family violence. 62 per cent of those women who have presented to ED because of family violence have done so following a gambling loss of their partner. So that is pretty stark. You were talking earlier that one of the key challenges to improving access to services is around workforce. We went through the different work that you have done to recruit nurses and midwives. I would like to look at the mental health worker side of that. There was an initiative in the 2022–23 budget around this. It was the strengthening and supporting the mental health and wellbeing workforce. Can you update us on that initiative? What were the programs that it was doing? What was the plan, and how did it go?

Euan WALLACE: I can. I might ask Ms Geissler to give us the detail. The workforce branch, including mental health workforce now, lies with Ms Geissler's division. Before Jodie says anything of course, and you allude to the 2022–23 budget, but really the past four state budgets since 2021 have invested some $600 million in mental health workforce. We have had a particular focus on mental health workforce because we identified, as others have elsewhere, that one of the choke points of care provision is psychologists, psychiatrists and other mental health providers. In Ms Whetton's division the government released in December at the end of 2021 a mental health and wellbeing workforce strategy. That strategy is an enduring framework, if you like, for the actions that are required and investments that are required. But I might ask Ms Geissler to give us an update on the mental health workforce recruitment.

Jodie GEISSLER: Focusing on that budget, the government's investments have supported a training pipeline of new workers including more than 400 nurses, more than 600 allied health workers, more than 300 psychologists and more than 100 psychiatry registrars. It has also supported a range of other initiatives focused on increasing supply, all of which are well into implementation. Those include a national and international campaign to attract people to work in mental health – of the over 2000 people recruited over the course of the international campaign, which we discussed today, in 2022–23 at least 159 were recruited specifically to mental health positions, including 115 psychiatrists; an expanded graduate program for nurses and allied health clinicians, with 400 new allied health graduates commissioned, who will commence in 2023, 2024 and 2025; a training program to transition experienced nurses and allied health clinicians into mental health – in total we have commissioned services to employ 165 transition nurses and 93 allied health workers to commence in 2022 to 2024; postgraduate scholarships to support specialty skill development for a range of disciplines – nearly 400 scholarships in 2023 have been awarded to date; a pilot earn and learn program for new workforces to enter the mental health system through supported training pathways, with 50 roles funded and filled; and finally, expanding funding for foundational mental health training to Victoria's junior doctors so that more doctors choose to specialise in psychiatry and to ensure that Victoria's future medical workforce have critical mental health training to support consumers across the health system, no matter where they end up practising. Over three years of intakes, including 2024's planned intake, this investment will have supported over 1700 junior doctors to do that rotation. The 2022–23 budget also included funding for improving the

capability of the workforce through the implementation of the mental health workforce capability framework and building cultural safety across mental health services so they are more responsive to the needs of all Victorians, including those who are culturally and linguistically diverse and LGBTIQ+ Victorians. So all the initiatives are underway and well progressed.

Euan WALLACE: I might add that, of all of those initiatives, that junior medical officer rotation through psychiatry was actually a question that Mr O'Brien asked in the 2021 PAEC hearing, when it was in its infancy, and as we have just heard now, north of 1500 junior doctors through that program. We are the only jurisdiction that has a requirement for junior doctors to rotate through psychiatry in the country, in the hope that of course, as Ms Geissler says, some of those junior doctors will say, 'Actually, this is a career for me,' and we will continue to grow our own psychiatrists.

Lauren KATHAGE: Fantastic. I have met some constituents that are benefiting from some of those programs. I have one who is undertaking a nursing scholarship at the moment, who plans to go on to mental health nursing, which is great. And I was at a citizenship ceremony with the Deputy Chair a little while ago, and I met a psychiatrist from one of your major facilities, and I was really touched by how compassionate he was towards the people that he treated. So, yes, lots of different ways into the workforce.

When you were talking about the different mental health hubs that are coming online, I was actually quite struck – of the list that you said, the vast majority were regional type ones. I think you were talking about Echuca, Shepparton, Orbost, Bairnsdale – I cannot quite remember the others. I do not know if it is related to the earlier budget line – in 2021–22 actually, so it predates that – but we have got 'Supporting the mental health and wellbeing of rural and regional Victorians'. That was from the 2021–22 budget. What has that funding been going towards in terms of the pipeline of mental health workers? Because if we have got the hubs in the regional areas, we need the workers in the regional areas as well, so how is that going?

Katherine WHETTON: Thank you for the question. As you said, it was the 2021–22 budget that allocated $13.3 million, and that was particularly to support the mental health and wellbeing of regional and rural Victorians. Now, the funding went to a few different things. It included the rural and regional workforce incentive scheme, which you have just talked about, and I will talk about that in a moment. But funding also went to running trials in two locations for digital mental health care to be provided, and it also went to continuing the Live4Life and Be Well in the Ranges programs for a further year as well.

If I go back to that rural and regional workforce incentive scheme, it has now been operating since July of 2022, and it responds to a particular recommendation of the royal commission in recognition that it can be challenging to attract workers to regional and rural locations. The scheme allows that community and specialist mental health and alcohol and other drug services can attract new workers to regional and rural areas by offering incentive payments of up to $20,000. That money can be used flexibly. For example, it could be used for relocation costs for that worker, housing, child care, professional development and training costs. We have the Rural Workforce Agency Victoria, who run the scheme for the department and work directly with services and eligible workers to access that funding. I am pleased to say that as of October this year the scheme has delivered 92 positions: 77 of those positions have been recruited to area mental health services and 15 positions have gone to alcohol and other drug community mental health services. We have done some early evaluation of that scheme, taking the things that are working well to keep going and looking how we can keep improving it. But, yes, a great scheme so far.

Lauren KATHAGE: Does that include OTs? Because I think sort of towards the start of the year there was talk about support for OTs to work in regional areas. Is that part of that or something separate?

Katherine WHETTON: If it is to work in a mental health service specifically, then they would be able to access that scheme.

Lauren KATHAGE: Great. I would like to move on to aged care. Public sector residential aged care – I think there was a boost in the budget in 2022–23 for that. Can you update us on what that funding is being used for?

Euan WALLACE: Yes. We have obviously two programs that we are funding: one, outputs, which is for the additional support that the public sector aged-care facilities have on top of Commonwealth funding; and then of course our capital infrastructure funding. I might ask Mr Hotham to give us an update on the

infrastructure, but we have now 172 aged-care facilities – about 5500 beds across the state, which is about 12 per cent of all aged-care beds across the state, the rest being of course in private. Since about 2016 the government has invested nearly $700 million in aged-care capital. The budget you referred to was 2022–23?

Lauren KATHAGE: Yes.

Euan WALLACE: There was $142.8 million in that budget specifically for new infrastructure in Camperdown, Mansfield and Orbost. Camperdown is a 36-bed facility, replacing the existing Merindah Lodge there, so no new beds – 36 replacement beds. Early work began in November 2020, with major construction works this year, and we expect Camperdown to be completed in 2025. There is a 30-bed facility in Mansfield, and renovation of the existing 42 beds at Bindaree, so 42 replacement beds and 30 new. It is currently in the design phase. Major works we expect to commence in mid-2024, to be completed in 2026. And then Orbost – I think Orbost was the subject of a question from Ms McArthur at a previous PAEC hearing. A new 38-bed residential facility in Orbost replaces the existing beds at Lochiel and Waratah Lodge, so 38 replacement beds and no new beds. Again, main construction work is expected to commence in mid-2024 and be completed into 2026. There are also some additional investments for planning. Do you want to talk to –

Chris HOTHAM: Yes, I am happy to do just a brief look back. The 2021–22 budget also invested in Rutherglen, a 50-bed facility there, with an additional 10 new beds at that site. Construction commenced there this year. That is on track to complete in 2025. As you suggest, Secretary, looking forward: that continued upgrade in our regional and rural settings continues with the 2023–24 budget, where we have got a further $162 million invested in Cohuna, which will be a 24-bed co-located facility with the district nursing home there; Maffra, a 30-bed facility at Maffra hospital; and Numurkah, a 36-bed facility there, replacing the Pioneers Memorial Lodge. I think back to those headline figures: since 2021–22 now $270 million and significant upgrades to seven facilities and planning for another two projects.

Lauren KATHAGE: In terms of the service users, what is the sort of profile of people who are using these public sector aged-care services?

Euan WALLACE: It differs depending on where we are. In the metro we have got a modernisation program, as you know, around metro aged-care beds. Obviously it varies, but typically the residents of metro facilities have very high-care needs facilities, and that is because there are lots of other private providers in metro where the majority of residents are. In regional and particularly rural settings often the only aged-care facility is a public aged-care facility. So while there might well be high-end needs clients – residents – in those facilities, actually it is the aged-care facility for the town. Think of Alexandra, for example. It has a public aged care facility, Darlingford, that provides for Eildon and Alexandra, so Murrindindi shire. The clients vary in their needs. I think it is probably best characterised that the public aged-care footprint is to provide need where need is not otherwise provided. I think as a community we are beneficiaries of that. Some of our interstate colleagues have 600, and growing, aged-care citizens who are sitting in acute hospital beds because there is no aged-care provider for them and there is no public bed. We do not have that issue here because we have public beds for them.

The CHAIR: Thank you.

Euan WALLACE: Chair, if it pleases the committee, I have an update on a question from Ms Sandell around the criteria for our sexual and reproductive hubs that Professor Wainer has.

The CHAIR: Thank you, Secretary.

Zoe WAINER: Thank you, Secretary. Thank you, Chair. It is based on a series of criteria, including locality and geography – so existing infrastructure, sexual and reproductive health investment – as well as access. It is also based on population health data from the ABS, so the size or service demand, cultural diversity, the SEIFA index and homelessness rate, as well as service overview, so understanding landscape of the services that are already being provided, and where the gaps are prioritising those. It includes workforce capacity as well.

Ellen SANDELL: Thanks. Sorry, was that just a department assessment, internal?

Zoe WAINER: Yes. For the criteria.

Ellen SANDELL: Thank you.

The CHAIR: That is great. Thank you. Much easier than taking it on notice, right? We have come to the end of questions from the committee today. Secretary and officials, thank you so much for taking the time this morning to come and talk to us. We really do appreciate it. The committee will follow-up on any questions taken on notice in writing, and responses are required within five working days of the committee's request.

The committee is now going to take a lunchbreak before beginning its consideration of the Department of Families, Fairness and Housing at 1:30 pm.

Witnesses withdrew.