T R A N S C R I P T S

PUBLIC ACCOUNTS AND ESTIMATES COMMITTEE

Inquiry into 2016–17 Financial and Performance Outcomes

Melbourne — 13 February 2018

Members

Mr Danny Pearson — Chair
Mr David Morris — Deputy Chair
Mr Steve Dimopoulos
Mr Danny O'Brien
Ms Fiona Patten
Ms Sue Pennicuik
Ms Harriet Shing
Mr Tim Smith
Ms Vicki Ward

Witnesses

Ms Kym Peake, Secretary,

Mr Terry Symonds, Deputy Secretary, Health and Wellbeing,

Ms Chris Asquini, Deputy Secretary, Children, Families, Disability and Operations,

Mr Nick Foa, Deputy Secretary, Housing, Infrastructure, Sport and Recreation,

Ms Anne Congleton, Deputy Secretary, Community Participation, Health and Wellbeing,

Ms Melissa Skilbeck, Deputy Secretary, Regulation, Health Protection and Emergency Management,

Mr Greg Stenton, Chief Finance Officer, Corporate Services, and

Dr Margaret Grigg, Executive Director, Health Service Policy and Commissioning, Department of Health and Human Services;

Associate Professor Tony Walker, Chief Executive Officer, Ambulance Victoria; and

Ms Sue Clifford, Chief Executive Officer, Family Safety Victoria.

The CHAIR — I declare open the public hearings for the Public Accounts and Estimates Committee inquiry into the 2016–17 financial and performance outcomes. All mobile telephones should now be turned to silent.

I would like to welcome Ms Kym Peake, Secretary, Department of Health and Human Services; Mr Terry Symonds, Deputy Secretary, Health and Wellbeing; Ms Chris Asquini, Deputy Secretary, Children, Families, Disability and Operations; Mr Nick Foa, Deputy Secretary, Housing, Infrastructure, Sport and Recreation; and Mr Greg Stenton, Chief Finance Officer, Corporate Services.

In the gallery are Ms Melissa Skilbeck, Deputy Secretary, Regulation, Health Protection and Emergency Management; Ms Anne Congleton, Deputy Secretary, Community Participation, Health and Wellbeing; Dr Margaret Grigg, Executive Director, Health Service Policy and Commissioning; Ms Sue Clifford, Chief Executive Officer, Family Safety Victoria; Professor Euan Wallace, Chief Executive Officer, Safer Care Victoria; Mr Robert Fiske, Chief Executive Officer, Housing, Infrastructure, Sport and Recreation; and Associate Professor Tony Walker, Chief Executive Officer, Ambulance Victoria. I would like to welcome all witnesses sitting in the gallery. Any witness who is called from the gallery during this hearing must clearly state their name, position and relevant department for the record.

All evidence is taken by this committee under the provisions of the Parliamentary Committees Act, attracts parliamentary privilege and is protected from judicial review. Any comments made outside the hearing, including on social media, are not afforded such privilege. The committee does not require witnesses to be sworn, but questions must be answered fully, accurately and truthfully. Witnesses found to be giving false or misleading evidence may be in contempt of Parliament and subject to penalty.

All evidence given today is being recorded by Hansard. You will be provided with proof versions of the transcript for verification as soon as available. Verified transcripts and any PowerPoint presentations and handouts will be placed on the committee's website as soon as possible.

Witness advisers may approach the table during the hearing to provide information to the witnesses if requested, by leave of myself. However, written communication to witnesses can only be provided via officers of the PAEC secretariat. Members of the public gallery cannot participate in the committee's proceedings in any way.

Members of the media must remain focused only on the persons speaking. Any filming and recording must cease immediately at the completion of the hearing.

I now give the witness the opportunity to make a very brief opening statement of no more than 10 minutes. This will be followed by questions from the committee.

At the outset I would like to declare that I am the chair of the Public Housing Renewal Advisory Group.

Visual presentation.

Ms PEAKE — Thank you, Chair. It is good to see you back, Mr O'Brien, and thank you to committee members for the opportunity to present today. I would like to start by acknowledging the traditional owners of the land on which we meet and pay my respects to their elders past and present.

Ms SHING — Could you speak up a little? Sorry. We do have some problems for all witnesses today with the acoustics in here and the air conditioning, which is on. If you could do a comparative bellow into the microphone, that would be wonderful.

The CHAIR — Actually I might just ask all witnesses if you could all move the microphones just a little bit closer to you now so that we do not have to repeat that instruction during the hearings.

Ms PEAKE — Our focus is on improving outcomes for people who rely on our services and activities. As the committee is aware, we are responsible for developing and delivering policies, programs and services that support and enhance the health and wellbeing of all Victorians. But the majority of the Victorians we come into contact with are often in their hour of need, and in July 2017 our impact on Victorians expanded with the addition of two new portfolios of family violence and gender equality. They are responsible for a wide range of government functions, from system stewardship to regulation and program management and with two-thirds of our 11 200 full-time equivalent staff engaged in direct service delivery.

We are also responsible for a large number of portfolio agencies and fund around 2000 agencies — non-government and local government service providers — to deliver services to our patients, clients and victim survivors. We have one of the largest budgets of all Victorian government departments, with $23.2 billion in total expenses in 2016–17.

The work of our 11 200 staff is of course underpinned by our vision, which is there on the screen. It is to achieve the best health, wellbeing and safety for all Victorians so that they can lead a life they value. Our vision reminds us of our purpose every day — of our commitment to our patients, clients and victim survivors of family violence. And understanding our strategic context enables us to actively plan and respond to both present but also emerging challenges and to capitalise on innovation and opportunities for improvement.

We do continue to face some really significant challenges, which include sustaining timely, equitable access to services in the face of rising demand, rapidly changing patterns of need and a different settlement pattern to what we have seen in the past. It requires us to understand and plan for changes in the profile of our patients and clients and where our services will be needed in the future. It also requires us to think really creatively about how to best deliver our services flexibly, using our human capital and technological resources to ensure equitable and timely access, no matter where our clients and patients live. And we have also been challenged to ensure that we are providing quality, safe services right across all of our portfolios. We want to make sure that Victorians have confidence in their health and human services system, and that was a very big focus in 2016–17 and will continue to be so into the future.

We are also very focused on harnessing opportunities and innovations across all of our portfolios. There are opportunities to reorient our systems towards prevention, earlier intervention and more connected services. We encourage our staff to think about a patient's or client's needs holistically and design systems that put the patient or client at the centre, with opportunities for connection and referrals across services being harnessed.

We have introduced an outcomes framework to guide the prioritisation of our work and help each of us to anchor everything that we are doing to the outcome we are wanting to achieve for those patients, clients and victim survivors. Under the five domains of our outcomes framework, we have set ourselves priorities to achieve, such as Aboriginal children being connected to their family and culture, or ensuring people are able to access our services easily and in a timely way, while of course always ensuring those services are efficient and sustainable.

We also have a focus on the enablers to achieving those outcomes, such as becoming leaders in the Victorian public service in co-design, engagement and ethical and shared decision-making. This is a particular focus for us because not only does it improve the design and delivery of services, it also equips people to effectively manage their own health and wellbeing and their capacity to make changes in their own lives.

I think we are getting much better at translating risk into strategy, with significant work having been undertaken to bring together our risks, outcomes and performance perspectives so that we know where we are doing well, but also where our results are lagging and what we can do to make a difference. A really key part of this work is to use data in a more sophisticated way to understand the mix, sequence and intensity of services being used by our patients and clients and how this is impacting on their results, as well as listening to the voices of our clients, our staff and our partners so that our advice on policy, service development and investment is informed by their experiences and the outcomes that matter most to them.

We are putting our efforts into continuously improving the experience of working in and with the department. While there is still much to be done to realise our vision, there are a significant number of reforms and initiatives that were delivered in 2016–17 that I wanted to touch on for the committee. We worked extensively with Ambulance Victoria and our hospitals to improve ambulance response times and reduce elective surgery wait lists across Victoria, despite record demand. Both Safer Care Victoria and the Victorian Agency for Health Information were established and commenced delivery, which has helped put patients first and enabled action to embed a culture of safety and quality with the target of zero affordable harm.

Victoria's perinatal mortality rate continued to fall in 2016. At 8.8 per 1000 births, adjusted, this rate is among the lowest in Australia. Of particular importance is that after almost a decade of steady improvement the 2016 adjusted perinatal mortality rate for babies born to Aboriginal women was for the first time comparable to babies born to non-Aboriginal women. On 21 November, after a marathon 28-hour sitting, the Voluntary Assisted Dying Bill passed into legislation.

I do want to acknowledge the way the department and health system as a whole responded to the learnings from the unprecedented thunderstorm asthma event. We have significantly improved our systems, communication and collaboration across the state so that we can respond to both more familiar as well as more unusual emergency events, focusing on their impact rather than the type of event. We have also provided effective relief and recovery to many Victorians in the aftermath of the Bourke Street tragedy and more recently the similar Flinders Street tragedy as well as the Wye River fires and statewide flooding.

We have also made significant progress in the implementation of the *Roadmap for Reform* policy for children and families, with a focus on expanding and improving services to strengthen families, keep victim survivors of family violence safe, and improve the trajectory of vulnerable children's lives. In this space we have supported the establishment of Family Safety Victoria and begun to implement our response to the family violence royal commission, and in particular we have acted to increase adult victim survivor and child safety through strengthening the risk assessment framework in child protection, through information sharing with police and by appointing 12 specialist family violence workers in child protection offices; we have increased the safety of children and young people in residential care by allocating 35.9 million for an additional staff member on duty each night; and we have been working to connect more children to a reliable, caring adult through targeted care packages, which have now assisted over 320 children and young people to transition out of resi care and prevented a further 160 children and young people from entering resi care by the end of last year.

We are also continuing to work closely with the National Disability Insurance Agency to support the rollout of the NDIS, with our staff out in the field working hard to make sure that the plans that people receive as they enter the NDIS are going to enable them to exercise choice and get the support they need to live an ordinary life.

On the capital front, we have delivered a large capital program, which generates significant economic benefit for the community as well as delivering high-quality health services where people need them. In the 2016–17 financial year we completed projects with a total estimated investment of over $1.3 billion, which created almost 4000 jobs in local communities. I am sure we will talk a bit more about some of the major projects as the hearing continues. We have also finished the redevelopment of both the Sandhurst Centre in Bendigo and the Oakleigh Centre, which provided new disability accommodation for residents. In the sport and recreation portfolio, stage 4 of the Simonds Stadium redevelopment provided a significant boost to the Geelong region through jobs created and additional capacity for AFL games and other events staged at Kardinia Park, with all of those projects complying with the Victorian Industry Participation Policy, providing a boost to local jobs and suppliers.

In relation to budget performance we have always had and we maintain a focus on prudent financial management; and, in 2016–17, 10 of our 13 output budgets were either on or within the accepted range of 5 per cent of target. The variance in ambulance services reflected additional midyear budget funding for improving ambulance wait times with increased funding for activity, growth and wage costs. The variance in child protection and family services reflected additional investment and the transfer of the 16–17 budget initiative Safe at Home — Flexible Support Packages from the housing assistance group, and the underspend in public health was driven by delay of expenditure on essential vaccines and real-time prescription monitoring, with this being recognised by expenditure incurred in 17–18 being carried over.

You need me to finish?

The CHAIR — I am just conscious of time, Secretary, so if you could just —

Ms PEAKE — Yes. I am nearly there. Really quickly, on output performance, of our 244 non-financial measures 143 met or exceeded the target and 46 were less than 5 per cent away from target. I am sure we can talk in more detail about targets that were not met, but really the three themes in explaining that go to the increasing demand in the system, areas where increases in quality of care are needed, and evidence-based changes in models of service and operational practice.

I just did want to emphasise before I finish two areas of performance outcome that were particularly pleasing, which included the continued increase in vaccination rates, with the percentage of Victorian children aged 60 to 63 months who were fully vaccinated reaching 94 per cent; and, in 16–17, results showing we were effectively intervening earlier to improve the outcomes for children at risk, with an increase in Child FIRST assessments and interventions. I will leave it there, Chair, and welcome any questions.

The CHAIR — Thank you, Secretary, and I would like to remind yourself and all the other witnesses that the scope of the hearing today relates to the 16–17 financial year, so all comments should be in relation to what the department undertook over the course of that year and obviously not the 17–18 financial year, which is the year we are currently in.

Ms SHING — Thanks very much, Secretary. Thank you, witnesses. I would like to talk about the Regional Health Infrastructure Fund on the basis that for the 16–17 period it has been part of a number of commitments to improve the equity of services and the quality of services and rapid response provided to people in regional centres and in rural towns and settlements. I would like to take you to budget paper 3 of the 16–17 budget and page 89, if I may, and the reference to the $200 million Regional Health Infrastructure Fund. Information in relation to this fund and the outputs is something that I am keen to have us understand more about in relation to where we have started, in terms of benchmarking for quality of care and response and in terms of where we have ended up insofar as how the infrastructure fund has had at its core the objective of delivering greater benefits through that investment.

Ms PEAKE — Thank you. As the committee is aware, the $200 million Regional Health Infrastructure Fund is really designed to assist regional and rural health services, as Ms Shing indicated, to improve the safety and quality of their services as well as adopting innovative models of care, increasing service capacity, improving patient and staff amenity and improving service efficiency. Approximately 134 million of funding was allocated in round 1. That supported 93 projects in 81 health services which really range from small refurbishments and equipment replacement to large developments and new buildings. There is a second round that is now open. That is in this financial year, and those applications are currently being assessed. But so far, if I just talk to a couple of the highlights of the fund and if I focus in on Gippsland in particular —

Ms SHING — Thank you, that would be very kind. I am sure Mr O'Brien will also be enlightened.

Mr D. O'BRIEN — Been to Foster lately, Ms Shing?

Ms PEAKE — The Gippsland —

Members interjecting.

The CHAIR — Order! The secretary to continue, without assistance.

Ms PEAKE — The Gippsland region received $24 million in round 1 across 17 projects in nine health services. That includes the Yarram and District Health Service receiving $4 million to construct a new integrated health centre. That is currently in the design and development stage and is due for completion in June this year, which will deliver increased local access to primary care. Central Gippsland Health Service received $4.1 million to expand the operating theatre at the Sale hospital to provide more orthopaedic surgery — again, currently in schematic design and due for completion in May 2019. And the Latrobe Regional Hospital received $2.6 million to expand the special care nursery — in design and development and due for completion in November this year.

Ms SHING — So how does that change the way in which funding was previously delivered, with the introduction of the Regional Health Infrastructure Fund, by reference to those projects, including Sale, Central Gippsland and Latrobe Regional Hospital?

Ms PEAKE — Certainly. So this has really provided an impetus for us to plan with regional communities around both the needs of their communities and opportunities for improvement and innovation in the ways in which services are delivered. As you can see from some of those projects, there has been a real focus on how we connect from community into acute services, and I might just ask Mr Foa if there is anything else that he would like to add.

Ms SHING — If you could also, Mr Foa, by reference to that question, discuss the increase in patient numbers as a consequence of that expansion, that would be helpful.

Mr FOA — In terms of performance of the system I draw on Mr Symonds, but in regard to what the secretary mentioned about the program, importantly these applications are developed with the community and also with the hospitals themselves. It is a contestable round so that the best projects that have the most patient outcomes and the biggest bang for buck are coming through that program. It also leverages a great deal of

support within the local communities through philanthropy and those sorts of things that are able to get behind some of these projects regionally. In terms of patient outcomes and numbers of patients addressed —

Ms SHING — Feel free to take that on notice if that is data you would like to provide to the committee at some later stage.

Mr FOA — Yes, that would be fine. Thank you.

Mr D. O'BRIEN — Secretary, this time last year basically — 15 February last year — you answered a question to me about the VCCC and you said that the VCCC included 'space for a new 32-bed medical-surgical inpatient unit on level 8 of 1B'. Is it correct that these 32 beds on level 8 are counted as part of the VCCC?

Ms PEAKE — I actually do not recollect a conversation about those beds, but I am more than happy to talk to them today. I do not doubt your reference.

Mr D. O'BRIEN — I can show you the quote.

Ms PEAKE — So the 32 beds that are on level 8 of the VCCC were part of the business case for the whole project, but they were not designated for a specific purpose or a cancer purpose. They were designated as being there for medical and surgical purposes. It is also worth saying that in the count of the 160 cancer beds that would be provided through Peter Mac and Melbourne Health in consortia through the Victorian comprehensive cancer collaboration, those included beds that were currently in Royal Melbourne and continue to be in Royal Melbourne, and so those 32 beds are continuing to be delivered through Royal Melbourne health.

Mr D. O'BRIEN — So elsewhere other than level 8?

Ms PEAKE — Correct. They are in another location in Royal Melbourne.

Mr D. O'BRIEN — Can you give us any further information on where and in what role? Are they still part of the VCCC?

Ms PEAKE — They are still part of the VCCC collaboration, and if we go back to the whole purpose of the VCCC, it is as much around collaboration on research, clinical trials and translation of education into excellent practice in cancer care. Those beds are absolutely part of the consortia that ensures that that translation of the very best practice occurs.

Mr D. O'BRIEN — And so the 32 beds that you said last year were on level 8 of 1B, they are no longer there. They are in the stroke unit now, I understand.

Ms PEAKE — There was a shell space. They were no beds on level 8. There was a shell space. Royal Melbourne was responsible for determining where in their facility those beds would be. They have made the decision that those beds will remain where they are and that the best use of that shell space was to, at their cost, fit it out to provide care for stroke.

Mr D. O'BRIEN — So another 32 beds have been found, though, for cancer patients in Royal Melbourne.

Ms PEAKE — They were existing beds and that was what was reflected in the original business case, and they continue to be dedicated beds for cancer.

Mr D. O'BRIEN — They were existing beds, so they are not new beds as part of VCCC.

Ms PEAKE — They were in all of the business case and all of the numbers that have been reflected to this committee and publicly — so the 160 cancer beds. They were always included as 32 beds that were within Royal Melbourne. The question for Royal Melbourne was whether they would stay in their existing location or move into the shell space. The judgement that Royal Melbourne made was that they were best delivered in their existing location and the shell space deployed for the delivery of that alternative care.

Mr D. O'BRIEN — So on 20 July 2016 a government spokesperson said the VCCC was built 'as a hospital for the future' and would allow for increased capacity in coming years. The 32 beds which, we were told last year, were allowing for that increased capacity you are now saying were existing beds already in Royal Melbourne. So how is there any additional capacity?

Ms PEAKE — I apologise if there was any confusion from the reference in July that you refer to. My read of that reference in July, and I have seen the transcript, is that there was a reference to this new space being used for medical or surgical purposes, and it has been. It has been fitted out by Royal Melbourne Hospital for stroke care.

Mr D. O'BRIEN — Did DHHS sign off on the use of level 8, building 1B, as a stroke unit?

Ms PEAKE — It is certainly a decision that is devolved. The flexible use of space is a decision of the individual boards and individual health services. They certainly engage with the department for planning purposes, but it is a decision of the individual health services.

Ms WARD — Good morning everyone; lovely to see you all here again. I am sure you are happy to be here.

In the presentation, Secretary, you spoke about the NDIS. If I can refer you to budget paper 3, page 247, Victorian Contribution to National Disability Insurance Scheme, there are 20 205 people who are listed as being part of that initial rollout, which includes my own area in the north-east of Melbourne. That is a lot of participants, so if you would not mind talking briefly regarding that rollout and how that is working for the 200 000-odd people? But if you could also give us an idea of what is happening for those people who are not yet a part of the rollout?

Ms PEAKE — Certainly. Thank you very much for the question. The National Disability Insurance Scheme is such an important initiative to provide people living with disability with more choice and control over their own lives and, with the growth in services that is promised through the NDIS, really the ability to exercise that choice and control. It is the case that we have been working incredibly hard with the national disability insurance agency to make sure that we have provided all of the data that they need to transition clients into the NDIS and that we are working really hard — we have seconded staff, we have provided additional staff — to make sure that the plans that new entrants receive really reflect their needs.

Just in terms of some of the numbers, about where we are up to. As at 30 September 2017 there were 18 826 participants. That is 79 per cent of the expected estimate of 23 857 participants — and that excludes children. So it has been the case that there has been a real challenge through the NDIA in getting everybody who is due to be in the scheme into the scheme. That is why we have been doing all the work to really make sure that we are assisting with locating people, making sure that their plans are up to date, and are using our own resources to make sure in the meantime they continue to receive services that they require.

Ms WARD — I am sure I do not need to flag with you that young people can find disability and services particularly challenging to navigate. So for young people who are not yet a part of the NDIS, is the department working specifically to try and help people in that category, or is it just a broad stroke, a broad approach?

Ms PEAKE — It might be something that you also want to pick up with the education department about the early childhood intervention service that is administered by them, but certainly our departmental staff have been working really hard to make sure that both younger people who are not in the ECIS program but, interestingly, also older people who find it more difficult to access services are well supported through this transition period into both the new aged-care system and the new NDIS system.

Mr D. O'BRIEN — If I could continue on the VCCC, Secretary. In the previous PAEC hearing we were told that about 723 000 was the rental cost for 50 per cent of level 13. Could you tell us for 16–17, for the whole of the 13th floor, not just the expansion space, any other costs for the fit-out — electricity et cetera? And also, was any income received from the 13th floor with respect to leasing the space or other activities?

Ms PEAKE — For 2016 and 17? Under the PPP that we entered into and the budget that we received money for that there was no rent that was budgeted for to be received until the middle of this year. So there was never intended to be rent that was received in 2016–17, and there was no rent that was received in 2016 and 17.

Mr D. O'BRIEN — So is the floor leased out to other parties? What is the status at the moment?

Ms PEAKE — Yes, sure; I am very happy to run you through that. If you will indulge me, this is complex and I want to be really clear about this. It is worth saying that level 13 contains three distinct areas. The first is the Ian Potter centre for new cancer treatments. That area is owned by the state and it is to be occupied by the Ian Potter centre for new cancer treatments. The state has subleased this space to the VCCC alliance for a

peppercorn rent consistent with other Crown lease arrangements, and the cost of this space was already factored into the plenary PPP; there is no recurrent cost on top of that to the state. The Ian Potter centre for new cancer treatments will provide a home for the Peter Mac-led VCCC immunotherapy research program, and we discussed, I think, last year that 11.8 million was allocated for the fit-out of that space, which is well underway and is scheduled for completion in April this year.

The two other spaces were the main spaces we have talked about in previous hearings. The first of those was state-leased space from Plenary Health. It was to be subleased, when we talked about this last year, by the Victorian Cytology Service. They subsequently withdrew, and instead this space has subsequently been subleased by the University of Melbourne. The university has taken out a very long sublease at market rent and has assumed responsibility for the fit-out cost. Melbourne Uni is partnering with Peter Mac, and they have recently announced they will use this space to house a major new collaborative initiative in clinical informatics and health service research, which will bring together expertise in cancer medicine, biomedical engineering and computer science. They have commenced design work for this space and anticipate it will become operational later this year.

Then the third space, which is again state-leased space from Plenary, has been subleased to the Australian Genome Research Facility. The AGRF — for want of, using an acronym — have also taken out a longer sublease at market rent and fitted out the space at their own cost, and they are moving in next week. So taking into account that we were not anticipating receiving rent until the middle of this year, the combined rental income of 805 000 from the University of Melbourne and the Australian Genome Research Facility will exceed the base rental of 723 000, which is payable by the state to Plenary Health for level 13, by about 11 per cent, or 82 000; and because we have got AGRF in there from next week we will receive rent during this financial year, which means that for 2018–19 our base rental to Plenary Health will be covered by all of those subletting arrangements.

Mr D. O'BRIEN — Just very quickly, is it now completely full?

Ms PEAKE — It is completely leased, yes.

Mr DIMOPOULOS — Good morning, Secretary and department officers. I just wanted to talk about ambulance response times and ask you a couple of questions. I would not mind saying again that we have had the best response times in seven years, and I know we have made a whole bunch of investments in relation to ambulance services. Budget paper 3, page 82, for the 16–17 financial year refers to the Response Time Rescue Fund. Can you give us a bit of an unpack of what are the elements of that rescue fund, particularly in relation to improving the wellbeing of paramedics?

Ms PEAKE — Certainly. Thank you again for the question. Obviously one of our major priorities — and I flagged it in my opening presentation — has been to really improve those response times. Since 2015 Ambulance Victoria has been distributing ambulances across the emergency care system, as is their responsibility. When emergency demand is high, department demand is high, we now have a system where hospitals initiate their internal escalation processes to create additional capacity and work with the ambulance services to make sure that even in the face of increasing demand those response times can remain high. It was really encouraging to see that in quarter 4 of 2016–17 there was a statewide code 1 performance result of 81 per cent by Ambulance Victoria, which is the first time, as you mentioned, in seven years that consecutive quarterly performance has been 80 per cent or better and it represented a 6 per cent improvement over that time last year. I would say that the investments that government has made have really enabled that sustained performance to occur.

Mr SYMONDS — If I could add something, Mr Dimopoulos, I think you were asking also about the allocation of funds from the rescue fund for paramedics' wellbeing.

Mr DIMOPOULOS — Yes.

Mr SYMONDS — In the 16–17 financial year $2.73 million was allocated from that fund to improve paramedics' health and safety. Those strategies and initiatives included development of an organisational mental health and wellbeing strategy for Ambulance Victoria; developing mental health training for paramedics and managers — and we understand that three-quarters of staff have completed that training to date, which is very encouraging; and reviewing current internal measures that are used by Ambulance Victoria to stay on top

of the health and wellbeing for their workforce. That funding in 16–17 followed 1.3 million that was provided in the previous year for improving access to peer chaplaincy and support services.

Mr DIMOPOULOS — Just in relation to that — either to the secretary or yourself — we have seen a campaign around violence against paramedics. It is interesting. Prior to that I think not many people outside the sector talked about it, because most people were not aware. It makes intrinsic sense that as paramedics attend the most awful contexts and circumstances of course they will be unfortunately prone to violence. I do not know what metrics you have in terms of that or just injury generally to paramedics. Are they trending up or down or are they the same? Has either the awareness campaign or the fund that the budget has committed to in 16–17 actually had an impact on the health and wellbeing of paramedics in that regard?

The CHAIR — Just momentarily, Mr Dimopoulos, was this in the context of 16–17?

Mr DIMOPOULOS — Yes.

The CHAIR — Just in relation to what you might have seen in the 16–17 financial year.

Mr SYMONDS — Sure. I will give an initial response, and if Mr Walker is here, I might ask if he will follow up and provide some more detail as well. The Response Time Rescue Fund has also provided funding for virtual reality training for the paramedic workforce to help them identify and respond to risks and harm from occupational aggression and violence. I might add it was recognised, receiving a Minister for Health's award for improving workforce wellbeing, in the 2017 awards. There was also funding allocated through the broader Health Service Violence Prevention Fund available to all health services, not just for Ambulance Victoria, for a trial of paramedics' body-worn cameras to reduce occupational violence as well. While it is too early to comment on the results of that, I think the results are encouraging and I think overall those initiatives have led to, I suspect, an increase in reporting but a reduction in harm. I might ask Tony if he wants to add to that.

The CHAIR — Just briefly, please, Professor Walker.

Assoc. Prof. WALKER — Thank you. As a result of the initiatives we put in in 16–17, there were 567 occupational violence incidents reported compared to 580 the previous financial year, and we have seen a reduction in WorkCover-accepted claims for occupational violence, a reduction in claims of lost time injury and a reduction in occupational violence incidents of 100 FTE, and the percentage of occupational violence incidents resulting in staff injury has also reduced.

Mr DIMOPOULOS — So there have been declines — that is excellent.

Assoc. Prof. WALKER — There have been. There have been measurable declines in all of those measures as a result of the work we have been doing in the occupational violence space.

Mr DIMOPOULOS — Just one more.

The CHAIR — Mr Dimopoulos, we might stop there.

Mr DIMOPOULOS — It is about injury. It is an important one. In terms of the physical injury from actually transporting patients, did that decline in 16–17?

Assoc. Prof. WALKER — The number of paramedics that have actually been injured as a result of occupational violence has reduced. The number of incidents is relatively the same but the number of actual paramedics injured has reduced, and we think that is largely due to the situational awareness training we have provided, which has highlighted for them the environmental factors that were contributing to it in the past.

Mr DIMOPOULOS — Thanks very much.

Mr T. SMITH — Secretary, referring to the Ice Action Plan, on budget paper 3, page 24 of the 16–17 budget, what consultation was undertaken with regards to selecting the site for the Grampians alcohol and drug rehab facility?

Ms PEAKE — Mr Smith, I might just ask Ms Congleton to come forward to talk in a little bit more detail, but I would just preface that by saying that as you would appreciate, the work that we do in determining

locations is absolutely informed by the views of local communities but also takes account of demand patterns and the most efficient way to provide the service within the existing facilities and resources that we have. But I will just ask Ms Congleton to comment further.

Ms CONGLETON — Thank you. It is Anne Congleton, deputy secretary for community participation, health and wellbeing. As Kym mentioned, the Grampians facility was announced in the 2016–17 budget for initial or capital funding, and there had been consideration about where hotspots were and there had been a desire in the past by that community for an alcohol and drug facility. Over the course of the last period of time there have been a number of consultations that have occurred with the local community about the development of the facility. I can advise that the provider has been selected — Windana — and again they have also participated in conversations with the local community about the facility.

Mr T. SMITH — Can you give me an indication of what consultation actually occurred? You talk about consultation, but give me an understanding. Was there a community meeting? Who was spoken to? How did that work?

Ms WARD — In the 16–17 period.

Ms CONGLETON — In terms of those consultations, it has been meetings onsite around that area with local community members that have involved both representatives from the Department of Health and Human Services and also the provider. There have been a number of meetings. That consultation has occurred mostly in this last year, but we could certainly provide information about what consultation sessions occurred.

Mr T. SMITH — That would be very helpful, thank you. So in terms of the actual project, is it running to time and budget?

Ms CONGLETON — Yes, at the moment. It is due to be completed and open in October 2018. We have just gone through a process of tender assessment and going through the awarding of the contract. So construction is due to start in this month.

Mr T. SMITH — And how much recurrent has been allocated to operate the facility?

Ms CONGLETON — So what we do is the capital budget is provided initially and then we go back in a future budget for recurrent funding. That is our standard process. So at this point what has been secured is the capital funding and then we will go back through a future budget to secure the recurrent funding to operate this facility.

Mr T. SMITH — All right. Just moving on. Secretary, were there any additional alcohol and drug rehab beds opened during the 2016–17 year?

Ms PEAKE — Certainly. And again I might just get Ms Congleton to step you through. As the committee is aware, this has been a real focus of the last couple of years in recognition that while we had very strong day bed capability, there was more that we needed to do to complement that with residential capability. And overall 100 new beds are coming online, but in terms of your specific question around the beds through 2016–17, I will defer to Ms Congleton.

Ms CONGLETON — Just going back, in 2015–16 there were 32 additional beds that were opened. In the 2016–17 budget there was the announcement about the Grampians facility. So there were no further beds in 2016–17, but, as I said, a commitment to expand by 20 at the Grampians facility. And then in the 2017–18 budget there has been a commitment for land purchase for three rural facilities in Barwon, Gippsland and Hume. And there was also a commitment initially in the budget to commission 30 additional beds to bring that online within existing capacity. That was more recently increased to 100 additional beds.

Ms PEAKE — So I just want to reemphasise that point that by March this year, if we look back over the last three years, there will be an additional 100 beds that have been opened.

Mr T. SMITH — I am happy for you to take this on notice, but could we get a list of where all those new beds are?

Ms PEAKE — Sure. I think we provided a lot of that last year, but certainly very happy to give an update.

Mr T. SMITH — That would be great, thank you.

Ms PENNICUIK — Thank you, Secretary, and everyone else for attending today to help us with our inquiry. I have got a question which is a bit more broad-ranging than just a measurement of certain things. Many of the outcomes in the questionnaire are not really outcomes but are rather targets or output measures, particularly the answer to question 1 in the questionnaire. But also just going through your presentation, particularly pages 5, 8 and 11, again there are references to outputs, outcomes, targets, measures, so it is a bit of an interchangeable definition, I suppose.

This was noted as a problem in the PAEC final report on the 2017–18 budget estimates, where it quoted the Royal Commission into Family Violence and noted that the scarcity of outcome-based metrics was part of a broader problem with how government and government-funded services measure what they do. And you actually responded, saying that there has not been the decisive shift towards outcomes away from outputs because they require both good definition and good data sources. So it is a problem. Helpfully, on page 2 of the questionnaire there is a definition of 'outcome', which says that outcomes are the impacts of service delivery on the community rather than the description of the services delivered, although what we actually see as outcomes are often just the services delivered or the number of places or that sort of thing. That is, as I often do, a long introduction to what I think is an important question: is there a broader recognition within DHHS as to this problem, and are you working on it?

Ms PEAKE — What are we doing about it? Certainly. It really is an area that we are very focused on. I mentioned in my opening remarks that we have designed an outcomes framework with key results and we are now doing a lot of work to define both the measures that will make the most sense against those key results and identify where we have data sources for them and where we have data gaps. We see this as being incredibly important both in us understanding whether the things we are doing are making a difference but also quite frankly to be able to inform all of our advice to government about service development, expansion and investment. So we have set up a dedicated team that is doing that analytical work to improve the link between outcome measure and output, and then to understand what are the short-term sort of progress measures and what are the long-term more population-based measures, because often, as you are aware, they take a very long time and will be influenced by factors other than our responsibilities. But we do not want to lose sight of those. But we want to also hold ourselves to account with what are the sort of interim or proxy measures that are referable to the things that we can do.

It is something that I talk regularly with the Auditor-General about — how we do make this shift. We have been doing work both specific of our programs within some of our prevention public health activities — Family Safety Victoria and our family violence initiatives — and in the child and family space to translate what are system and program outcomes also into really clear client outcomes and look at how we use surveys and other devices to collect the results from individual clients. Doing a lot of work through Safer Care Victoria as well around patient-reported outcomes and collecting information about what matters most to patients as well. So an area I am really passionate about, something that we are dedicating resources to and very keen to keep engaging the committee on.

Ms PENNICUIK — Thank you, Secretary. For example, on page 5 of your presentation it says 'outcomes', but they are very, very, very broad outcomes, and then page 8 is about priorities, and then when you get to page 11 we really go down to outputs, which is percentages and numbers et cetera. So I wonder — I do not know if it is possible if you are saying you would like to keep engaging with the community — whether there is anything you could take on notice in terms of fleshing out more of what you are describing as to what is happening, because I think particularly in this area, in this department, more qualitative outcomes are more meaningful than simply targets and outputs.

Ms PEAKE — Certainly, and I am certainly happy to provide you with an outline of what we are doing but also to talk separately with the committee at any time about where we are up to, some of the challenges we confront and where we think we can get to over the next few years.

Ms PENNICUIK — Thanks, Secretary. Just on page 8, you were talking about the number of children in residential care — the number of children coming out of residential care — and I was trying to get those figures but I did not quite get them. Could you either provide them or provide them on notice?

Ms PEAKE — Just the numbers of children in out-of-home care generally and then residential care in particular?

Ms PENNICUIK — Yes.

Ms PEAKE — I might just ask Ms Asquini.

Ms ASQUINI — Thank you very much. We have about 10 000 children and young people in out-of-home care, with approximately 480 of those being in residential care. About 5000 of the children are in kinship care arrangements and another 3000 would be in permanent care and foster care-type arrangements as well.

Ms PEAKE — It is worth mentioning that one of the things we worked very hard on over the last couple of years is how we move children — which was the numbers that I quoted in the presentation — out of residential care or prevent them from entering residential care because we recognise that that reliable connection with a caring adult is critical to their healthy development. I can just give you those numbers again if that is helpful. In terms of the targeted care packages that have been one of our major mechanisms for achieving that shift, we have assisted — and this is over a three-year period — 320 children and young people to transition out of resi-care up to the end of 2017 and 160 children and young people have been prevented from entering residential care.

Ms PENNICUIK — Thank you.

Ms WARD — Secretary, you mentioned in your presentation, page 6, about immunisation programs to increase participation rates to protect the health of all Victorian children. If I could get you to turn to the 16–17 budget papers, page 239, it goes through the numbers of targets for immunisations that you want to achieve, and I understand that 95 per cent is what we are calling the herd rate?

Ms PEAKE — Yes.

Ms WARD — Herd immunity, and I see that in 14–15 it is at 93, which of course would be a red flag for any government, but can you talk us through what has happened in the 16–17 financial year, what have been the policies that have been implemented and how targets have or have not been met?

Ms PEAKE — Certainly. It is a really good news story. Over the last 18 months our vaccination coverage rates have been increasing steadily, so currently the coverage rates for Victoria ending in December are higher than the average national coverage rates. For one-year-olds the Victorian immunisation coverage rate is 94.25 per cent, two-year-olds, 91.2 per cent, and for five-year-olds, 94.5 per cent, which again compares favourably with national figures. More recently, in the fourth quarter of 2017, we had the second highest coverage rate for four-year-olds according to figures supplied by the Australian Immunisation Register, with 95.3 per cent fully immunised.

The sorts of things that we have been doing to really raise those immunisation rates have been a combination of really good information out from the chief health officer and through all of our partners around the value and importance of immunisation, as well of course as the no jab, no play policies, which have really indicated the importance of particularly achieving herd immunity for children. I think we really are seeing the results of those policies. We of course continue to work with the commonwealth to make sure that immunisation is a priority. You would have seen recent announcements from the commonwealth in terms of meningococcal. We continue to advocate to the commonwealth in terms of flu vaccinations, and it is just one of those areas where we need to continue to be ever vigilant.

Ms WARD — Going with meningococcal, last year didn't the state government run a meningococcal W program?

Ms PEAKE — We did. That is correct. In the absence of the commonwealth stepping up to the plate initially, the state announced in February last year that $7.1 million would be spent to deliver a one-year vaccination program for 15 to 19-year-olds.

Ms WARD — So that was money that the state government had to allocate because the commonwealth was not fulfilling its obligations in that space.

Ms PEAKE — Correct, and as a result of the advocacy of Victoria, amongst others, there have been more recent announcements — very recent announcements — about the commonwealth applying the national immunisation program in this space.

Ms WARD — How are whooping cough immunisations going? The government last year — or the year before I think — implemented the reintroduction of whooping cough vaccines and it being subsidised; how has that worked?

Ms PEAKE — So since June 2015 when that free vaccination for expecting parents and parents of newborns was introduced —

Ms WARD — Sorry, if I get you to talk 16–17.

Ms PEAKE — If I just give you some aggregate numbers.

Ms WARD — Yes.

Ms PEAKE — There were 2004 cases of whooping cough in 2017 compared to 2888 cases in 2016 and 4731 in 2015, so you can really see the impact of that investment.

Ms WARD — Yes, thank you.

Mr MORRIS — Good morning, Secretary. Can I ask you a little bit about mental health? Page 46 of your annual report indicates that the percentage of emergency patients admitted to a mental health bed within 8 hours is sitting at about — not about, at — 60.4 per cent. Two years ago it was 74 per cent. There is a target of 80 per cent, so can I ask you if there have been any changes to the number of allocated mental health beds, and if so, where they have been added or cut, whether there has been an investment and particularly the strategies that the department might have in place to improve acute mental health presentations?

Ms PEAKE — Thank you, and again a really important area of priority for us in the department and one that has been a focus of our key results. The committee would be aware that government released a 10-year plan for mental health and has also really increased our analysis of results in mental health through the release of two annual reports. What all of that work is really showing is that we have the real strengths in community-based services, particularly in residential alternatives to acute care. We have the highest number of community bed-based residential units actually in the country and that, to your question about where investment has been, has been a particular priority of investment in the last few years. Prevention and recovery care services, for example, provide an alternative to hospital admission for patients in need of acute mental health treatment and support their recovery.

There was $8.2 million that was provided last year for a new park in Ballarat. There is a park that is opening just now, in the next few days, in the south-west, in Warrnambool, that provides 10 beds, and in addition to that investment in residential services the 16–17 budget provided $132.3 million in growth funding for clinical mental health services, including expanding conduct disorder services for children and a focus on suicide prevention. In addition, we have continued to build on that in terms of the most recent budget, which I will not dwell on, but there has been an extra $20 million per year that has been committed through the most recent budget to provide about 3300 Victorians with about 50 000 additional community mental health service hours.

On top of that, to your question about beds, since 15–16 the government has funded an additional 98 beds, including psychiatric assessment and planning units at Eastern Health, where there were four beds opened in October 2016; Austin Health, four beds were opened in February 2017; Peninsula Health, where six beds were opened in May 2017; and 38 beds at Bendigo Health, of course also complemented by more investment in forensic mental health.

It is an area where we continue to work closely with services to look at what the right models of care are, what the right workforce models are and how we make sure that there are really good processes through our emergency departments to make sure that people are safe in emergency departments, but it is equally important that people with mental health conditions are receiving service both either inpatient or back through into the community, and that will be something through the 10-year plan work that we continue to really focus on and advise governments on in the future.

Mr MORRIS — Just a couple of things that come out of that answer. First of all, can you tell me what the cost of an additional bed is?

Ms PEAKE — I am just going to ask my colleagues. We might need to take that one on notice.

Mr MORRIS — While you are thinking about that, or taking it on notice is fine —

Ms SHING — And just specify which period, obviously, that that —

Mr MORRIS — Sorry?

Ms SHING — The costs may change depending on which period you are talking about, so —

Mr MORRIS — Yes, absolutely, and we are talking about the 16–17 year, clearly. The other, which is a far more general, question, and I do not want to dwell on the drop, but given that what you say to the committee is that there is investment going on and more beds being put in place but the indicator has dropped from 74 per cent down to almost 60 per cent in the last couple of years. You have got a target of 80. Are we doing enough essentially or does the department have a further strategy that will address that decline in terms of presentations?

Ms PEAKE — And as I indicated, the work under the 10-year plan, which really genuinely is a 10-year plan, around the ways in which we move through to really continuing to look at alternatives to inpatient experiences where people can be supported in the community even where they have quite complex needs as well as looking at different models of care within health services — they are all things that we continue to work really closely with the sector on under the umbrella of the 10-year plan, and will continue to advise government on.

Ms SHING — I would like to talk about family violence and victim survivor responses, and in that regard I would like to take you to budget paper 3, page 9, and also to refer to your presentation, to people coming into contact with services as they relate to family violence and also more broadly gender equity. We have seen 22.87 million accommodated within the reporting period of 16–17 to fund I think 26 projects across Victoria and four that specifically target Indigenous communities and specifically the content of the royal commission and its recommendations as they related to those cohorts. Moving from a traditional model of crisis response to focusing on therapeutic response over the long term as it may be required by victims and survivors and in particular therapeutic interventions, what sort of interventions have been funded within the envelope of this $22.87 million and what are they intended to deliver by way of substantive outcome and improvement for the reporting period in question?

Ms PEAKE — Certainly. I just want to be clear in the question whether we are talking about more prevention initiatives or we are talking about more response initiatives. I just missed the reference.

Ms SHING — There are a number of components to the family violence space, and the recommendations are broad-ranging in that they cover both prevention and intervention as well, so I am happy to actually deal with those as two separate tranches to the question as it relates to the outputs and the budget initiatives under that 22.87.

Ms PEAKE — Certainly. I will make a couple of introductory comments and then ask Ms Clifford to talk a bit more about the work that is happening in Family Safety Victoria.

The investments that government have made have really enabled us to expand flexible therapeutic packages for victim survivors of family violence. They have provided us with a basis to provide more intensive intervention with children who are affected by family violence as well as do some very targeted work on what works with perpetrators to change their behaviour. There has been work in the perpetrator space that has been led by an expert advisory group that is really looking really at what works across both criminal justice and court-ordered settings as well as what works in our portfolio in terms of more community-based settings.

All of those interventions are then backed up by the new model of access to services that we are putting in place through the establishment of support and safety hubs, with five hubs coming online in this financial year. Those hubs will provide a really destigmatising way of both referring victim survivors into service supports for help but also over time we really want to make those places where people feel comfortable to come themselves for help as well. But I will just ask Ms Clifford for specifics.

Ms SHING — Just to frame the context in which you might consider responding to this question, again looking at the $22.87 million allocated within that 16–17 period and the projects which were delivered as part of that package, what they are intended to deliver and how within that space they are reflecting a delivery on the recommendations of the royal commission.

Ms CLIFFORD — Susan Clifford, CEO of Family Safety Victoria. The investment of 572 million over three years in the 16–17 budget has an immediate response to family violence. Of this amount, there was 173.3 million of funding applied in the 16–17 period to the following department outputs: community-based services, child protection and family services, and housing. Initiatives that received short-term funding are being independently evaluated to ensure that funding is directed towards projects that achieve the best outcomes for families. Initiatives include changing perpetrator behaviour (men's behaviour change programs), flexible support, statewide crisis response and therapeutic interventions, including therapeutic interventions for vulnerable children. The reform process includes co-design with service users as well as service providers and other experts to ensure that we achieve the best outcomes for victim survivors.

Ms SHING — So in which context does that include supports and services for Aboriginal victims and survivors of family violence as well as that perpetrator context?

Ms CLIFFORD — Initiatives like the support and safety hubs which are accessible and child-friendly will make it easier for people from all backgrounds to feel comfortable seeking and accessing help and support that they need. We are also rolling out specialist responses for LGBTI communities, multicultural communities, and working with Aboriginal communities and service organisations to ensure our services are culturally respectful and safe and provide options, such as holistic healing.

In the 16–17 financial period 34 million was provided for flexible support, investment in changing perpetrator behaviour, investment in the Safe at Home flexible support packages that advice was drawn on from community sector organisations.

Ms SHING — Thanks. If I could get on notice as well the programs specifically targeting Aboriginal communities and victims and survivors of Aboriginal communities within that 16–17 budget. I note the general comments you have made. I would like to target that cohort if I may, please.

Ms PEAKE — I am happy to take that.

Ms SHING — Thank you.

Mr D. O'BRIEN — Secretary, the upper house inquiry into youth justice heard claims about youth offenders being placed in isolation. Can you provide for the reporting period when DHHS was in charge of youth justice how many times you approved a young offender being place in isolation and also, if you are aware, what percentage of isolations were classified as being made in the interests of the security of the youth justice centre?

Ms PEAKE — I do not have the specific data on isolations with me, but I am very happy to provide it out of session.

Mr D. O'BRIEN — Okay. If you could provide that on notice, that would be wonderful.

Still on child matters — child protection — the annual report for 2016–17 for the first time does not carry the rates of unallocated cases of child protection. Can you explain why?

Ms PEAKE — I am certainly happy to indicate the rate. It has remained consistent at 19 per cent of unallocated cases. I am happy to step through what we have done in that space, if that would be helpful to the committee.

Mr D. O'BRIEN — Yes. While you are doing that, could you perhaps explain what 19 per cent equates to in actual numbers as well?

Ms PEAKE — Certainly, yes. We have talked about this a couple of times at these hearings, and it is a really important question. It is really important to start by saying that the number of children notified to child protection and subsequently found to be in need of protection has grown exponentially in the last decade. This is

linked to the increased awareness of family violence on children, changes in reporting requirements — professionals such as Victoria Police in that regard — but also the impacts of intergenerational transmission of disadvantage and the historical impacts of dispossession of Aboriginal communities.

In 2012 the department responded by introducing a new operating model for child protection, which increased the percentage of staff designated as case-carrying from approximately 63 per cent of the workforce to more than 78 per cent. That had the effect of boosting allocation capacity by more than 700 cases. But by 2014, even with that increased allocation capacity, case loads for each individual worker had grown from an average of about 12 to an average of 17, with more experienced workers continuing to carry even more cases than this.

Mr O'Brien, to your specific question about numbers, since then the number of children needing to be allocated has continued to really grow. To give you a sense, in the period from 30 June 2014 to 30 June 2017 investigations increased by 47 per cent, which required an additional 9961 cases to be allocated, and protective interventions increased by 80 per cent, which was another 7492 cases. So keeping our allocation rate in the last two years at 81 per cent has meant that we have been able to hold steady in making sure that even in the face of that really significant growth we have been able to allocate as many children as possible.

At the same time, as I think we have explained to the committee before, it is the responsibility of each team to keep oversight of all children. So even where a child is not directly allocated to an individual practitioner, they are overseen by a team. The team manager has to have systems in place to look at the cases awaiting allocation, including arranging visits, arranging for other services involved with the family to provide information and referrals and to regularly review who is allocated and who is not directly allocated to make sure the highest risk cases are being attended to.

I just want to finish by saying that in the last 12 months two things that we have done to really strengthen that team management capacity to manage risk have been strengthening the risk management framework that is used by the child protection program, and secondly, some really intensive work around infants to make sure that we are really attendant to the risks of high-risk infants.

Mr D. O'BRIEN — I am not sure if I got an answer to the question on the number that it equates to. I know you gave me an overall number.

Ms PEAKE — Yes. I am happy to take that on notice, but I just did want to emphasise that that 81 per cent has held at a time when there have been increasing demands. We are allocating many, many more cases than we ever had before.

Mr D. O'BRIEN — You gave a figure of 9961 —

Ms PEAKE — That is the number of additional cases since 2014 that we have had to allocate, and it is actually 9000 in investigation and 7500 in the protective intervention phase.

Mr D. O'BRIEN — Can you give me a figure now for how many there were?

Ms PEAKE — I am happy to take it on notice, but again, there is no silver bullet on how we manage demand in this program. The work that we are doing to make sure that we stay at 81 per cent, both through recruitment and through that strengthening of early intervention services, has been our real priority in the last two years.

Mr D. O'BRIEN — Sorry, again back to my question, which was: why was it not included in the annual report?

Ms PEAKE — Again, I will have to take that on notice. It is certainly data that we release.

Mr D. O'BRIEN — If I could just finish with one very quick one. In the annual report it also refers to a consultancy with the Nous Group to undertake a strategy of management of unallocated child protection cases, which I think is either ongoing or was ongoing this financial year. Can you update us on what that has found?

Ms PEAKE — It really goes to some of the things I was just stepping you through around how we do that work around both risk assessment and teams being able to constantly look at how other services can help with

supporting families, the referrals that should be made and the models of care. Ms Asquini might want to comment.

Mr D. O'BRIEN — Has that report been finished?

Ms ASQUINI — It has.

Mr D. O'BRIEN — Is it publicly available?

Ms ASQUINI — It is not, no.

Ms PEAKE — It is really work that was with our teams around looking at the sorts of strategies they use and how they strengthen their risk assessment, as opposed to it being a sit-on-the-shelf-type report.

Mr DIMOPOULOS — Secretary, just following on from Mr Morris's questions in relation to mental health, I want to ask a bit about suicide prevention because it is obviously a key element of mental health. We want to keep people safe and alive. In the 16–17 budget we allocated $27 million for suicide prevention. The previous year, 2015 — I think that is the last year we have statistics for — the suicide rate was more than double the road toll in Victoria. I am just wanting to get a sense from you if you can unpack that 27 million and, as much as you can, measure the outcomes in that particular financial year of that investment.

Ms PEAKE — Yes. Thank you for the question. The $27 million, which was over four years, was to support the implementation of two flagship initiatives. The first is place-based suicide prevention trials, which are being delivered by primary health networks in 12 sites across the state. Over that period each site was establishing governance structures, really pulling together the data on who are the groups that are at risk of suicide in the communities and starting to develop local actions to intervene. The sorts of activities that they have been undertaking have included training to build the confidence and skills of people with lived experience in talking about suicide within their communities, supporting GPs to recognise and help people at risk of suicide and then working with other members of the community about how to respond.

The second initiative, which is really important, is a hospital outreach post-suicidal engagement initiative. We know that post-discharge is a really high-risk time, so this initiative is all about providing post-discharge support for people who present to hospital for intentional self-harm or suicidal ideation. It is underway at all six sites: St Vincent's Health, Alfred Health, Peninsula Health, Barwon Health, Eastern Health and Albury Wodonga Health. So my figure of how many people have been helped is more recent than 16–17, but as at January there were more than 220 people who had been supported through that initiative.

The headline figure that I really want to emphasise is that we have seen a reduction in the number of suicides in Victoria of nearly 5 per cent between 2015 and into 16–17. It shows that those really community-based initiatives and very targeted initiatives through hospitals really do work.

Mr DIMOPOULOS — I understand our initial investment was for six, three place-based and three hospitals statewide, and it has expanded — doubled, I think — through the primary health network investment, partnering with them, which is great. Just in terms of laypeople understanding this, can you give us a couple of examples of what cohorts are being covered by the place-based? I imagine some would be teenagers in schools and some would be migrants or single parents. Can you give us a couple of vignettes so we understand in that 16–17 period, when they were doing the planning stages, what cohorts they were covering?

Ms PEAKE — It is different groups in each place. Again there has been specific emphasis on Aboriginal young people, young people and working closely with schools as one of the community groups. LGBTI groups have been a particular focus for us. But again I might just ask Ms Congleton if there are any more specifics to your question.

Mr DIMOPOULOS — Yes, and how they were chosen. I imagine that they fit a high-risk profile.

Ms CONGLETON — Thank you. Just further to the secretary's comment, particularly looking at those areas, they were areas where there had been a number of suicides so there was interest from local communities, and one of those was particularly around Benalla where I think there had been a number of issues for young people. So there was a bit of an opt-in process, and then we also looked at the data as well to select. As you mentioned, there were six that were identified by the state, but then there were six through the commonwealth,

the work around suicide prevention, so their primary health networks joined in. So we were able then to expand the reach across Victoria. And the primary health networks have also taken a leadership role in assisting the rollout.

As you mentioned, there has been that focus — local communities to come together. I know that in the Benalla community one of the examples that was given to me was around the development of a protocol — what happens when there is an event — so that there can be support for young people in particular but then also for schools and others to come in to support, as well as those affected by a suicide. So the reach has been pretty significant. Also we have seen a real build in the expertise of the professionals to be able to better respond and for that to be owned by the whole community. So for a school area, I think generally it is reliant on the school term and people to be around, but this has really built ownership in the broader community.

Mr DIMOPOULOS — Just the last question on a cohort. Thank you. You gave me a bit of an understanding — so Indigenous communities, LGBTI, school students. I know part of it is, from what you say, opt in, so the community helps decide. Are any of these pilots working with older retrenched male workers, people who have been made redundant in their 50s or early 60s? I have had a few over the last three years in my office. I am obviously not a mental health clinician, but they were very precarious situations, and I just wondered: do any of the pilots work with those, or is there a plan to? In the 16–17 financial year, were any of those early studies done in relation to that cohort?

Ms CONGLETON — I know that they have looked at what the population issues are. I know that there is one down in the south-west which I think, may take into account too some of the issues for farming communities and older people who might be experiencing distress and pressures there, and then in terms of the metro areas, again I am sure they are looking at those issues. I do not have that information here, but we can —

Mr DIMOPOULOS — I would love to get some information on notice on that issue.

The CHAIR — Maybe take it on notice.

Mr MORRIS — I have a question about ambulance services. Good morning, Mr Walker. You will recall that we were here about this time last year — I think a little later in the month — and we had a conversation, or you and Mr O'Brien had a conversation, about code 1s. Mr O'Brien asked if there was a list of incidents or categories that would have been code 1 before and are now code 2, and you responded, and quoting from the Hansard transcript:

> Yes, there is. So we have essentially our dispatch grid, which determines, based on the acuity of the call, the type of resource that we send …
>
> Mr D. O'BRIEN — Okay. Are we able to get a copy of that … for the committee?
>
> Assoc. Prof. WALKER — I can certainly take that on notice; it is available, yes.
>
> Mr D. O'BRIEN — Are you also able to indicate how many call-outs in 2015–16 would previously have been code 1 but are now classified as code 2?
>
> Assoc. Prof. WALKER — I do not have that detail in front of me today, but I can take it on notice.

None of that information was provided to the committee. Why not?

Assoc. Prof. WALKER — Good morning. After the PAEC hearing we completed an evaluation, which provided all that information. My understanding — and I apologise — was that that information in the evaluation report was provided in the public domain and it covered off the numbers of cases that were changed from code 1 to code 2 and other changes within the new response model.

Mr MORRIS — Why was that information not provided to the committee?

Assoc. Prof. WALKER — Again, Sir, we provided —

Mr MORRIS — The document that we requested, the response that actually came back was essentially, and I am talking about the grid, which is what was offered in the hearing, the dispatch grid, 'We can get a copy of that to the committee'. The response that we got back, and I am quoting here, saying it would be available —

Assoc. Prof. WALKER — So again —

Mr MORRIS — That information was not provided, and essentially the answer, when we queried it, which we did, was, 'Oh, you wouldn't understand it'. I am not sure it was quite that polite, actually.

Assoc. Prof. WALKER — I apologise if I was impolite, Sir. The dispatch grid is — and I think I recall at the time I said the dispatch grid is — over 1000 lines of specific code for a computer-aided dispatch system, and we had concerns around the understanding of that information more broadly, because it is designed for a computer-aided dispatch system, and a particular one which dispatched those resources. Again, I apologise if I was impolite; it certainly was not my intent.

Mr MORRIS — Well, you gave a commitment to the committee that you would provide it. Will you now provide it?

Assoc. Prof. WALKER — Again, I can take that on notice, Sir. Sorry, I might just step back there. This is currently subject to an FOI that is also underway.

Mr MORRIS — Regardless of what is happening anywhere else, this is a parliamentary committee. Twelve months ago you gave an undertaking to the committee that you would provide the information; 12 months on we still do not have it. You gave an undertaking 12 months ago.

Assoc. Prof. WALKER — I am sorry, Sir. I understood —

Mr MORRIS — You failed to meet it.

Assoc. Prof. WALKER — My understanding was I said I would take that on notice. That is what I understood I said.

Mr MORRIS — Yes, and the assumption is and always has been in the nearly eight years I have been on this committee that when a witness says, 'I will take it on notice', the information will be provided. It is not, 'Oh, I'll think about it and perhaps give you something'. It is, 'I will provide the information '. That is not what has occurred. So I am asking now: will you make a copy of the grid available to the committee?

Assoc. Prof. WALKER — Again, I will take that on notice, Sir.

Mr MORRIS — What does that mean?

Assoc. Prof. WALKER — I will go back and have a look at —

From my perspective, as I said earlier, some of our concern is around the understanding of it and how that is interpreted. It is a highly technical document, but again if the committee is asking for that information I will provide it.

Mr MORRIS — Thank you. Could I move on to the actual results from the 16–17 year. In 15–16 the under-15 minute code 1 response benchmark was met in 247 869 cases. In 16–17 that had dropped to 210 255, so essentially you are getting to 37 000 fewer cases in under 15 minutes. There has been a $100 million boost to the funding of the organisation, but you are getting to 37 000 fewer cases in under 15 minutes. Now the target response is 85 per cent. The published achieved figures are 78.3 per cent. If you were still getting to the 247 000 cases, by my arithmetic you would be over 92 per cent response. You would be way over your targets. But you are not. Can you tell us why?

Assoc. Prof. WALKER — I should probably provide some context. We have implemented a new clinical response model —

Mr MORRIS — We are aware, yes.

Assoc. Prof. WALKER — which provides for better matching the right service to the right patient at the right time. As a result of that, there has been movement of a number of patients that previously would have received a code 1 under the previous system that would now receive a code 2 or a code 3 or advice over the phone around appropriate clinical management. As part of the implementation of that system, we are now seeing more than 7000 reclassified patients — the ones still within that code 1 bucket, if that makes sense —

now getting a quicker ambulance response time than previously. I cannot specifically answer the question about the arithmetic around what you said before about what it would have been under the previous model. I can only talk about what we have seen today.

Mr MORRIS — No. What I am saying is on a code 1 you got to in 15–16 247 869 calls in under 15 minutes. In 16–17 that had dropped to 210 255, so 37 000 fewer code 1s were achieved in under 15 minutes. There is a significant drop in performance. That is the point I am making. If you kept the 15–16 figure, regardless of how other things are classified — this is code 1 — so regardless of that, if you had achieved the 15–16 figures, you would have been, as I say, over 92 per cent in under 15 minutes. There is a lot of money gone into the system. I am simply asking why the performance has effectively dropped.

Mr SYMONDS — Can I just try and clarify the question if I could, Mr Morris? The percentage performance for each financial year and for each quarter is the numerator over a denominator. You are quoting a numerator, I think, in terms of people who were treated within time, but you cannot compare those without seeing what has also changed in the denominator.

Mr MORRIS — I am talking about total cases.

Mr SYMONDS — Total cases seen in time or total cases?

Mr MORRIS — Total cases seen in time in 15–16 — 247 869.

Mr SYMONDS — Cases seen in time, do they not have to be seen in the context of the total —

Mr MORRIS — Response under 15 minutes — not seen in time, under 15 minutes.

Mr SYMONDS — But the performance measure that Tony and his organisation are held to is a proportion — that is, that number in the context of total demand for that code — and you have to understand both those —

Mr MORRIS — Surely, the point is that there is 100 million extra gone into the service and if it gets the results, that is money well spent as far as I am concerned, not a problem. But regardless of the size of the system, 37 000 fewer calls are responded to in less than 15 minutes in a 12-month period, despite that massive investment. That is the question I am asking.

Mr SYMONDS — It may be that an increased total number of cases were also seen and the performance measure — that is, the proportion of those cases seen within time increased. That is actually what happens. So in 16–17, 78.3 per cent were seen in time compared to 75.2 per cent the year before.

Mr MORRIS — Yes. I know how the percentages work. What I am interested in and have been for my entire adult life is what is the actual result. The actual result in this case is that 37 000 fewer cases saw an ambulance in under 15 minutes, despite a massive investment.

Mr SYMONDS — Perhaps the safest thing is to take it on notice and provide a breakdown of numerators and denominators, so we are not just referring to the percentages, but provide all of the numbers — total volumes and proportions seen in time and not seen in time — over that period.

Mr MORRIS — The debate is not about hospital transfers. The debate is about code 1 calls achieved in less than 15 minutes. That is what the question is about. I am not interested in anything else. We have had a massive investment. As I said, as far as I am concerned it is money well spent, but we have to get results, and as far as I am concerned the figures are going backwards.

The CHAIR — Deputy Chair, I think the witness has indicated that he is prepared to provide some additional information on notice. I am conscious of time. You are welcome to return to this when we come back from the break. Ms Pennicuik, just before we go on a break.

Ms PENNICUIK — Secretary, if I could follow up on some questions that Ms Shing was talking about with regard to family violence. I refer you to page 21 of the general questionnaire where, under the project 'Communal family violence refuges — replacement and growth', there is a budget there of $9.5 million but only $300 000 has been spent, and the explanation is construction has been delayed subject to the location of

suitable sites. Could you provide a bit more information about the delays, what is happening with the location of suitable sites, what is the reason and what the projected time line of that work would be?

Ms PEAKE — Certainly. You would recall that this was one of the really important recommendations of the royal commission, that we fundamentally redesign the model of refuges so that we move to a core and cluster model, so the approach that we have taken has been one of deep engagement to make sure that we get that model right. As you have indicated, we began with a $300 000 investment in consultants for the business case development and architectural services to deliver the program and strengthen service delivery. Three of the four sites have been secured, and we are working hard to secure the fourth site, including looking at government-owned land as well as the private market. There is no doubt it has been a complex project. We have needed larger sites, sites that are safe but are still close to services, shops and schools. They also have to, as you know, cater to a really diverse range of needs, including people with disabilities, to stay true to the royal commission's recommendations. So the bulk of the investment is allocated to the construction phase and, to your question, is expected to be completed by September this year.

Ms PENNICUIK — Great. Thank you. If there is any further information you can provide to the committee with that, that would be good.

Just on the previous page, page 20, of the questionnaire with regard to the underspend on Western Health — again a budget of 11.5 and expenditure of $2.7 million. You would possibly recall that I referred to this in the estimates last year, but it seems that there is an ongoing delay with this particular project. So what exactly is the hold-up here with the Joan Kirner Women's and Children's project, and how is it impacting on health capacity, given the ongoing urgency — which I have raised a couple of times — of these facilities in Footscray and Sunshine?

Ms PEAKE — Thank you. The specific reference in the questionnaire was about the cash flow for the Western Health urgent infrastructure, with the works at Sunshine Hospital having, as you indicated, an interdependence with the work that we are doing with Joan Kirner Women's and Children's.

In terms of the Joan Kirner hospital project, that is being worked on in two stages. We have been doing a lot of work to make sure that the construction design is right and have had to really look at that hard. I would actually say it has been a really good example of how the new building authority has worked very constructively with the builders so that we have not ended up needing to have expensive litigation or any involvement with lawyers in working through the building design and adapting that design for latent ground conditions that just could not have been known until the commencement of construction. But I am pleased to advise the committee that that has happened — the design has been resolved, and Western Health remains committed to undertaking the clinical commissioning in sufficient time to operate clinical services in the new building in May next year.

Ms PENNICUIK — Nineteen?

Ms PEAKE — Yes.

Ms PENNICUIK — May 19. Okay. Thank you.

The CHAIR — Secretary, I understand you might have some answers to some questions on notice.

Ms PEAKE — Yes. I will just throw to Mr Symonds in terms of the question about the cost of a mental health bed for 16–17.

Mr SYMONDS — The question I think was the cost of mental health beds. We publish every year in our policy and funding guidelines the prices that we pay on a bed day basis. So for acute care for children, adolescents, adults and the aged, the price in 16–17 was $646 per day, which equates over a full year to about $235 000.

Ms PEAKE — The other question was Mr Smith's question about consultation in relation to the new Grampians residential rehabilitation facility. The answer is that there were three community information forums held at the facility, and there will be ongoing consultation or further engagement with residents in the lead-up to the commencement of the operations led by the service provider for the facility.

Ms WARD — Secretary, on Saturday I was at the footy watching some women play some great football. I got tackled by my 12-year-old daughter afterwards and I am still a little sore. So that brings me to page 37 of the annual report by your department and the work that Sport and Recreation Victoria and the government are doing in the space of women and girls in sport. Can you please talk us through some of the changes, the investments and the programs that have gone on over that financial year that are working towards improving girls' participation in sport?

Ms PEAKE — Certainly. You would recall that the Change our Game plan was released and $1 million was committed prior to the period but in January 2016, which delivered a suite of resources to raise awareness and inspire action to address under-representation of women and girls in sport and recreation. Through the period, though, the recommendations of the game plan inquiry that we have advanced are to publish a female-friendly sport infrastructure guide which provides really useful tips and tools and techniques to build and redevelop —

Ms WARD — Sorry, what is the guide called?

Ms PEAKE — It is called the female friendly sports infrastructure guide. It is all about how you redevelop community sport facilities to be female friendly. There has been funding to local government through the female-friendly facilities stream of the Community Sports Infrastructure Fund to improve equity and access for female participants. That is all about building new change facilities and upgrading out-of-date change facilities. The Supporting Victorian Sport and Recreation initiative is all about having a minimum of 40 per cent of women in leadership positions or as board members by January 2019. That was one of the really important commitments in the plan. Currently 48 per cent of organisations funded have met this target, which is a great result.

Ms WARD — I will fly the flag for my own community. I was at a junior football club committee meeting last night and there was only one bloke — the rest were all women.

Ms PEAKE — There you go. The remaining 52 per cent have until July next year. Tools, advice and support have been provided through Vicsport to really make that possible, and we have established the Change our Game champions program, which is all about the leading state sport and recreation organisations playing their role in cultural change initiatives, backed by 10 ambassadorial roles to support gender equality initiatives implemented by each sector.

Ms WARD — You talk about the Change our Game campaign. How is the appointment of the Office for Women in Sport and Recreation connecting to that and working through that?

Ms PEAKE — I am really pleased that we have appointed Dr Bridie O'Donnell, who is a world record holding cyclist and national rowing champion — Mr Smith might be aware — who commenced as the head of OWSR at the end of 2017. She is really a leading voice in the medical community as well as being a champion sportswoman and will use her unique background in medicine and sport to empower and inspire change through increased leadership and participation. So it really gives, if you like, resources and capacity to take forward that Change our Game initiative, working with sporting sectors, working with local communities and working with other champions of women's participation in sport.

Ms WARD — A big part of this is the female-friendly change rooms. Page 60 in your 16–17 report shows the number of community facility grants approved is just over 26 per cent above the target. How has that change rooms program gone? I have to say I have been quite successful in my community. There are quite a few changes, which is terrific. How has it been across Victoria?

Ms PEAKE — We have seen 107 family friendly projects funded from the $10.7 million invested, which, as you know, really means that you have more opportunity for girls and women to participate in sport in their local community, and we know all the benefits that flow from that. We also know that even with all that we are doing, we still only have women participating at about half the rate of men, so it is critically important that we keep going.

Mr MORRIS — Just before I start, just going back briefly to our discussion about the grid, I understand that there were some explanatory notes on the grid prepared. Perhaps if you include those for the information of the committee, that might assist us as well.

Assoc. Prof. WALKER — Sure. I'll see what information is able to be provided.

Mr MORRIS — Mr Walker, can I ask you about bypass? Of course we do not have time on bypass any more because it is no longer measured, but I understand that Ambulance Victoria has initiated what is referred to as a redistribution to manage demand on hospitals around the state. I understand colloquially it is still known amongst the paramedic community as 'bypass'. Can you tell the committee: how many times were ambulance crews redistributed in an Ambulance Victoria-initiated redistribution, as captured by the hospital information coordinator logs? Give us a bit of information about the major reasons — the hotspots, perhaps the top five hospitals, that sort of thing.

Assoc. Prof. WALKER — Mr Morris, back in 2015 the previous system of bypass was changed, and Ambulance was given responsibility for distribution of patients across the system. So basically we are monitoring the performance of the number of crews that may be at health services at a particular time and making decisions about whether we move past that hospital to another hospital, which may see that patient be seen more quickly. That distribution process has allowed us to, if you like, flatten the load and avoid what is known as clumping, which means that where we have, for example, four or five ambulances arriving in a 15 to 20-minute period, we know that places undue pressure on the health service and can result in delays around transfer by our paramedics.

We do not have any particular reporting that I am aware of around the distribution processes. I am happy to see what information we have available, but there is no specific report, to the best of my knowledge, that reports the specific distribution of patients across the system.

Mr MORRIS — There is no data that comes to you regularly on that issue?

Assoc. Prof. WALKER — No, there is not, Mr Morris, no.

Mr MORRIS — On a similar subject, I am trying to get a handle on what is happening in terms of ramping. Can you indicate to us what data you do collect on ramping levels at hospitals, if five, six, or seven ambulances are queued at a hospital at any one time, and can you provide the committee with a table for 2016–17, at least on a monthly level, by hospital and the frequency that you have had ambulances ramped?

Assoc. Prof. WALKER — Again, I am not sure exactly what level. I do not receive reports other than the aggregate clearing times and transfer times for the system in health services. But I am happy to see what information is available and provide that.

Mr MORRIS — If you can investigate that and provide us with whatever you have got, that would be good.

Assoc. Prof. WALKER — Yes, Mr Morris.

Mr MORRIS — Secretary, just finally on this subject, the 16–17 budget update had a combination of 343.3 million in output initiatives for improving ambulance response times and 66.9 million in asset initiatives to improve response times. That to me adds to $410.2 million. The government said there was $500 million in new money for ambulance services. Can you indicate to the committee where the remaining $89.8 million is?

Mr SYMONDS — I will just have to take it on notice and reconcile the numbers that you have just given us with the numbers we have got and provide a breakdown.

Mr MORRIS — I have provided the budget figures.

Ms PEAKE — I am certainly happy to take that on notice, Mr Morris, and come back to you.

Mr MORRIS — So what will come back is a reconciliation of the budget figures to budget update figures which do not add to $500 million and whatever else is in there that amounts to —

Ms PEAKE — We are happy to come back to you with what information that we have that indicates what investments were made in that period.

Mr MORRIS — Thank you.

Mr SYMONDS — Can I just check — you are after a breakdown of the $526 million announced by government?

Mr MORRIS — Yes.

Mr DIMOPOULOS — Secretary, I just want to ask you about elective surgery. My electorate is in the catchment predominantly of Monash Health and a bit of Alfred Health. I know that the Minister for Health in the previous government ripped a billion dollars out of health in Victoria, and it meant that the elective surgery waiting lists ballooned. We invested in both 15–16 but also 16–17. Specifically on 16–17, my understanding is that budget paper 3 on page 78 has a $167 million investment to improve access to elective surgery. Often it is the kind of procedure that improves enormously people's quality of life. They have to wait longer sometimes because it is not urgent, but it is the kind of thing that actually impacts on the quality of life of people in my community and across Victoria. So I am proud of that investment.

I just wanted to ask you: within the 16–17 financial year, that $167 million investment for elective surgery, what actual impact did that have in that financial year? But also, previously what was the pattern, in terms of if it has gone down or up?

Ms PEAKE — Certainly. So to the first question: that $167 million in 16–17 allowed for the treatment of an additional 17 098 patients, compared to the previous year, so it is an additional 17 098 patients. That resulted in the lowest waiting list that we have ever reported, so a waiting list at the end of 30 June, of the period, of 36 398 patients waiting, which compared to a target of 38 498 — so 2100 fewer than the target that we were aiming for.

Mr DIMOPOULOS — Sorry, Secretary, the 16–17 result was that you took 17 098 people off the elective surgery waiting list?

Ms PEAKE — Yes, so there were an extra 17 000 patients who were serviced, which meant that the wait list was 36 000.

Mr DIMOPOULOS — And that wait list is the lowest ever recorded?

Ms PEAKE — Correct.

Mr DIMOPOULOS — Ever?

Ms PEAKE — That is correct. Look, I just want to reflect that that is a lot of hard work by our health services, our elective surgery staff as well as the frontline health service staff. It also reflects a lot of work that has been done within the department to support our health services. You asked about some of the comparisons. Overall, 195 481 patients were admitted for elective surgery last year, and as I said, 17 000 more than 15–16. As you have indicated, it just means more people being able to get access to services in a timely way.

Mr DIMOPOULOS — As a supplementary, I understand — well, I do not really, so I am asking you — or I get a sense that within that cohort of people waiting for elective surgery, they are not all on the same sort of classification; there are different ones and there are people that have been on — is there a list called the long waiting list, even within that? I just want to see what part of that investment in that financial year, what part of that $167 million investment, went to those who were waiting the longest. What cohort is that and what impact did that have in that year?

Ms PEAKE — Sure. I will make a couple of comments, and then I will just ask Mr Symonds to also comment. But really what you are getting at is that time-to-treatment performance for people who have different levels of need. The proportion of patients treated within time for all categories — 1, 2 and 3 — improved by 1.5 per cent to 89.4 per cent, and that includes all the category 1 elective surgery patients. So they received surgery within 30 days. Those are the patients who require that elective surgery most urgently. I might just ask Terry to make any other comments just to unpack that a bit more, and the sort of patients that involves.

Mr SYMONDS — The three categories that are used for coding the patients according to their urgency include category 1 — the most urgent patients; they are all seen within 30 days. A very large percentage, probably the majority of those patients, would be cancer patients, but there are also high-risk cardiac patients. Categories 2 and 3 then have a combination of less time-critical surgery but still surgery that ideally happens

within time frames of 90 days for category 2 and a year for category 3. The long waiting list that you have mentioned may refer to initiatives that the department and health services frequently put in place to tackle the longest waiting patients within those categories and have those treated. Your specific question about how much in the 16–17 year went towards treatment of those patients and what happened to those patients is probably one for us to take on notice in terms of what has happened at that end of the waiting list.

Mr DIMOPOULOS — So how did they end up being the longest waiting patients? I do not understand. Is that a medical condition issue or is it just a chronological thing?

Mr SYMONDS — I guess it is a feature of two things. One is clinical need. That is the overwhelming issue; there are always more urgent cases. There are cancer patients in category 2 and there are cancer patients in category 3.

Mr DIMOPOULOS — So it is clinical need.

Mr SYMONDS — That is right. And unfortunately, if your case is not life-threatening, in a system that has finite resources you will wait longer for your treatment — unacceptably long, but that is the reality.

Mr D. O'BRIEN — I have got a couple of questions that I expect will need to be taken on notice. I am seeking some data. So I might just get them out of the way. The VPTAS — the Victorian Patient Transport Assistance Scheme — can we get the budget for VPTAS in 2016–17? What was the value of claims paid for transport — the dollar value? What was the value of claims paid for accommodation, and the value of administration and indirect expenses? And was there a deficit or surplus on VPTAS? Also, with respect to palliative care, which is in the same output group, I understand, how many Victorians received care and support from community palliative care agencies in 2016–17?

Ms PEAKE — Certainly. I am happy to take those detailed questions on notice. I just would note that in terms of palliative care, as you have indicated, there has been a real shift, and it turns up in our performance measures from acute bed-based care into more delivery in community settings.

Mr D. O'BRIEN — That was what I was particularly chasing. If I may just continue, on disability, in the 16–17 budget — in the year actually — in October the state NDIS workforce action plan was released, which referred to growing workforce capacity to meet demand. Obviously that will be coming. Can you give an outline of what has been achieved since that report was released, particularly given reports of workforce shortages in some areas?

Ms PEAKE — When was the report released?

Mr D. O'BRIEN — October 2016 — the state NDIS workforce action plan.

Ms PEAKE — So certainly the workforce plan, as you point out, is a really important part of looking at the existing workforce — and how they are developing their capabilities in Victoria is an advantage in this regard but continuing to develop their capabilities to operate in an environment where there is more choice and control on the part of disability clients — as well as the increase in numbers, or in the supply of the workforce. I would have to go away and get you specific information about the implementation, such as that information is available. It is a workforce, as you would appreciate, where we have done census work to develop that work plan. That strategy is not something where we have quarterly updates on the size of the whole disability workforce in Victoria, but it is something that we work on closely with our commonwealth colleagues, who do do periodic census work.

So I am not sure exactly how much information I am actually going to be able to provide to you, depending on what data collection is actually available, but I can certainly give you qualitative information around the initiatives that were put in place for both purposes — both to support the transition to the NDIS and to build planning and engagement capability to deliver plans, as well as the supply question.

Mr D. O'BRIEN — Thank you for that. Specifically, there are reports of workforce shortages in rural areas, so if we could have a particular focus on what the government is doing as a result of that plan in response. If you can answer it now, that is fine.

Ms PEAKE — The only thing I was going to say is that, as this becomes increasingly a commonwealth responsibility to develop the market for disability services, it has been an area that we have been talking very deeply with the NDIA and DSS about — about how the commonwealth understands both the current state of play in terms of market development and the supply of workforce and the sorts of initiatives that they need to put in place to support the development over time.

Mr SYMONDS — If I could come back to a question, I have an answer to your question so far in relation to VPTAS.

Mr D. O'BRIEN — Yes.

Mr SYMONDS — For 16–17, $17.15 million was paid in expenses to 27 700 Victorians; 11.28 million of that was for travel expenses.

Mr D. O'BRIEN — That was 11.28?

Mr SYMONDS — Yes, 11.28; $5.87 million was for accommodation. There were 68 160 claims received in 2016–17.

Mr D. O'BRIEN — And the value of administration and indirect expenses?

Mr SYMONDS — I just want to clarify what you mean by that. Do you mean overheads for the VPTAS scheme itself?

Mr D. O'BRIEN — Yes.

Mr SYMONDS — Right. I do not have that information. Was your other question related to the —

Mr D. O'BRIEN — The deficit or surplus on the VPTAS budget.

Mr SYMONDS — Can I take those two on notice?

Mr D. O'BRIEN — Yes, please. Thank you; I appreciate that.

Ms SHING — I would like to continue with the theme of supports for people in regional Victoria and in particular the allocation of $27.3 million to respond to the health needs of residents of the Latrobe Valley around priority services and preventative health programs as part of the health innovation zone and the knock-on effects of the mine fire inquiries and their recommendations. That includes both references to increased health assessments and early interventions, as well as allocations to young people and the supports that can be provided to them. By reference to both the regional interface and to young people in areas like Morwell and Ballarat, for example, and page 86 of budget paper 3, what is the information on the projects that were initiated in the 16–17 period, and the outputs and deliverables that are worked in to improve outcomes for young people in these areas?

Ms PEAKE — Thanks, Ms Shing. I will make a couple of introductory remarks and then I might throw to Ms Congleton to elaborate. As you indicated, there was $27.3 million that was contributed to the Healthy and Strong Latrobe initiative. It is a really innovative approach that we are taking with the department working in partnership with Latrobe Health Assembly, so that community voice is front and centre in really shaping and driving initiatives around prevention, early detection and effective management of chronic disease.

Some of the highlights to date have included setting up an Aboriginal community space in partnership with the local Aboriginal community, delivering additional hours of respiratory nursing and allied health services, expansion to the telehealth and community health dental program, implementing a health check trial, increasing smoking cessation support, as well as implementing initiatives to promote physical activity and improve cancer screening participation rates.

I think you also referred to the out-workings of the Hazelwood mine fire inquiry and in particular the long-term health study, which we also continue to support, and we will provide, as you know, information about any long-term health effects of exposure to smoke from the mine fire. In just one example of a study undertaken to

date, it includes the Latrobe early life follow-up. You asked about children. The early life follow-up cohort study will report its first findings later this month.

Ms SHING — There are children and young people, so that first 1000 days cohort, as well as young people who might well need that intervention and assistance through programs that already exist, whether that is — I do not know — Gippsland Multicultural Services or YACVic or those sorts of bodies, what sorts of initiatives are going above and beyond the end of reporting period to tackle those entrenched areas of need?

Ms PEAKE — One in particular that I draw attention to — and again focusing on young children — is the first 1000 days of a child's life, so conception to age two. There are new approaches that are being trialled by the Inner Gippsland Children and Youth Area Partnership through co-design to really build the capacity of local parents to foster that environment in which children can thrive. That is both young children and families generally in the community, but it also has initiatives for Aboriginal children and families as part of it, a strong focus on family violence prevention, as well as cultural connection for Aboriginal children, and again, it really focuses, as you indicated, on trying to break those intergenerational transmissions of disadvantage.

Ms SHING — A supplementary, just quickly: what is the specific demographic of young people accessing not just these services in the Latrobe Valley but the broader initiatives as part of that scheme for areas like Ballarat, Warrnambool, Swan Hill?

Ms PEAKE — Of the children and youth area partnerships in particular?

Ms SHING — Yes.

Ms PEAKE — The children and youth area partnerships are really focused on more vulnerable members of our community and bringing together the universal services as well as the more focused secondary prevention-type services to look at creative ways of reducing risk factors as well as encouraging active, positive participation in local communities. I do not know, Anne, if there is anything you would want to add to that?

Ms CONGLETON — I will just add in terms of the outreach programs that we have for both the Centre for Multicultural Youth, which has got regional offices in Ballarat and Morwell, and YACVic as well — and I am sure you know what that acronym is — in Warrnambool and Swan Hill. I think, going to that point, in Gippsland it is with young people who may be at risk of being disconnected from school. There is some fabulous work that is being done with schools and other organisations.

One example, as part of that, is the My Story living project, which is working through the United Muslim Sisters of the Latrobe Valley, and it is about promoting social cohesion through the delivery of storytelling. That is just one example of the work that is done that, if it is locally driven, can then be very much tailored to local needs. As the youth space develops, they will also link into the pretty significant investment in sport and recreation, which is a real platform for our young people to get connected.

Ms SHING — Thanks, Ms Congleton. Thanks, Ms Peake.

Ms PEAKE — Chair, if you do not mind, we have just got a breakdown of that 526 million ambulance spend for Mr Morris, if it is convenient for us to step you through that now. I will just ask Mr Symonds to do that.

The CHAIR — Yes.

Mr SYMONDS — The breakdown is on the output side, on the operating side, $411.7 million for additional paramedics and operational resources, $7.45 million for the mobile stroke unit, $40 million for improving ambulance off-load times at emergency departments, so that is money that went to —

Mr MORRIS — Sorry, can you just repeat that last sentence?

Mr SYMONDS — Forty million dollars to emergency departments for initiatives to reduce off-load times for ambulance crews at hospital. On the asset side, $15.4 million for vehicles, $41.5 million for new branches and $10 million in minor works at emergency departments to improve ambulance off-load times.

Mr MORRIS — Sorry, that last figure again?

Mr SYMONDS — Ten million dollars. Essentially it is a $10 million capital component to match the $40 million given to emergency departments to improve off-load times. I am advised that total is $526 million.

Mr MORRIS — That is what it has been spent on, and I thank you for that information, but the question was where did the money come from? If you do not have those figures immediately in front of you, essentially the amounts announced as available in the budget were $89 million less than the $500 million that the government claimed.

Mr SYMONDS — I am sorry. Okay. That is a question I will have to take notice, In terms of reconciling sources. I thought it was a breakdown of the allocation.

Mr MORRIS — That is useful, and I thank you for it, but the question was actually about where the money came from.

Mr SYMONDS — Sure.

Mr T. SMITH — On page 258 of budget paper 3 in 16–17 is the department's performance in the youth affairs portfolio. I am just interested as to why between 14–15 and 16–17 there is some 25 per cent decline in the participation in this portfolio by young people. Participation by young people in programs that provide opportunities to be involved in social and economic life in their communities is dramatically down on the year before. Why was that the case?

Ms PEAKE — I apologise, Mr Smith; we will need to take that one on notice, and we will come back to you with a response.

Mr T. SMITH — You cannot tell me which programs?

Ms PEAKE — I do not have that information in front of me, but I am happy to take it on notice and come back to you.

Mr T. SMITH — I find that quite difficult to understand, why you would not have an indication of what —

Ms SHING — Well, it has been taken on notice.

The CHAIR — Order! Mr Smith.

Mr T. SMITH — Okay. I am genuinely shocked that you cannot further enlighten me at this hearing about a number of programs in the youth affairs —

Ms WARD — I am shocked you cannot move on.

The CHAIR — Order!

Mr T. SMITH — Moving on, in sport could you provide — $108 million spent on the sport and rec budget in 16–17 — a breakdown of this program by area?

Ms PEAKE — Mr Smith, sorry, I am just getting advice. I am happy to look at what we can provide. I think we have provided some information in the past. I am happy to look at what we can provide.

Mr T. SMITH — Was the female friendly facilities program included in the sports infrastructure fund?

Ms PEAKE — Yes, that is correct. I think in my answer a few moments ago I indicated the value was part of the Community Sports Infrastructure Fund.

Mr T. SMITH — That is part of that 108 million?

Ms PEAKE — Correct.

Mr T. SMITH — The Athlete Pathway Travel Grants Program and its earlier form as the Victalent program has provided benefit to regional sportspeople and clubs in the past. How much was spent on this program in the 16–17 budget?

Ms PEAKE — Again, I do not think I have that specific detail, but I am very happy to give you a breakdown. I will take it on notice and come back to you.

Mr T. SMITH — Okay. Thanks very much.

Ms PATTEN — I have got just a couple of quick questions. The first question I wanted to ask was around medicinal cannabis. I noticed in the annual report that you speak about delivering medicinal cannabis to children with severe intractable epilepsy in March 2017 with a program using imported medicinal cannabis and that also in addition the government has continued to implement Victoria's patient access schemes. I am just wondering if you could give me some information about where specifically the funds are spent to assist with Victoria's patient access scheme and any costs that you can identify there?

Ms PEAKE — Certainly. I might ask Ms Skilbeck just to respond. I would say, though, that obviously we are very conscious that for access to services through Victorian public health services there is not a cost that is incurred, and I think that is part of the context to the answer that we will provide.

Ms PATTEN — That is right, but obviously you would try to help people access?

Ms SKILBECK — Yes, all right. Melissa Skilbeck, deputy secretary, regulation, health protection and emergency management. Thank you for the question. I suspect I will not be able to answer it exactly, but let me try the best. The funding that we applied that year, 16–17, was directed, as the secretary has mentioned, to hospitals to ensure that the funding for the imported product, which was the only delivery of the product in that year, was fully funded. So we have coordinated the access to the imported product, but it is accessed directly through the hospitals and then we recompense.

Ms PATTEN — So that was for the children, the epilepsy —

Ms SKILBECK — Precisely.

Ms PATTEN — More generally there is the Victorian patient access scheme, and a lot of those patients obviously cannot access the product in Victoria, so they are having to go through the federal scheme. It appeared looking at the annual report that you were referring to other patients other than that compassionate access scheme, or was it purely for those children?

Ms SKILBECK — It was purely for the children within the compassionate access scheme, and it remains the case.

Ms PATTEN — Okay. Thank you. I just wanted to turn a question to the availability of mental health beds and where the performance measures were not met in residential day beds, and that was in two areas. First in residential day beds there was sort of a $19 000 reduction, and the reason that you give in the annual report is a:

> … reduction in demand for public sector aged-care residential mental health service beds, following a shift to … community-based treatment … combined with a reconfiguration of aged-care facilities.

You also go on to say that another performance measure, which was around emergency patients receiving a bed within 8 hours, was not met:

> … due to the high levels of demand as more people are presenting directly to emergency departments needing an acute inpatient admission, particularly in … growth areas in the metropolitan areas.

So my questions are: the availability of beds for people experiencing mental health issues, how have they been reconfigured in light of the aged care changes? And the pressure of the high demand for emergency departments, how is that being addressed?

Ms PEAKE — Certainly. I will ask Dr Grigg to talk specifically, Ms Patten, to your question about the aged care piece. We did have a longer conversation before the break around the sort of work that we have been doing under the auspices of the 10-year mental health plan to look at how we continue to build community-based capacity. There have been investments in particular in the PARC model, so in the last budget an investment in a new facility in Ballarat. I mentioned before the break that there is a new 10-bed facility that is about to open in Warrnambool, as well as an investment again in the last budget of an extra $20 million per annum to make sure that in addition to those residential services there is follow-up care in the community, so community-based care.

In Victoria we have always sought to have a balance of and an emphasis on community-based or recovery-based care, and that continues to be a really significant priority for our investment. But under the auspices of the 10-year mental health plan we are doing work, and will continue to do work, with the mental health sector around innovations in models of care — workforce models — to make sure that we do keep a weather eye to those demand pressures that exist in the system. I will just ask Dr Grigg to answer your specific question around the aged care changes.

Dr GRIGG — The aged care changes refer really specifically to the closure of a residential aged care service in the north-west of Melbourne that was closed for a couple of reasons. One is reduced demand. The occupancy was relatively low. That was really a function of other alternatives and new models of care, and the money has been redirected into providing both more intensive community-based support and support from other more mainstream residential care providers, giving families much more choice.

Ms PATTEN — So the shortage, the not meeting that measure —

Dr GRIGG — I should say that, other than that we use the words 'mental health' for both of them, they are completely different service models. If you could imagine a nursing home versus an acute mental health unit sitting in a hospital — they are actually not interchangeable services or infrastructure or care models.

Ms PATTEN — So the closure was what created the —

Dr GRIGG — Absolutely. That was really about older people with psychogeriatric problems in need of nursing home care.

Ms PATTEN — I am not sure that I quite understood how we are working on that high demand for acute care in the emergency setting in those growth areas?

Dr GRIGG — There are probably a couple of ways in which we are working. Firstly, we are very conscious of not just creating new beds and really just creating a cycle of acute care that people fail at. We have been looking really strongly at our community investment, actually looking at both keeping people out of hospital — early intervention — but actually providing some intensive support for people towards the end, so really working towards the flow of people out of hospital.

We have been working really strongly with emergency departments, particularly through the collaborative work of Better Care Victoria. They have been working with 10 emergency departments on innovation and improved flow. Mental health has been a really, really strong feature of that. We have been looking really strongly at models of care. The introduction of our PAPUs, I think, is a really important example of a new innovation. And we look at and see perhaps some of the other innovations that are happening in some of the other states that we need to learn about, which is really the creation of better, more effective, newer models — certainly having hospital care available for those who really need it, but actually making sure that we have got really good investments in the alternatives and rebalancing our system a little bit.

Ms PATTEN — So what you are saying is that in trying to keep to that 8-hour target, you are now trying to work with community organisations to meet that target?

Dr GRIGG — Yes.

The CHAIR — Ms Pennicuik —

Ms PEAKE — Sorry, Chair.

The CHAIR — Briefly.

Ms PEAKE — I want to repeat something I said earlier, so I will be very, very brief. In terms of that community investment, that 20 million that I reflected on, that should support an additional 3300 Victorians and provide about 50 000 additional community mental health service hours. Sorry, Chair.

Ms PENNICUIK — Following directly on from Ms Patten's questions, on page 16 of the questionnaire, with respect to the mental health and alcohol and other drug facilities renewal, I think $10 million is allocated to that. This is an area that has been neglected for some time. My question is: how many facilities received this

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

Ms PEAKE — I am happy to take that on notice and have a look. Certainly the variance in that $10 million was really about the submissions being assessed. It is also a timing issue, but I am happy to take that on the specifics of how many.

Ms PENNICUIK — How many applied and how many are still are needing renewal — that would be great. Thank you.

If I could go to a completely different question with regard to the agency questionnaire to Alfred Health. On page 7 of the Alfred Health questionnaire in relation to the non-salary labour costs, the expected budget was 6.9 million, but it was 16.7 million — so non-salary labour costs were estimated, as I said, at 6.9 but the expenditure was 16.7. It says 'due to high agency costs and temporary replacement staff'.

On the next pages, 8 and 9, with regard to the budget paper 5 initiative to reduce the use of labour hire firms, how is Alfred Health going on that? The answer was nil, but clearly it is a very significant part of the expenditure according to the answer to the questionnaire there. Could you provide some details as to what is going on there?

Ms PEAKE — Certainly. I will just ask Mr Stenton to respond.

Mr STENTON — I do not have the questionnaire in front of me. We can take the majority on notice, but hospitals flex their labour force up and down a bit, and temporary staff are —

Ms SHING — Sorry, can you speak up a little bit? It is just the curious acoustics in here.

Mr STENTON — That is okay. Hospital expenses, particularly labour costs, will flex up and down, so they will use agency staff where they are short. Particularly within a year if there is additional funding for elective or other activity, then they will not have permanent staff available, so they will flex their staff up with temporary staff. So the balance between salaried labour staff and non-salaried labour staff moves a bit, depending on how well they can forecast their demand. We can take on notice the progress about how they are moving. Generally what happens is they will reconfigure their ongoing workforce in the following year if they think that increased demand is a permanent fixture.

Ms PENNICUIK — I appreciate that. It is just that if you look at that you are talking about a balance, but it is a rather large balance in favour of agency and temporary staff as opposed to salaried staff or permanent staff at Alfred Health. And given that it was an initiative under budget paper 5 to actually move to reducing that and in terms of the questionnaire it looks as if there has been nothing happening with regard to that, it sort of looks more like two-thirds agency labour hire staff and one-third salaried staff.

Ms PEAKE — We are happy to get further information from the particular health service, but I guess the other thing I would just add is that we were talking about a period where there were some pretty remarkable demand pressures, particularly in terms of the flu season, and being able to staff up quickly to respond to that. The other thing I would say is that clearly this plays into the discussions that we have with the commonwealth around having predictability and reliability of funding that is coming through so we and health services can plan effectively for budgets and staffing.

Ms PENNICUIK — Thank you. I appreciate your taking that on notice.

Ms WARD — Secretary, I am sure you are aware of a challenge that women in particular experiencing family violence have. When you are leaving the family home because of violence, you need to go somewhere safe. The family home is no longer safe. You want to remain in your community — that is where your children are and where they are going to school. It is where you yourself have also got supports, and I know that this is an issue within my own community. The royal commission also addressed this issue and spoke to concerns around secure housing for women, especially regarding rental properties. If I can get you to go to budget paper 3, page 8, there is a reference there for housing support for family violence victims, private rental housing access and safe at home flexible support packages. Can you please talk us through those two initiatives and whether or not they are actually addressing that issue of secure housing for women who are fleeing family violence?

Ms PEAKE — Thank you very much for the question. It is absolutely the case that a really strong theme of the royal commission was providing support to women to be able to be housed really quickly. We have already spoken in this hearing about the work that we are doing on refuges, but alongside that the specific investments that you are referring to have gone to making sure that we have rental assistance that is made available to women. So the 50 million family violence rapid housing initiative —

Ms WARD — Sorry, can I just interrupt for one moment? Is that on top of rental assistance that they may be eligible for from Centrelink, from the commonwealth?

Ms PEAKE — The commonwealth provides you with a subsidy for your rent. The sorts of initiatives that we have introduced at a state level are about providing headleasing. It is quite difficult to get in, as we know, to the rental market, particularly if you are in urgent need, fleeing a family violence situation and you have no resources.

Ms WARD — And you have no rental history.

Ms PEAKE — That is correct. So the 16–17 budget provided 16 million as part of the 152 family violence housing blitz for private rental assistance to help secure and sustain tenancies in the private market, including for women and children. I started to mention that we also had 100 headleased properties: 120 properties headleased for 12 months with a 1.44 million contribution from government, and that provides the opportunity for tenants to take over the lease after 12 months, should they wish to remain in the property. The headlease program has been rolled out in priority areas right across the state, including rural and regional locations — for example, regional LGAs that received headlease funding included East Gippsland, Latrobe, Wellington, Greater Bendigo, Greater Shepparton and Greater Geelong.

Ms WARD — Thank you. Can you let me know how this differs from the rapid housing assistance fund, which is also in budget paper 3, page 8. How does that differ? Does it have similar success rates? How do the two compare?

Ms PEAKE — I might ask Mr Foa to comment further. The 50 million for the rapid housing assistant fund again had two components to it. One was around social housing, so there were 185 new social housing dwellings, and then the other was the headleasing piece that I was just talking about for 124 dwellings. Then the rental assistance is really about then providing both brokerage and support to be able to sustain the tenancy.

Mr FOA — I would like to add on to that that we worked with the community housing sector very, very closely, and out of 100 headleased properties we achieved 124, and out of our forecast 130 spot purchases and new builds we achieved 185 properties by leveraging the capability within the community housing sector. That is part of a broader initiative around Homes for Victorians and about growing their role in the provision of social housing more broadly.

Ms WARD — Thank you. And I do want to thank you, Secretary, and your department for the amount of work that has gone into this space and the seriousness with which you have pursued it. You are really making a difference in the lives of women and children across Victoria.

Mr MORRIS — Just a couple of quick ones. I imagine the first will have to be on notice and the second may need to be on notice. With regard to the 2016–17 financial year, Secretary, can you provide the committee with a list of programs for which funding concluded and was not renewed; secondly, funding which concluded and was renewed; and in the context of the second part, the period for which the program was renewed and the funding that was provided?

Ms PEAKE — Certainly. We did have the advantage of hearing this question asked of Mr Martine yesterday, so we do have some of that information available for you today, and I will ask Mr Stenton to just step you through the programs, a number of which had been funded from 13–14 and would have otherwise lapsed at the end of the financial year for the end of 15–16 that continued on. I will just get him to step you through it.

Mr STENTON — Thank you, Mr Morris. As Kym says, we have a number of programs. It is not unusual for us to have sunset funding. So if I start with the 13–14 budget, there was once-only funding for skin cancer and information for seniors, which was not renewed. There was an innovation and improvement fund, and I should preface this with: translating between prior years, sometimes the titling changes, so we have taken the

line of continuity of service delivery. The innovation and improvement fund was re-funded in the 16–17 budget, and $5 million was sunsetting. We got a $10 million allocation in 16–17, which is also being continued into 17–18. Again, accommodation options for families was picked up and rolled into the family violence program. It was a lapsing program from 13–14. On the 13–14 pre-election budget update there were two lapsing components there — one for additional mental health services. That was a once-only allocation which was not continued.

A shooting sports grant program for 5.8 million was replaced in the 17–18 budget with a million-dollar allocation. Victorian social housing framework: again, a once-only allocation of $11 million. Youth participation and engagement: there were a series of allocations in the 14–15 budget for youth participation and engagement, 800 000 in total; they have now been replaced at the end of the 16–17 year with a $1.5 million allocation in 17–18 and 18–19 and then a further 500 000 in 19–20 and 20–21.

Whole of Victorian government Aboriginal affairs: young Aboriginal people's health and wellbeing, 875 000, again replaced in the sunset of 16–17 into 17–18 and 18–19. Hazelwood fire inquiry: 875 000, replaced with an ongoing allocation starting at $6.68 million and moving to 6.9 in 19–20 and then reducing to 5.3 in 20–21, but it is an ongoing allocation. The Better Care Victorian Innovation Fund of $10 million I mentioned earlier; that was a 13–14 lapsing and again replaced. Future public sector residential aged-care provision of $25 million, again lapsed at the end of 16–17, replaced in 17–18; that has been a recurring allocation year on year.

Getting ready for the national disability insurance scheme: again there were a range of announcements in the 16–17 budget totalling $21.2 million, which have been replaced in the 17–18 budget, again by a range of things totalling 20.9 million in 17–18, reducing to 14.2 in 18–19 and 1.1 in 19–20. Homes for Homes program in 16–17 —

Mr MORRIS — Chair, I am wondering, in the interests of time — I have probably used my time allocation now, and I appreciate the fullness of the response and the preparation ahead of time — is it possible to have that document tabled?

Ms PEAKE — Certainly.

Mr STENTON — We can provide it on notice. It is a bit messy, Mr Morris; it has got my scribbles all over it.

Mr MORRIS — Well, a clean copy.

Ms PEAKE — We will tidy it up.

Mr MORRIS — Yes, absolutely.

Mr DIMOPOULOS — Secretary, I refer you to budget paper 3, page 89, and in particular the item 'Modernisation of metropolitan Melbourne public sector residential aged care' — now there is a title! — it is obviously a very significant investment in funds and a boost to residential aged care. I cannot recall that occurring in the past; in fact what I do recall in the past is a sell-off. Are you able to outline some of the history of this investment in particular and say why it is necessary after the previous preceding budget years that might have been without that investment?

Ms PEAKE — Certainly. In terms of residential aged care, you would be aware that our public residential aged-care services really cater for older people with some of the most complex needs. At 30 June 2015 there were 792 public sector residential aged-care places in metropolitan Melbourne across 22 facilities. Going forward this development will play a really critical role in maintaining the public sector system capacity for those clients with really complex needs. As we know, the number of people with those needs grows and ages. A couple that I would just call out that we have been working on: in May 2016 Minister Foley announced a new $55.57 million facility at St George's Hospital in Kew —

Mr DIMOPOULOS — In Kew?

Ms PEAKE — In Kew, which is a new 90-bed facility and will also include specialist aged persons mental health beds — going back to the earlier conversation — and will be operated by St Vincent's Hospital, Melbourne. It has really been designed fit for purpose to support delivery of best practice care and better

respond to the changing needs and expectations of the community and to facilitate the role of the public sector in meeting the needs.

When I talk about 'complex', they are both clinical and physical complex mental health needs of the people who are supported in that facility. We did take an approach to planning that facility that involved a broad range of experts, including clinical staff, to produce a design that incorporated features to enable contemporary models of aged care and create homelike environments, really importantly, so that people feel that they have the experience of ageing in place. We thought that campus was suitable too because it is accessible by public transport and provides a range of specialist aged-care services which can be accessed by residents. I might leave it there.

Mr DIMOPOULOS — Thank you. That was comprehensive. Just taking you back to part of my question, though, obviously there was a need for that investment because from what you have said I imagine those facilities were outdated, the quantum was not sufficient —

Ms Shing — There had not been any investment previously.

Mr DIMOPOULOS — There had not been any investment. What was the driver? There are a million ways you can spend public taxpayers money. What was the driver in particular for this investment?

Ms PEAKE — There were a couple of drivers. The first, which you have alluded to, was the state of disrepair of the facilities that were available. They tended to be smaller facilities, and this is a program of work that we will continue to advance, attached, under the current program, to health services. So part of what we have been seeking to do is to consolidate into bigger, fit-for-purpose facilities. The suitability as well as the state of the facilities was the first driver, and the second was really that point that I made about more people in the community ageing with complex needs.

Mr DIMOPOULOS — Some of the things you were talking about were about more suitable stuff like literally an ensuite — not having shared bathrooms — and ageing in place whereby in the same facility I imagine you can go from low care to high care. Is that what you mean?

Ms PEAKE — That is correct. There is a combination of the amenity of the facility, being a more home-based environment, as well as the clinical capability of it, actually the layout, the design of the facility — as you say, enabling that sort of flow through all the while being close to other amenities like services and shops.

Mr D. O'BRIEN — Secretary, I have a couple on family violence and child protection. The first on family violence may need to be taken on notice. For the period 2016–17 can you advise how many women and children required emergency crisis accommodation in motels? Could we get a breakdown according to local government area if that is —

Ms PEAKE — So women who required access to hotels coming through specialist family violence services? Is that the specific question?

Mr D. O'BRIEN — Not necessarily, but I guess that would be where they would —

Ms PEAKE — Coming through our services though?

Mr D. O'BRIEN — Through your system, yes.

Ms PEAKE — So you are talking about the adults? Sorry, I just want to be clear about the question. You are asking about women as opposed to children?

Mr D. O'BRIEN — Women and children was the question.

Ms PEAKE — Right. I am happy to take the question on notice, but the reason that I ask is that in the children's space we have done a huge amount of work to reduce contingency places that have historically needed to be used, including motels. I gave that data earlier around the reductions that we have seen in residential care, and that includes emergency residential care such as placement in motels.

Mr D. O'BRIEN — Yes — including women and children referred through agencies like Safe Steps, for example.

Ms PEAKE — Certainly.

Mr D. O'BRIEN — And also what the average waiting time for women and children to be given emergency accommodation is and how many of those women and children exiting emergency accommodation in motels accessed homelessness services, if that information is available — and also, if it is available, as a breakdown by local government area if possible.

Ms PEAKE — Again I am not sure what specific information is available. We do not have datasets that are reported to me that go to that level of detail around the flows into emergency housing. Again I would flag the work that is underway that we talked about earlier around the increased capacity and more suitable models of refuge as well as the investments that we are making in housing. I am happy to take the question on notice, but I just flag that it will depend on what information we can get.

Mr D. O'BRIEN — If you have it by some other geographic identifier, that would be useful. Just on child protection, could you advise how many children who are in out-of-home care and/or residential care go missing each week and what is the longest period of time that a child in residential care has been missing for? Do you have any of that?

Ms PEAKE — We certainly have incident reporting, as you are well aware, that looks at the incidence of children who are missing. I do not have with me, and I am not sure what we have access to in terms of aggregated longest time missing. I am happy to look at what we can provide to the committee, depending on what is possible.

Mr D. O'BRIEN — There was a report recently about a pilot program between police and DHHS in 2017 which involved 50 investigations into the potential sexual exploitation of youths who, I understand, were mostly in residential care. I wonder whether you could tell us how many of these youths were in residential care of the 50 and, of those, how many were girls and how many were boys who were allegedly sexually exploited. What was the outcome of the investigations that were undertaken and were any referred to police or SOCIT?

Ms PEAKE — Certainly. I will get Ms Asquini to give you a bit of information. This is work that has been happening in the eastern division that you are referring to, are you aware?

Mr D. O'BRIEN — I thought it was Geelong.

Ms ASQUINI — I think it is our response with the police around what we call the enhanced response model that you may be referring to, where we have got five areas across the DHHS area and police where we are working a bit differently with regard to young people when we understand they are being sexually exploited. The nature of the intervention is one that sees police allocate an individual officer to a young person, irrespective of where the alleged offence may have occurred, and also the engagement of the sexual exploitation workers that we have got within the child protection program, the practice leaders, who support the information sharing and gathering with police in regards to those young people. So there are particular enhanced responses that we have got at the moment working with police, but more generally, yes, there are connections obviously and reports made to police when we understand that there are young people subject to exploitation.

Mr D. O'BRIEN — The specific pilot program I was referring to, I think, was in Geelong, so can we get some data on those questions I asked on notice?

Ms PEAKE — Yes. We will look at what data we have for that specific pilot in Geelong, and there have been five pilots in different places. But one of the things that struck me as data that an analysis has come through on is that actually quite a lot of the exploitation is not happening in residential care; it is happening more generally in the community. But I am happy to get you more information.

Mr D. O'BRIEN — If you could break it down to that degree if you have it, obviously —

Ms PEAKE — I am not sure if we have got it specifically for Geelong, but we can certainly look at what we can provide.

Mr D. O'BRIEN — No, sorry — when you say community versus residential care, if you have it specifically that would be good.

Ms PEAKE — Yes, we can. A number of the young people that are being exploited are residing with kinship carers or family.

Mr D. O'BRIEN — And, Secretary, you just mentioned there were a number pilots. If we could get the data for all those pilots — the original question was about Geelong, but if we could get them for all of them.

Ms PEAKE — More broadly, yes. While we are talking to you, Mr O'Brien, we do have a few reports back on questions we have taken on notice from your questions, if it would be helpful to feed those back.

Mr D. O'BRIEN — It just depends how long it will take.

The CHAIR — Briefly; that is all.

Mr SYMONDS — They are mostly just numbers. Community palliative care patients in 16–17, I think, was a question. The answer is 17 655 patients were assisted in community palliative care that year. For the VPTAS scheme the total administrative and processing costs in 16–17 was 819 000. The net financial position for the VPTAS scheme at the end of 16–17 was a small deficit of $194 000. I would add the context for that, which is 8.2 per cent growth per annum each year over five years.

Mr D. O'BRIEN — Growth in demand?

Mr SYMONDS — That is growth in demand; that is right.

Mr D. O'BRIEN — In demand or in finance?

Mr SYMONDS — I will check that one. I have got one more answer for Ms Pennicuik, if I could, Chair, about facilities renewal growth — the grants that were provided. There were 84 applications, and 67 of those were successful: 7.8 million of the money allocated was for 38 mental health projects, $1.9 million was for 29 alcohol and other drug projects and $300 000 was for Aboriginal community-controlled health organisations.

Ms SHING — I would like to talk about the funding base and growth, and the way in which that has been revised throughout the 16–17 budget period and in the revised budget update, which was published in 17–18 budget paper 5, page 164. Looking at budget paper 3, pages 78 and 79, we have got items for meeting hospital services demand under the subheading of 'Mental health', and meeting clinical services demand. These items include anticipated contributions from the commonwealth, which were then subject to a revision by you. I understand based on the data from within the primary budget and the revised budget update that there is a shortfall of around $104 million owing from the commonwealth, which obviously will impact upon the base plus growth calculation. On what basis is it maintained that Victoria is owed that $104 million by the commonwealth, and to what extent for the 16–17 period will that impact upon the delivery of services for that period and delivery of further base and growth calculations going forward?

Ms PEAKE — Certainly. I will make a couple of comments, and then I will ask Mr Stenton to elaborate, but to your question about the basis for the claim on the $104 million, there is independent architecture that sets the framework for the activity-based funding model in the country. They set the weightings that are applied and they are also the administrator and they are also responsible for then reconciling the activity that we submit and providing that information through to the commonwealth to make its payments. The $104 million is the outstanding reconciliation that relates to the activity that we delivered based on the weightings that were the policy at that time — Greg, correct me — for 2016 —

Mr STENTON — Fifteen.

Ms PEAKE — 15–16, and so we have been working with the commonwealth, with the administrator to try and finalise — we have provided the information, but to respond to their requests around further information, which we have done endlessly, for that reconciliation to be finalised. The main item that is in that is home ventilation services, and as I say it is very difficult to manage budgets and to provide certainty for health services in their staffing when those funds are subject to ongoing interrogation and are not reconciled in a timely way. But I will ask Mr Stenton to comment.

Mr STENTON — Thank you. Two points to note: the first one, the difference between budget update and the annual budget —

Ms SHING — And the annual report, to the extent that it covers off on those figures.

Mr STENTON — We forecast our commonwealth contribution in the annual budget based on a non-policy change basis, and we provide that to the commonwealth in December of each year, so we will always get a timing difference between the two, and then we update it in the budget update. As Kym says, the outstanding $104 million issue is associated with the 2015–16 reconciliation. So at the end of each year we submit data. The independent pricing authority counts the activity and provides that advice to the funding administrator. The administrator calculates the amount of funds owed to each jurisdiction. We received correspondence in April of 2017 advising that we were owed an amount including the $104 million, and we are still awaiting that.

Kym's other point about budget certainty — we use those estimates to provide budgets to our health services, so effectively what is happening in the interim is a subsidy of the state to the commonwealth until we receive those funds.

Ms SHING — So in the event that that subsidy is not returned, whether through health services or, for example, through dental arrangements and agreements where that money is not forthcoming, that then means that the state has to pick up the bill, which has a knock-on effect in relation to the services that can be provided throughout the current period and beyond?

Ms PEAKE — Correct. There are two parts to that: there are the services that have already been delivered but also how that then counts into our projections and base for funding into the future.

Ms SHING — So backfilling plus shortfall.

Mr STENTON — The commonwealth contributes 45 per cent of additional activity each year. So until we know the finishing position, if you like, for 15–16, we cannot easily calculate the additional amounts for 16–17 or 17–18.

Ms SHING — Just quickly, with the very limited time we have remaining, what is the impact of these particular cuts, as they stand, to the way in which health services are delivered across the state?

Ms PEAKE — It really goes to the certainty that we can provide to health services in terms of their staffing. It goes to the opportunity cost, if you like, where the state has — as Mr Stenton has just indicated — been covering the gap. So it is not having a service impact because the state is meeting the cost, but it provides a significant pressure for the state going forward.

Ms SHING — Thank you very much.

The CHAIR — I would like to thank the witnesses for their attendance: Ms Peake, Mr Symonds, Ms Asquini, Mr Foa, Mr Stenton, Ms Skilbeck, Ms Congleton, Dr Grigg, Ms Clifford, Professor Wallace, Mr Fiske and Associate Professor Walker.

The committee will follow up on any questions taken on notice in writing. There were a few that were provided, but I think there were a few that are outstanding. A written response should be provided within 10 business days of that request.

Witnesses withdrew.