V E R I F I E D V E R S I O N

PUBLIC ACCOUNTS AND ESTIMATES COMMITTEE

Inquiry into 2015–16 Financial and Performance Outcomes

Melbourne — 15 February 2017

Members

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

Witnesses

Ms Kym Peake, Secretary,

Mr Terry Symonds, Deputy Secretary, Health Service Performance and Programs,

Ms Chris Asquini, Deputy Secretary, Operations,

Mr Greg Stenton, Chief Finance Officer,

Ms Amanda Cattermole, Deputy Secretary, Community Services Programs and Design,

Mr Nick Foa, Deputy Secretary, Sport and Recreation, Infrastructure, International Engagement, Director of Housing,

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

Ms Melissa Skilbeck, Deputy Secretary, Regulation, Health Protection and Emergency Management, Department of Health and Human Services;

Associate Professor Tony Walker, Chief Executive Officer, Ambulance Victoria.

The CHAIR — I declare open the public hearings for the Public Accounts and Estimates Committee inquiry into the 2015–16 financial performance outcomes. All mobile telephones should now be turned to silent. I would like to welcome Ms Kym Peake, Secretary; Mr Terry Symonds, Deputy Secretary, Health Service Performance and Programs; Ms Chris Asquini, Deputy Secretary, Operations; Ms Amanda Cattermole, Deputy Secretary, Community Services Programs and Design; and Mr Greg Stenton, Chief Financial Officer, Infrastructure, Industrial Relations, Finance, Sport, and Director of Housing.

I would also like to welcome other witnesses sitting in the gallery: Mr Nick Foa, Deputy Secretary, Infrastructure, Industrial Relations, Finance, Sport, and Director of Housing; Ms Melissa Skilbeck, Deputy Secretary, Regulation, Health Protection and Emergency Management; Ms Anne Congleton, Deputy Secretary, Community Participation, Sport and Recreation, Health and Wellbeing; Ms Jan Shuard, PSM, Commissioner, Corrections Victoria; Ms Amity Durham, Acting Deputy Secretary, Portfolio, Strategy and Reform; Mr David Clements, Deputy Secretary, Organisational Redesign; Ms Elizabeth Langdon, Deputy Secretary, People, Capability and Oversight; Professor Euan Wallace, Chief Executive Officer, Safer Care Victoria; Ms Diane Watson, Chief Executive Officer, Victorian Agency for Health Information; Ms Leanne Price, Director, Infrastructure Planning and Delivery; Ms Jackie Barry, Director, Housing Asset Strategy and Financing; Ms Fiona Williams, Director, Property and Asset Services; Mr Justin Burney, Director, Sport and Recreation and Industry Development; Ms Janine Toomey, Project Director, National Disability Insurance Scheme; and Associate Professor Tony Walker, ASM, Chief Executive Officer, Ambulance Victoria. 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 the 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 they are available. Verified transcripts, any PowerPoint presentations and handouts will be placed on the committee's website as soon as possible.

Witness advisors 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 be only be provided by officers of the PAEC secretariat. Members of the public gallery cannot participate in the committee's proceedings in any way.

I will now give the witnesses an opportunity to make a very brief opening statement of no more than 10 minutes, and this will be followed by questions from the committee.

Ms PEAKE — Thank you, Chair, and thank you to the committee for the opportunity to outline our challenges and the achievements of the Department of Health and Human Services for the 2015–16 year. As you would be aware, the department is responsible for developing policies, services and programs that are aimed at supporting and enhancing the health and wellbeing of all Victorians. We have nearly 11 500 full-time equivalent staff, who are directly employed by the department, as well of course as a lot of employees in funded agencies, working very hard to deliver those services. We are also responsible for a large number of portfolio agencies.

We are responsible for a number of stewardship functions on behalf of government. We collaborate with our government and non-government partners to advance system-wide and local priorities. We are very focused on building our capabilities so that we can identify and respond to risks earlier. We exercise system leadership to promote improvement and innovation but also to add value when an event or an incident transcends a single service, and of course two-thirds of our staff are involved in directly delivering services. For those staff, our area-based structure positions us really well to work with other agencies within local communities to make a positive difference in the communities in which they live and work. Our total expenses from transactions for 2015–16 were $21.8 billion.

The department has a very clear direction, which is expressed through our vision. We aspire for all Victorians to be healthy, safe and able to lead a life they value. More than any other department I would say that we are the voice within government for those who face more barriers to a good life at all ages and stages. We seek to break

disadvantage by working to harness all of government's resources to build capability, opportunity and inclusion, to help people participate fully in their community and the economy and to access the services they value. Through our support for medical and social services research and our approach to sport and recreation investments, we also seek to contribute to Victoria's knowledge and visitor economy and the design and development of communities that promote people's health, happiness and wellbeing.

Of course our work is shaped by our environment. Rapid social and economic changes are driving unprecedented growth in demand for health and human services. Population growth, concentrations of disadvantage and increased complexity in client needs, as well as behaviours, have combined to create significant demand growth for virtually every one of our services. For example, presentations to emergency departments have continued to grow, with an additional 4.4 per cent of presentations in 2015–16, representing 1.68 million patients, with 1.72 million patients admitted to hospital and 178 375 patients having elective surgery. We have also seen reports to child protection grow by more than 30 per cent over the past three years, from 82 000 in 2013–14 to nearly 107 000 in 2015–16.

So much of what we do is related to human behaviour. For example, a recent study suggests that across Australasia chronic disease causes 85 per cent of the total burden of disease, and I am sure we will talk more today about the challenges we have seen in changing patterns of behaviour for the small group of youth responsible for such significant unrest in our youth custodial settings. Establishing what changes behaviour in youth, families and communities is hard enough, but helping to make it happen and make it stick is harder still. We know we need to continually adapt to maximise the value of the services we deliver and oversee, which is why we seek to be an organisation that listens to feedback from our clients and workforces, learns quickly from their experiences and the best evidence of what does and does not work, and leads system-wide improvements.

In this context we have delivered an integrated strategic plan over the past 12 months for health and human services, through which we are pursuing four strategic directions, set out on this slide, really to focus our efforts on improving measurable outcomes and achieving our vision for the people of Victoria, directions that are based on the best available evidence of what works and what is going to generate improvement in our impact.

Our most important enabler, of course, is our people. Every day our staff develop policy, promote participation and wellbeing, regulate high-risk activities and deliver critical services to Victorians, which is why we have also placed a very strong focus on developing a clear set of shared values that guide how we deliver on our vision and an outcomes framework that helps us to measure our impact.

To deliver on our strategic directions, on the next slide, in 2015–16 the department progressed a number of significant reforms, including continuing reform of our ambulance system; beginning to shift the focus of child protection to prevention and early intervention through the road map for reform; progressing work on Victoria's state disability plan and transition to and rollout of the national disability insurance scheme; rolling out significant investments in response to the Royal Commission into Family Violence; releasing a 10-year mental health plan; improving the level of transparency of public reporting across many of our services; and internally developing a strategic plan, leadership charter and responding to feedback from our People Matter survey to build leadership and management capabilities and advance a series of workforce inclusion and wellbeing actions. We have also made significant progress in addressing what the committee I think last year described as a bit of a train wreck of inaccessible and fragmented websites.

In terms of expenditure, the department is on track, with output groups being managed within 1 per cent of the target. The two budget outputs that you will see highlighted on this slide, with more than 5 per cent below target, were small rural services, which was driven by a reduction in third-party revenue — that is, private patient — in some services and movement of funds to the parent output for home and community care transition, and public health, driven by funding carried forward in 2016–17, associated with vaccine expenses.

If we then move to non-financial performance, the accepted measure on material variation is above or below 5 per cent. Of the 252 non-financial measures for our department, 179 met or exceeded the target and a further 37 were less than 5 per cent away from the target, which meant in total 86 per cent of performance measures were either above or within 5 per cent of target, which is comparable to our performance 2014–15.

For measures where performance was more than 5 per cent away from target, six were more than 20 per cent under target. These included the number of hits on Seniors Online cost savings information pages, which was 30 per cent under the 40 000-hit target. On this one, having been introduced in 2013–14, increasingly our

experience was that seniors who were interested in cost saving offers have utilised them and the hits on the website are declining.

The second measure here, the rate of admissions for ambulatory care sensitive chronic conditions for Aboriginal Victoria, does appear significantly lower than target. I would just draw the attention of the committee, though, that this is because of the changes to national data rules, which mean the target is no longer comparable to the performance, and it is a target that we are looking to work with the committee to update for next year.

The number of persons screened for prevention and early detection of health conditions, pulmonary tuberculosis screening, was 21.9 per cent less than the target, which reflects year-to-year variation in the number of infectious tuberculosis cases notified and the number of large-scale screening programs required.

The percentage of new clients to existing clients in drug treatment and rehabilitation is the next, which was 26 per cent lower than the target, but I would note that on the same page you will see in our annual report that the number of successful sessions completed was 29 per cent above target, showing that our services are being targeted to the people with high needs.

The average working days between screening of clients and commencement of residential-based drug treatment was eight rather than the target of six. This measure is understood to be more reflective of the date client data is entered rather than the actual wait times and again is an area where we are working hard to redevelop the data collection so that we can provide better data to the committee in future.

Finally, the number of sporting uniform grants approved was 473, compared to a target of more than 600, which was due to the sporting uniform grants program being replaced by a broader sporting club grants program, but the total combined grants for those two programs was 779.

If we then move on to where we have seen real progress against our objectives and cut through the cacophony of BP3 results, there are a number of areas we know need more work, but I would like to draw the attention of the committee to positive improvements, which include the percentage of Victorian children aged over six months who are fully vaccinated, which has continued to improve, reaching 92.85 per cent in 2015–16 compared with 90.07 per cent in 2013–14. All category 1 emergency patients were treated immediately. All urgent elective surgery patients were admitted within 30 days. The number of people on the Victorian elective surgery waiting list fell to 37 004, down from 40 351 in 2014–15, and the number of separations where at least part of the treatment is in the patient's home rose to 34 401 in 2015–16 from 31 000 in 2013–14 and 2014–15.

Against our other objectives — and I will finish after this — the department has worked closely with service delivery organisations to improve the stability of placements for children in our care, with the vast majority of children and young people in 2015–16 under the guardianship of the secretary in relatively stable placements, 91 per cent, with no more than two placements over 12 months. We are effectively intervening earlier to improve outcomes for children at risk, with an increase in Child FIRST assessments and interventions of 12 per cent to 15 190. All young people of compulsory school age in detention attended education or training.

The average time public housing dwellings are vacant between tenancies has been consistently falling from 32.9 days in 2013–14 to 21.9 days in 2014–15 and 28.6 days in 2015–16. We expect that improvement to continue this year. We have also seen improvements in the number of households assisted with crisis or transitional accommodation and the total number of social housing dwellings, which increased by 1072, or 2 per cent, to 86 226 in 2015–16. That concludes my opening remarks. I look forward to your questions.

The CHAIR — I will commence, and in doing so I do wish to declare that I have recently been appointed the chair of the public housing renewal advisory group. I would like to ask my first question in relation to housing and the announcement in the 2015–16 financial year of the Rapid Housing Assistance Fund. I am quite interested in this fund because Raj Chetty, who is a US academic, talks about the fact that if you can pick up a child in an area of disadvantage and relocate them to a more prosperous area, it has material impact on the outcome. He models that if you look at Cook County, which is a very impoverished area, and you place a child into Salt Lake City, then for every year from a child's birth it equates to about a 0.5 per cent increase in their earning capacity. So if you pick up a newborn child from Cook County, put them in Salt Lake City for 20 years from birth, you will see a 10 per cent increase in the value of income that they will achieve, as opposed to if they were stuck in Cook County. That is by way of preamble. I just wonder in relation to your Rapid Housing

Assistance Fund what steps the government undertook in terms of 2015–16 to spread some of these properties in outer suburban areas and regional areas in order to provide a more broader experience for those people.

Ms PEAKE — I might just start by reflecting that the Rapid Housing Assistance Fund was part of the government's $152 million housing blitz, which was announced in response to the family violence royal commission. But the housing assistance fund was progressed as a priority following its announcement in April of 2016, evidenced by the completion of the expression of interest process for the family violence component in just over five weeks. Fourteen agencies were successful in obtaining grant funding through this EOI process, which enabled a total of 184 properties to be purchased by the agencies and 124 properties to be head leased for 12 months, which was above the initial target of 130 purchased properties and 100 leased properties by 30 June 2017. That work has commenced for agencies to be purchasing and leasing in the market, but I might ask Mr Foa then to comment on your specific question around the spread in the outer metro and regional locations.

Mr FOA — When we went out for the expression of interest for this project we specifically targeted areas of the state where demand was highest, and we worked right across regional Victoria as well as with our metro offices to get the best intel we could in targeting the program. Of the family violence acquisitions program, out of the 184 the secretary has mentioned, 48 of those were regional. In the leasing space, out of the 124, 30 were regional, and they were pretty well spread. Latrobe Valley was probably the largest out of that group, and the others were spread across regional Victoria where demand was higher.

The CHAIR — Where there were instances of high levels of family violence you sought to rent properties there so people still had a degree of connectedness to their community, so it was not a case of basically picking someone up and transplanting them over to the other side of the state, for argument's sake?

Mr FOA — No, a range of inputs for the process were used, including the L17 reports about where the instances of family violence were, but also where we were undersupplied in properties and unable to meet local service system demands. So, yes, we did take intel from the family violence service sector.

The CHAIR — And what sort of housing stock was leased as part of that? I am assuming that overwhelmingly the purchases related to leasing rather than purchasing freehold stock. Am I right in that?

Mr FOA — The acquisitions program was spot purchases and the leasing program was of available leasing product within those areas within the identified LGAs that the respondents tendered on.

The CHAIR — In terms of the housing stock that was either leased or purchased, was it a mix between townhouses, apartments and — —

Mr FOA — Yes. Some required more bedrooms than others in terms of children, but there were a number of single-bed properties too.

The CHAIR — All right, thank you.

Mr MORRIS — Can I start with youth justice. When did the department first begin the process of identifying new sites for a youth justice facility?

Ms PEAKE — Following the receipt of the Muir report, which I know people have seen, as it has been leaked to the media, we in the middle of last year started a process of business case preparation and preparing a preliminary business case. That preliminary business case was completed in October 2016 with a preliminary view on potential sites. Of course then the incidents of 12 to 14 November, which are getting outside of the period of this hearing, meant that we really needed to accelerate the work on the identification of a preferred site so that we could get back to an operating facility and a fit-for-purpose operating site as quickly as possible. So the primary objective was and still is to return to that sustainable operating model.

Since October and really since November we have really accelerated the work on considering sites against a set of criteria that really went to making sure that we could meet our obligations under the Children, Youth and Families Act — for there to be access to courts, access for families and access to services, which are all legislated requirements on me — but also that we were able to move quickly by identifying public land that was not occupied so that we could expedite the works.

Mr MORRIS — Are you able to indicate to the committee what those criteria were?

Ms PEAKE — It was really that criteria that I have just stepped through — making sure that it was a site that was on public land so that we could accelerate the development and not have a longer period of time with a substandard facility at Parkville and that it was a site that met all of my obligations under section 482 of the Children, Youth and Families Act around access to services, public transport for family visits and access to courts. You would be aware that remandees need to return to court every 21 days, so the Children's Court has been very focused with us on ensuring that whatever developments are in youth justice that access to courts is maintained. And then it was a site where there was going to be a buffer between the site and residential accommodation.

Mr MORRIS — That is the total list of criteria?

Ms PEAKE — Correct.

Mr MORRIS — Can I continue in the same vein, particularly with regard to the damages and repairs to youth justice assets and infrastructure as a result of riots. Can you indicate to the committee the cost of damages specifically for the riots that occurred at Parkville during 2015–16, including the riots of 31 October 2015 and of 6 and 7 March 2016?

Ms PEAKE — I think that we are on record in providing feedback to the community that for that 2015–16 period the damage across both Parkville and Malmsbury was in the order of $1 million to $2 million, and that is obviously for like-for-like repair of those facilities.

Mr MORRIS — Okay. I understand that, but what I have actually asked is what the cost was for Parkville for each of those dates.

Ms PEAKE — The repairs for Parkville were $1.74 million for 2015–16, and Malmsbury was $636 000.

Mr MORRIS — Do you have figures for each of those events?

Ms PEAKE — I do not have those figures with me, no.

Mr MORRIS — Are you able to provide those on notice?

Ms PEAKE — I am happy to take that on notice. I am sure we will have another conversation about this at the parliamentary inquiry next week.

Mr MORRIS — Going on with that issue, can you advise the committee which recommendations of the two Muir reviews that were commissioned following both of those riots have been implemented at Parkville?

Ms PEAKE — Certainly. There have been a series of reviews into really operating model and infrastructure across the custodial sites, and there has been a lot of work that has been happening, particularly over the last 12 months, to look at how we stabilise our staffing. We have had a new recruitment methodology that we have adopted to ensure that we have sufficient staff and stable staffing across all of our sites. We have also had a process of really reviewing the security of the site, which has led to fortification works prior to November and obviously a lot of fortification works that have happened since November and are underway, and we have also been really looking at our operating model. We have been putting our staff through different training so that they are able to de-escalate incidents more quickly and safely, and we are really building on that now with some further training that is going to be led by Corrections Victoria for our staff in how to undertake formations to really de-escalate incidents.

The final thing I would say that comes through a number of the reports, not just the two that you mentioned but other reviews as well, is really looking at behaviour management. We have been trialling a different approach down at Grevillea to behavioural management, which really works on a fairly simple gold, silver, bronze scheme that rewards youth for good behaviours and has consequences when expected behaviours are not met, and that is something that we are looking to roll out across all of our settings. Together that work on operating model, the capability of our staff, the stability of our staff and the security of our facilities we think is critically important to adapt to what is a very different clientele that we are seeing in our custodial services.

Mr MORRIS — Finally, to round that out, Secretary, can you indicate how many computers were replaced or were in need of replacement at both Parkville and Malmsbury during the 2015–16 financial year?

Ms PEAKE — I will need to take that one on notice.

Mr MORRIS — If you could, I would appreciate it. Thank you.

Ms SHING — Just to clarify, are you asking as a consequence of those incidents in 2015–16, Deputy Chair?

Mr MORRIS — Yes.

Ms SHING — Thank you, Secretary and witnesses, for attending today. I would like to pick up on some of the comments that were made in response to the Deputy Chair's questions in relation to youth justice, and in particular your obligations under section 482 of the act. I note there has been commentary from a number of quarters in recent days about whether a youth justice facility to replace Parkville could be located in somewhere like Gippsland. Just to declare my interest in this, I am a member who represents the region, as is Mr O'Brien sitting opposite me, and one of the issues around the criteria that apply around the use of public land that is available and of a sufficiently large footprint as well is access to public transport, suitability of soil et cetera. They are things that need to be taken into consideration. I note the Supreme Court has had something to say about that too. In light of the fact that we have got mapping that indicates the majority of staff are from the north and the north-west of the city and that access for family visitation, education and specialist services is a crucial part of discharging your obligations under the act, why can we not put a replacement facility for Parkville in the Gippsland region?

Ms PEAKE — This really does come back to building on my answer to the Deputy Chair, which is that I have very clear obligations under the Children, Youth and Families Act to ensure that any youth who are detained in custody have access to services. We have a number of young people who have experienced significant trauma over their lives and have quite complex medical conditions, and so access to specialist services and continuity of access to those specialist services is very important.

Secondly, I have obligations to ensure that there is an entitlement to access to legal representatives and to family. Certainly very strong feedback from the Fitzroy Legal Service and the Human Rights Law Centre through the matter you referred to — the previous matter in front of the Supreme Court — was that the logistics are important to them to be able to provide legal representation to their clients and access their clients on a regular basis, as well as that important requirement for us to return young people to court every 21 days where the court is located predominately in the CBD. We are working very hard with the court to ensure that there is consistency of the magistrate hearing matters; we do not want to end up in a situation where it is a different rotating magistrate around country courts.

Ms SHING — So a circuit option is not appropriate in the circumstances?

Ms PEAKE — It really does not maintain that continuity of magistracy.

Finally, it is important that we are able to get those services outreached into the facility. That includes counselling services. It includes social services that provide through-care so that there is continuity care beyond the period of detention back into the community on release. We have a number of social services that offer those services to our young people as well as the continuity of the relationship with their youth justice and child protection case managers. So when you combine all those obligations under 482, and the operational factors, it is very important that the location of the new facility is proximate to the CBD and that it is connected to regular public transport and able to access those services.

Ms SHING — Taking what you have just indicated in your answer as being the necessary combination to get right in the placement of a new youth justice facility, what challenges has Malmsbury encountered, given its location at 100 kilometres from Melbourne in relation to the provision of specialist services, attraction and retention of staff, training and the sorts of obligations that you have under 482 of the act?

Ms PEAKE — There are two things that I would draw out in particular. Really when Malmsbury was first developed its intent was to provide a service for 18 to 21-year-olds who were on dual track, were sentenced and were quite stable. It was not really built with the intention that there would be that return of remandees to the court in the CBD every 21 days.

We have had real challenges, as you allude to, in terms of the retention of staff at Malmsbury, and certainly in exit interviews one of the things they have raised is the travel time involved in working at Malmsbury. But the

third thing, which I did not mention in my first answer, and which is important, is that you can see right around the country the volatility of youth justice sites, and one of the challenges for us at Malmsbury, which was writ large in events a few weeks ago, is the ability to get specialist staff onto the site to defuse situations that are escalating quickly. Malmsbury is really dependent on local police to provide that third level of response. For specialist police or corrections to come from Melbourne takes, as you say, an hour, and that is a long time when an incident is starting to escalate. The benefit of a closer proximity to the bigger centre is that we can have access to that specialist support and in the future justice can have access to deploy their specialist resources more quickly.

Ms SHING — Thank you. Finally, in relation to the gold-silver-bronze model that you talked about and in relation to the challenges being faced by other jurisdictions we are really, at least if you read what has been published in recent times, in an unprecedented time of action by people who are in youth justice facilities. What can the department learn, what can you learn and what are you learning from other jurisdictions where this may have occurred? Is this a trend that is occurring more broadly than this particular state, or are we in essence standing on our own here?

Ms PEAKE — There is a bit in that question. Certainly my conversations with colleagues in other jurisdictions have indicated that we are seeing some similar behaviours and challenges right across the country. In the past 18 months to two years we have seen a real shift in the population, the cohort, that is coming into our facilities. There has always been a small number of young people who have been recidivist offenders who start offending young and whose offending becomes more serious as they grow older. But what Victoria Police is identifying and the crime statistics unit is reporting is that we are seeing more young people coming into contact with the youth justice system for the first time when they are older and for more serious offences. To give you a bit of a sense of that, we have seen in 17-year-olds a very high proportion where the offence they are facing is an offence against the person, and more aggravated offences as well.

Ms SHING — And that is in other jurisdictions as well?

Ms PEAKE — It is. To your specific question about whether we are all sharing information and learning, there are really two categories. One is the sorts of programs that change behaviours. The second is the behaviour management that I mentioned, the way in which there are incentives and consequences for behaviour that are built into the management of facilities. I do not think anyone has got this right. We really are learning from one another. A review that has been underway since the second half of last year by Professor James Ogloff, who is a forensic psychiatrist from Forensicare, and Penny Armytage, who is a very respected ex-public official, has really looked worldwide at what are the sorts of approaches for this small but very significant group of offenders who are very well networked and are providing a real challenge for us to manage — the sorts of programs and the sorts of behavioural management approaches that have the best prospect of success.

Ms SHING — Thank you very much. That is very helpful.

Mr D. O'BRIEN — Secretary, just before I move on to another question, you mentioned, I think, that 12 or 13 sites were considered for — —

Ms PEAKE — I did not mention that.

Mr D. O'BRIEN — You did not mention that. You mentioned that various sites were considered. Is it possible for the committee to have a list of the sites that were looked at?

Ms PEAKE — Again I think we are straying outside of the 2015–16 period, but the sites are subject to the business case, which is cabinet-in-confidence, so it is not a call for me to make.

Mr D. O'BRIEN — Thank you. Can I just ask a bit about the heart hospital. There was a $900 000 business case funded in the 2015–16 year, and we heard in estimates last year that that was still underway but due to be finished this financial year. Has that business case been completed?

Ms PEAKE — Thank you for your question. As you have indicated, the government committed $150 million towards the establishment of the specialist heart hospital to be a centre of excellence for patient care, research and clinical education. It will be developed in partnership with Monash Health and Monash University and built on the Monash University site in Clayton.

The design service and infrastructure plan for Victoria's cardiac system was released on 6 May 2016, which really was the first step in setting out the role of the new heart hospital in a public cardiac care system and a vision for better care and outcomes for Victorians who are at risk of heart disease. The heart hospital is really central to the vision of that plan.

To your question, where we are up to, early planning was completed recently, with a master plan and feasibility study which will then inform the development of a full business case. We have deferred early works on the site, really to enable the further discussions between the project partners on project delivery following a review of the business case. So we are stepping this through in a methodical way, which has led to that underspend of that $2 million.

Mr D. O'BRIEN — So that master plan: did it identify a final cost for the entire hospital?

Ms PEAKE — That will really come through in the more detailed business case, which will come next.

Mr D. O'BRIEN — And presumably then the question of when the heart hospital will be finished will still be up in the air until the business case is finished?

Ms PEAKE — I might ask Mr Foa if there is any more detail we can provide.

Mr FOA — So the full business case will be subject to the deliberations of government in the very near future. We are — —

Mr D. O'BRIEN — Sorry, I think I just missed that. The full business case will be what, sorry?

Mr FOA — Subject to the deliberations of government in relation to the budget. But we are able to confirm that Monash University have now committed to the project and have also made the land available.

Mr D. O'BRIEN — Financially?

Mr FOA — And they have indicated a financial commitment to government. So there are really positive signs for that project.

Mr D. O'BRIEN — Have they set an amount?

Mr FOA — That would be not within my remit to reveal at this point, but they are making a substantial commitment to the project. Therefore we could not do the early works before we had those commitments sorted and access to the site sorted, but that now has actually been confirmed. I think government will have more to say about that project in the near future.

Mr D. O'BRIEN — Have any other partners committed to the project as yet?

Mr FOA — We are working very, very closely with the health service, Monash Health, and we are working through what their commitment will be.

Ms PEAKE — But it is fair to say that there has not been a funding commitment from the commonwealth, who is the obvious other partner in this project.

Mr D. O'BRIEN — Have they been asked for a commitment?

Ms PEAKE — They have.

Mr D. O'BRIEN — They have. So just on that then, is there any likelihood that the state will need to put in more money for the project?

Ms PEAKE — I cannot answer that question. It is pre-empting the finalisation of the business case and deliberations of government.

Mr D. O'BRIEN — So just for clarification, when is the business case likely to be finished? You said deliberations shortly, but it has not actually been done, is that the case?

Ms PEAKE — The business case is underway.

Mr D. O'BRIEN — It is underway. And the likely timing of that?

Ms PEAKE — Again, that is really subject to the decision-making processes of government for it to be completed and considered. As Nick has said, I am sure government will have more to say about that. When we are back here next year I am sure we will have more to tell you.

Mr D. O'BRIEN — So the estimated completion time is still up in the air as well? That was the question we were asking.

Ms PEAKE — Subject to all those processes.

Mr D. O'BRIEN — Just continuing on hospital issues, the Victorian Comprehensive Cancer Centre, as you know, opened in June 2016. All the reports and media releases and everything talk about 160 overnight inpatient beds at the VCCC. There are, I understand, three 32-bed wards at Peter Mac and one 32-bed haematology ward at Royal Melbourne, which adds up to 128 beds. Can you tell me where the other 32 beds are?

Ms PEAKE — I might just ask Mr Symonds. Are you in a position to answer that question? Otherwise we can take it on notice and come back to you during the hearing.

Mr D. O'BRIEN — Sure. The follow-up to that is the 13th floor. Has any work happened on the 13th floor or is it still empty?

Ms PEAKE — You would be aware that on 16 July — which is again straying beyond the period of the hearing — it was announced that level 13 will be the Ian Potter Centre for New Cancer Treatments, including providing a home for the Peter Mac led VCCC immunotherapy research program, the Australian Genome Research Facility, the cooperative research centre for cancer therapeutics and innovative clinical trials centre, as well as housing the new international cancer research centre to really forge relationships with other global clinical trials and research entities. The Victorian Cytology Service will also join the tenants of level 13 to strengthen links between cancer research, screening and treatment. As Professor Grant McArthur, who is the new executive director of the VCCC, noted last week, all of those tenants are really critical to the vision of the VCCC, creating that collaborative hub of immunotherapies for cancer treatment.

So in terms of where we are up to, the fit-out of the leased area is the responsibility of the incoming tenants. The design of the areas is being progressed by each of the tenants in accordance with their tenancy arrangements, which we have entered into, and the fit-outs are expected to commence very shortly and to be completed by the end of 2017.

Mr D. O'BRIEN — The end of 2017.

Ms PEAKE — For the completion of all the fit-out works.

Mr D. O'BRIEN — Right. So the 13th floor should be open by the end of 2017?

Ms PEAKE — Mr Foa, is there anything you wish to add to that?

Mr FOA — No, that is accurate.

Mr DIMOPOULOS — Just on something entirely different: HIV prevention. I just wanted to get a sense — a bit more detail — on budget paper 3, page 64, there is an investment of $2.24 million, and I think part of that is a continuation of the Pronto! rapid testing service. I just wanted to get a sense about that but also more broadly about HIV prevention. Specifically with Pronto!, how many people have benefited? Do we have any actual tangible outcomes?

Ms PEAKE — Certainly I can provide an update on part of that. Pronto!, people would be aware, is a shopfront service offering rapid tests from a drop of blood from a finger prick for HIV and was established to get more people tested. Removing testing from a clinical environment provides also a supportive environment for counselling and information on safer sex practices and other measures to reduce the spread of HIV.

Certainly what we can see in our data is there has been a significant increase in testing that has happened and as a result an increase in notifications.

Mr DIMOPOULOS — So just on that, I cannot remember where I saw this, but I saw it somewhere, probably at the carnival or some LGBTI community event, that the HIV rate has increased. I am not sure if that is the same for the 2015–16 financial year, and I wonder whether that is around notifications.

Ms PEAKE — Yes, I think that is the right diagnosis. So to give you some numbers, there is a 17 per cent increase from 2015 to 2016. From 1 January 2016 to 30 November 2016 — so I know that is across two financial years — there were 304 new HIV diagnoses notified in Victoria compared to 260 new notifications for the same period in 2015. Our analysis, our assessment, is that that is absolutely related to more people participating in testing.

Mr DIMOPOULOS — And would that bear our then that most of those would have come through the Pronto! centre?

Ms PEAKE — Definitely through the Pronto! centre as well as through other local primary care services. Just of interest, of note, is the increase in the number of people diagnosed who have never been tested before their HIV diagnosis and have not been tested for at least three years, so it really reinforces that destigmatising. Taking it out of a clinical environment is leading to better identification, which of course then means better access to treatment.

Mr DIMOPOULOS — Within that financial year, what other investments have been made in relation to HIV prevention? I know the minister announced something on World AIDS Day last year.

Ms PEAKE — PEP and PrEP?

Mr DIMOPOULOS — Sorry, of course — PrEP.

Ms PEAKE — Just a quick update on both PEP and PrEP. PEP — post-exposure prophylaxis — is when someone takes HIV medication to try and prevent the virus taking hold. It is sort of the equivalent of emergency contraception, if you think about the sort of equivalent of the morning-after pill.

PEP is now distributed through a hub-and-spoke model, with Alfred Health serving as the hub. Anyone who is requiring PEP is referred to the closest spoke, which includes selected GPs, so section 100 prescribers, hospital emergency departments or infectious disease units and sexual health clinics across metropolitan and rural Victoria. We fund the Alfred to distribute the antiretroviral treatments. A baseline HIV test is undertaken and then further tests following completion of the course at 28 days of medication.

The second part is PrEP — pre-exposure prophylaxis — which is taken on a daily basis as a way to prevent becoming infected with HIV. So again the comparison would be taking an oral contraceptive pill. That is currently available — and I think this is what you are remembering, referring to a trial of approximately 3200 people identified as at risk — and includes baseline HIV and sexually transmitted disease tests, which are then repeated throughout the course of the trial, about every three months.

Mr DIMOPOULOS — I think the minister announced something like there will 70 less infections. I cannot remember, but there was a number of 70. I do not what it related to, whether it related to not being infected or being assisted in some way. Do we have a measure for the success of that program?

Ms PEAKE — I might just ask Ms Congleton to come up and give you any further detail.

Ms CONGLETON — It is still in the early stages, so there is no measure apart from the budget paper measure that we have got at the moment, but we will be looking at all of our budget paper measures in the lead-up to the next — —

The CHAIR — Sorry, could you just move your microphone a bit closer? We are having trouble hearing you.

Ms CONGLETON — It is a relatively new program, so looking at its impact is something that we will be looking forward to in the next budget. But the measure that we have got now is really around testing rather than

the impact of what it is doing to stave off infections. We are seeing, as the secretary mentioned, a number of people through that who have been diagnosed. It has obviously been with some for some time, so it is identifying but also, through that testing on a three-monthly basis, providing ongoing support, because it is not just about the testing, it is also then about support to other people. It is pretty much also not just workers but also in terms of peer workers and support. It is not just about the identification of the disease, but assistance and guidance with a number of other outcomes for people.

Mr DIMOPOULOS — Associated issues.

Ms CONGLETON — That is right.

Mr DIMOPOULOS — Just in relation to the federal funding of both PrEP and PEP, apart from the fact that the feds fund Medicare, so your visit to the GP, is there any subsidy or funding commitment from the feds on those medications?

Ms CONGLETON — We have sought that a number of times, through the PBS. I think it was considered a few months ago, late last year, and it did not get up. That is something that we will be seeking support for, as other states and territories are. What Victoria has done a couple of other states and territories have done as well. We would say that we are seeing good outcomes where we think this is a good investment for the future in terms of future healthcare costs being allayed but also the impact on people's lives is pretty significant.

Mr D. O'BRIEN — Just a quick one on the VCCC: will the state government put any money into the 13th floor fit-out?

Ms PEAKE — No, that is all a matter for the tenants.

Mr T. SMITH — Secretary, in relation to the 240 residential rehab beds, as detailed on page 22 of the DHHS annual report, where are the additional 32 beds located?

Ms PEAKE — Again I might just ask Ms Congleton. Certainly, as you have said, there are 32 residential beds for forensic clients that were established in 2015, which increased bed capacity by 15 per cent.

Mr T. SMITH — Is that only for forensic clients?

Ms PEAKE — Correct. That was the commitment. I am happy to talk to you more about the difference between how we approach treatment compared to other jurisdictions like New South Wales that have a higher residential component, but to your specific question — —

Ms CONGLETON — I can advise the committee that those 32 beds were expanding services and access at existing facilities, so expanded bed capacity across a range of, I think, six locations across the state that the 32 was connected to.

Mr T. SMITH — Could you elaborate on where they are perhaps?

Ms CONGLETON — There is Bendigo, the Salvation Army. Perhaps what I could do is provide a list to the committee of their locations. For example, at Odyssey House there is an expansion of bed capacity, 15, which is in outer metro Melbourne.

Mr T. SMITH — If you could provide a list of facility name and geographical location, that would be greatly appreciated.

Ms PEAKE — I think the important point that Ms Congleton has made is that they are all expansions of existing facilities, but we can get you that list.

Mr T. SMITH — Sure. If we can get the list on notice, that would be greatly appreciated. All these 32 beds, they are all open?

Ms CONGLETON — They have been activated, yes.

Mr T. SMITH — Were there any additional residential rehab beds planned in rural and regional Victoria during the reporting period?

Ms CONGLETON — So there was, as part of the last budget, for 2016–17, an announcement about a rehabilitation new facility in the Grampians region of 18 to 20 beds. So that fell in the 2016–17 budget. There was in the 2015–16 period, as part of the Ice Action Plan, the expansion and the addition of therapeutic day rehabilitation services, and that was nine places across the state, predominantly in regional Victoria but also parts of outer metro as well. That is offering people who need support the capacity to get access to treatment and support therapeutic treatment close to home. It is offering a different service response that supplements and complements other activities in the drug treatment area.

Mr T. SMITH — On the Ice Action Plan, if I could, how many clandestine drug labs have been identified since the project was established?

Ms PEAKE — I think that would be a question more appropriate for Victoria Police than for us.

Mr T. SMITH — Okay. You cannot give us any indication of convictions? You do not have any of that?

Ms PEAKE — That is not in our portfolio.

Mr T. SMITH — Can you outline the specific programs that are provided for offenders particularly within the youth justice system who are ice affected or affected by any other drug or alcohol issues?

Ms PEAKE — Certainly. As you have indicated, Mr Smith, we will focus on the youth justice cohort. The interventions that are made available to adult offenders obviously fall into the justice portfolio. In terms of the young people in our care, in custody, we certainly have both processes of detox and then counselling services that are provided to young people who are misusing substances, and that is something that the review that is underway at the moment that I mentioned earlier — Professor Ogloff and Ms Armytage's work — is also looking at: what is the best practice around the world in that space which will inform further development of those programs in the future?

Mr T. SMITH — Thanks very much.

Ms PENNICUIK — Thank you, Secretary, and everybody else who is here today from your department and agencies. I just want to ask a little bit about child protection. In your presentation at page 6, 'A year of progress', it states:

> Begun shifting the focus of child protection from crisis response to prevention and early intervention as part of the *Roadmap for Reform: Strong Families; Safe Children*

In some ways is a little bit surprising that there was not a focus on prevention earlier. Could I also refer you to the questionnaire and responses from the department to the questionnaire on page 6, which is titled 'Child protection workforce reform', which includes outcomes from the 2012–13 budget performance report with a date of completion of November 2012. The expected outcome was an increase from 63 to 75 per cent of the child protection workforce designated as case carrying and a related increase of case-allocation capacity by 700 cases. It is all there.

Ms PEAKE — Yes.

Ms PENNICUIK — And a KPMG report found that that outcome had been exceeded and the increase in case allocation capacity had been sustained. This looks like a success story. One of the questions, which I will just ask you to hold for a moment, is: why are the figures that are presented here going back so far, to 2012–13? I also wanted to say that statistics that have been obtained last year through FOI tell that the number of reports of abuse or neglect to the department doubled from 2011–12 to 2014–15, that the proportion of unallocated cases also doubled, from 7.8 per cent to nearly 17 per cent, and also that demand for out-of-home care, particularly foster care, still exceeds capacity and staff retention is problematic. You mentioned that earlier in your statistics, but I did not write those statistics down. So we still have a problem with this area. Of course the Ombudsman's report into the youth justice stuff that we have been talking about pointed out that the Youth Parole Board found that 45 per cent of youth offenders were previously involved in child protection. What is the update on the number of unallocated cases at the moment, and what measures are in place to address this problem?

Ms PEAKE — I will focus on 2015–16, but as I said in my introductory comments, we have continued over the last three years to see really substantial growth in reports to child protection — 30 per cent growth. I think I mentioned in 2013–14 there were 82 000 reports. In 2014–15 that rose to 91 348 and in 2015–16 almost 107 000 reports. The 2015–16 average annual rate of case allocations, which, as you reflected, is in our annual report, was 81.1 per cent. So if we get underneath those numbers, the increase in reports is largely connected to family violence, and other reports from Victoria Police and the Family Court really raise awareness that has come through from the royal commissions into family violence and institutional responses to child sexual abuse raising community awareness and highlighting the vulnerabilities of children and young people.

I think a positive sign, but definitely a factor in our increased reports, has been a 21 per cent increase in the number of reports received on unborn children between 2014–15 and 2015–16, which does give us the opportunity for that earlier intervention. If we then look at the rate of reports of concern to Child First, they have been pretty steady. What that then means is an increased volume of work across the entire child protection program. So as part of receiving reports of concern about children in 2015–16, child protection workers undertook 28 525 investigations, which is 3472 more than the previous year. There were 15 295 substantiations, which is 508 more than the previous year, and we are also seeing an increase in the amount of allocated work.

I think we talked a bit last year about the process for allocating cases according to the complexity of the client, taking account of age and vulnerability, the experience of staff, and that when a case is not directly allocated it is still absolutely monitored by more senior staff and there is a constant process of allocating and reallocating to make sure that high-risk cases are adequately worked. So the team manager has responsibility for overseeing all of the cases and services involved with families and children.

In June 2015 then, going to your question about some of the things that we are doing to try to address this, we had 1403 child protection practitioners, and over the 2015–16 year we did a lot of work to change our recruitment practices, with the budget capacity that we were provided, to really increase our number of workers. The number of workers grew to 1510, which obviously gives us more case-carrying capacity — albeit that there is always a lag, because you get new workers on, they need to be trained and they require proper supervision and support. But we have seen, as a result of the $65.4 million investment in 2015–16, growing of the capacity of the child protection program by 148 positions. That has enabled us to reform our intake services to consolidate all of our intakes into four, which again frees up more people to be involved in carrying cases. We have had 88 new practitioners, therefore, to meet demand and allocate a practitioner when it is needed.

We have completed the statewide rollout of the after-hours service, the rural after-hours emergency service, and we have created four dedicated positions to identify children at risk of sexual exploitation, 24 positions to improve permanency planning, so early case planning, and more family-led decision-making. So we have been doing a lot of work around really getting more expertise and more capacity into the child protection system in the face of that continuing growth in demand.

We have also been doing a lot of work with schools, with health services and with police to look at how we have community-based responses to try to reduce risk factors earlier. Part of your question really went to how do we not just rely on the allocation of child protection resources but how do we build up that earlier intervention support, and there was also a $48 million investment in our family services to really try and divert people, provide earlier support and change family behaviours so that the statutory risks do not manifest themselves. I might pause there.

In terms of your question about why we went back in time in the questionnaire, my understanding is that the basis of the question was looking at programs and investments that were coming to an end in that part of the question that went back to that budget period.

Ms PENNICUIK — Thank you, Secretary, for that very comprehensive response.

The CHAIR — Just briefly, Ms Pennicuik.

Ms PENNICUIK — Thank you, Chair. As I say, I am only onto my first supplementary question.

Ms PEAKE — I will be briefer.

The CHAIR — Yes, Ms Pennicuik, but you have now been going for 9 minutes.

Ms PENNICUIK — It is a very important area that the department works with.

The CHAIR — Indeed, and we all have to share our time.

Ms PENNICUIK — It has far-reaching ramifications if it is not handled properly. My follow-up question is really regarding staff retention and prevention, because staff retention, as you have said, is an issue. What particular measures do you have to retain staff, and with the prevention is the department looking at why it is that, of that cohort of youth justice offenders, 45 per cent of them have the child protection background? And is there some work being done as to how to reduce that number of children coming out of the child protection system and entering the youth justice system, as you outlined before?

Ms PEAKE — I might start with that part of the question, and I would want to be clear that while there is an over-representation of children who have been in out-of-home care in youth justice, that does not mean every child who is in out-of-home care ends up on that pathway. There is very impressive work that is done by many of our foster and kinship carers, as well as our resi care workers, to set youth up for a positive life.

Ms PENNICUIK — I appreciate that. I was not trying to say that was the case.

Ms PEAKE — One of the things that we have invested a lot of work in in the last 12 months is really looking at those models of out-of-home care, as well as, as I mentioned, the quicker permanency planning so that there is a good case plan for very young children when they come into out-of-home care so we can get them home quickly or we can get them into a stable placement, because we know that that sort of disruption in care is one of the contributors to later behavioural issues.

In terms of the work we are doing in out-of-home care, we have been doing a lot of work with the sector on looking at the sort of wraparound supports for foster and kinship carers but also a new model of intensive treatment support as an alternative to residential out-of-home care which would look at children who have problematic behaviours and look at what sort of interventions can address those to enable them to be supported in a home-based environment, because we know those stable relationships are so critical to their life outcomes. That is some of the key work that is happening in that space.

We are also doing a lot of work right across government — and this is being led by Premier and Cabinet, with our support — looking at what new models of place-based connected integrated support can look like, built around the hubs that were announced in the 10-year strategy for family violence at the end of last year. A lot more will be said about that, with implementation plans that will be released in a month or so's time. So I think in the prevention space we will see a lot more of the fruits of all of the co-design work that has been happening in the months ahead.

The CHAIR — Briefly.

Ms PEAKE — In terms of the retention efforts for our workforce — I will be quick — we have been really focused on that recruitment process and on-boarding process. We know that we lose a lot of workers early in their career, so making sure that their first experience of child protection is a supported one. We have been continuing to work on our learning and development program to ensure that there is that support, and obviously

The CHAIR — Secretary, if I could turn you to budget paper 3, page 63, there is a line item there for $3.6 million for Ebola preparedness. I was just wondering whether you could advise the committee how those funds were expended in relation to Ebola preparedness in the 2015–16 financial year, please?

Ms PEAKE — Certainly. I might ask Ms Skilbeck to come up to the table. But there are sort of three parts to this. One is around the labs that have been invested in and the second is the testing and equipment that is used in those labs, with strong support from the Royal Melbourne and Royal Children's to make sure that we have dedicated capacity for this testing. Ms Skilbeck, I might ask you comment.

Ms SKILBECK — Certainly. More specifically, the equipment that was funded through that commitment related to what is known as a physical containment level 3 lab, a very, very secure lab arrangement for these extraordinarily infectious viruses, and an array of personal protective equipment to protect medical staff — both testing viruses but also managing the treatment of any patients. As the secretary noted, the investments were focused on the Royal Melbourne Hospital and the Royal Children's Hospital, which remain our primary hospitals for managing any cases of suspected Ebola or any other viral haemorrhaging-type fever viruses. Both

of those programs have been completed. That equipment and those facilities remain the key part of the Victorian Ebola virus disease plan that the department has put together and administers. It is one of many things that we have in place and hope we will never use.

The CHAIR — So the overwhelming majority of that $3.6 million was spent on capital costs or was infrastructure that could be used for a future contagious event.

Ms SKILBECK — I cannot confirm for you, Chair, whether it was actually capital in an accounting sense, but it was certainly equipment and very sophisticated laboratory equipment. Some of that will have been a key fit-out. So it is both capital and equipment expenditure.

The CHAIR — So, broadly speaking, because of that investment made in that particular year, in the event there was an event like this to occur subsequently, then you would feel reasonably comfortable that we would have the tools and the equipment to be able to respond to that?

Ms SKILBECK — To the extent one can forecast a particular event like that, yes, we certainly have a much better set of facilities than we had prior to the investment.

The CHAIR — I think Mr Smith had a point of clarification.

Ms PEAKE — Chair, I can also come back to, I think it was, Mr O'Brien's question about bed numbers at VCCC when it suits the committee as well.

Mr T. SMITH — I will keep going.

The CHAIR — We will do the trifecta. We will do one, two, three. So Mr Smith, off with you.

Mr T. SMITH — If I could just return to the Ice Action Plan, in your annual report in 2015–26 it says nine new therapeutic day rehabilitation services will be provided. Where are those services located, and are they all open and accessible to the public?

Ms PEAKE — Thank you, Mr Smith. As you indicated, $80 million over four years was invested to expand therapeutic day rehabilitation, providing support for an extra 500 Victorians per year. Nine additional services were funded across rural Victoria and metropolitan Melbourne. There are seven services in rural Victoria — for example, Warrnambool, Latrobe and Shepparton; two in metropolitan Melbourne: Casey-Cardinia and Wyndham-Melton. But again, I am happy to get you the full list of the — —

Ms CONGLETON — Secretary, I can.

Ms PEAKE — Ms Congleton can.

Mr T. SMITH — Of the full list?

Ms CONGLETON — Yes, so I can just run them through. So there is one in Ballarat that covers Ballarat-Horsham. There is one that covers Wyndham, Melton and Maribyrnong, so that is an outer west area, western metro.

Mr T. SMITH — Where is that?

Ms CONGLETON — That is through Odyssey House. So that is through Wyndham, Melton and Maribyrnong. There is one that covers the Sunraysia area and it is located in Mildura. There is one that is located at Shepparton that covers the Shepparton-Mitchell — Goulburn Valley area. There is one at Geelong that covers the Greater Geelong area, and one that is located in Bendigo. There is also one that is located in Warrnambool, which covers the Warrnambool and Glenelg area; and there is one that covers that Casey and Cardinia area. The last one is at Latrobe. As the secretary mentioned, they are predominantly in rural Victoria, with a couple in outer metro Melbourne.

Mr T. SMITH — And they are all operational as we speak?

Ms CONGLETON — Yes.

The CHAIR — Now I think the Secretary has some advice for Mr O'Brien.

Ms PEAKE — Yes. Mr O'Brien, I was just going to follow up on your question about the bed numbers at VCCC. So the project has delivered a physical capacity of 202 overnight inpatient beds in total, compared with the original business case requirement for 200. Within the Peter Mac Cancer Centre tenancy — and I think you referred to these numbers — there is 96 overnight inpatient cancer beds across level 5, level 3 and level 6. In addition there has been extensions and refurbishment to the existing Royal Melbourne Hospital, which provides a further 106 beds, comprising a new 32-bed haematology inpatient unit on level 7 of building 1B, space for a new 32-bed medical-surgical inpatient unit on level 8 of 1B and a 42-bed-capacity critical care unit on level 6 of building 1B.

Mr D. O'BRIEN — Sorry, those last ones were all at Royal Melbourne?

Ms PEAKE — They were all at Royal Melbourne, yes.

Mr MORRIS — If I can move to the disability sector, back in September 2015 there were some comments from the department in the media indicating that it would top up individual support packages for those with disabilities to compensate for additional costs primarily caused by additional labour costs with penalty rates for the AFL Grand Final. Given that one client said additional costs to her on that day were $467, can you indicate to the committee what the total cost to Victorian taxpayers was for topping up the ISPs as a result of that public holiday?

Ms PEAKE — I am not in a position to be able to provide that data to you. I am not sure that there is anything I can add to that.

Mr STENTON — No, I do not think there is anything we can add to that, other than the individual ISP costs for an individual client depend on the client, so it depends on their personal needs, and our prices are set at price levels, so they are not componentised.

Mr MORRIS — So extra funds were allocated, but you cannot tell me why they were allocated?

Ms PEAKE — Extra funds were allocated for more ISPs, but as Mr Stenton has indicated, they are not broken down for the component parts of the price.

Mr MORRIS — I may come back to that.

Ms PEAKE — Certainly.

Mr MORRIS — Sticking with the disability sector we can move to the rollout of the NDIS. There has been some criticism that there were insufficient community information sessions to educate and inform families. Can you indicate to the committee how many sessions were run by the department in the lead-up to the 1 July rollout in the north-eastern suburbs?

Ms PEAKE — There were 140 sessions that were rolled out between April — and that continues through to December of this year, so starting before the rollout started in July but then beyond that. Obviously those were sessions that were done in conjunction with the NDIA.

Mr MORRIS — Can you provide the committee with a list of those?

Ms PEAKE — We can do, certainly.

Mr MORRIS — Thank you. Just on the same subject, obviously the department has a big role to play in educating clients and educating the community. Is there a KPI around the number of information sessions for families that should be held in each rollout area?

Ms PEAKE — There is not a KPI per se, but we certainly work very closely with local providers, local families and local communities to ensure that where there is a desire for more information we look at the best ways of meeting that. We have certainly been funding not only the information sessions but support for advocates so that there is a good engagement with families about what the NDIS means for them, as well, of course, as information to new providers about what it will mean to operate in the NDIS.

Mr MORRIS — Given there is no KPI, in terms of the larger areas — so, for example, the Central Highlands region — is it the intention of the department to run more sessions, given the expansive geography?

Ms PEAKE — Yes. For example, we have run 40 sessions between July and December for Central Highlands. So as we get to each part of the rollout, a core part of our preparation is those information sessions. We absolutely, as I said in my opening, are very committed to learning from each of these experiences so that the information that is provided is being adapted as we go and we understand more about what the specific interests of client groups are.

Mr MORRIS — Just finally, is there a target for the number of people who attend those meetings, or is it basically just those who turn up?

Ms PEAKE — There is not a target, but they are open, and as I have said, if there is more demand than the sessions that are scheduled, we will always hold more sessions.

Mr MORRIS — Do you keep track of how many people attended each session?

Ms PEAKE — We do. I might just ask Ms Asquini whether we have got that data with us; otherwise we can certainly get you further data on attendance.

Ms ASQUINI — No, we do not have the data with us, but we can certainly provide it.

Mr MORRIS — If you could provide it, it would be very helpful. Thank you.

Ms SHING — I would like to talk about elective surgery numbers, if I may, and in particular the $60 million investment that was made with the intention of alleviating the skyrocketing numbers of those patients who are waiting for surgery. As I understand it, prior to that $60 million investment we had some 50 000 Victorians needing surgery who had often languished on waiting lists, with sometimes very acute conditions, for extensive periods of time. As a consequence of that investment to backfill the $1 million that was taken out of the health system under the former government, we have seen significant changes that are referred to on budget paper 3, page 63, to the way in which elective surgery has been funded. What has this delivered in real terms as far as the numbers of people who are on waiting lists, not just from a metropolitan perspective but regionally over the relevant period?

Ms PEAKE — Thank you very much. It is worth just giving a bit of context here, that in 2015–16 there were 21 Victorian public health services that reported to the statewide elective surgery dataset. Our performance, as you have referred to, was urgent category 1 patients seen within 30 days achieved at 100 per cent, consistent with the result from 2014–15. Semi-urgent category 2 patients seen within 90 days was 77.2 per cent, which was under the 80 per cent target but an improvement on the 2014–15 result by 1.4 per cent. The non-urgent category 3 patients seen within 365 days was 93.7 per cent, under the target of 94.5 per cent but again an improvement on 2014–15 by 1.2 per cent.

To the specific question, in 2015–16 the final statewide elective surgery waitlist was 36 436 patients, which is data that is available publicly on the performance reporting website. It was published on 25 November and represented an improvement on the 2014–15 result by 3915 patients or 8.2 per cent, so down from 40 351 patients on the waitlist at previous year.

Ms SHING — What about patients staying in emergency for more than 24 hours? That has been a figure that has in previous reporting periods been quite significant, numbering in the hundreds. For the 2015–16 year it is my understanding from the budget papers and the performance measures that we are looking at 254 patients. How does that compare with previous years, and how do we continue to drive that down, following this initial investment?

Ms PEAKE — Thank you. I think I mentioned in my opening remarks that presentations to emergency departments have grown significantly, an additional 4.4 per cent in 2015–16, but 74.3 per cent of patients attending an emergency department were treated within clinically recommended times. That was a slight, 0.7 per cent, reduction from 2014–15 — really due to the higher volume and acuity of patients presenting to EDs — and 71.2 per cent of patients had a length of stay of less than 4 hours, which was a 1.2 per cent improvement from 2014–15.

A few things we have done because we know this is a really important area for the Victorian community for us to continue to improve on: government brought forward $20 million into 2015–16 to enable minor capital works to improve the flow of patients and access to emergency care and elective surgery, and an additional $5 million was allocated to facilitate community mental health services expansion to try and do something about the demand presenting at EDs.

And then really importantly we have been working collaboratively with the 11 health services that have the biggest demand and perhaps the biggest challenges in meeting that demand, together with Better Care Victoria, to really look at what the system-wide constraints and patient-flow issues are and to implement service improvement projects by November of this year. Each of those 11 participating health services is going to identify, or have been identifying, key projects which address the issues for their health service, because each health service has different characteristics of their patient cohorts and different reasons or different things they need to work on.

Industry coaches are working with each of those health services to support testing and trialling of new ideas and initiatives. They are then required to provide status reports four times over the 12-month period.

Ms SHING — Just in relation to the way in which health services operate from a cross-agency perspective to get the best results that you have just referred to, bush nursing services and smaller units with limited acute-care facilities is an area which — again to go back to Gippsland — is one of the things that has presented a challenge for people in accessing urgent care, particularly in peak tourist and visitor times when there may be a spike in the number of people who need that assistance. How has this funding, if at all, contributed to the way in which better oversight is implemented for the people who do rely on bush nursing services and who do rely on the very small hospitals often in remote and rural locations?

Ms PEAKE — I will make a couple of comments, and then I just might ask Mr Symonds to also comment. One of the things that we have been really working hard on is supporting the collaborations between regional health services to really look at how they support one another in terms of services provided and flow of patients across the regional location. That goes to everything from the flow of access to emergency services, to access to specialists, to the use of paramedics, as you mentioned, also through the service and infrastructure planning exercise, which is due to report in the middle of this year, again just looking at just what the availability and the best approach to the mix of services is across regional locations. I might just ask Mr Symonds to comment further.

Mr SYMONDS — Sure. In your original question you asked about the $60 million elective surgery boost, and you asked in particular how that might impact on regional and rural services. I might start there —

Ms SHING — Fantastic. Thanks, Mr Symonds.

Mr SYMONDS — and then tie that into the broader question about regional and rural services. In that year we did a lot of work to bring two new services into the elective surgery reporting system for the state. They are Albury Wodonga Health and South West Healthcare at Warrnambool. That work was carried out in 2015–16, and those services will be reporting publicly their elective surgery numbers in 2016–17 as a result. From the boost, Albury Wodonga Health received $1.85 million and South West Healthcare received $280 000 for additional elective surgery. In addition to that there were funds from the boost provided to a range of smaller services that are not part of the public elective surgery reporting system but do carry out elective surgery as part of a regional network of services, which is part of, I think, what you were alluding to.

Ms SHING — Yes.

Mr SYMONDS — Echuca, for instance, received $180 000. Kyneton received $360 000. So smaller services received a share of that boost as well, which was terrific.

Ms SHING — Was that a greater proportionate share than in previous years, as allocated under that envelope or equivalent envelope?

Mr SYMONDS — Yes, because traditionally elective surgery additional funding is weighted towards or solely provided to those services that publicly report elective surgery in the interests of obviously optimising

public elective surgery performance. I think the allocation of funds towards some of the smaller services that do not publicly report elective surgery is a recognition of the regional networks that exist for healthcare provision.

Kym has alluded to some of the other aspects of care and oversight. The review of quality and safety that was conducted in the wake of the tragic events at Bacchus Marsh made strong recommendations about improving regional oversight for health care as a result of that, and in response to the recommendations of the review the department has funded and supported the establishment of regional mortality and morbidity committees for maternity to ensure that regional and rural maternity services get the appropriate oversight and support to conduct safe health care. We also have provided funding in the 2015–16 financial year to each of the major regional services to reach out and strengthen and support the network of smaller services around them, which gets to some of the areas I think that you are talking about.

Ms SHING — Along the lines of bush nursing hospitals et cetera.

Mr SYMONDS — Exactly. That is right.

Ms SHING — Thank you very much, Mr Symonds. That is very helpful.

The CHAIR — We might just have a point of clarification and then we will break.

Mr MORRIS — Just coming back to that public holiday issue, if I can, Ms Peake, I understand that some clients have indicated that the top-up funds have not fully covered all costs for public holiday services that were delivered. Are there any outstanding settlements in dispute?

Ms PEAKE — I will have to take that on notice — not that I am aware of, but I will take it on notice.

Mr MORRIS — Thank you.

The CHAIR — The secretary wishes to update the committee.

Ms PEAKE — Mr O'Brien, you asked me whether we had made a fit-out contribution at all to the VCCC, and my answer related to part of level 13, which is leased by others. There is a part of level 13 which we have leased from Plenary. So just for completeness: there was a contribution from us of $11.89 million for the part of level 13 that we are leasing.

Mr D. O'BRIEN — That was $11.89 million for part of the floor?

Ms PEAKE — Yes, correct. That is for the fit-out of the part of the floor that the department is controlling.

Mr D. O'BRIEN — So that was allocated. Did that come out of this year's — 2016–17?

Ms PEAKE — That was in 2015–16.

Mr D. O'BRIEN — Thank you, Chair. I will continue. If I could just go back to the heart hospital for a clarification. You mentioned, Secretary, that the commonwealth had been asked for a contribution. How is that done? Is it done formally? Is it a letter from the minister?

Ms PEAKE — I have certainly been part of conversations, but I might just ask Mr Foa to elaborate.

Mr FOA — That has been raised at AHMAC and other places — the officer network — but it has also been raised in various infrastructure forums.

Mr D. O'BRIEN — But there has been no formal letter of request from the minister?

Ms PEAKE — We would have to check that for you, but certainly I have been part of conversations with the commonwealth, with my counterpart, and around the health ministers' council.

Mr D. O'BRIEN — You mentioned AHMAC, was it? Pardon my ignorance.

Ms PEAKE — It is the secretaries group.

Mr D. O'BRIEN — So it has basically been done at the secretary level?

Ms PEAKE — Yes.

Mr D. O'BRIEN — I have got some questions on ambulances now, for which Mr Walker may want to come forward. Page 40 of the annual report reports on ambulance response times to code 1 incidents. I understand ESTA are now triaging calls differently regarding code 1 and code 2. I was just wondering if you could give us a couple of examples of an incident that would previously have been code 1 and is now code 2.

Assoc. Prof. WALKER — A code 1 case, using the example of abdominal pain, would have previously had an emergency ambulance response. It now goes through a secondary triage, and if it meets certain safety parameters — the governance safety parameters — then they will receive either advice over the phone or they may receive a non-emergency patient transport ambulance to transport them to hospital or an alternative service provider provided to their response.

Mr D. O'BRIEN — Is there a list of incidents or categories that would have been code 1 before and now are code 2?

Assoc. Prof. WALKER — 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 to it.

Mr D. O'BRIEN — Okay. Are we able to get a copy of that list 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.

Mr D. O'BRIEN — Okay, thank you. Just a clarification for Ambulance Victoria members, have they now been told that they should not necessarily expect an ambulance to be dispatched if they make a 000 call?

Assoc. Prof. WALKER — On our website we have identified that there has been a change to our clinical response model and that basically, based on the information provided at the time, we will provide them with the right service based on their needs. This system in its previous iteration has been operating for over a decade, so there is an understanding in some parts of the community around it. We have provided information on our website to let people know when you call 000 you may not necessarily get an ambulance response but you will get the right response to your clinical needs.

Mr D. O'BRIEN — So that is on a website, is it? Has there been a promotional campaign other than that?

Assoc. Prof. WALKER — No, we have not done a promotional campaign. Our initial view was that we would deal with each individual client when they called. We have been having conversations about whether there may be some benefit in actually making that more overt through a campaign.

Mr D. O'BRIEN — Have you had an increase in complaints since the change in the code 1/code 2 priorities?

Assoc. Prof. WALKER — We have seen an increase in people that have raised concerns that they have called for an ambulance and did not get one, but we have been able to follow those up. There have been no adverse events associated with that. It is more about expectations.

Mr D. O'BRIEN — I will move on. Also on ambulance, the annual report has a breakdown of the ambulance emergency services output. It is on page 40 of the annual report. There is an increase in the output cost of $83 million from the target to the actual — we are obviously talking 2015–16. Can you tell me what that was spent on and how much of it, if any of it, was with relation to the additional wages as a result of the work value case?

Assoc. Prof. WALKER — I would have to take that on notice. I am sorry, I do not have the specifics of the breakdown in front of me.

MS PEAKE — I might be able to just provide part of an answer to that, though, Mr O'Brien. The 2015–16 result reflects the realignment of some corporate costs and a transfer from ambulance non-emergency output relating to the revised fee structure in the policy and funding guidelines. We can certainly get you more detail on that, but that is my understanding of the difference.

Mr D. O'BRIEN — That is a very big difference, though, 13 per cent for those issues that you mentioned, which are also listed in the footnote. Perhaps on notice too — —

MS PEAKE — If you would like, I can certainly ask Mr Stenton to take you through that.

MR STENTON — Yes. Obviously we can take it on notice and get some detail, but one of the major movements was some historical funding that was funded from the acute services — sorry, the ambulance output that has been moved to the acute services output, so part of the ambulance bypass remediation was to take some funding — sorry, the other way around — from acute to ambulance. It was an output movement more than an increase in funding, so across the whole budget not a lot has changed.

Mr D. O'BRIEN — Presumably. though, some element of that increase would be the work value case, additional wages?

MR STENTON — I would have to take that on notice. My recollection is no, but I will take it on notice.

Mr D. O'BRIEN — If we could get a breakdown of that, on notice, for 2015–16, that would be great, and if possible, for the out years as well.

The CHAIR — I am not sure you could ask for a breakdown for the out years, because we are looking at the 2015–16 year. I am happy if that information can be provided for 2015–16.

Mr D. O'BRIEN — Perhaps I will put it on notice for estimates then.

Mr DIMOPOULOS — Secretary, in the most recent budget — as you know and a lot of us know — the government made an investment of $27 million as an effort to halve the suicide rate by 2025. The suicide prevention investment started earlier. I note that on page 15 of your annual report you talk about a 10-year mental health plan and you reference the suicide prevention framework. That work had commenced the year before the $27 million announcement. Can you give us some more detail about what was achieved in the implementation of the framework in the 2015–16 financial year?

MS PEAKE — Certainly. As you have mentioned, the $27 million over four years included funding for six health services to attest assertive outreach models to support people and their families following a suicide attempt, and six place-based trials where local communities develop and implement proactive suicide prevention strategies. But as part of the 2015–16 budget the government also announced grants to provide additional support to young, same-sex-attracted people, referred to as HEY grants, and these funds have been expended fully. While they contribute to the suicide prevention effort, they are not part of those more recent suicide prevention activities.

Mr DIMOPOULOS — In the 2015–16 financial year suicide prevention framework — you mentioned HEY grants — was there any other work done?

MS PEAKE — I might ask Ms Congleton to come and add to this, but we were pursuing a lot of work across 2015–16 and subsequently with primary health networks to really make sure that we have a coordinated approach to our investments — and particularly a targeted approach to Aboriginal communities where we know that we have higher rates of suicide — and really looking at both the cultural competence of primary health services and community health services as well as what are more culturally appropriate models of providing information and outreach.

The other thing that we did during the start of 2016 was a very targeted, assertive approach to farmers, in recognition relevant to Gippsland as well as to other parts of the state, to look at farmers who were facing some pretty significant challenges in relation to pricing — milk prices. We were seeing a bit of a spike in numbers, so we worked with the farmers federation and with Deakin University to look at ways of outreaching and engaging to really try and provide that support.

Mr DIMOPOULOS — I have got two quick follow-ups. In terms of the sector, I am referring to an article by Richard Willingham in the *Age*, May 2014, 'Mental health funding cuts spark fears of 'social mess''.

> At least 25 specialist mental health organisations helping the homeless, domestic violence victims and young people face an uncertain future after the Napthine government stripped them of funding.
>
> Community Services Minister Mary Wooldridge recently announced the winners of the government's recommissioning of community mental health services but the move has been described as the 'corporatisation of welfare' by many organisations.

Then there is a whole bunch of concerns by those organisations, described by many as a mess that the previous government got them into. I just wanted to get a sense of that recommissioning process. Where has it landed now, and what did we do in 2015–16 to maybe mitigate some of the impacts, if any.

Ms PEAKE — Certainly one of the things — and I think we might have talked a little bit about this last year — that we saw as the recommissioning process was being bedded down was some real challenges in terms of the data that was coming through. A piece of the work was really about working with the individual providers to make sure that their data systems were more effective.

Alongside that, we undertook a comprehensive review of the model that had been implemented. One of the concerns that was raised around the new intake process was the centralisation of intake — there being a sort of double handling and a distinction between the initial triaging and screening and then clinical assessments to determine appropriate interventions. This is relevant in drug and alcohol as well as in community mental health services. The review took place in the 2015–16 period and in the last few months. As part of the broader work that we are part of, whole of government, around — new hubs and new models of making it easier for people to access services — we have been working with those sectors around what should be the new arrangements going forward. Again, there will be more information on that to come.

Mr DIMOPOULOS — Thank you. Finally — it is probably like an omelette; it is hard to unscramble — is it possible to quantify the funds provided to the sector in 2015–16 vis-a-vis the previous financial year?

Ms PEAKE — Specifically for suicide prevention or mental health more generally?

Mr DIMOPOULOS — Just in terms of mental health services generally, yes, in terms of recommissioning and mental health services?

Ms CONGLETON — Certainly we could look at what funding was provided both to the mental health community support services, which are part of the recommissioning, and also the drug and alcohol services in terms of allocation of funding for both of those streams.

Mr DIMOPOULOS — My understanding is recommissioning ended up with fewer organisations providing those services.

Ms PEAKE — Correct.

Mr DIMOPOULOS — So the quantum of funds for 2015–16 to those same services, albeit with fewer organisations, vis-a-vis the funds provided for it?

Ms PEAKE — We can certainly take that on notice. I think I mentioned earlier, which is related but not specific to your question, that there was also an additional $5 million that was brought forward into 2015–16 for community mental health services to take some of the pressure off emergency departments, but we will get you that comparative data.

Ms PENNICUIK — I think last hearings I was talking a bit about public health and preventative measures. I am just looking through the presentation that you made this morning. On page 4 you highlight the chronic and increasingly complex needs of patients in concentrated places of populations and increasingly complex needs and behaviours, and under that the need to accelerate the translation of research into practice and revised models of care to improve outcomes and quality and safety. There is a bit of a mention on the strategic directions and values with regard to early intervention et cetera. And on page 6 you mention the Victorian public health and wellbeing plan. But if we look at everywhere else, there is not much of a discussion about prevention and public health campaigns. I am just wondering if you could expand on that and how much of the actual health budget in terms of health is spent on public health campaigns and prevention campaigns.

Ms PEAKE — Certainly. I will make a few introductory remarks and then ask Ms Congleton to come back on your specific questions. You would be aware that we undertook a quite significant review of our prevention activities. Robyn Kruk completed that review for us in 2015–16 and really highlighted to us the need for us to work more effectively with VicHealth to make sure that our combined effort was complementary and that there was a very strong focus on priorities around children, priorities around family violence and priorities around broader public health.

On the back of that, there has been a significant body of work that has occurred and is under development around the family violence piece. In November last year the Premier announced that there would be a prevention strategy that will be released alongside implementation plans around the anniversary of the royal commission, so more to come in that space. Obviously family violence is a big contributor to burden of disease.

In the children's space we have been doing a lot of work with the Royal Children's Hospital, the Murdoch Children's Research Institute, to really look at what are the most effective ways of promoting child health and wellbeing. We released an evidence-based guide for services earlier, in 2016, which leaves the big public health piece.

In this space we have done some particular work, as you mentioned, through the municipal health and wellbeing plans with local governments. We have got particular investments that are going down to Hazelwood to look at a very different approach to how we promote whole-of-population health and wellbeing, led by local people, so through the health assembly, which is an approach that we really want to trial that brings together public health and community development and look at what we can learn from that to apply more broadly across the state. We have also been having continuing negotiations with the commonwealth about their role in this space as well, but I might just ask Ms Congleton to give you some more specifics.

Ms CONGLETON — Thank you, Secretary. As Kym mentioned, the release of the Public Health and Wellbeing Act sets out a frame for us, and particularly penetrating not just statewide organisations but really taking that to a very grounded level across local government. What has been released recently too is an outcome frame and some indicators so we can track our progress across public health and wellbeing. So that is setting that policy frame. If we take a social determinants of health point of view, which I think is really important when we talk about prevention, we are making sure that across the whole of the Department of Health and Human Services we are maximising people's participation and health and wellbeing. So there is an investment in VicHealth and making sure that we are working very closely with them to maximise what they are spending and what we are spending so that we are not duplicating expenditure.

If we think about population groups and also places — so really focusing on where there are significant gaps in health and wellbeing — we know, for example, for Aboriginal people there is a significant gap in their health and wellbeing status. So we have embarked last year, and are furthering it this year, on the development of a new Aboriginal health, wellbeing and safety strategic plan that is really being very much driven by community about their priorities. It is bringing together the whole of the four ministers' portfolios to think about what it is we can do in a more holistic way to lift health and wellbeing. That is one example of a population group where we are having focused effort and increased effort and energy. I think the other area is looking at place. The Latrobe Valley post the Hazelwood mine is giving us a really good spot to think about and recognise what can be different. So there is an investment of I think over $27 million, that was invested at the last budget, to cover off on a whole lot of areas of improved services. That is also important, that we also leverage our existing service base.

We have had a health task force, which has now recently morphed into a health assembly, and the secretary mentioned the importance of engaging with community about what their priorities are but also what things they can bring to the table in terms of lifting health and wellbeing. So it is a really strong focus. I think the secretary started with our strategic directions, and the focus around prevention and early intervention is very, very strong across all of our portfolios, right through to things like sport and recreation and making sure that we are lifting participation of at-risk groups through sport and recreation as well.

Ms PENNICUIK — Thank you for those responses. One of my questions was: what percentage of the health budget is actually spent on prevention and public health campaigns? It does not really jump out. I hear what you are saying, but what does jump out is the increasing chronic disease et cetera, and I think the community is pretty aware that that is increasing, not decreasing. It seems that prevention is probably the key way to see these chronic problems decreasing. So the question is: the percentage of the budget?

Ms PEAKE — I am certainly happy to take it on notice. Ours but also I think VicHealth's expenditure in this space is a critical component of that. I would just also say in terms of the link to chronic disease that the other work that we are doing is really looking at how we work more effectively between acute and primary health so that earlier in the onset of chronic disease there is a more coordinated, holistic approach to supporting people to manage their conditions so they do not deteriorate. So I agree with you on the prevention piece, but that early intervention is also really critical.

Ms PENNICUIK — Yes. Secretary, you mentioned family violence.

The CHAIR — Just briefly, Ms Pennicuik.

Ms PENNICUIK — Thank you very much, Chair. On page 7 of the questionnaire there is the answer that $4.4 million is set aside from the Treasurer's advance to respond to the urgent need for funding for unforeseen demand in services through the royal commission. I just wondered how much of this has been spent and where it has been spent?

The CHAIR — Briefly, if you could, please, Secretary.

Ms PEAKE — So in terms of family violence, the funding that has been brought forward has been spent. There has been increased funding on counselling, on sexual assault services and on providing support to women who are seeking emergency accommodation. I am being wound up, but I am happy to give a more fulsome account to you of all those family violence — —

Ms PENNICUIK — If you have got any more information on that, that would be great; thank you.

Ms PEAKE — Yes.

The CHAIR — I jumped the opposition — figuratively, not literally — and missed the opposition earlier, so Mr O'Brien on a point of clarification, then Mr Smith.

Mr D. O'BRIEN — Just a quick clarification on the question on the ambulance work value case. I mentioned the $83 million, but if we could get whatever figure you have got for the whole cost of budget — so if there are any other costs as well, not just the $83 million that I talked about.

Ms PEAKE — Sure.

Mr T. SMITH — Secretary, you were saying previously that lawlessness in youth justice seems to be, in your opinion, an affliction across the country. But that does not stand up to scrutiny, because the Productivity Commission's report for 2015–16 found that of the eight serious assaults in youth justice in this country, six of them were in Victoria. Could you outline in which youth facilities those serious assaults occurred, and without revealing the identity, provide to the committee an overview of what occurred during those unfortunate incidents?

Ms PEAKE — Yes, certainly. Just to the first part of your question, Mr Smith, it is the case that what is counted as assaults differs from state to state, so I do not think that we can draw from the ROGS data that there are less incidents in other parts of the state, so I just put that on the table.

Mr T. SMITH — I do not agree with that, but anyway.

Ms SHING — It is why you are not the secretary, Mr Smith.

Mr T. SMITH — I think the secretary should stick to the question, to be honest.

The CHAIR — Order! The secretary is answering the question.

Ms PEAKE — But in terms of the assaults I do not have the data in front of me, in terms of at what facilities over 2015–16 those assaults took place. But certainly we have a very strong commitment to our staff and clear protocols where there is a client on client assault as well, around the response to that, where there is a threat to either an individual or another client.

Mr T. SMITH — Sorry, Ms Peake, I want to know where those assaults occurred.

Ms PEAKE — So as I indicated, I do not have the data with me around — —

Mr T. SMITH — Can you provide that on notice, please?

Ms PEAKE — Certainly. But then in terms of the second part of your question around how we respond, the act is really clear — if I understood your question correctly — how we respond where there are those incidents.

Mr T. SMITH — No, I was not asking how you responded; I want to know what happened during those incidents.

Ms SHING — That is part and parcel of the question, Mr Smith.

Mr T. SMITH — No, I am asking a question of the secretary; thank you, Ms Shing.

The CHAIR — Through the Chair.

Ms PEAKE — So I do not have the data in front of me about each of those assaults, so I cannot really answer the second part of your question either.

Mr T. SMITH — Will you be providing that on notice as well?

Ms PEAKE — Certainly I can provide data about the assaults and the nature of the assaults, and we do provide regular public reporting on our incidents as well. But I am happy to take that on notice.

Mr T. SMITH — Thank you very much. How many assaults on staff were there in Victoria's youth justice system during the period 1 July 2015 to 31 December 2015?

Ms PEAKE — Perhaps the way to come into this is to look at WorkCover claims for the youth justice custodial workforce. It is the reality that our claims are higher for youth justice than for other parts of the department, and that is exacerbated by my references earlier to there being a higher number of remand clients. To give you a sense of it, though, we have seen, since the introduction of improved training, the introduction of specialist safety and emergency response teams and closed-circuit TV, a 29 per cent decrease in the number of WorkCover claims in the youth justice custodial workforce over the last three financial years. But, having said that, there have been 22 claims at the end of January 2016 compared to 33 claims at the end of January 2017. The data is over calendar years rather than financial years, but over the last year there was an increase in claims.

Mr MORRIS — Chair, the question that was asked was the number of assaults not the number of WorkCover claims. I appreciate there is a genuine attempt to answer the question, but the question was specifically about assaults rather than claims.

Ms PEAKE — I do not have that data broken down, so WorkCover claims is the proxy that I can provide.

Mr T. SMITH — Could you please provide that on notice?

Ms PEAKE — I am happy to.

The CHAIR — The only sort of qualification I would add would be I am not sure whether the department would necessarily have all that data available in terms of what is an assault.

Ms PEAKE — I am happy to have a look.

Mr MORRIS — Chair, if you are telling me the department do not know how many of their staff have been assaulted, I would say we have got major problems. I am sure the Secretary can provide that information.

Ms PEAKE — We have got definitions of what qualifies as an assault. I am happy to take the question on notice.

The CHAIR — That is the point I was trying to make.

Mr T. SMITH — Just going to the point you were making about WorkCover claims and referring to what you were saying before: what was the number for 2015–16, and what was the total amount of sick leave taken by permanent staff during 2015–16?

Ms PEAKE — The data I have is calendar year rather than financial year. As I indicated, there were 33 claims to the end of January 2017.

Mr T. SMITH — Can you say that again?

Ms PEAKE — Thirty-three compared with 22 to the end of January 2016.

Mr T. SMITH — Of the $6.4 million in salary expenses, what is the breakdown for each of these areas?

Ms PEAKE — Sorry, Mr Smith, I missed the start of the question.

Mr T. SMITH — Of the $6.4 million in your salary expenses for youth justice, what is the breakdown for each of these areas — for example, consultants, management, agency staff, permanent staff and the like?

Ms PEAKE — One of the things that we have been working on over the last 12 months is really — to answer the basis of your question — the agency staff as a proportion of our permanent staff, and we have been working very hard to stabilise our workforce and to increase the proportion of our staff who are either choosing to work on a casual basis but are employed by us or who are full-time employees. I might just ask Ms Asquini to give you a bit more detail there.

Ms ASQUINI — We do not have the salaries broken down by casual versus ongoing or permanent staff, but, as the Secretary has indicated, it is a significant effort that we are undertaking to stabilise the workforce. A bit similar to what we talked about earlier with respect to the child protection recruitment, we are trying to approach recruitment differently in this area to enable us to — —

Mr T. SMITH — I just want to know the breakdown and particularly the proportion of agency staff.

Ms ASQUINI — I do not have that detail.

Mr T. SMITH — Can you please provide that on notice?

Ms ASQUINI — And the timing that you were asking for in terms of the calendar year?

Mr T. SMITH — It is 2015–16. Thank you very much. Going back to your previous answers, Secretary, earlier today with regards to the cost of riots in youth justice facilities in 2015–16, the government has actually said that figure is not correct. Could you perhaps provide us with a month-by-month breakdown of riot repair costs in 2015–16?

Ms PEAKE — Certainly the number that I gave was for 2015–16, so it obviously does not include the November 2016 incident, and the numbers that I provided were accurate for the 2015–16 period.

Mr T. SMITH — So can we have a month-by-month breakdown on the cost for riots, please?

Ms PEAKE — I can certainly provide the breakdown of what were the maintenance and repair costs across the period by month.

Mr T. SMITH — No.

Ms PEAKE — Because they are not all going to be linked to specific — the two incidents that you mentioned are obviously at two points in time. There was one in March 2016 and then there was one towards the end of 2015, but I am happy to provide a monthly breakdown.

Mr T. SMITH — A monthly breakdown for riot costs and also routine maintenance costs incurred at Parkville and Malmsbury for 2015–16?

Ms PEAKE — Yes.

The CHAIR — Secretary, when you were here last year I did ask you a question about what actions the department was taking in relation to providing work experience and internship opportunities for African-Australians, many of whom reside in my electorate. I was wondering if you could inform the committee what actions have occurred over the 2015–16 financial year in that regard?

Ms PEAKE — Certainly. We introduced a program over that period which was for people who had qualifications but were really finding it difficult to break into the workforce. I had the great pleasure to meet with the first cohort, who had completed their internship just before Christmas. Their feedback to me was that it was a very positive experience. They worked right across the department but really in areas that aligned with their skill sets and their interests to get into a career path, and a number of them have subsequently secured employment either in parts of the department or in our broader church of hospitals or other agencies. So that is a program that we will certainly be continuing.

The CHAIR — Excellent. In terms of 2015–16 specifically, how many went through the program, do you know?

Ms PEAKE — I would have to get some detail for you on exactly how many went through. I met with six who were finishing in their particular cohort before Christmas. As I said, they worked right across the department, were selected on the basis that they had qualifications but were finding it difficult to break into the Health and Human Services workforce without having Australian work experience to point to.

The CHAIR — And were they overwhelmingly African Australians or were there some African Australians and the rest were asylum seekers that — —

Ms PEAKE — Yes, it was a combination. They were all people who were newly arrived to Victoria and to Australia, but it was a mix of nationalities.

The CHAIR — And they tended to be studying at university or recent graduates? That sort of cohort?

Ms PEAKE — Correct, or had work experience but then had gone back to university and were now looking to have career changes. So there was a combination of some younger but also people mid career as well.

The CHAIR — Has there been much buy-in from some of the health services in terms of the program, or is it mainly driven out of DHHS?

Ms PEAKE — No, there has been. So there was one woman in particular who had a background in epidemiology and research, and she has gone on to find employment with one of our health services. But I am happy to get you more details on that.

The CHAIR — I would be interested in that additional information.

The other point I would probably make is that certainly if I look at some of the African Australian communities I have dealt with, there does seem to be a gender divide, so women tend to spend more time at home and perform academically better than boys. So I think that while it is important that there is a focus on getting new graduates or people studying at university, in terms of many African Australian communities, a lot of them would be female. I think that if there were a capacity to look at opportunities for portering, catering and cleaning for younger African Australian males who might be at risk of engaging in antisocial behaviour and providing them with that practical on-the-job work experience and training, that would be desirable.

Ms PEAKE — And interestingly, one of the other young women who is from an African background was working with our youth justice program and was very interested in how she might play an ongoing role in terms of outreach back into the community. So there is I think, both for the young girls and for the boys that you are referring to, a huge role that we can play as a department.

The CHAIR — Thank you. I look forward to hearing the update in 12 months time, and if you could provide me with any additional information on the efficacy of the program, that would be fantastic.

Ms PEAKE — Chair, I do have an answer just around the output budget. Is it appropriate for me to provide it now?

The CHAIR — Sure.

Ms PEAKE — So the mental health community support budget was $128.1 million in 2015–16, which represented a 4 per cent increase from the 2014–15 year, which was a budget of $123.4 million.

Mr DIMOPOULOS — What is the name of the budget bucket?

Ms PEAKE — It is the mental health community support service output budget.

Mr T. SMITH — Secretary, going back to riots, code blacks are called constantly, and I understand that is when a very serious incident occurs. What counselling and support is provided to your staff for these constant outbreaks of lawlessness?

Ms PEAKE — Certainly we have a routine approach to debriefing after incidents. One of the things that we have been working with WorkSafe on is how we learn from some of the work that groups like Ambulance Victoria do to provide more assertive outreach and counselling to staff who have been involved in serious incidents. So that is something that we will work on with justice as the program transitions to justice, and I am sure they have their own programs that they will bring to bear as well. But we do have a process around debriefing after an incident or after a serious event, as well as then providing any follow-up that individual workers need. Ms Asquini, is there anything you would like to add to that?

Ms ASQUINI — Yes. We certainly also encourage the workforce to access the employee assistance program as required, and similarly there is work done through the supervision that staff are given via their unit managers to support them following an incident as well.

Mr T. SMITH — Sorry, I am just a bit confused. We have had constant riots for two years, so can you give me a better understanding of what you do to help our staff who are traumatised by these incidents?

Ms PEAKE — I am happy to start. There are things after incidents and then there are activities pre-emptively. So in terms of after incidents, I think as we have outlined there are professional debriefs, supervision sessions, access to the employee assistance program and other counselling as required. What we have also been working hard on, and I think I mentioned this earlier, is different training programs that we have been working up with Corrections Victoria to equip our staff better to de-escalate situations so that we do not have as many incidents and we do not have — —

Mr T. SMITH — Ms Peake, when you use the word 'debrief', these people have been assaulted — what do you mean by 'debrief'? When I get debriefed I sit in a room and go through a piece of paper. These people have been bashed up. What are you talking about?

Ms PEAKE — Again, I can only repeat what I have said twice, which is that there is a process of talking people through what happened and what to learn from, there is access to the employee assistance program and access to medical and other counselling support as it is required and then there is follow-up training where that is appropriate as well.

Mr T. SMITH — The review of category 1 reporting for youth justice assaults was due by the end of 2015. Why has there been more than a year delay in resolving these issues?

Ms PEAKE — I am certainly happy to work through what we are doing in terms of incident reporting. The current critical incident management policy was adopted in 2011. As you know, it is a snapshot in time of events and allegations made by clients of our department that are recorded and remain as incidents regardless of whether further information becomes available to substantiate or disprove the event. The purpose of that incident reporting is to enable providers to take corrective action to protect the wellbeing and safety of clients when necessary, but also to really understand the underlying causes of the incidents to prevent their recurrence.

As you are aware, category 1 incidents are the most serious incidents and include things like allegations of physical or sexual assault and serious client behavioural issues that impact on the client or staff safety.

So following legislative changes made early in 2016, all category 1 incident reports for a child or young person detained in a youth justice facility or in a residential centre are provided to the Commission for Children and Young People. So that is something that has been a change since the last time that we discussed this. We have

continued to provide category 1 incident reporting data externally on an annual basis on our website. That has been the practice since the 2010–11 financial year, and we have recently commenced providing category 1 incident reporting data for youth justice custodial on a quarterly basis on the department's website, so that is the second development in the last 12 months. The public availability of that data has been legislated into the Children, Youth and Families Act.

So then in terms of the work to reform and strengthen our oversight and management of incidents, the new client management incident system, which will focus on the most serious incidents and increase accountability, will commence from 1 July 2017. One million dollars was committed outside of this reporting period but in November 2016 to support the rollout of the new system. So we have delivered the first phase of that, which was completed in June 2016 and which developed a new policy, and the second phase is rolling out the system across the service providers.

Mr T. SMITH — My question was around why it was delayed, Secretary. Why was it delayed?

Ms PEAKE — I am just taking you through all the things that mean there has not been a delay; there has been real progress that has been made. So we have introduced the policy, we have introduced the reporting and changed the reporting practices. The new system in full will commence from July 2017. Obviously there is a lot of training and development of staff in operating under the new system that is really critical to its effective rollout, and that has been part of that preparation period.

Mr T. SMITH — Thank you, Secretary. What was the value of pizza, soft drink and other junk food, such as KFC and McDonald's, delivered to Parkville and Malmsbury and charged to G4S or the department to placate rioters?

Ms SHING — For rioters or for employees? It is unclear as to what you are asking.

Mr T. SMITH — Or employees — take your pick.

The CHAIR — I think for the period — —

Ms PEAKE — Again, I might on this one just ask which reporting period you are talking about.

Mr T. SMITH — Well, let's go with 2015–16.

Ms PEAKE — As a matter of principle we do not offer pizza as an inducement to clients. So I would put that on the record.

Mr T. SMITH — As a principle?

Ms PEAKE — We do not offer pizza as an inducement to clients. Part of your question was how much have we paid for pizza to induce clients.

Mr T. SMITH — So you are saying you have never done that?

Ms PEAKE — We do not provide pizza as an inducement to clients.

Mr MORRIS — No. The question was not about inducement. The question was about how much on these items.

Ms PEAKE — So we do not pay for pizza for clients —

Mr T. SMITH — Never ever?

Ms PEAKE — to resolve incidents. I think it was the cost related to incidents. Was that not the question?

Mr MORRIS — No, no. The question was about the products, not about how they were used —

Mr D. O'BRIEN — Or why.

Mr MORRIS — or why. I do not have the list of products in front of me, but the question was effectively — —

Ms PEAKE — How much do we spend on pizza for clients?

Mr MORRIS — How much do you spend on pizza, how much do you spend on KFC et cetera?

Ms PEAKE — So if we remove the reference to incidents, because that part of my answer is that we do not provide pizza to clients to resolve incidents —

Mr MORRIS — I do not think there was a reference, but anyway.

Ms PEAKE — I am happy to take on notice whether we have a record of what has been paid in relation to pizza for clients or staff.

Mr T. SMITH — And other junk food — that would be appreciated.

Ms PEAKE — I am not sure that we will be able to provide information on pizza in particular. We do have a canteen, and youth receive, as I understand it, allowances that are part of a sort of reward scheme which enable them to purchase from the canteen. So again I am not sure that I am going to be able to get you a breakdown of what is the supply that has been purchased of — —

Mr T. SMITH — Of junk food to these facilities — that would be appreciated on notice.

Ms SHING — To these facilities or to employees or to clients, because you are moving around with the question a lot, Mr Smith.

Mr MORRIS — The question was very simply about the products, not about whether it was for an inducement, not about whether it was for staff. The question was about the products and how much the department is spending. That is the extent of the question.

Ms PEAKE — We can certainly have a look at, on a vendor basis, what we have spent to stock the canteen and to provide those supplies, but I am not sure that I am going to be able to break it down, how much went to clients, how much went to staff, because we do not purchase in that way. We purchase stock through a vendor.

Mr MORRIS — No, no. The question is about purchasing.

Mr DIMOPOULOS — Moving away from the opposition's new-found interest in youth justice — they ignored the Ombudsman's report for four long years, but nonetheless — to talk about the Monash Children's Hospital helipad, an election commitment I was proud that Labor made in 2010 and then re-prosecuted in 2014, budget paper 4, page 39, and in fact page 42, talks about the Monash Children's Hospital. It is obviously a project that is close to my heart, as I represent an electorate neighbouring the children's hospital. We have invested $3.8 million. I just want to get a sense of what the outcomes were for that investment or whether they are still being delivered.

Ms PEAKE — Thank you. As you have indicated, in the 2015–16 state budget, additional funding of $3.8 million was provided for the rooftop helipad, which was not previously in scope and will service both the adult Monash Medical Centre and the new Monash Children's Hospital. Both the helipad and the Monash University additional space, which was alongside this, were completed as part of the Monash Children's Hospital project. The new hospital is close to being operational. The helipad was used around three times a week to transport critically ill neonatal, paediatric, maternal and adult patients to the hospital as well as for urgent patient transfers from other hospitals. Is there anything else, Mr Foa, that you would add to that?

Mr FOA — No. You have mentioned the additional teaching space, which was the other variation in the 2015–16 budget papers.

Mr DIMOPOULOS — Great. Thank you. My understanding is that the Monash Children's Hospital, when it opens — in fact, Monash now is the second busiest paediatric hospital in the country after the Royal Children's, and I think Westmead in Sydney is third or something to that effect.

Ms PEAKE — Correct.

Mr DIMOPOULOS — So when you say three neonatal cases on average a week will use the helipad, is that based on the current cohort size of the hospital, the current intake, or is it expected to grow? Can you give me more flavour of what the — —

Ms PEAKE — So that is based on the current. When complete, the services will have 230 beds, and you would expect that you would continue to see growth in the use of that helipad as well.

Mr DIMOPOULOS — And will that be the same helipad, will it, for both hospitals?

Ms PEAKE — Correct.

Mr FOA — That is correct, Mr Dimopoulos. So the helipad will service both sites and both hospitals. Lend Lease was appointed in July 2014 with the expected completion on time on budget in December 2016.

Mr DIMOPOULOS — I remember locally in the community there was a lot of disquiet — and I am sorry; I am going to have to be political again — about the previous government scoping out the helipad and mismanaging that part of the project. I was just wanting to get a sense — —

Mr MORRIS — You were in government in 2015–16, remember.

Mr DIMOPOULOS — No, no, hang on. That is right, but I am setting the scene for the 2015–16 year. In terms of the commitment that was made in 2015–16, that was a conversation that was happening in the community when I was not in government, Mr Morris. Then the 2015–16 year was the budget year that that investment was made. I just want to understand in a more layman's fashion: what is the difference in having a helipad and not having a helipad? What are the quality-of-care differences? Is it, as a headline screamed at one point, literally people dying or kids dying if you do not have that access? Can you give me an example of one of those cases that would benefit from having the helipad as opposed to making your way down Clayton Road with the congestion and the traffic and the level crossings?

Ms PEAKE — Certainly. I might just ask Mr Symonds to comment there.

Mr SYMONDS — It might even be that Mr Walker also can think of some cases. Obviously the helipad provides emergency access. It serves as a platform that is used by Ambulance Victoria to transport cases. Ambulance Victoria make the decisions based on clinical priority, distance and availability of other options, such as road transport. Having the helipad will increase options available across the state for transporting critically ill children to available care at Monash Children's. Tony, I do not know whether you want to — —

Assoc. Prof. WALKER — I think in answer to your question, the types of cases that might benefit are essentially time-critical patients. So an example of that might be a patient that is at Monash, in the particular case of children, a patient that requires urgent surgery at, say, the Royal Children's Hospital, and that provides for an immediate transfer, a much safer transfer. Instead of moving to an ambulance to a nearby park and then flying, they essentially load them straight into a helicopter and land at the Royal Children's, where they can get the care there. So in essence it is those time-critical type events. It may also be major trauma that has come in there because it is the closest hospital for that particular case. They are stabilised and then transferred on for more specialist care at, say, for example, the Royal Children's.

Mr DIMOPOULOS — Just wrapping up, Chair, there is a statistic that floats around public discourse around every minute you wait for an ambulance is a — I can't remember. But there is a consequence in terms of the chance of survival. It is similar, I would imagine, with those few cases that are time critical, for the helipad? So every minute delayed — —

Assoc. Prof. WALKER — It is a bit different in the community in the sense of cardiac arrest, which you are talking to. There is a 10 per cent reduction in survival for every minute that there is a delay for an ambulance or the first response to arrive. In this setting it is often more complex around patients that have already been in a medical facility and have been stabilised but their next level of care is at a higher level centre — so, for example, the Royal Children's — and in those circumstances, you are quite correct, depending on the case, time is of the essence.

Mr DIMOPOULOS — Great. Thanks for your help.

Mr D. O'BRIEN — Just before I go on to some financial questions, Secretary, we talked before about the 13th floor of the VCCC, which you clarified — $11.8 million for fit-out by the state. Is there any income from the partners on the 13th floor for rent or other income to the government?

Ms PEAKE — I am happy to take that on notice.

Mr D. O'BRIEN — Take it on notice? Okay, thank you. Some of these may also need to be taken on notice, but on page 54 of the questionnaire response, there was $32.9 million reprioritised. For all those three prioritisations in 2015–16, can I get the initiative or line item that the funding was reprioritised from, the initiative the funding was reprioritised to and the amount reprioritised for each initiative in 2015–16 and over the forward estimates?

The CHAIR — I think the scope of this inquiry is for the 2015–16 year.

Mr D. O'BRIEN — It is, but with respect to that, it was reprioritised going back a few years. I am not looking for new information; it is only from that year.

Ms PEAKE — I might just ask Mr Stenton to give a bit of an overarching answer, but we will need to take the details.

Mr STENTON — Yes, the detail on notice. As I outlined before, we often move funds between output groups, so we do not necessarily have an initiative that we are moving funding from to as much as within the overall output group. Where there is capacity to reprioritise, we move from one output to a particular purpose usually.

Mr D. O'BRIEN — Good. As much detail as you can provide would be great. Equally, on page 53 of the response to the questionnaire, there is $10 million in savings identified. Could you identify how much in savings come from each of the following areas: health purchasing, improvement in patient flow and administrative overheads? And could you explain how these savings were realised specifically in relation to improving patient flow, if you could?

Ms PEAKE — I am happy to take that on notice.

Mr D. O'BRIEN — Happy to take that on notice? Great. And continuing on on the financial side of things, page 37 of the 2015–16 annual report shows that the actual total acute health service expenditure was $285 million above budget. I appreciate that a chunk of that will be additional patient episodes more than expected, but can you give an explanation as to why that there was an increase in expenditure or what that was made up of?

Ms PEAKE — I might just ask Mr Symonds to update you on that one.

Mr SYMONDS — Thank you. So the extra outlay at the end of the year compared to the published budget is related to a combination of factors. Part of it is a move between output groups related to a change in funding policy. In this case we moved funds from the emergency output group to the admitted output group, and that is related to having a clear line of sight for the costs of admitted patients through the hospital. Their costs had previously been separated, or funds had been separated between output groups. So the proportion of care provided in an emergency department is funded under one output group and then the costs of ward care provided under another. We have moved the costs and funding from the emergency output group to the admitted output group to ensure that their costs are in one place for a clear line of sight.

That is one factor. Another that you have alluded to is additional activity by health services, and we reported, I think in the questionnaire, 1.5 per cent additional activity compared to the previous year, and that attracts additional commonwealth contributions as well. So a combination of those things is the explanation for the additional costs in that output group.

Mr D. O'BRIEN — Could we get, perhaps, a breakdown, on notice, of what all those various aspects of it are?

Mr SYMONDS — Sure.

Mr D. O'BRIEN — And any others as well.

Mr STENTON — If I might add, Mr O'Brien, the target in the annual report is the published budget number, and part of that Terry alluded to, which is there is a commonwealth estimate of revenue in there, and the timing of things — so the commonwealth requires us to submit our estimates before the state budget is determined. So we obviously conservatively estimate on any growth until the state budget is determined, so it will generally always be understated to some degree.

Mr D. O'BRIEN — I am more than happy to have that included as part of the explanation. That would be great. Likewise there are some reported underspends in the annual report. The emergency services total output was $70.5 million below target. Again, I am happy to take on notice what the components of that are. There are footnotes, but the footnotes do not really tell us much.

Ms PEAKE — Right. Again, I think we mentioned a bit earlier that there was a transfer of more than $50 million to the admitted output costs, so it does go to part of the explanation Terry has just given you that there is a relationship between those two line items, so we can pick that up in the material will provide you.

Mr D. O'BRIEN — The final one is the acute training and development total output, which was $51.6 million below target. Again, if you need to provide that on notice, that is fine, but I would be interested now as to whether that had any impacts or what the ramifications were on decreased training.

Ms PEAKE — I am happy to take that on notice.

Mr STENTON — Again, I think we will take the detail on notice, but one of the drivers behind that particular move was some movement of funding from what was training and development into the output price for hospitals in recognition that a lot of the training happens as part of the clinical process, and that was in part to align us with national health funding classifications.

Mr D. O'BRIEN — So realigned from departmental budget to hospital budgets?

Mr STENTON — No, realigned within. So the departmental budget turns into funding for hospitals. We allocated it in training and development and in acute admitted, if you like. So the acute admitted price did not include an element of training and development, so we have moved those funds from the T and D output into the acute output. As I say, that was partly to align with national health classifications.

Mr D. O'BRIEN — I have a very quick one, Chair, on finances, but in a slightly different area. This is a sport and recreation question. The annual report notes $147 million was to be spent on improving sport and rec facilities. Could we get a full breakdown of that by project and location? I am particularly interested to see the breakdown between metro and rural for that. Finally, what percentage of that sports infrastructure fund went towards women's facilities specifically?

Ms PEAKE — In terms of the final question, the female-friendly facilities, there were 28 grants totalling over $2.6 million that were provided in the 2015–16 year.

Mr D. O'BRIEN — Could we get a breakdown of those grants?

Ms PEAKE — Sure.

Mr D. O'BRIEN — And likewise the $147 million to building and upgrading a range of important community sports and recreation facilities throughout Victoria. That is page 30 of the annual report, for reference. A breakdown of those would be great.

Ms SHING — Just to pick up on something which Mr O'Brien has asked around women's facilities for sport. That $2.8 million figure I assume is the 28 grants that were allocated for upgrades to facilities to deal exclusively or predominantly with the improvement of amenity for women. Are any of those other projects also facilities upgrades that included upgrades to women's facilities but were not solely dedicated to that purpose?

Ms PEAKE — I will need to take that on notice and provide you with information.

Ms SHING — If you could take that on notice. It strikes me that there are number of grant within the list that may in fact have actually covered the improvement of facilities across the board and may then have included upgrades to women's facilities — —

Ms PEAKE — For example, there were 165 facility grants that were approved, which is higher than the target of 130, and that was because of a higher than expected number of approvals across the netball program and the inner-city netball program. We can certainly get you a breakdown of the numbers, but I think your hypothesis is correct — that beyond the particular grants for female-friendly facilities there will be other investments that have gone to making local sporting clubs more female friendly.

Ms WARD — There are the rural netball grants, I think.

Ms SHING — Yes. I would like to pick up on a number of things which again Mr O'Brien raised in his question and the questions that you answered, Mr Symonds, around the impact of commonwealth contributions and the way in which a combination of factors have related to movements of savings, how savings are realised and how funding has been moved between output groups. I understand that we have had a significant number of changes and federal cuts to Victorian health services, which has had a really significant impact on in particular Peninsula Health and also Gippsland, as it relates to the Bass Coast regional health area, that Bass Coast will lose $51 million as a consequence of changes to the commonwealth funding arrangements and that Peninsula Health will lose $672 million.

I am keen to understand what this will mean for patients and performance at these hospitals. I note that there is a significant injection of state funds, but to what extent can that ameliorate against these losses when we have got a federal health minister who despite fancying himself as a bit of a fan of these two areas because they are in his electorate does not necessarily seem to be able to deliver the actual dollars on the ground? What will the impact be for the period and again through forward estimates, as reported?

Ms PEAKE — I think when we were here last year we were particularly concerned that there had not been an agreement reached on a new healthcare agreement and the impact that that might therefore have on services. Under the NHRA, the federal government provides 45 per cent of new activity for in-scope services, and that was to grow to 50 per cent. Some of our concerns were able to be negotiated through the reaching of a new agreement, but it is the case that we remain concerned that their contribution is going to be lower than it would otherwise have been. I might just ask Mr Symonds. I am not sure that we have got a breakdown by individual health services, but certainly the sorts of impacts of that change in funding arrangement.

Mr SYMONDS — The modelling that you are referring to, or the notional allocation of the cuts by health service, was based on modelling that was done around the 2014–15 commonwealth budget announcements, which were to essentially withdraw unilaterally from the national health reform agreement and return to a block funding arrangement for states in which contributions to the states would be based on population increases and CPI increases alone and not based on the national health reform agreements commitments to funding a share rising to 50 per cent of the costs of additional activity performed in hospitals. At the time the estimate that we developed was of a $17.7 billion reduction in funding between the new proposal in 2014–15 compared to the national health reform agreement's original commitments over 10 years, and that was then notionally allocated out to health services based on their contributions towards statewide activity.

As Kym alluded to, there was a fairly public conversation between states and territories and the commonwealth over that, and the bulk of the impact of those projected reductions was reversed in the agreement reached in April of last year between the states and territories and the commonwealth in the COAG heads of agreement. That heads of agreement deferred the withdrawal from the national health reform agreement and rolled it over for three years from 2017 to 2020, with the most significant change to the previous agreement being the maintenance of the commonwealth share of hospital funding of 45 per cent instead of 50 per cent. So in other words, from July this year the commonwealth share of each hospital's costs for admitted care was to grow from 45 per cent to 50 per cent. That will now not happen. It will stay at 45 per cent for the remaining three years of the agreement. That is a change from the original national health reform agreement negotiated in 2011, and that does represent a reduction in funds compared to what was previously agreed. We have not done modelling on that specific impact by health service, but there is no doubt that is a reduction compared to what we would have had before.

In terms of the impact on performance, it has the obvious effect that it increases the impost on state funds and reduces the amount available for other purposes, and if that reduces overall hospital budgets, the consequence at an operational level will be a reduction in available beds, a reduction in available operating theatres, a reduction in elective surgery admissions and so on.

Ms SHING — We heard evidence from the Department of Treasury and Finance earlier this week in relation to the growth in our population and the fact that in some assessments we might be referred to as a 'donor state', whereby we contribute a disproportionately high share to national coffers without getting a return on investment. To that end, can I just check whether the last federal budget — noting what you have said about the national health reform agreement and that those things have been held in abeyance and thus led to substantive reductions — included in fact any capital investments for Victorian hospitals and Victorian health-related infrastructure in light of the decisions around who should get what around Australia?

Ms PEAKE — Mr Foa can step you through that.

Ms SHING — Thank you.

Mr FOA — In the 2015–16 year — —

Ms SHING — For the relevant period? Sorry, it should be taken as a given that at least from my end I am talking about the relevant period. If there is any other relevant information that goes to forward estimates — for example, as others have done — then I am also very happy to hear about that too.

Mr FOA — In the 2015–16 period the one project that did vest in that year was the VCCC, where there was a substantial federal contribution, but there were no further announcements of additional funding in the 2015–16 federal budget.

Ms SHING — Was one metropolitan infrastructure investment and nothing for the suburbs or for regional Victoria at all?

Mr FOA — That is correct.

Mr MORRIS — Before I go to the main subject of this segment, just a quick follow-up to Ms Shing and the relationship with the commonwealth. In terms of health activity funding in March last year Minister Hennessy said:

> … we have been left with no option but to take this to the High Court.

That was backed up by a media release of the same date. I am just wondering if the department is still pursuing the case, and if so, when it is expected to be in court.

Ms PEAKE — Certainly. Later in the 2015–16 year the departments advised that regarding the $73 million adjustment, as Terry has just indicated, the renegotiation of the healthcare agreement meant that that had been dealt with. Sorry — that is the national agreement. Separate to that, there had been a $73 million adjustment that was, by happy coincidence, offset by another contribution from the commonwealth. So as a result at all times our focus was on patient care and getting the health budget back in balance and patient funding restored so that there was not a need to proceed with a potentially costly court case.

Mr MORRIS — So were there any costs to the department in terms of legal advice in preparation for the case before the decision not to proceed was made?

Ms PEAKE — We received advice that was within our existing budget.

Mr MORRIS — So no money has been spent?

Ms PEAKE — No.

Mr MORRIS — Thanks for that. If I can move to child protection, can I ask you, Secretary, how many children as at 30 June 2016 were living in residential care?

Ms PEAKE — About 450, Deputy Chair.

Mr MORRIS — Okay, thank you. Can you indicate to me how many of those were under the age of 12?

Ms PEAKE — I would need to take that on notice. Certainly one of our big focuses has been looking at using targeted care packages to move youth aged under 12 out, but the challenge with that is, particularly where they are part of a sibling group, finding appropriate accommodation.

Mr MORRIS — But if we could have the number on notice, that would be good. Can I also ask, as to the same date, how many young people were in a contingency placement, and for those numbers can you indicate what type of contingency placements — whether it was a motel or some other sort of accommodation.

Ms PEAKE — We will certainly take that on notice, but there have been real inroads made in reducing contingencies, largely attributable to the use of the targeted care packages and providing flexible supports for alternative placements in families, but we can get you the number. But I can inform the committee it is reduced.

Mr MORRIS — If we could have the number and the style of contingency as well with that.

Ms ASQUINI — Just to also add that part of what the targeted care packages have been doing is that they are not just for the children in residential care but they are also trying to put packages around situations where it may be that children will come into care — so to try and mitigate the risks of children coming into care. So packages have been used for that purpose as well.

Mr MORRIS — On the subject of sexual assaults in care, the Commission for Children and Young People's annual report indicates that of the 2833 reports of category 1 incidents received by the commission during 2015–16 year the majority of reported category 1 client incidents involved children living in residential care — 62 per cent of all reports. It also separately reports that incidents relating to 'behaviour — sexual exploitation' increased from 162 in 2014–15 to 412 incidents in 2015–16. Can you provide the committee with the number of incidents relating to 'behaviour — sexual exploitation' but specifically relating to those incidents which occurred in residential care for 2015–16 and, if possible for comparison purposes, 2014–15?

Ms PEAKE — Certainly, and I can take the specific question on notice, but I would say that we have made a huge effort to improve the reporting in this place so there has been an increase in the reports. I do not think that should be seen as an increase in the incidents. Very positive collaboration is happening with police to intervene more quickly to really target the perpetrators of sexual exploitation as a means of trying to disrupt that behaviour — so not only focusing on interventions with the young people but really holding the perpetrators to account.

Ms ASQUINI — I think the other component, just to pick up the Secretary's point, was that $2 million was invested for specific practice leaders in the sexual exploitation area within child protection. Just to pick up Kym's point, we think that that has made a significant difference with respect to the reporting and the discussions and understanding of those issues within both residential out-of-home care and child protection.

Mr MORRIS — Just further on that issue, from the report *"… as a good parent would …"* how many recommendations have been fully implemented?

Ms PEAKE — Thank you for the question. We have certainly been very focused on progressing all of the implementations in that report. You would be aware that part of the response associated with *Roadmap for Reform* was a commitment of $168 million over two years from 2016–17, a bit outside the reporting period. Since 1 July we have been trialling a range of different approaches to supporting foster carers and kinship carers as well as, as I mentioned earlier, a different approach to intensive support as a substitute for residential care. We also invested $16 million in 2015 to uplift 150 placements, which was one of the recommendations of the report, to improve safety and supervision requirements, which included mandatory stand-up staff overnight for all four-or-more-bed residential care homes. There has been subsequent investment in 2016–17 — $35.9 million — which means every placement in residential care is now subject to those safety and supervision requirements.

We have also invested up to $8 million in upskilling the residential care workforce so that they all have minimum relevant qualifications by the end of this year, and $1.5 million was provided in 2015 over an 18-month period for spot performance audits — again a recommendation of that report — to monitor the quality of care for children and young people as well as improve practice and compliance. As at 31 December

2016, 105 spot audits have been conducted across the state across 347 sites, reflecting 244 residential units and 103 of the associated offices of the providers of those services.

There have also been actions taken to upgrade, redesign and renovate out-of-home care properties in line with the recommendations of the report; $7.5 million was allocated for that purpose in 2015–16, with an additional $1 million announced in August 2015, with a real focus on the properties most in need of urgent and essential maintenance works. The 2016–17 budget committed a further $11.7 million, which was focused both on renewal and replacement of up to 24 resi care properties and $2.3 million to address urgent and essential maintenance. Against all of the recommendations there are actions underway that are really to address the physical environment, the models of care, restrictive training and procedures around the use of restrictive practices, a common assessment framework for assessing placement decisions and improving the support for foster care, and consistency of staff.

Mr MORRIS — Perhaps I could ask it — and I am happy to finish on this point — in a slightly different way. I think the question was: how many recommendations have been fully implemented? I appreciate the comprehensive nature of the response, but I did not actually get the number.

Ms PEAKE — All of the implementations are in progress. I would have to get you a number for how many have been completed.

Mr MORRIS — Have any been fully implemented yet?

Ms PEAKE — I can get you that number, but a number of the recommendations are not a one-off action.

Mr MORRIS — Can we know how many of the ones that were a specific action have been completed, how many are yet to be completed and, if they are yet to be completed, when they will be completed?

Ms PEAKE — Certainly, but I can say again that all of the recommendations have been acquitted — some are just in progress — so I will get you that detail.

Mr MORRIS — That is helpful. Thank you.

The CHAIR — I am conscious of time. It is 11.58. So Ms Pennicuik, if you are willing to be succinct, I think we have time for one question.

Ms PENNICUIK — Chair, you know I am always succinct. Secretary, perhaps this is a question that you could take on notice. It relates to page 30 of your responses to the general questionnaire — the top of the page, with regard to youth justice centres, increasing capacity and improving infrastructure statewide. It shows the figure of $54.5 million, with actual investment of $54.4 million and actual expenditure $5 million, and that the actual completion date was quarter 4, 2015–16. What I would like to know, I suppose, is what does that involve, in particular not just in infrastructure but in capacity. I do not know if you would be able to respond to me in 30 seconds.

Ms PEAKE — I think we all need a strong cappuccino at this point, don't we? I am happy to take the question on notice, but you would be well aware that as a result of the incidents on 14 to 16 November we have lost 60 beds at Parkville. We can give you a point in time for 2014–15 as a result of those works, but it looks very different at the moment.

Ms PENNICUIK — I totally understand that, but I was just wondering what that was for and where we were then.

Ms PEAKE — Certainly. We can get you those numbers. In Parkville at the end of 2015–16 we were at 123 beds. We are now at 60. At Malmsbury on the secure site we are at about 45 and on the open site it is 82 or 83, I think. These are numbers we are poring over every day in terms of capacity, but we can certainly give you them at a point in time.

The CHAIR — Thank you, and just one final declaration from me. I should have advised the committee earlier that I am also the ambassador for children's health. I neglected to do so. I would like to thank the witnesses for their attendance. The committee will follow up on any questions taken on notice in writing. My

last count was that about 23 questions were taken on notice. A written response should be provided within 10 business days of that request. All recording equipment must now be turned off.

Witnesses withdrew.