ATTACHMENT: QUESTIONS TAKEN ON NOTICE AND FURTHER INFORMATION AGREED TO BE SUPPLIED AT THE HEARINGS

Ms Kym Peake, Secretary

DEPARTMENT OF HEALTH AND HUMAN SERVICES

1. **Regional Health Infrastructure Fund** - Please provide details of the increase in patient numbers and other performance outputs and outcomes as a consequence of the expansion in health infrastructure in the Gippsland region (i.e. Sale Hospital, Central Gippsland Health Service and Latrobe Regional Hospital).

   (Ms H. Shing - pages 5-6 of the Department of Health and Human Services portfolio transcript, 13 February 2018)

   RESPONSE:

   The Regional Health Infrastructure Fund (RHIF) program commenced in 2016-17 with round one projects funded part way through the year after allowing time for submissions to be lodged and then evaluated. Nine health services in the Gippsland region received funding for projects as part of round one of the program.

   Completion of all the RHIF round one Gippsland projects is expected by early to mid-2019.

   The program has a focus on expanding capacity, improving safety, quality and efficiency of services, as well as patient and staff amenity so not all projects will increase the number of services delivered. A full evaluation of the impact of funded projects will be undertaken as part of the evaluation of the program.

2. **Ice Action Plan – Additional alcohol and drug rehabilitation beds** – The Secretary advised that over the last three years an additional 100 beds have been opened.

   Please provide the number and location of these additional alcohol and drug rehabilitation beds in each of the three years referred.

   (Mr T. Smith - page 10 of the Department of Health and Human Services portfolio transcript, 13 February 2018)

   RESPONSE:

   2015-16

   The 2015-16 State Budget supported the establishment of 32 new residential rehabilitation beds across a range of existing services in Maryknoll, The Basin, Bendigo, Darebin, Lower Plenty and Yarra Ranges.

   2016-17

   The 2016-17 State Budget allocated $6.0 million over three years for the establishment of a 20 bed residential alcohol and drug rehabilitation facility in the Grampians region. This new service will progressively commence from October 2018.

2017-18:

The locations for the 100 beds under the *Drug Rehabilitation Plan are*:

- 31 beds in Lower Plenty
- 30 beds in Maryknoll
- 11 beds in Healesville
- 8 beds in Bendigo
- 20 beds in St Albans.

In addition, $9.7m in funding has been provided for site acquisition and planning for three new regional facilities, one each in the Gippsland, Barwon and Hume regions, in the 2017-18 State Budget.

Once all new facilities and beds are fully operational, this Government will have more than doubled the number of drug residential rehabilitation beds in Victoria. Over fifty per cent of additional residential rehabilitation beds are being delivered in rural and regional Victoria.

3. **Outcome-based metrics** – Please provide information on the actions being taken by the Department to address the scarcity of outcome-based metrics for measuring performance in DHHS.

(Ms S. Pennicuik - page 11 of the Department of Health and Human Services portfolio transcript, 13 February 2018)

RESPONSE:

Victoria has a strong health and human services industry with a proud history of enhancing the health and wellbeing of all Victorians, and providing additional support to those who need it. However, there are inconsistencies in the way the Victorian Government has collected the data necessary to measure the effectiveness of funded and delivered services.

Increasingly, there is recognition that it is ineffective to simply report on the number of services government departments and agencies provide, without understanding how these actions make a difference to people's lives.

This is reinforced by rising expectations from the Victorian community on the level and quality of services provided or funded by government. To address these concerns, the Victorian Government has started embedding outcome focused measurements in health and human services.

The department is undertaking a range of work to embed outcomes approaches and outcomes measurement to understand the impact of services. This includes:

- Measuring the impact of services on people's lives, in order to better understand what works, what doesn't, and why
- Investing in high quality, evidence-informed services that support the achievement of better outcomes for Victorians
- Driving the health and human services workforce to continuously consider the purpose of their work and how best to achieve results for Victorians.

Key work to measure outcomes includes:

1. The development and implementation of the DHHS Outcomes framework
2. The establishment of the Victorian Public Health and Wellbeing Outcomes Framework
3. Working with the community services sector on a 10 year industry plan that includes strengthening outcomes as a priority area of focus and developing the family services outcome test.

4. Developing the *Family Violence Outcomes Framework* to better understand the impact of our family violence reforms.

1. <u>The DHHS Outcomes Framework</u>

The department has established an Outcomes Framework which was first published in the 2016 Strategic Plan. The Outcomes Framework measures the impact of services on clients and how to support continuous improvement over time.

The Outcomes Framework measures 38 Key Results across five domains, including four that are people focused (health and wellbeing; safety and security; capabilities to participate; connections to culture and community) and one that is system focused (services that are person-centred and sustainable).

A consultation process in late 2016 identified a range of potential measures for reporting on the Outcomes Framework, and during 2017 full specifications were developed for the majority of these measures. Further work is underway to continue to refine and maximise the use of existing data and identify additional measures.

2. <u>Measuring public health and wellbeing outcomes for the population</u>

The *Victorian public health and wellbeing outcomes framework* provides a transparent approach to monitoring and reporting of collective efforts to improve public health and wellbeing at population level. The framework was released in 2016 with a commitment to report every four years.

Achieving population level outcomes can take many years and requires concerted and collective effort across a range of sectors. Shorter term measures of change are required to provide feedback on whether the department and agencies are on track to achieving these population outcomes.

In order to develop measures of shorter term change, or progress measures, the following work has been completed:

- consultation with agencies involved in prevention and health promotion on priority areas including healthier eating, active living, tobacco-free living and improving mental health
- review of draft evidence-informed changes required to achieve progress towards public health and wellbeing outcomes (based on a discussion paper summarising the evidence)
- identification of possible measures and respective data sources that would indicate progress towards public health and wellbeing outcomes.

Further work will finalise the changes required to achieve progress towards health and wellbeing outcomes and confirm progress measures that will guide local planning, implementation and monitoring.

3. <u>Community Services Industry Plan and the Family Services Outcomes Test</u>

As well as maximising the use of existing data, the department is working towards testing the collection of new outcomes data from clients, in order to measure the impact of services and embed outcomes approaches.

'Strengthening outcomes' is one of the 10 key priority areas that the Victorian Council of Social Service (VCOSS) and the Department of Health and Human Services (DHHS) have been

focusing on as part of the development of the 10 year Community Services Industry Plan. This includes ongoing sector consultation and an evidence review by the Future Social Services Institute.

Feedback on all the priority areas, including outcomes, is included in the Community Services Industry Plan Consultation Report, are now available on the VCOSS website.

The implementation of outcomes data collection supports the Roadmap for Reform commitment to establish an outcomes framework across all agencies for child and family services in Victoria.

The department is facilitating a test of outcomes data collection, with practitioners in family services. The Family Services Outcomes Test will collect outcomes data from clients at least twice during their service engagement, in order to document and measure the impact of services. This will support a systematic approach to the implementation of outcomes measurement and monitoring, and provide a holistic view of clients' lives. An expression of interest was sent out to agencies to participate in the test, which will occur in 2018. The test will be supported by an evaluation, which will inform next steps.

4. Family Violence Outcomes Framework

The Family Violence Outcomes Framework domains and outcomes were published in March 2017. This framework includes outcomes relating to our department, as well as those targeted to Victoria Police and the Department of Justice and Regulation.

Outcome indicators were subsequently published in the 2017 Family Violence Action Plan.

The Outcomes Framework is being used to inform all aspects of family violence reform, and further work is underway to identify clear outcomes measures and targets to track progress.

4. **Family violence programs and initiatives** – Please provide information about the 2016-17 family violence initiatives and programs specifically targeted at Indigenous communities and the victims and survivors within those communities.

(Ms H. Shing – pages 14-15 of the Department of Health and Human Services portfolio transcript, 13 February 2018)

RESPONSE:
Of the $22.87 million allocated to therapeutic responses demonstration projects in 2016-17, $3.61 million has been allocated to programs specifically for Aboriginal families.

These projects respond to the whole family and offer a range of interventions for Aboriginal families impacted by family violence including yarning circles, one on one counselling, group work and intensive case management.

Table 1: Therapeutic responses demonstration projects for Aboriginal families in 2016-17.

Victorian Aboriginal Child Care Agency (VACCA)	VACCA's multi-site, multi-intervention approach includes one-on-one counselling for women, children and men impacted by family violence, therapeutic cultural healing groups with women, children and men, group behaviour change programs with adolescent

	offenders, and therapeutic interventions with women in prison.
Boorndawan Willam Aboriginal Healing Service	Boorndawan's demonstration project, working in partnership with the Australian Childhood Foundation (ACF), incorporates intensive group programs and one-on-one counselling offered to children and adolescents who have experienced family violence.
Ballarat and District Aboriginal Co-Operative (BADAC)	BADAC's demonstration project focuses on the whole family, incorporating a wrap-around model of support for women, men and children impacted by family violence. This includes intensive engagement and case management with a strong focus on culture as a strength and opportunity to protect all Aboriginal families from the impacts of family violence.
Centre for Non-Violence (CNV), Njernda Aboriginal Corporation (Njernda) and Bendigo District Aboriginal Co-Operative (BDAC)	CNV, Njernda and BDAC's demonstration project incorporates a multi-intervention, community specific approach, with therapeutic interventions tailored primarily to the communities in Bendigo and Echuca. The interventions include healing and wellbeing activities and support for adolescents, women and children.

DHHS website: https://providers.dhhs.vic.gov.au/therapeutic-interventions-demonstration-projects-word

5. **Youth Justice** – Please advise:

   a) How many youth offenders were placed in isolation during the 2016-17 period?

   b) What percentage of those isolations were classified as being made in the interests of the security of the Youth Justice Centre?

(Mr D. O'Brien - page 15 of the Department of Health and Human Services portfolio transcript, 13 February 2018)

RESPONSE:

Isolation as specified by section 488 of the *Children Youth and Families Act 2005* includes isolation due to the young person's behaviour presenting an immediate threat to their safety or the safety of other people or property (s488(1)) and isolation in the interests of the security of the Youth Justice centre(s488(7)). Isolation under s488(7) is also referred to as lockdown.

From 1 July 2016 to 3 April 2017, when DHHS was responsible for Youth Justice, 342 young people experienced an episode of isolation.

Prior to April 2017, lockdowns were recorded on paper based registers by unit, rather than by individual young person. This has created issues for reporting on the number of individual episodes of lockdown experienced by young people prior to April 2017. It is therefore not possible to provide an answer to (b).

Since April 2017, lockdowns are recorded electronically in the Client Relationship Information System as a period of isolation and are differentiated from behaviour based isolation. In addition, the Department of Justice and Regulation has established quarterly reports of the number of individual episodes of lockdown experienced by young people to be provided to the Commission for Children and Young People.

6. **Child Protection – Rate of unallocated cases of child protection** – It was noted that the 2016-17 Annual Report does not indicate the rate of unallocated cases of child protection as per previous years' Annual Reports.

   a) Please explain why the rate was not reported in 2016-17?

   b) What exactly does the rate equate to in terms of the actual number of cases?

(Mr D. O'Brien - pages 15-16 of the Department of Health and Human Services portfolio transcript, 13 February 2018)

RESPONSE:

a) The rate of unallocated cases of child protection was publically reported in the *Child protection and family services additional service delivery and machine readable data 2016-17* and can be found at https://www.dhhs.vic.gov.au/child-protection-and-family-services-additional-service-delivery-data-2016-17.

b) In 2016-17, the average rate of unallocated clients was 19.1 per cent. The average number of unallocated clients for each quarter in 2016-17 is calculated from the number of unallocated clients at the end of each month in the quarter.

7. **Mental Health – Suicide Prevention funding initiatives**

a) Please provide information on the cohorts being addressed by the Department in 2016-17 in the planning of the "place-based" suicide prevention initiatives and why they were selected?

b) Did any of the trials focus on older retrenched male workers, who have been made redundant in their 50s and 60s?

(Mr S. Dimopoulos - pages 17-18 of the Department of Health and Human Services portfolio transcript, 13 February 2018)

RESPONSE:

Two flagship projects, the place-based suicide prevention trials and Hospital Outreach Post-suicidal Engagement (HOPE), are funded under *Victoria's suicide prevention framework 2016-25* and have a wide reach across different demographics and populations.

The place-based suicide prevention trials are a partnership between the Victorian Government and Primary Health Networks at 12 Victorian locations where each community is identifying local solutions to prevent suicide.

- Priorities for the place-based suicide prevention trials are based on needs analysis to identify priority groups and settings for suicide prevention activities.
- Priority groups vary across trial sites including different age and gender cohorts, vulnerable groups, different industry groups, and those with a lived experience of suicide. An important part of these trials is developing culturally appropriate suicide prevention approaches and exploring particular issues for Aboriginal communities.
- A range of activities that will support men across different age groups are being planned and implemented by trial sites. Older males have been identified as a priority population in a number of trial sites, although none of the trials specifically target older retrenched male workers.

As part of the response package to automotive industry closures in Victoria, the Department of Health and Human Services has also worked with the Department of Economic Development, Jobs, Transport and Resources to develop information that highlights the emotional and physical responses that might be experienced by someone who has been retrenched, and where to reach out for services.

8. **Ambulance Services – Coding of dispatches**

a) Please provide the number of cases which were changed from a Code 1 dispatch to a Code 2 dispatch under the new response model in 2015-16 and 2016-17.

b) Please provide a copy of the "dispatch grid" which was previously sought as part of the 2015-16 Outcomes inquiry, together with explanatory notes on the grid.

(Mr D. Morris - pages 18-19 and pages 22-3 of the Department of Health and Human Services portfolio transcript, 13 February 2018)

RESPONSE:

a) Ambulance Victoria implemented changes to its dispatch grid in stages, commencing May 2016 and concluding October 2016. As part of this process, 105 cases were changed from a Code 1 dispatch to a Code 2 dispatch.

b) In 2015, Ambulance Victoria undertook a comprehensive review of its dispatch grid – a database of more than 1000 classifications that are assigned to patients during Triple Zero (000) calls.

As a result, Ambulance Victoria progressively introduced a revised Clinical Response Model, with each stage subjected to stringent assessment, trial, evaluation and rigorous clinical oversight by medical experts.

The attached dispatch grid outlines case classifications that changed with the introduction of a revised Clinical Response Model in October 2016 that have led to faster response times, improved cardiac arrest survival and better patient outcomes.

9. **Ambulance Services – Response times**

The figures reported in 2015-16 and 2016-17 for Code 1 responses achieved in less than 15 minutes have fallen between 2015-16 and 2016-17. The figures indicate that 37000 fewer cases have been responded to within the 15 minute timeframe. At that same time there has been a $100 million increase in funding to the organisation.

a) Please advise why performance targets in this area have fallen between 2015-16 and 2016-17.

b) For 2015-16 and 2016-17, please provide the total number of Code 1 cases; the number of Code 1 cases responded to within 15 minutes; and the total number of Code 1 cases not responded to within 15 minutes.

(Mr D. Morris - pages 19-20 of the Department of Health and Human Services portfolio transcript, 13 February 2018)

RESPONSE:

a) The State Budget notes that ongoing reform drives change in this measure. In 2015-16 Ambulance Victoria responded to 843,051 emergency and non-emergency incidents, providing care for 791,659 patients.

In 2016-17 this increased to 854,603 emergency and non-emergency incidents, providing care for 830,132 patients.

Ambulance Victoria's implementation of the revised clinical response model was designed to ensure 000 callers receive a response most appropriate to their needs. A result of the revised model is that the number of emergency incidents (including Code 1) has decreased by approximately 3.9 per cent with an increase in non-emergency incidents of 14.4 per cent.

b) In 2015-16 across the state there were a total of 329,641 Code 1 incidents, with 247,871 of these incidents responded to within 15 minutes (75.2 per cent). There were 81,770 Code 1 incidents not seen within 15 minutes.

In 2016-17 across the state there were a total of 269,235 Code 1 incidents, with 210,696 of these incidents responded to within 15 minutes (78.3 per cent). There were 58,539 Code 1 incidents not seen within 15 minutes.

10. **Family violence – Communal family violence refuges** – Information is sought in relation to the budget of $9.5 million provided for '*Communal family violence refuges – replacement and growth*'.

The Department has reported expenditure of $300,000 with delays in construction due to the location of suitable sites. The Secretary provided some information at the hearing (page 21) and the Committee is interested in any further details which can be provided with respect to:

a) The reasons for the delay in spending on communal family refuges?

b) Progress being made on the location of suitable sites for these refuges?

c) The projected timeline for the project?

(Ms S. Pennicuik - pages 20-21 of the Department of Health and Human Services portfolio transcript, 13 February 2018)

RESPONSE:

a) Sourcing suitable land for the project and planning delays has affected construction commencement and resulted in deferred expenditure.

b) Progress has been made. The first four sites for redevelopment have been secured and design work has commenced.

c) The first refuge is expected to complete by December 2018. Late procurement of final site coupled with planning delays will now see the last refuge delivered by March 2019.

11. **Ambulance Services – Redistribution of patients (formerly known as "bypass")**

The Committee is seeking information in relation to the distribution of patients across the health system by Ambulance Victoria. It was agreed that Ambulance Victoria would provide any information available in respect to the following questions:

a) How many times were ambulance crews redistributed in an Ambulance Victoria-initiated redistribution, as captured by the hospital coordinator information logs?

b) What are the major reasons for redistribution?

c) What are the top five hospital "hot-spots" where a redistribution is often required?

(Mr D. Morris - page 23 of the Department of Health and Human Services portfolio transcript, 13 February 2018)

RESPONSE:

a) Ambulance Victoria does not routinely monitor or generate data regarding the distribution of ambulances across the hospital system and therefore this information is not available.

The Hospital Coordinator Information logs are an activity log that captures the actions of the paramedics within the Communications centre. The logs are not designed to generate data, they are a capture of the daily activities of the hospital information coordinator, undertaken as part of normal business activity.

b) During periods of high demand, Ambulance Victoria ensures the clustering of ambulance arrivals at busy hospitals is mitigated as far as possible to ensure patients receive timely, quality care.

c) Ambulance Victoria does not routinely monitor or generate data with regards to redistribution therefore this information is unavailable.

12. **Ambulance Services – "Ramping" of ambulances at hospitals**

The Committee is seeking information in relation to ramping of ambulances at hospitals. It was agreed that Ambulance Victoria would provide any information available in respect to the following questions:

a) What sort of data is collected by Ambulance Victoria on ramping levels at hospitals?

b) The number of ambulances queued at each hospital on a monthly basis during 2016-17?

c) Data indicating the frequency of ramping at each hospital during 2016-17?

(Mr D. Morris - page 23 of the Department of Health and Human Services portfolio transcript, 13 February 2018)

RESPONSE:

a) Ambulance Victoria monitors performance at hospitals against both transfer time and clearance times in line with the agreed Statement of Priorities.

The department collects and reports data on the time taken for patients who arrive by ambulance to be transferred from the ambulance stretcher to the care of emergency department staff. The data is reported as a performance measure called the 'Ambulance Patient Transfer Time'.

All public hospitals with emergency departments have a target that 90 per cent of patients are handed over with 40 minutes from the time of arrival to time handover is complete (including the triage process, the physical transfer of the patient and the completion of a clinical handover to hospital staff).

The 'Ambulance Patient Transfer Time' is reported quarterly on the Health Performance website as both a percentage and the median time at: http://performance.health.vic.gov.au/Home.aspx

b) Ambulance Victoria does not routinely collect or report this information.

c) Ambulance Victoria does not routinely collect or report this information.

13. **Ambulance Services – 2016-17 Budget update**

The Committee is seeking a reconciliation of the 2016-17 budget figures to the budget update figures of $343.3 million for output initiatives and $66.9 million in asset initiatives to improve ambulance response times which does not equate to the Government's announcement of $526 million for ambulance services.

It appears that the amounts announced as available in the budget were $89 million less than the Government announcement.

Please indicate the source of the Government's funding announcement for ambulance services and provide a reconciliation of the figures to identify the remaining $89 million which appears to be missing from the figures.

(Mr D. Morris - pages 23-24 and page 27-28 of the Department of Health and Human Services portfolio transcript, 13 February 2018)

RESPONSE:

In the 2016-17 State Budget Update the Government provided new funding of $410.3 million over four years to improve ambulance response performance. In addition to this allocation $115.8 million in funding was approved to support the ongoing output requirements of the funded initiatives, from 2020-21. The total investment including output and asset allocations and the ongoing requirement is $526.1 million.

14. **Victorian Patient Transport Assistance Scheme (VPTAS)**

Information was provided at the hearing in relation to the total budget in 2016-17 and categories of expenditure for the Victorian Patient Transport Assistance Scheme (VPTAS).

The Department also advised that there was a small deficit in 2016-17 of $194,000 with 8.2 per cent growth per annum expected over five years.

- Please clarify whether the 8.2 per cent growth refers to growth in demand or growth in financial terms?

(Mr D. O'Brien – page 36 of the Department of Health and Human Services portfolio transcript, 13 February 2018)

RESPONSE:

The 8.2 per cent growth per annum refers to growth in demand, which is the growth in 'claims received' to the Victorian Patient Transport Assistance Scheme.

The 8.2 per cent is an average of annual growth in claims over the past six years.

15. National Disability Insurance Scheme (NDIS) workforce action plan

Please provide information available in relation to actions taken by the Department to implement the NDIS workforce action plan, released in October 2016 and to address issues related to workforce shortages in some areas e.g. rural areas.

(Mr D. O'Brien – page 25 of the Department of Health and Human Services portfolio transcript, 13 February 2018)

RESPONSE:

On 20 October 2016, the Minister for Housing, Disability and Ageing launched *Keeping our sector strong: Victoria's workforce plan for the NDIS*.

The plan is supported by a **2016-17** State Budget investment of $25.8 million over 5 years (including $4.88 million from the Commonwealth Sector Development Fund) and a **2017-18** State Budget investment of $1.8 million.

The plan includes nine priorities that seek to:

- build intelligence to inform workforce planning,
- build workforce capability and supply, and
- maximise opportunities for innovation.

The plan includes a number of actions to respond to workforce challenges, including in regional and rural areas.

In 2016-17 critical planning work was conducted to establish the governance structures to implement the plan. Implementation activities are being undertaken by a number of Victorian Government departments, including Department of Premier and Cabinet, Department of Health and Human Services, and Department of Education and Training.

Key actions undertaken in 2016-17 include:

- Establishment of the $4 million NDIS Regional Readiness Fund, in collaboration with the Commonwealth Government. The first round of funding grants will be distributed in mid-2018.
- Research and stakeholder consultation conducted on the barriers to entering the disability workforce, including the particular issues facing people in regional and rural areas. This work is informing strategies to promote careers in disability throughout 2017-18.
- Development of the Supervision and Delegation Framework for Allied Health Assistants. This is particularly critical for regional and rural areas that face challenges in recruiting qualified staff such as therapists and specialists. To support the delivery of the framework, training sessions have commenced and will continue until August 2018.
- Stakeholder and industry consultation was undertaken and is informing the:
    - review of disability related qualifications;
    - design of professional development for VET Trainers and Assessors, focussing on the access needs of Trainers and Assessors based in rural areas; and
    - work placement structures in disability qualifications and recommendations to improve access to quality placements for students.

In 2017-18, implementation activities to deliver the plan are continuing. This includes:

- Commencement of the workforce longitudinal research. This unique survey was launched in March 2018 and will provide critical insights into the workforce's experience of NDIS transition.
- Vocational educational scholarships delivered through the Future Social Service Institute.
- Commencement of ProjectABLE workshops to years 10, 11 and 12 to promote a rewarding career in the disability sector.
- Appointment of Regional NDIS workforce coordinators to strengthen local networks and identify local priorities.

16. **Youth Affairs programs – participation performance**

Page 258 of the 2016-17 Budget Paper 3, indicates the Department's performance in the youth affairs portfolio.

Please explain why there is a 25 per cent decline in the '*participation by young people in programs that provide opportunities to be involved in social and economic life in their communities*' between the actual for 2014-15 and the expected outcome for 2016-17?

(Mr T. Smith – page 28 of the Department of Health and Human Services portfolio transcript, 13 February 2018)

RESPONSE:

The actual number of young people participating in youth affairs programs continued to exceed the targets between 2014-15 and 2016-17.

The actual number is updated in the following year's budget pages to reflect reporting by funded organisations as part of their service agreements as the end of September each year, after the Annual Report has been finalised. This is the same approach that has been used for reporting expected outcomes in previous budget papers.

17. **Sport and Recreation**

a) Please provide a breakdown of the $108 million spent on the Sport and Recreation budget in 2016-17 by program area.

b) Please advise how much was spent through the *Athlete Pathway Travel Grants Program* in 2016-17.

(Mr T. Smith – pages 28-29 of the Department of Health and Human Services portfolio transcript, 13 February 2018)

RESPONSE:

a) The $108 million listed in budget paper 3 went towards, but not limited to the following programs and initiatives:

- Community Sport Infrastructure Fund
- Country Football and Netball Program
- Better Indoor Stadiums
- Sport Club Grants
- Emergency: Sporting and Recreational Equipment

- Athlete Pathway travel grants
- Female Friendly Facilities
- Significant Sporting Events
- Supporting Victorian Sport and Recreation
- Defibrillators for sporting clubs and facilities program
- Shooting sports facilities program
- State level facility development
- VIS scholarships.

b) In 2016-17, a total of **$561,500** was spent on Athlete Pathway Travel Grants (328 grants from over 60 sports)

18. **Mental health, alcohol and other drugs facilities renewal**

The Committee is seeking information in relation to the allocation of funding for mental health, alcohol and other drugs facilities renewal funding (refer page 16 of the Department's Outcomes questionnaire response).

The Department provided some details at the hearing (refer page 36) indicating that of 84 applications for funding, 67 were successful.

Please provide the following outstanding information:

a) How many facilities are still in need of funding?

b) How much money is anticipated to be needed to be spent on capital expenditure or renewal services to meet demand?

*(*Ms S. Pennicuik – pages 30-31 of the Department of Health and Human Services portfolio transcript, 13 February 2018)

RESPONSE:
The program is an application based grants funding program, where eligible mental health and alcohol and other drug services, determine facilities and capital projects that are in need of renewal and make applications in the form of funding submissions accordingly. Evaluation processes reflect departmental principles of asset and infrastructure management. A list of the eligible mental health and alcohol and other drug services is available on the Department of Health and Human Services website.

The 2017-18 Budget provided a further $10 million for the program. Under the 2017-18 funding grants process, alcohol and drugs submissions are capped at 2 submissions per agency with a project minimum of $10,000 and a maximum of $100,000 for minor construction, remodelling and refurbishment projects. Mental health submissions are capped at 2 per agency with a project minimum of $10,000 and a maximum of $500,000 for minor construction, remodelling and refurbishment projects.

19. **Alfred Health – Non-salary labour costs**

Information provided by Alfred Health indicates expenditure of $16.7 million in non-salary labour costs against a budgeted figure of $6.9 million (refer page 7 of the Alfred Health questionnaire response). The over budget expenditure is explained as being '*due to high agency costs and temporary replacement staff.*'

Please provide details on how Alfred Health is progressing in relation to the Budget Paper 5 initiative to reduce the use of labour hire firms.

(Ms S. Pennicuik - page 31 of the Department of Health and Human Services portfolio transcript, 13 February 2018)

RESPONSE:

The non-salary labour costs relate mainly to the use of agency nurses, fee for service doctors and temporary agency staff primarily related to the ability of Alfred Health to flex labour to meet demand.

Increase in 2016-17 is partly due to use of psychiatric specialist nurses and patient attendants to deal with issues such as behaviours of concern. In 2016-17 Alfred Health budgeted for a large increase in the pool/bank (employed nurses who act mainly as relief nurses) and therefore allowing the reduction of agency use. Alfred Health was, however, only partially successful in reducing use of agency nurses due to the increase in activity over the initial budget.

Other increases in 2016-17 is due to increased surgical activity, which included additional work undertaken to increase elective surgery procedures and reduce waiting lists.

In the medical space, the ability to flex up and down depends on the availability of surgeons and that sometimes lead to increase in the fee for service payments (which is also non salary labour).

Year to date to February 2018 spending for non-salary labour costs is $8.0 million. Estimated full year spending for 2017-18 is $11.5 million (compared to $16.7 million in 2016-17).

Of the total estimated spending for 2017-18, approximately $3.6 million is the fee for service medical staff, which is an alternative way to pay a doctor rather than a sessional payment through payroll. This is unrelated to labour hire firms.

The other costs that relate to spending, other than Nurse Agency costs, are estimated at $5.4 million for 2017-18. These relate to short term project work across the organisation where specific expertise is required, or the project is short term in nature, or it is backfill while permanent staff are recruited. The majority of this is non clinical. Most of this cost is related to a temporary offset in salaries and wages for short term work or while recruitment is occurring.

Nurse Agency expense is $2.1 million year to date to February 2018. Spending for the full 2017-18 year is estimated to be approximately $2.8 million (significantly below $7.2 million for 2016-17).

In 2017-18, the internal approval process for nurse agency and temporary staff has been reviewed. Additional controls have been introduced around appropriate usage, which has successfully reduced the cost while still providing appropriate levels of support.

Actions taken in the nurse agency, psychiatric specialist nurses and extra patient observer have significantly reduced costs since the early part of 2017-18. Specific actions include:

- significant changes in approval policy for Nurse Agency and temporary staff
- changes in model of care and strategies related to behaviours of concern
- increase in size of nurse pool and bank who are on the payroll
- changes to leave planning and backfill policies.

20. **Program funding – conclusion and renewal**

The Committee is seeking details in relation to the funding of 2016-17 programs. Specifically:

a) A list of programs for which funding concluded in 2016-17 and was not renewed.

b) A list of programs for which funding was to conclude in 2016-17 but which were renewed.

c) In relation to programs listed under part (b) the period for which the program was renewed and the funding provided for the program renewal.

(Mr D. Morris - page 32-33 of the Department of Health and Human Services portfolio transcript, 13 February 2018)

RESPONSE:

Table 1: 2016-17 Lapsing programs

Note: Table 1 includes only those programs that have sunset funding in 2016-17. It includes initiatives that have been re-titled but resulted in continuity of service provision. The table excludes Initial response to Family Violence - Allocated into Family Violence Package.

Budget Year	BP3 Title	Total	Budget Year	BP3 Title	Lapsing Year	2017-18	2018-19	2019-20	2020-21	2021-22	Comment
2011-12	Longitudinal study on the impact of out-of-home care	200,000.00									Once Only Cost Reported in 2017-18 BEQ
2013-14	Increasing the availability of information for senior Victorians	500,000.00									Once Only Cost
	Innovation and improvement funds	5,000,000.00	2017-18	Better Care Victoria Innovation Fund	2017-18	10,000,000					
	Skin cancer prevention - shade in public places	1,000,000.00									Once Only Cost
	Accommodation options for families	4,898,000.00									Once Only Cost
	Bairnsdale Mental Health and Wellbeing Centre	300,000.00									Once Only Cost Reported in 2017-18 BEQ
2014 PEBU	Additional resources for mental health services	1,000,000.00									Replaced by Ice Action Plan, funded in 2015-16, 2016-17 and 2017-18 Budgets Reported in 2017-18 BEQ
	Shooting Sports Grant Program	5,800,000.00	2017-18	Shooting Sports Facilities Program	2017-18	1,000,000					
2014-15	Victorian Social Housing framework	11,000,000.00									Once Only Cost Reported in 2017-18 BEQ
	WoVG - Aboriginal Affairs - Young Aboriginal people's health and wellbeing	875,000.00	2017-18	WoVG - Aboriginal Affairs - Aboriginal Youth Mentoring Program	2018-19	875,000	875,000				
	WoVG - Hazelwood Mine Fire Inquiry (Review fire emissions protocols; State Smoke Plan, guidance and protocols)	875,000.00	2016-17	WoVG - Hazelwood - Healthy Strong Latrobe	Ongoing	6,689,000	6,750,000	6,945,000	5,384,000		Once Only Cost Reported in 2017-18 BEQ Extended through further funding in 2016-17 Budget
2016-17	Better Care Victoria Innovation fund	10,000,000.00	2017-18	Better Care Victoria Innovation Fund	2017-18	10,000,000					
	Future public sector residential aged care provision	25,000,000.00	2017-18	Future public sector residential aged care provision	2017-18	25,625,000					
	Getting Ready for the National Disability Insurance Scheme	21,261,000.00	2017-18	Supporting the transition to the National Disability Insurance Scheme	2019-20	20,949,000	14,213,000	1,125,000			
	Homes for Homes	500,000.00									Once Only Cost Reported in 2017-18 BEQ
	Suicide prevention app	500,000.00									Once Only Cost Reported in 2017-18 BEQ
	Community Sports and Events Package (Moorabbin Oval redevelopment, Elsternwick Park (Old Melburnians), Carrum Downs Recreation Reserve)	8,050,000.00									Once only cost
	Improving access to elective surgery; meeting hospital demand services; meeting clinical services demand	85,000,000.00	2017-18	Improving access to elective surgery; meeting hospital services demand; meeting clinical services demand	2017-18 (part) Ongoing (part)	233,188,000	49,600,000	50,840,000	52,111,000	53,410,000	
	Securing access to surgery	102,500,000.00									
	Improving the sexual health of children in out-of-home care	1,001,000.00									Once Only Cost Reported in 2017-18 BEQ
	Leukaemia Foundation Patient Accommodation	500,000.00									Once Only Cost Reported in 2017-18 BEQ
	Perinatal Depression Funding	1,600,000.00	2017-18	Perinatal Depression Funding		1,640,000					
2016-17 Budget Update	Redevelopment of public housing estate program	16,250,000.00									Once only cost; linked to $185 million TEI asset program
Grand Total		**305,593,000**				**318,016,000**	**71,488,000**	**58,910,000**	**57,495,000**	**53,410,000**	

21. Family violence and child protection – Emergency accommodation

Please provide the following information with regard to women and children requiring emergency crisis accommodation in 2016-17 by local government area or other geographic identification, if possible:

a) How many women and children required crisis accommodation in hotels/motels in 2016-17 by local government area or other geographic identification?

b) What was the average waiting time for women and children seeking access to emergency accommodation in hotels/motels in 2016-17?

c) How many of those women and children exiting emergency accommodation accessed homelessness services by local government area or other geographic identification?

(Mr D. O'Brien – page 34-35 of the Department of Health and Human Services portfolio transcript, 13 February 2018)

RESPONSE:

In 2016-17, 2,860 women and children experiencing family violence received emergency accommodation paid for by a specialist family violence or homelessness provider. This includes motels, hotels and range of other forms of purchased accommodation. There is no specific data that breaks down the number of women and children placed only in motels.

Please note that clients can have more than one period of support in a financial year. The table below provides the number of women and children in an emergency crisis facility at a Department of Health and Human Services area level.

Data on wait times to access emergency accommodation is not available as clients are placed in emergency accommodation immediately.

Of the 2,860 women and children who received emergency accommodation in 2016-17, in the month after they were provided with crisis accommodation, 1,179 were supported by a specialist homelessness agency, and 1,357 women and children were supported by a specialist family violence agency, with 547 clients receiving support from both agency types.

Table 1: Number of women and children in an emergency crisis facility at a Department of Health and Human Services area level.

Women and children provided with purchased crisis accommodation due to family violence, in 2016-17, by unique clients across areas (service location)

Area	Clients
Barwon	133
Bayside Peninsula	425
Brimbank Melton	76
Central Highlands	81
Goulburn	26
Hume Moreland	45
Inner Eastern Melbourne	62
Inner Gippsland	94
Loddon	148
Mallee	46
North Eastern Melbourne	211
Outer Eastern Melbourne	88
Outer Gippsland	11
Ovens Murray	139
Southern Melbourne	134
Western District	31
Western Melbourne	1563
Unique Clients[1]	**2860**

Notes:

[1] Clients can be assisted in more than one area. Clients are counted in each area they are assisted in. Therefore the sum of the rows will be greater than the number of unique clients stated.

22. Child protection – Incident reporting

Please provide the following information in relation to children in out-of-home care:

a) How many children in out-of-home care go missing each week?

b) What is the longest period that a child in out-of-home care has been missing?

(Mr D. O'Brien – page 35 of the Department of Health and Human Services portfolio transcript, 13 February 2018)

RESPONSE:

In 2016-17, the Department of Health and Human Services received 299 category one client incident reports relating to occasions when children in out-of-home care were absent or missing from their out of home care placement *(Commission for Children and Young People, Annual Report, 2016-17, pg 35).* Note these are not unique clients.

The department does not collect aggregated data on a weekly basis, or for the length of time children are absent or missing from placement.

23. Child protection – investigations of alleged child sexual exploitation

The Committee is seeking information in relation to the Department's response to alleged sexual exploitation of children in residential care.

The Department advised that there is an "enhanced response model" implemented with Victoria Police investigating allegations of sexual exploitation across DHHS areas.

Please provide data in relation to the response programs between the Department and Victoria Police investigating alleged sexual exploitation of youth in residential care and other care, separating the information between:

- each of the DHHS areas
- the number of boys and girls
- residential care and other care/carers

(Mr D. O'Brien – pages 35-36 of the Department of Health and Human Services portfolio transcript, 13 February 2018)

RESPONSE:

The Enhanced Response Model is a partnership between the Victoria Police and the Department of Health and Human Services aimed at protecting children and young people from sexual exploitation. The Enhanced Response model pilot sites are located in Epping, Dandenong, Brimbank, Ballarat and Shepparton *(Protecting Children from Sexual Exploitation, Media Release, 1 July 2016).*

The department wishes to correct its response from the hearing that there was an Enhanced Response Model in Geelong, as the Model is not being piloted in that area.

Children involved in the Enhanced Response Model (ERM)each quarter of 2017 by pilot site, gender and out of home care placement (2017).

October - December 2017

ERM Site	Total	Male	Female	Intersex	No in OOHC	% in OoHC
Dandenong	**10**	0	10	0	9	90%
Ballarat	**8**	1	7	0	6	75.0%
Shepparton	**6**	0	6	0	5	83.3%
Epping	**8**	0	8	0	4	50.0%
Brimbank-Melton	**12**	0	11	1	10	83.3%
	44	**1**	**42**	**1**	**34**	**77.3%**

* Note these are not unique clients.

In Geelong, the department is funding MacKillop Family Services to pilot the Positive Community Engagement Program. The Program involves a former Victoria Police Youth Liaison Officer working with eight young people in residential care to decrease their engagement high risk behaviours. The pilot commenced in July 2017.