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

PUBLIC ACCOUNTS AND ESTIMATES COMMITTEE

Inquiry into 2013–14 and 2014–15 Financial and Performance Outcomes

Melbourne — 18 February 2016

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Ms Kym Peake, Secretary,
Mr Lance Wallace, Deputy Secretary, Corporate Services,
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Ms Anne Congleton, Deputy Secretary, Mental Health, Wellbeing, Social Capital and Ageing,
Ms Chris Asquini, Deputy Secretary, Operations,
Mr Arthur Rogers, Deputy Secretary, NDIS REform and Director of Housing,
Ms Amanda Cattermole, Deputy Secretary, Regulation, Health Protection and Emergency Management,
Mr David Clements, Acting Deputy Secretary, Community Services Programs and Design, and
Ms Leanne Price, Director, Infrastructure Planning and Delivery, Department of Health and Human Services.

The CHAIR — I declare open the public hearings for the Public Accounts and Estimates Committee inquiry into the 2014–15 financial and performance outcomes. All mobile telephones should now be turned to silent.

I welcome Ms Kym Peake, Secretary to the Department of Health and Human Services; Mr Lance Wallace, deputy secretary, corporate services; Ms Frances Diver, deputy secretary, health service performance and programs; Ms Anne Congleton, deputy secretary, mental health, well being social capital and ageing; and Ms Chris Asquini, deputy secretary, operations. I would also like to welcome all witnesses sitting in the gallery. Any witness who is called from the gallery during this hearing must clearly state their name, position and relevant department for the record.

All evidence is taken by this committee under the provisions of the Parliamentary Committees Act, attracts parliamentary privilege and is protected from judicial review. Any comments made outside the hearing, including on social media, are not afforded such privilege. The committee does not require witnesses to be sworn, but questions must be answered fully, accurately and truthfully. Witnesses found to be giving false or misleading evidence may be in contempt of Parliament and subject to penalty. All evidence given today is being recorded by Hansard. You will be provided with proof versions of the transcript for verification as soon as available. Verified transcripts, any PowerPoint presentations and handouts will be placed on the committee's website as soon as possible.

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

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

Visual presentation.

Ms PEAKE — Thank you, Chair, and thank you committee members for the opportunity to give you some context around both the formation of the department but also the environment within which we deliver oversight and fund services for Victorians.

As you would be well aware, our department works to improve the health and wellbeing of all Victorians. In many cases our clients are amongst the most vulnerable in the state, and when Victorians need to go to a public hospital or need an ambulance or access to community health and mental health facilities, they all use services supported by the department. When Victorians need public housing or aged care, they use facilities supported by the department. We support people with a disability to participate in our shared community, and we help children who are at risk or are being abused, survivors of family violence and indeed men at risk of perpetrating violence, and we support community and economic participation, including through sporting and recreational activities.

The department as currently formed was established on 1 January 2015, combining the former departments of human services and health with Sport and Recreation Victoria to better align and integrate social policy and service delivery to improve the health and wellbeing of the Victorian community. With over 11 000 staff directly employed by the department, in addition to many more employed by agencies and community sector partners that we fund, we also play an important role in the economic life of the state.

Our vision then is to develop and deliver policies, programs and services that support and enhance the wellbeing of all Victorians, and we respond to, I think, some of the most difficult challenges in public policy — of individual wellbeing, active living, socio-economic participation and vulnerability — which requires us to work with a really diverse set of individuals and organisations to achieve our vision.

This is reflected in our values, which place a strong emphasis on working together with these individuals, families and communities while respecting their diverse backgrounds and contexts. The ability of the department to support vulnerable Victorians also places a focus on how we go about our jobs with integrity and accountability so that the community can have confidence that they will get the services they expect when they need them. Finally, meeting these expectations in the context of constrained resources means we obviously need to continuously improve the way we develop, deliver, fund and regulate all of our services.

Of course these aims do not exist in isolation, and our services confront a number of challenges. The population itself is growing, and older Victorians are making up an increasing proportion of the Victorian population. The burden of disease is shifting to longer term and more complicated conditions, which I know we spoke about with this committee a bit last year, increasing the required duration and importantly maintaining a focus on the quality and safety of the services we are involved with.

Recent actions by the commonwealth, including unilaterally ceasing agreements early; removing funding, including reward funding; and allowing agreements to expire without further funding commitment have had significant implications for service delivery of health and human service programs in Victoria. Unexpected cuts without consultation that were announced in the 2014–15 commonwealth budget included cessation of funding guarantees under the national health reform agreement, the national partnership agreement on preventive health, the national partnership agreement on certain concessions for pensioner concession card and Seniors Card holders, and reward funding under the NPA on improving public hospital services from 14–15 onwards.

The focus on preventing family violence and child abuse has rightly increased in recent years, but increased community expectations have also placed pressure on the services that we deliver. And as we understand our clients better, the impact of entrenched disadvantage among some population groups and in some geographic areas becomes clearer, including the correlation with the greater use of more complex and higher cost services. Really tackling the social determinants of health is one of our high priorities. In this context, in 14–15 the department continued to progress a number of really significant actions to improve the services that Victorians need and expect. Work continues ahead of the commencement of the National Disability Insurance Scheme across Victoria from 1 July 2016. Over that 14–15 period the ambulance performance and policy consultative committee released its interim report in March 2015, outlining a range of steps to improve the delivery of ambulance services. The Travis review set the foundation for building and improving hospital bed capacity across the state.

There was also significant investment in improving out-of-home care, including support to move children from residential care into home-based care arrangements. There was a statewide rollout of the Strengthening Risk Management program to really make sure that we are making progress in sharing information and risk assessments for victims and survivors of family violence, in addition to expanding services for those experiencing or at risk of experienced family violence.

Finally, in addition to these higher profile activities, 2014–15 saw a range of activities across the department. Further construction to expand the public hospital system took place at the Latrobe Regional Hospital, Bendigo Hospital, the Victoria Comprehensive Cancer Centre and Monash Children's hospital. Thirty-three new and replacement ambulance stations were completed. We expanded the capability of the health system to respond to a potential outbreak of Ebola at a time when tens of thousands of people were dying in West Africa and the threat of global epidemic looms large.

Disability clients at the Barwon trial site were transitioned to new personalised support plans. In support of improving the wellbeing of Victorians, the department funded 61 significant sporting events that enhance community life across the state. We also worked with other colleagues across government to tackle the growing use of crystal methamphetamine and its associated health and social problems. That really concludes my opening marks and I am happy to take questions on the department's financial and performance outcomes for the 14–15 financial year.

The CHAIR — Thank you, Secretary. I might start, if I may. I am very fortunate as the member for Essendon to have a very large public housing community, with both the Flemington housing estate and the Wingate housing estate. I note that in the course of the 14–15 financial year that there were some improvements made in terms of maintenance particularly on the high rises in Flemington so there was the capacity to have air-conditioning units installed in some of those units if residents chose to have a unit installed. I am just wondering if you could inform the committee broadly what were some of the highlights and achievements in terms of the public housing portfolio in that 14–15 year. What sort of investments were made and how was the quality of those assets maintained and improved over the course of the 14–15 financial year?

Ms PEAKE — Thank you, Chair. I might actually invite Mr Rogers up to the table to take you through the improvements over 14–15.

Mr ROGERS — My name is Arthur Rogers. I am the deputy secretary of NDIS reform and director of housing in the department. I might just refer generally now to the sort of maintenance and upgrade program that the department operates in public housing, how we target that program and then talk a little bit about the acquisition and turnover program we run where houses have reached the end of the useful life.

In terms of maintenance and upgrades in 14–15, the department spent a total of $256 million on both upgrades and maintenance of public housing. That program is targeted at the beginning of the year around the condition of stock. We run a number of upgrade programs. You particularly mentioned public housing upgrades — so high rise upgrades. We do have a high rise upgrade program where we target different buildings around the state. We have substantially completed a large upgrade program of high rises, but that continues. It is generally carried out on the basis of a floor in each of the high rises. The tenants are relocated temporarily and we upgrade quite substantially on that floor in terms of an upgrade program. We of course do maintenance in those high rises and others as required, so we do responsive maintenance.

The upgrade program also refers to standalone properties and what we call walk-ups, which are generally two or three-storey high buildings. That program also continues along with the high rise upgrade program. The program basically is a range of program maintenance and program upgrades of public housing, which is larger than the maintenance program. It is a large-scale upgrade. There is also the responsive maintenance program.

For instance, as part of that $256 million that we spent in 14–15, we operated a call centre, which is the central point for the people who want maintenance of their public housing. The call centre in that year received over 300 000 calls from tenants and resulted in 2890-odd job orders for maintenance, which was basically responsive maintenance where tenants have made some calls. We do survey tenants on their satisfaction of maintenance and generally it is around about the high 80 per cent of tenants who are satisfied with the maintenance they receive.

In addition to the maintenance upgrade program, the stock is modernised through an acquisition and disposal program. Every year the director of housing disposes of properties that have reached the end of their useful life or there is no demand for them, and we replace them with new properties. Each year there is an acquisition and disposal program as well. That is, again, planned against the condition of the properties. We have recently done a property condition audit so we now have an understanding of which properties will be reaching the end of their useful life where it is probably not useful to upgrade them anymore. They are replaced by new properties mostly in the same location. Tenants have a choice to move back into those properties if they wish to.

The CHAIR — Is it usually like for like? So, for example, would you dispose of, say, $50 million worth of assets and then buy $50 million worth of assets?

Mr ROGERS — Generally, but the program is not quite set up like that. The acquisition and disposal program for that sort of upgrade is generally like for like, yes. We obviously do not want to reduce the number of public housing stock we have available so we would certainly never be reducing the numbers through the disposal and acquisition program. Generally where we have, say, a family in a property and that property needs to be replaced and that family wishes to still be in the same area, we would obviously replace that with a similar-type property.

On vacancy, we have a look at the demand in the area, and it might well be that the demand is a different pattern than the house we have already got, so sometimes we will change the property based on the demand for that house. Often properties are swapped at vacancy time rather than requiring someone to leave, but that is not always the case. We certainly would not be reducing the stock levels in public housing through that program. We may marginally increase and will change them, but we would not reduce the stock levels.

The CHAIR — In terms of 14–15, in terms of what you acquired and disposed of, was that a standard year in terms of the quantum, or was it an outlier as a year?

Mr ROGERS — It was a fairly standard year. I will just run through the numbers and cover those off. In 14–15 we acquired 655 properties, which is lower than we had been in previous years, but it needs to be borne in mind that that is sort of more like the historical sort of numbers — lower than the historical numbers, but still quite high. But prior to that there was quite a large number of acquisitions due to Nation Building — the large influx of money that the commonwealth paid to the states due to the global financial crisis. So there were some historically high levels of acquisitions through 9–10 through to 12–13, and it has tapered back to 655 in 14–15.

But just by way of comparison, we disposed of 468 properties that year, so there was a slight growth in the number of properties through the disposal and acquisition program.

The CHAIR — Okay. If you are able to provide on notice any further details in terms of the acquisitions and disposals for previous years, that would be helpful, if that is possible.

Mr ROGERS — We could give you those figures.

The CHAIR — Thank you.

Ms PENNICUIK — A clarification, please?

The CHAIR — Sure.

Ms PENNICUIK — Thank you, Chair. Thank you, Mr Rogers. You did mention a figure for maintenance, but I did not catch it earlier on.

The CHAIR — I think it was $256 million in the 14–15 year.

Mr ROGERS — The combined upgrade and maintenance program was $256 million in 14–15.

Ms PENNICUIK — Okay. Is there generally a backlog of maintenance, or was there a backlog in that particular year, as in maintenance required but not being done?

Mr ROGERS — There is always some lagging when maintenance is requested and when it is done. That is just by nature of organising the work. Through the property condition audit we did see that there were some properties that were in need of some repairs, so we have actually programmed some increase in maintenance beyond 14–15 to respond to that. So yes, there were some revealed through the property condition audit, but there are some planned increases in maintenance and upgrade expenditure to rectify that or to start working on those.

Mr MORRIS — Good morning, Ms Peake; welcome back. I think it is a slightly larger stage than the last time we met. Can I refer you to question 2b of the questionnaire, and that is the section that outlines the additional cost in 2014–15 as a result of the government's election commitments. I think there are some 15 line items there. Can you tell me the amount in the case of each of the line items that relates to the additional funding for the cost of the Easter Sunday public holiday?

Ms PEAKE — Certainly. I am actually going to ask Mr Wallace to just step through the public holiday policy and the resulting treatment in our department.

Mr WALLACE — Sure. I think committee members are well aware that the government had a commitment to introduce two public holidays. One particular public holiday, the Easter Sunday public holiday, fell into the 14–15 year. I can inform the committee that the government delivered on that commitment to introduce that public holiday, to provide additional penalties to workers who worked on Easter Sunday. The additional penalties arise from the fact that different awards and enterprise agreements have sometimes differential penalties for a public holiday in comparison to a Sunday in a normal week or a weekday under their particular awards. I can inform the committee that that commitment was delivered. Additional funding was provided to the department to meet that commitment. That funding is included within the employee expenses lines in the department's budget.

Mr MORRIS — Can you just repeat that last sentence again?

Mr WALLACE — The additional funding that was provided to the department is included within the employee entitlements — employee costs — lines within the department's annual report and within the budget papers.

Mr MORRIS — So you cannot give us the information that I asked for? Regardless of where else it has been published, what I specifically asked for was the amount for each of the 15 line items in question 2b.

Mr WALLACE — If you are specifically asking me about all of those line items, we would be able to provide some details of that, but I just inform the committee that some material, particularly public holidays

material, was provided in cabinet-in-confidence budget material to government, and I do not believe I am authorised to provide that information.

Mr MORRIS — So you are refusing to provide the information?

Mr WALLACE — I am indicating that I do not think I am authorised to provide the information.

Mr MORRIS — This is a financial year that is completed.

Mr WALLACE — That is correct.

Mr MORRIS — Can you then, given that you will not provide me with a break-up, confirm that the additional costs are included within item 2b?

Mr WALLACE — Yes, I can. I can also confirm the fact that the department provided estimates to government and was fully funded for the estimates that were provided.

Mr MORRIS — I did not really need to know that, but thank you.

Ms WARD — Good morning, everyone; thanks for coming to see us today. I am interested in your survey response, if you go to page 21 regarding the Eye and Ear Hospital. It talks about the initial start-up delays in mobilising the site and procuring trade contractors and so on, which resulted in an underspend. Can you just talk through that delay for us, please?

Ms PEAKE — Certainly. It is probably worth just informing the committee that the redevelopment project included major upgrade, expansion and reconfiguration of on-site clinical and administrative functions, together with teaching and research activities. Construction commenced in December 2013, and the project was delivered in multiple stages due to the need for the works to be carried out in an operating environment of a busy specialist hospital while minimising disruption to patient service needs, and I would like to for the record really acknowledge both patients' and staff's forbearance over what is always a complex process when it is an operating environment.

In terms of the progress, and then I will move through to time and costs, the Peter Howson wing roof replacement and ground floor works have been completed. Works are currently underway on the teaching, training and research floors, together with infrastructure upgrades throughout the buildings, and construction of the emergency department is expected to be completed shortly.

As the works unfolded asbestos issues were encountered in numerous locations in the existing buildings and were needed to be very carefully managed to ensure no safety risks were created for the construction workforce, patients, visitors and hospital staff. As a result of the identification of those asbestos risks the project experienced time and budget pressures. Construction was originally due to be completed in December 2017, now expected in late 2018. The budget has increased from the original 165 million to 196.4 million, which includes some internal funding from the health service.

Given the substantial costs and time blowouts and the uncertainties associated with the project, as that asbestos was identified, the department initiated a detailed independent review of the project's status to provide assurance prior to any further investment of funds this year. That included in the review a review of the planning to date; the identification and assessment of risks, including suitable risk management plans for the remainder of the project; and it also proposed options to improve current processes in the approach to planning, scope, buildability and project management. All of those recommendations are being implemented by the department.

Ms WARD — Thank you. Given the age of the building, can you explain how there was such little knowledge about the asbestos that was within the hospital?

Ms PEAKE — I might just ask Ms Diver to respond to that.

Ms DIVER — Sure. So when projects are being developed and an assessment of the costs, there are a number of audits that are undertaken in relation to asbestos to determine if asbestos is going to be an issue. One of the challenges for those audits in an operating environment in a public hospital is that at a certain level of

audit you would have to do destructive testing, so you would have to kind of break into walls. That is not appropriate in an operating hospital environment and so contingencies are made available to ensure that there is adequate funds to cover that.

As it turned out, there were more extensive asbestos issues in the hospital, and given the complexities of undertaking construction work in an operating hospital and managing the safety of the workforce additional measures were required to ensure the safety of the patients, the staff and the workers. That activity and the requirement to take extra care and protect the staff and the workers and the patients has resulted in both additional cost as well as a delay in the project, and that is why additional funds are being provided: to ensure the project can be completed. The independent review that was undertaken confirmed that the approach was appropriate. There are ongoing monthly meetings between the construction company, the hospital and the union to determine that they have got appropriate mechanisms in place and a range of measures to ensure that the hospital can continue to function whilst the capital works are underway.

Ms WARD — Thank you. And the additional money that has been required in order to complete the project, is that solely because of the asbestos issues and associated costs? Or have there been other issues that have you have also had to address that have required additional funding?

Ms DIVER — The additional funding is mostly related to the time and cost delay associated with asbestos. A small amount of additional funding has been provided by the Eye and Ear Hospital to do additional scope, so some education and training facilities that the Eye and Ear has chosen. That is of the order of about $4 million, but the remainder is a combination of government and Eye and Ear funding to support the completion of the original scope of the business case.

Ms WARD — Based on the asbestos problem?

Ms DIVER — Based on the asbestos problem.

Mr D. O'BRIEN — Secretary, good morning. I would like to go to the Victorian Comprehensive Cancer Centre. On 26 March 2015 the minister wrote to the Peter Mac chair confirming a $10 million shortfall in the philanthropic funding, down from 50 million to 40 million, and therefore a $10 million scope reduction in the VCCC. Can I get a list of what was actually de-scoped as a result of that $10 million shortfall?

Ms PEAKE — Certainly. Firstly, the shortfall of $10 million in funding resulted in a reduction of project scope, which included deleting elements of the internal fit-out from one part of level 13 and omitting some procurement of some equipment which could be procured and installed at a later date.

Mr D. O'BRIEN — Are you able to given us some more detail on that? I am happy to take it on notice if you can do so.

Ms DIVER — The scope reduction related to a lab cluster. The commitment to raise $50 million — at the time the government signed off on a potential scope reduction should that $50 million target not be achieved. In the event that it was identified that $10 million was not able to be met the scope reduction started to occur. The items were agreed by the steering committee, which involves Peter Mac and the other partners involved in the Victorian Comprehensive Cancer Centre building project, and the first item that was agreed for scope reduction was the fit-out of a lab cluster, as well as some equipment. The equipment is able to then subsequently be purchased at a later date or through other funding arrangements.

I suppose the other point to make is that this is a joint commonwealth-state funded project and there was within the business case a set area for laboratory space. But whilst we have reduced the laboratory space by taking out that lab cluster, we are still meeting the requirements of the commonwealth agreement to provide laboratory space, so in effect it was over and above what we had originally scoped for the business case.

Mr D. O'BRIEN — So for a layman like me, a lab cluster is just a laboratory space?

Ms DIVER — Correct; a laboratory space.

Mr D. O'BRIEN — For research purposes presumably.

Ms DIVER — For research purposes, yes.

Mr D. O'BRIEN — Just by way of supplementary, is there still a $40 million contribution from Peter Mac to the VCCC? If not — —

Well, I will let you answer that question first.

Ms DIVER — Yes, there is still a requirement for the partners to contribute $40 million to the VCCC project.

Mr DIMOPOULOS — Just a follow-up, Chair, if you don't mind. You said there was federal funding. Was there a commitment in terms of when Victoria needed to spend that federal money, and were the issues around the 13th floor complicating the time lines? Was there any risk to federal funding in relation to that agreement?

Ms PEAKE — Again I might ask Ms Diver to respond to that.

Ms DIVER — The issues around the descoping of the laboratory cluster have had no impact on the commonwealth funding.

Mr DIMOPOULOS — No, that is not my question. You said there was federal money. My question is: would the decision to proceed with the 13th floor or not to proceed with the 13th floor — in fact to proceed with it — have added to the time lines of the project, and did we have some deliverables with the commonwealth in terms of when we would have the project completed in order for them to supply their funds?

Ms DIVER — No, there has been no impact on commonwealth funding.

Mr DIMOPOULOS — Regardless of which way we went.

Ms DIVER — Regardless of which way.

Mr D. O'BRIEN — Just a clarification if I can. You mentioned some equipment was part of the descoping. Did you say that was later repurchased?

Ms DIVER — It is equipment that Peter Mac or any of the other building partners can purchase outside of the funding for the project.

Mr D. O'BRIEN — Are you able to tell us what that equipment was?

Ms DIVER — I am sure I can tell you what that equipment is.

Mr D. O'BRIEN — If we could get that on notice, that would be great. Thank you.

Mr DIMOPOULOS — I did not welcome you before. Welcome. In terms of the survey response to PAEC, on page 8 one of the initiatives listed is 'Hospital operations growth funding — including 800 new hospital beds election commitment'. The source is the 11–12 budget. The reason I ask this within the reporting period we are looking at today, 14–15, is that the completion date was within that reporting period, June 2015. I have looked at the actual outcomes of the other initiatives, and most of the descriptions are helpful. This description is not very helpful. For that initiative it says, 'Additional capacity for health services to increase access to services as expected'. I suppose my question is: the initiative was quite clear language around growth funding, including 800 new beds — quite a tangible figure — but the outcome description does not really explain what happened.

Ms PEAKE — Again I am going to ask Ms Diver to respond to you.

Ms DIVER — The commitment for 800 additional beds was a previous government commitment, and additional funds are provided to health services on an output basis. We do not fund on an input basis; we fund on an output basis. That is activity funding for episodes of care. That funding then goes to hospitals, which then determine how many beds they need to open to treat the number of patients, and then they earn the revenue to support the costs of opening those additional beds.

Bed numbers are published by the Australian Institute of Health and Welfare every year using a particular definition — a relatively narrow definition, you would have to say — of what beds are, and in the context of modern health care beds are not necessarily the only capacity that is available or that is useful, I guess, in providing health care. The Australian Institute of Health and Welfare exclude some of the more recently

developed models of care; for example, prevention and recovery beds for mental health are not included by the Australian Institute of Health and Welfare. Things like hospital in the home are not necessarily included. Contracted beds to the private sector are also not included, and some of the subacute ambulatory care, so community-based care that is really a bed equivalent. For example, a patient might 10 years ago have been in a rehabilitation bed, and that would have been counted as a bed; now that patient is actually in the home, receiving visits from nurses and physiotherapists for that care. The counting of beds, believe it or not, is actually a complex science.

That is the context, I guess, and then in terms of what additional capacity was provided, the AIHW have released data that shows the average available beds. That is using a census at the end of each month and then averaging it over the 12 months, and for 13–14 there were 13 583 beds, an increase of 134 beds from the previous year. That is the relatively narrow AIHW — Australian Institute of Health and Welfare — number. However, if you include all of those other models of care and use bed equivalents, then our calculation would be that there were 15 170 beds, an increase of 190 on the year before. That is 13–14.

Mr DIMOPOULOS — Do you have similar figures for 14–15?

Ms DIVER — The AIHW have not yet published their 14–15 data.

Mr DIMOPOULOS — Haven't they?

Ms DIVER — No.

Mr DIMOPOULOS — Just to follow up, I get the complexities. Thank you, that was a very comprehensive description, because when a taxpayer thinks of a bed they literally think of a ward and a bed in it, but I understand it is far more complex. I just want to get a sense, though, if this was a budget commitment in 11–12 and the following year we delivered 137 — —

Ms DIVER — The budget commitment was in 11–12, and the following year would be 12–13.

Mr DIMOPOULOS — Sorry, yes, and that was a figure of 137.

Ms DIVER — No, that was a figure of an increase of 46, and in 13–14 the increase was 134, using the narrow AIHW definition. If you use a more comprehensive definition that is perhaps more reflective of the way that services are funded, then the increase between 11–12 and 12–13 would be 104 beds and between 12–13 and 13–14 would be 190 beds.

Mr DIMOPOULOS — So it is close to 300 beds, yes, in those two years?

Ms DIVER — Correct. It was 294 beds between those two years, using a more comprehensive — —

Mr DIMOPOULOS — Which includes the complexity that you described.

Ms DIVER — Correct.

Mr DIMOPOULOS — We have one more year to go before the completion date, the accountability that is on this schedule, which is June; is that right? So there is one more year to go after that, which is 14–15.

Ms DIVER — That would only make three years.

Mr DIMOPOULOS — We need four, do we?

Ms DIVER — Yes. The commitments are — —

Mr DIMOPOULOS — It is 11–12, 12–13, 13–14 and 14–15.

Ms DIVER — Yes.

Mr DIMOPOULOS — So as at the end of that four-year period to June 2015 we only have figures of 294 beds, understanding that the Australian — whatever that agency is called — will release the next year's figures.

Ms DIVER — Yes.

Mr DIMOPOULOS — But I highly doubt next year's figures will make up the bridge between 294 and 800. What is your view about what the next figures are likely to be?

Ms DIVER — We need to wait for the figures, obviously, to be published, but I think if we are talking about a four-year commitment, we have also got the difference between 10–11 and 11–12 to include. But your question is really: have we met the 800-bed commitment —

Mr DIMOPOULOS — Yes, because the outcome does not describe — —

Ms DIVER — over the four years using that narrow definition that the Australian Institute of Health and Welfare uses or the broader definition that the department uses?

Mr DIMOPOULOS — That is right.

Ms DIVER — The data is in the public domain for the first three years of the commitment; the data is not in the public domain for the last year of the commitment, and I guess we need to wait for that data to be published.

Mr DIMOPOULOS — You are saying three years is on — —

Ms DIVER — Yes.

Mr DIMOPOULOS — So the three years amounts to 294, does it?

Ms DIVER — The three years amounts to about 300 beds.

Mr DIMOPOULOS — Okay. So essentially 300 out of 800, which is about 40 per cent of the commitment — —

Ms DIVER — Sorry, I should correct that — 400 beds.

Mr DIMOPOULOS — Four hundred, okay — I am trying to do the maths as well. So 50 per cent of the commitment was delivered in 75 per cent of the time provided, and then we have got one more year left to make up the other 50 per cent.

Ms DIVER — That is correct.

Mr DIMOPOULOS — This is about transparency; it is not about having a go at you or anything. So essentially we need 400 more beds for — what did you call that agency?

Ms DIVER — The Australian Institute of Health and Welfare.

Mr DIMOPOULOS — When do they come out with figures?

Ms DIVER — I do not actually have that information here. It just says that they are yet to be published.

Mr DIMOPOULOS — But essentially we are looking for a figure of 400 to make up the election commitment and the completion of that in that financial year — 800.

Ms DIVER — Correct.

Mr DIMOPOULOS — Which is highly unlikely, but that is just my — —

The CHAIR — Is there a question, Mr Dimopoulos?

Mr DIMOPOULOS — Done.

Mr T. SMITH — Secretary, for the 2014–15 year can you confirm the commonwealth has funded the social and community services sector pay equity order on a 70/30 wages/non-wages calculation and the state on an 80/20 calculation?

Ms PEAKE — I am just going to throw to Mr Wallace to provide you with information on that question.

Mr WALLACE — Yes, I can confirm that for the 14–15 year the federal government did fund the SACS award on a 70/30 split, and I can confirm that the state government funded it on an 80/20 basis.

Mr T. SMITH — Are future calculations for the funding of the SACS order calculated on an 80/20 wages/non-wages basis or do the calculations mirror the commonwealth's approach?

Mr WALLACE — What had happened was that the state had originally funded on a higher 80/20 basis for the SACS award but had not included those higher amounts in the forward estimates. There are amounts included for the financial year and then there are also provisions made in the forward estimates for subsequent amounts of funding. The amounts that had been provided in the year were at the higher levels, but the amounts that were provided in the forward estimates were not at the higher proportion levels.

Ms PEAKE — And obviously we cannot comment on future years prospectively.

Ms PENNICUIK — If I could just follow on a bit from Mr Dimopoulos's line of questioning about hospitals and your presentation where you point to the achievements at Latrobe regional, Bendigo, the comprehensive cancer centre, Monash Children's hospital et cetera, which are all welcome, I am just wondering about the Western General Hospital. Talking about beds, it seems that in the reporting year to 2014 there were 360 beds, and that is now 300 beds according to the annual reports. You can correct me if that is not correct, but it seems that there are less beds than there were and the general state of the hospital is pretty run down in certain areas. For example, in the emergency section it is very run-down — lack of cubicles, lack of privacy, equipment problems, space, lack of facilities and limited disability spaces et cetera. How much has been allocated to fixing up those problems and to reopening beds at Western General?

Ms PEAKE — I might just start while Ms Diver is just consulting with a colleague. One of the findings of the Dr Travis review that occurred last year was the benefit of taking a long-term approach to really looking at the capacity of the health service and the health system as a whole, and reflecting on the comments that Ms Diver made about thinking about both what that looks like in acute settings but also looking at different innovative models of care as well. That work, just to reassure the committee, is underway to look at what is the long-term pipeline of both capacity needed to meet demand and then bringing that back to a shorter term five-year program of work. That is certainly the approach that we are taking to really look at what are the constraints around the system and around the state. But I might throw to Ms Diver for the specifics around Western Health.

Ms DIVER — Western is obviously a growth corridor and the subject of significant planning by both Western Health and the department, and the master planning for Western Health has included a master plan for Western Footscray as well as Sunshine, and there are plans for a broader, larger scale redevelopment of both campuses. Stage 1 of that has already been funded by the government, and that is focused on the Sunshine women's and children's building — $200 million — which is currently under construction and will proceed.

As a consequence of the Sunshine redevelopment, what Western Health is doing is considering the whole health service, so what is the configuration of services between Western Footscray and Western Sunshine. As a consequence there has been a shift of services over to Sunshine that was partly accompanied by the opening of the intensive care unit and the cardiac laboratories. That has allowed there to be reconfiguration of services, which has meant there are less beds at Western Footscray, but those patients have been transferred over to Western Sunshine because you have got the right mix of specialties, and the planning is also continuing for Western Footscray in terms of potential redevelopment for the future.

Ms PENNICUIK — Can you tell me how much was allocated to Western General in terms of upgrades and maintenance to the actual site at Footscray in 2014–15?

Ms DIVER — All hospitals have access to a number of funds that are provided for all hospitals, so we have the medical equipment fund, and we also have a securing our health services fund, which is essentially for infrastructure and upgrades, as well as some maintenance funds. Those funds are available to all health services, and Western will have secured funding as part of those programs.

In terms of specific budget allocation for Western Footscray, there has not been a specific additional allocation for Footscray, but there is obviously a significant allocation of $200 million for Western Sunshine for the women's and children's building.

Dr CARLING-JENKINS — Thank you for taking the time to come this morning. I definitely appreciate your presentation, especially the outline of the challenges your department faces. I would just like to have you talk a little bit around the machinery of government changes to your department. I understand that has been quite a significant shift for your department. We have had figures quoted to us, for example, of staff transfers costing around 70 000 — that was reported to PAEC in June — and then the figure of 618 000, which was reported to the social and legal committee's inquiry, and you outlined those costs to them as well. I just wonder if you could speak to the restructure of the department particularly that was sparked by the machinery of government changes and the impact of those on the staff.

Ms PEAKE — Certainly. As I mentioned in the presentation, the bringing together of the departments involved supporting over 11 000 staff to come together into the new department. That involved the amalgamation of 1372 FTE from the former Department of Health and 9691 FTE from the Department of Human Services, and 63 former Sport and Recreation Victoria staff, with 10 staff then moving out of our department to Premier and Cabinet related to the women's affairs and equality functions. We picked up some functions related to medical research but without any transfer of staff.

At the time that the department was brought together there was an absolutely deliberate effort to look at how to build some of the synergies around functions that were around health and wellbeing being brought together while seeking to minimise the disruption on staff so that teams were kept together as much as possible. Over the subsequent sort of 15 months there has been work ongoing with staff to look at what are the natural groupings of activities that make sense to bring together in an organisational way, so looking at where are there functions where, through structure, the integration and cross-fertilisation of expertise should be progressed and where was it that those synergies, those ways of working, could best be supported through governance arrangements. So there has been a combination of approaches to really maximise the benefits of the range of functions that have been brought together.

The other thing that was a really important part of the formation of the department was a piece of work over 2014–15, or in the first half of 15, around what were the common values of the organisation. That was a piece of work that was really led by staff. It was a very inclusive process of groups of staff and groups of the executive saying, 'What do we want to stand for, how do we want to work and what values really reflect the commitment we make to one another and to the clients that we serve?'. Change always brings with it some disruption, but I do think that over the last 15 months there have been enormous efforts made to bring staff's views about what are the logical groupings of activities to the fore and that important work on culture, behaviour and values alongside that.

Dr CARLING-JENKINS — Thank you very much. I have just a couple of quick follow-ups. So the values then, they are the ones that you presented to us, those new ones?

Ms PEAKE — Yes.

Dr CARLING-JENKINS — Fantastic. I was very impressed with that. Now, can I just ask were there any staff reductions as a result of the amalgamation?

Ms PEAKE — Given that I was not there at the time, I might just ask Mr Wallace to comment on that.

Dr CARLING-JENKINS — You get all the hard questions, Mr Wallace.

Mr WALLACE — No, not at all. This one is relatively easy and has a very simple answer: no, there were no staff reductions as part of the amalgamation.

Mr MORRIS — Chair, just in light of the secretary's response, I wonder whether she could provide the committee with the most recent organisational structure, just so we can get the context.

Ms PEAKE — Certainly — very happy to do that.

Mr MORRIS — Thank you.

The CHAIR — I would like to refer you, Secretary, to your most recent annual report for 30 June 2015 and specifically note 27, page 228. I note that under the 'Improving public hospital services — National emergency access target (output)' there was $5.1 million in funding for the 2014 financial year but zero in 2015; under the 'Improving public hospital services — new subacute beds guarantee (capital)' there was 70.5 million in 2014 and zero in 2015; and in relation to 'Improving public hospital services — new sub-acute beds guarantee (output)' there was $84.2 million in 2014 and zero in 2015. Can you outline for the committee the background to these services or these agreements being terminated and the impact it had in terms of service delivery for 14–15, please?

Ms PEAKE — Certainly. And obviously some of this we also talked in some depth about at the hearing last year around the impact of — sorry, your specific question is around the impact of commonwealth decisions of funding flowing to the state. The commonwealth, as I said in my presentation, has taken an approach of really having, with very little notice, decisions taken that have quite profound impacts on the availability of funding to the state and the capacity therefore of the health services to meet growing demand of patients in Victoria. I might ask Mr Wallace to take us through, just step through, the specific financial impacts of decisions that the commonwealth has taken.

Mr WALLACE — What I probably will mostly refer to particularly there is the significant change in the way that funding has operated in volume funding — so probably just a little bit of context. Under the NHRA, whilst the NHRA has been in operation for a number of years, the first years it was in an introductory stage. So real financial transactions only occurred under the NHRA under the new funding model, moving away from indexation to moving to a volume — patients treated — basis, from the 14–15 financial year.

Probably there are a couple of issues to highlight. The first would be, as the secretary indicated, that in general the federal government has moved away from NPA funding, National Partnership Agreement funding, and so has ceased a number of funding sources that the department had relied on as part of its overall funding contribution for a number of years.

The secondary issue that has been getting some public consideration is that the way that the NHRA works from the 14–15 year is that the department is funded for additional patients treated. So when you need to fund for additional patients treated you first need to establish what the base number of patients treated was in the 13–14 year to then assess how many patients in total were treated in the 14–15 year to then calculate the number of additional patients treated, and then there is a formula which provides an amount of funding for each additional patient treated.

Whilst you may think that that calculation may be relatively simple, the fact is that all patients treated in health services are not exclusively funded under the national health reform agreement. A quick example would be: some patients are funded by the Transport Accident Commission, some patients are treated and funded through WorkCover sources and some patients had been treated under NPAs — 100 per cent commonwealth-funded national partnership agreements. The NHRA is a joint funding arrangement, where the funds are provided by both the state and the commonwealth.

So there have been issues in the definition of the starting point. The department tried to seek clarity on this because it was a large financial issue for the department and spoke to the administrator of the national health funding pool, which is the independent person appointed to adjudicate on funding arrangements. We did not get a definitive response from the administrator at the time, but we indicated to him how we proposed to tackle that matter, and really, by exception, he indicated that we were able to go ahead, whilst not ever particularly 100 per cent agreeing with that. We also wrote to the federal minister, the then health minister, the federal minister, also seeking clarification.

What eventuated was that the department did not get absolutely firm clarification of the 13–14 base, but we had provided our proposed approach to the relevant parties and nobody had indicated that they had issue with the way that we intended to tackle that matter. So what has subsequently happened is that, whilst the 13–14 base is now quite a way behind us, there has been a new acting administrator appointed, and the new acting administrator has re-opened up the definitions of the 13–14 base, which affects the numbers of patients treated in the 14–15 year, because if you adjust the base and in this case up, then the number of patients treated that you are funded for reduces. We have now had advice provided to us that in the acting administrator's view the base that was adopted by Victoria needed to be adjusted, and that has resulted in a $36.6 million funding reduction

for the 14–15 year and a $36.6 million funding reduction for the 15–16 year and ongoing, making a $73 million budget reduction to us.

The department is fairly aggrieved by this, because we believe that in good faith we had provided our intentions and our reasons under agreements to a number of parties, and we had thought that the position that we were adopting was considered to be a reasonable position by all parties. The previous administrator had funded us fully for the additional places in 14–15, so we had received the money. So we thought that once we had received those funds that that would have been the close of the 14–15 year and, by the actions of funding us for those moneys, that our position had been accepted.

We now find ourselves in a fairly difficult position, where we have a retrospective funding adjustment to deal with, and we are still litigating this matter. A new administrator of the national funding pool has been recently announced and will start shortly, so we will tackle that issue with that person as well.

Ms PEAKE — I might just make three additional comments. The first is that, while we had not had a written confirmation of the approach that we were taking in submitting our claim, as Mr Wallace has indicated, there was confirmation to COAG by the former administrator about the allocations that would be made. So we had certainly in good faith taken the decision that had been taken by the then administrator as being confirmed.

The second point to make is that the legislation that creates the authority for that independent funding authority to make decisions is very clear that its powers are prospective, not retrospective. So, having paid the money, we do not believe that there is actually a legal authority for a new acting administrator to overturn his predecessor's decisions.

The third is that the act is also very clear that, as you would expect from his title, the decisions that the administrator makes should be made through his or her own independent assessment and judgement. And the correspondence that we have received indicates that it is on the advice of a commonwealth minister that the decision of the past administrator has been overturned, so we also have concerns about the effect on the independent assessment of the office.

Mr MORRIS — If I can come back to the subject I started with, the issue of the cost of public holidays, I think the position is simply that the committee or some members of the committee are seeking to obtain the cost of the implementation of what was a government election commitment. I understand from the answer, essentially from Mr Wallace, that extra funding was provided, that through no fault of his own he cannot tell us what that funding was because the government prefers to keep it secret but that funding was provided. Am I correct so far?

Mr WALLACE — That is correct.

Mr MORRIS — Can you confirm that the entire amount that was provided to the department was paid to health services, and specifically how much was paid to each health service?

Mr WALLACE — What I can confirm for you is that the department operates a dataset; all health services provide us with staffing information and details. The department estimates were calculated from that information, which was available to the department. We were fully funded for the estimate we provided, and we provided those funds to health services.

Mr MORRIS — Provided the entire funds provided by government?

Mr WALLACE — Yes. When you say 'the entire funds', obviously we received supplementation for non-government organisations, Ambulance Victoria as well as public health services.

Mr MORRIS — In other words, it went out the door of the department? None of it stuck with the department, is essentially what I am asking you.

Mr WALLACE — That is correct.

Mr MORRIS — Thank you, Mr Wallace.

Ms WARD — I guess there is one question. Do you work on public holidays — or do you work on Sundays or public holidays?

Mr WALLACE — Not officially.

Ms WARD — No. Do people get sick on public holidays?

Mr WALLACE — They certainly do.

Ms WARD — I thought they might.

Members interjecting.

The CHAIR — Order!

Ms WARD — Don't ever get sick on a public holiday. I want to refer you, please, to page 5 of your survey response regarding ambulance service delivery for regional and rural. There is a note there that says:

> As part of the funding redirection, paramedic scholarships and the rural and regional call referral service (as mentioned in the PEBU) were not funded.

There was a funding redirection, I think. Can you talk me through — —

The CHAIR — Ms Ward, for the benefit of the witnesses, could you indicate which page of the questionnaire you are referring to?

Ms WARD — I did.

The CHAIR — Oh, did you? Sorry. My apologies. The Chair is sometimes wrong. Have you found the — —

Ms PEAKE — No. Sorry, would you mind just repeating the question?

Ms WARD — It is page 5 of your survey, and it just talks about paramedic scholarships and the rural and regional call referral service not being funded. I have got a note here that says — I think the funding might have been redirected. Could you talk me through that, please?

Ms PEAKE — Certainly. I might ask Ms Diver to provide you with some information there. I think we are going to take that one on notice.

Ms DIVER — At that level of detail, I will need to take that question on notice.

Ms WARD — Sure. No worries. On page 39 of your 2014–15 annual report, and I am referring specifically to the emergency service performance measures, can you just talk me through those performance measures, how ambulances performed during that period — was it to expectation and how that has been improved?

Ms PEAKE — Certainly. I think it is well known that over a number of years ambulance performance has been under pressure. There has been a significant body of work that was undertaken over 2014–15 to look at the strategies to improve ambulance performance, but I might ask Ms Diver just to step you through that.

Ms DIVER — As the secretary has said, it is now well known that ambulance response times have declined over the past few years. Performance against the statewide target of 85 per cent of code 1 incidents being responded to within 15 minutes fell from around 82 per cent in 2008–09 to around 73 per cent in 2013–14. In 14–15 we did see a slight improvement with the code 1 performance times, up to 74 per cent. I should say code 1 is the most urgent group of patients.

Ms WARD — What changes did you put in place that made that improvement occur?

Ms DIVER — In 14–15?

Ms WARD — Yes.

Ms DIVER — There is a range of work that has been undertaken to reform ambulance services. In particular, the minister established an ambulance performance and policy — —

Ms WARD — Sorry, the current minister or the former minister?

Ms DIVER — The current minister established in 2015 the ambulance performance and policy committee. That committee has undertaken a number of things, including the public reporting of response times as well as a range of reforms within Ambulance Victoria as well as some service expansions that have assisted in improving response times. There is an ambulance now — very timely.

I think it is fair to say that we had a significant decline over a number of years, and that has now stabilised with the signs of improving ambulance performance. There have been a number of reforms, including the service expansion and the call referral service, where patients who do not need an urgent ambulance are able to be referred to alternative service providers, as well as the way the ambulance service and hospital emergency departments work together to ensure that we have got timely transfer of patients. There was a task force chaired by Andrew Stripp that made a number of recommendations that ensured that we had ambulance staff and hospital staff working together. That included a transfer protocol, the collection of more data, KPIs around transfer times in hospitals as well as clearing times for ambulance staff, and the implementation of ambulance arrival supports, which is essentially — think of it as a kind of a TV screen in the emergency departments that gives hospitals notice of when ambulances are arriving.

There are a broader range of reforms that are now underway to support the further improvement of ambulance performance, because one of the things that did occur that contributed to that deterioration of performance over that time was the increasing proportion of urgent cases. About 60 per cent of ambulance calls are considered to be code 1 or urgent. In terms of international benchmarks, that is high, and so a number of reforms are being undertaken to review the coding and classification of patients that require an ambulance service. There was a review undertaken by a clinical panel chaired by Dr Joanna Flynn, who is chair of the medical board and also chair of Eastern Health, to review what are the clinical protocols associated with determining the classification of patients, and with a gradual implementation of those changes we are expecting to — and we are starting to — see some change in performance, where we can make sure that ambulances focus their resources on the most urgent patients.

Ms WARD — And you will get back to me about my first question regarding the survey?

Ms DIVER — Yes. Sure, yes, I will.

Mr D. O'BRIEN — Secretary, can I go to the 2014–15 annual report which states on page 34, with reference to Sandhurst Residential Services in Bendigo:

> The department will continue to manage and operate services for all 29 Sandhurst residents when they transition to new community-based accommodation in 2016.

My question is: will there still be an option for any of these residents to stay in DHHS care in Bendigo, noting that the new residential services are actually, as I understand it, to be managed by the private sector?

Ms PEAKE — I am going to ask Mr Rogers just to step you through Sandhurst.

Mr ROGERS — Sandhurst is an institution in Bendigo, as you pointed out, which the government has announced will close and the residents will move to five group homes in the Bendigo area. Sandhurst is operated by the Department of Health and Human Services. In late 2014 there was a process undertaken where the department sought interest from the non-government sector to operate those houses following the closure, and that process resulted in two non-government organisations being advised that they would operate those houses and we subsequently had discussions with those organisations.

In early 2015 the department asked the residents and families of Sandhurst what were their preferences and at that time they chose to stay, having their services operated by the Department of Health and Human Services.

Mr D. O'BRIEN — All of them?

Mr ROGERS — All of them. So the department continues to operate Sandhurst, and the houses have not yet been constructed. The general position around Sandhurst and every other service that we operate will be considered as part of the context of the NDIS and the government's proposal to look at its role within the NDIS proposal. So Sandhurst will be part of that, but at the moment we continue to operate the Sandhurst centre.

Mr D. O'BRIEN — So the money was there and the land has been purchased. Are the houses going to proceed at any time in the future, or are they proceeding now?

Mr ROGERS — They are proceeding. They are at different stages. We purchased the land in consultation with local families and the local staff. The design of the houses is being developed in consultation with families and they are on target to be constructed sometime this year. They are at different times Mr O'Brien, but yes they are on target to be completed.

Mr D. O'BRIEN — Is it right though that those two private not-for-profit firms are going to operate them?

Mr ROGERS — No. After consulting with the families we advised them that we would continue to operate them, so that process was stopped; it was cancelled. But as I mentioned before, the government is looking at its general role in service delivery as part of the NDIS environment and the new environment that that presents in terms of funding and operation of disability services in Victoria. The general direction for the residents in Sandhurst and who will provide their care into the future will be part of that broader process.

Mr D. O'BRIEN — Just to be very clear because there has been confusion in the local media up there. I mean the union understood that they were being transferred to Melba Support Services and Karden disability support services. But those homes will stay in DHHS control?

Mr ROGERS — The arrangement with both Karden and Melba were cancelled, following that consultation with families, but as I have mentioned, the government has announced its intention to look at the role of government in a broader NDIS environment, across all the services that we provide in disability, and that is a totally different context in environment under the NDIS. So that process about who will operate those houses into the future as well as other houses will be subject to that broader process.

Mr D. O'BRIEN — Sure. Sorry, I do not want to labour the point, but did that only happen recently with Melba and Karden?

Mr ROGERS — No, it happened — —

Mr D. O'BRIEN — Some time ago?

Mr ROGERS — Some time ago, last year. I just do not recall the month but some time ago the decision was advised to them and was advised to the Sandhurst staff and families.

Ms PENNICUIK — My question is in regard to the child protection area. Your annual report of 2015, and I am referring to page 59 of that report, looks at child protection out-of-home care data. It says there that the average rates of unallocated clients in that year was 16.9 or nearly 17 per cent, but if you compare that with the previous year, it was 12.8 and the before that it was 13.3, so there has been an increase. I was wondering if you could explain why that might be but also give just a bit of explanation as to what is meant by the term 'unallocated'.

Ms PEAKE — Certainly. We might start with the definition of 'unallocated', because I think that it is a bit like the previous discussion about hospital beds. It actually, when you unpack it, does not mean that people are not receiving a service. There is information that is provided; there are referrals to other services. But I might get Ms Asquini to take you through both parts of your question.

Ms ASQUINI — Thank you very much for the opportunity to talk to you a little bit about child protection services. As you can see, the demand for child protection services or the rate of reports has basically increased over the last couple of years. In 13–14 there were 82 000 reports and in 14–15 there were 91 000 reports. That generally results in an increased volume of work across the program more specifically.

The other aspect I think that I would like to draw your attention to is that whilst the unallocated, as Ms Peake said, does not mean that people do not get a service or children do not get a service, the amount of allocated work in the program has also increased.

Ms PENNICUIK — I am sorry; could you repeat that. I did not hear.

Ms ASQUINI — The amount of allocated work in the program has also increased. In June 14 there were 10 700-odd cases that were allocated to child protection workers, and in June 15 there were 11 729 cases allocated, so the volume of work has also resulted in a greater allocation of cases to child protection workers overall. More specifically, if cases are unallocated they still receive a service, so they are monitored by team managers. Planning is arranged for those matters that are unallocated. Visits and referral activity occur also for those cases. Team managers regularly review what is on the workers' lists and what might be in closure phase and therefore are able to then allocate further cases to child protection workers.

Ms PENNICUIK — Just for clarification, an unallocated client means that they do not have an allocated child protection worker?

Ms ASQUINI — They do not have an allocated child protection worker, yes; however, the team manager has the responsibility for oversighting the cases that are not allocated directly to one of the child protection staff.

Ms PENNICUIK — If I may, Chair: what is the reason for the increase in the number of unallocated clients?

Ms ASQUINI — Generally the increase in reports to child protection have largely been driven by family violence reports, commonly referred to as L17s. In 13–14 there were approximately 14 000 L17 reports to child protection — family violence reports — and in 14–15 there were approximately 17 000 family violence reports.

In addition to that, there have been changes to the family law court procedures that have resulted in nearly triple the amount of reports coming to child protection from the Family Court as well, from about 700 in 11–12 to over 2000 in 14–15.

In addition to that, there has also been an increase with respect to reports coming to child protection as a result of registered sex offenders. In 11–12 there were approximately 1100 reports related to registered sex offenders, whilst in 14–15 there were approximately 3200 reports with respect to registered sex offenders.

The overall impact of that means that there is more volume of work in child protection, and that work needs to be prioritised. The team managers, as I said, regularly review the work that is not currently allocated directly to a child protection staff member to determine whether it can be allocated, when it should be allocated and, as I said, also provide oversight of those cases through a monitoring process that they involve and that involve other staff as well.

The other element that I should also indicate is that often there are other services involved with those families and children where matters are not allocated. Family support services, for example, mental health services and drug and alcohol services may already be involved with those families.

Ms PENNICUIK — Chair, just a slight clarification: I understand I am hearing from you the volume has gone up, but there is also that the percentage has gone up. Is that as a result of not enough child protection workers, or is it a result of that and other factors in terms of why a client is allocated or unallocated?

Ms ASQUINI — Yes. The volume of work basically is, as I said, increasing within the program. There has been significant productivity for child protection through changes that were made — in 2012, I think — where approximately 63 per cent of staff were case carrying, and following the restructure of the child protection workforce the proportion of workers carrying cases increased to about 77 per cent, I think, of the workforce carrying cases, which resulted in, I think, something like a 13 per cent increase in the amount of workers that we had carrying cases as a result of the workforce restructure that we did.

In essence, it is the volume of work. We are constantly looking at how we can drive greater allocation, but largely it is an issue of volume of work.

Mr DIMOPOULOS — Secretary, I draw your attention to the annual report, page 42, under 'Mental Health Community Support Services'. There are a couple of outputs there that have a significant negative variance — so bed days, the target was 87 000, the actual was 73 672; and the client support units, 783 000 to 661 000. The one underneath is 5.4 per cent variance. I just wanted some background. If you could you unpack the first two: why do you think that happened and what the human impact was rather than just the numbers?

Ms PEAKE — Certainly. I will ask Ms Congleton to comment, but at a higher level what we have seen over a number of years is the increasing complexity of the supports that are needed for patients who actually needed to be admitted into our tertiary system with mental health conditions.

The investments that are made in primary care tend to be focused on those members of our community who are experiencing conditions such as anxiety and depression, and for people in our community who are experiencing very significant mental health challenges and conditions, then the investment is really predominantly through the public hospital system to support them, albeit that we are looking through the work that I mentioned earlier around service planning and infrastructure planning, at what might be the models of care that can provide greater continuity and step-up and step-down care in community settings.

Mr DIMOPOULOS — I imagine the second category also would take longer?

Ms PEAKE — Correct, and tend to have the characteristic of requiring urgent care. I might just ask Ms Congleton to go to your specific question.

Ms CONGLETON — Just in terms of the mental health community support services, there was during the period a recommissioning of the services, which did impact on a number of performance indicators in the budget papers, particularly around the mental health community support services. So you will see in a number of those that the target was higher than the actual reported amount. There were also during that period issues around some data collection, and that also had to do with the recommissioning. There were a number of issues in terms of the disruption that had been caused to service providers during that period both in the lead-up to it and then after the changes with some new providers taking leadership responsibility for those indicators. That is a feature of a number of the indicators that appear in the budget papers.

Mr DIMOPOULOS — So just to add some colour to it and an understanding for the average Victorian — I consider myself to be one — what exactly is a bed day in this context? What actually is it? It talks about the use of youth residential services and mental health community support services but what is a bed day? Is it like 8 hours in a residential facility?

Ms PEAKE — I might just get Ms Diver to step you through that.

Ms DIVER — A bed day is a way of counting a bed.

Mr DIMOPOULOS — For mental health purposes?

Ms DIVER — Pardon?

Mr DIMOPOULOS — In this context, for mental health purposes?

Ms DIVER — In this context, a bed for a year is 365 bed days. If it is occupied for 365 bed days, then it is occupied 100 per cent of the time. In this context there are a number of classifications of mental health beds. Some are acute mental health beds located in a hospital — not in this category, so just generally. There are forensic mental health beds, there are acute mental health beds, sub-acute mental health beds and residential mental health beds. My understanding is that this relates to community-based beds, which are more longer-term community care units. So if you have a 10-bed unit times 365 days, that is the capacity, and then how many days those beds are occupied gives you the number of bed days.

Mr DIMOPOULOS — It is quite clear then; it is really a bed for a day in multiple settings. Ms Congleton talked about two factors, one is recommissioning, which had an impact on data collection, which also comes out of recommissioning as well, but tangibly that is 13 328 less bed days in one financial year only. That is significant — it is way beyond 10 per cent — so what was recommissioning? Was that defunding or a reduction in funding? How can a recommissioning lead to 13 500 less beds for mental health in one year?

Ms CONGLETON — There were, as part of that recommissioning, some changes in access to services. There were also some changes in providers of services during that period and information for people accessing services. So there was some significant impact on performance both across some of the mental health community supports in the drug and alcohol area. There was subsequent to that a lift in performance in the following financial year, but there was certainly a gap in the delivery of services because of the disruption to the services. So some organisations, as they were, are not the holders of the funds in the new arrangements. They sort of geared down and then there was a gearing up of new service providers, so there was an element of disruption at that point of changeover, which was around — —

Mr DIMOPOULOS — Was there less funding in that year for that output measure?

Ms CONGLETON — No, I think the funding was the same. It was really about the changeover and the transition of the arrangements from one set of providers to the other. With that there had been, with some of those agencies that did not hold the funds into the future, some issues around workforce as well. It was an element of the transition, which, as I mentioned, has picked up performance subsequent to that.

Mr DIMOPOULOS — Yes. But the reality is that with the recommissioning there was no less money but the consequences were potentially 13 500 less bed days for mental health patients in that measure because of essentially the sector being in turmoil. That is my language, but in terms of trying to grapple with what was going on.

Ms PEAKE — I think Miss Congleton made two points. The first was the transition of business between funded agencies. The second was the data systems. For a period of time the data was not collected and reported effectively, so we did not have line of sight into all of the activity that was occurring, and it is a combination of those two factors.

Mr T. SMITH — Page 57 of the questionnaire outlines in 14–15 variations in trust funds and funds received and held outside the public account. My question is: how much specifically was the amount budgeted received under the national health reform in each of these areas, and how much was the actual?

Ms PEAKE — I am going to ask Mr Wallace to step you through that.

Mr WALLACE — Thank you for the question. The actual budget and actual figures can be found. The budget figures can be found in the 14–15 budget paper 5 and the revised figures can be found in the 14–15 budget papers. Of the actual amount received, the only place in the public domain where that is clear is in the administrator's annual report. That is the administrator I spoke about previously — the administrator of the national funding pool. The figures I have in front of me are that in the 14–15 budget paper 5, federal NHRA funding was $3757 million; in the 15–16 budget paper 5, the revised figure was $3829 million. The final figure that I have in front of me, in the administrator's annual report, if you go to the administrator's annual report for the actual payment, was $3863 million.

Mr T. SMITH — We received more in 14–15 under the national health reform than we budgeted for, so were these additional funds used, given you found out about the amount during the course of the year? For example, are they passed on to health services to increase budgets, or is the funding held by the department?

Mr WALLACE — So the increased funding usually is reflecting increased activity during the year. So all of the NHRA funding is based on an estimate of volume of activity that is occurring during the year. Higher volumes of activity in an actual health service will generate additional funding under the NHRA, and the funding is applied to that extra activity, in the vast majority.

Mr T. SMITH — I am sorry; I do not understand your answer.

Mr WALLACE — Sure.

Mr T. SMITH — You were expecting a certain quantum from the commonwealth.

Mr WALLACE — Sure.

Mr T. SMITH — You got more than you were expecting.

Mr WALLACE — Sure.

Mr T. SMITH — Explain to me where that money went.

Ms PEAKE — We will just take a step back. Initially we estimate how much activity we expect to experience in our health services. We then acquit that about actual activity. So it is not that there is a block funding that is provided to us, which is that then we have a windfall gain; it is that activity was higher in actuality than the estimate, and therefore the funding provided by the commonwealth was higher, to match that higher activity.

Ms PEAKE — So we are funded by activity.

Mr D. O'BRIEN — So it is basically passed straight through?

Ms PEAKE — Yes.

Mr D. O'BRIEN — Lance, I think you said 'in most cases'. What cases would there be where it would not be passed straight through?

Mr WALLACE — Well, the vast majority of funds — there is just not a perfect one-to-one match in every single situation, but the vast majority — would be passed through for that activity-based funding. If additional funding were to be provided, then in most cases there may be additional funds provided to health services for upgrades or other once-off new activities or projects.

Ms DIVER — The funding under the national health reform agreement for activity-based funding comes from the administrator directly to health services. Where there are block funding arrangements, then they come through the department, which then passes on the funding to health services. With activity-based funding, what occurs, even though the funding comes directly from the commonwealth, it matches targets that are negotiated between the state and each health service. For example, we will negotiate an activity target with an individual health service for X units of care, and they may deliver additional units of care. So that additional activity is then collected by our data systems, and that is reconciled with the estimate that we made, and in that year we provided additional activity, so that is services going slightly above their 100 per cent target of activity.

Mr D. O'BRIEN — So that is passed through. There may be a clipping of a ticket, depending on what agreement you might have, maybe for administrative purposes or something? Not really?

Ms DIVER — Not really, no. It is just that in our funding system there is activity-based funding for things like acute admissions, emergency departments and outpatient activity, but for some services that have less well-developed funding models, and they are much smaller amounts of money, there are block funding arrangements — for example, teaching, training, research, small rural health services, mental health, community support. They are block funding arrangements, and there are activity funding arrangements for activity, passed straight through from the administrator directly to a health service. Then the state funding is matched to that. But for the block funding arrangement it is a slightly different arrangement about the way the money passes through. But it is not that we necessarily take any money off the top of it; it is a transparent system in terms of the health services seeing what their commonwealth funding is and what their state funding is.

Mr T. SMITH — In terms of block funding, how much block funding did you get — extra block funding — and where was it passed on to?

Mr WALLACE — Well, the numbers I quoted you before include both activity funding and block funding. So those totals were indicated there. And the block funding is just a different type of funding, as Frances mentioned, for — —

Mr T. SMITH — But extra block funding?

Mr WALLACE — Well, there was a quite small — a relatively small — amount of additional block funding in the overall scale, and again that would have been allocated for additional block activities: small rural activities, training and — —

Mr T. SMITH — Could you come back to the committee on that?

Ms DIVER — I guess the better way, or not a better way, but a way, of describing it would be that block funding is a set amount at the beginning of the year — for example, teaching, training, research — that is an amount that is allocated to health services. There is no activity count for teaching, training and research; it is just an amount of money that is provided to hospitals. For activity — for example, acute admissions — we provide a target to services to say, 'Do this many units of care'. They might do additional units of care, and we get additional money for additional units of care. But, for example, for something like teaching, training and research, it is a set amount of money, and there is no count associated with that, so therefore there is no opportunity to pick up additional funding. I should point out that the block funding arrangement is a much smaller arrangement in terms of the context of all funding. Activity-based funding is overwhelmingly the largest proportion.

Mr T. SMITH — My question stands. Can we have an understanding about what that extra block funding was for and how much it was?

Mr WALLACE — We will take that on notice. I do not have that — —

Ms PEAKE — We can provide that information.

Mr T. SMITH — In terms of the additional activity funding, can you can explain to me: did it go straight to hospitals? Where did it go?

Ms DIVER — Yes.

Mr T. SMITH — All of it?

Ms DIVER — Yes.

Mr T. SMITH — Every single penny of it?

Ms DIVER — Yes.

The CHAIR — We might take a quick, 10-minute break.

Dr CARLING-JENKINS — My question is around the NDIS rollout, so I might get Mr Rogers to come to the table. I just wonder if you could speak to us about the NDIS rollout, particularly around two aspects: one is that I understand there have been a number of challenges around the financial modelling with the federal government and how Victoria is tracking with that; and then, secondly, to outline for the committee the preparation work — which was touched on earlier this morning — over that last financial year that we are here to talk about today, particularly around that move to increasing the numbers of individual support packages to assist that transition for people with disabilities to move more smoothly to the NDIS.

Ms PEAKE — Thank you. I will throw to Mr Rogers.

Mr ROGERS — Thank you for that question. In terms of planning for the NDIS we obviously had the Barwon site trial start in 2013 following the signing of the heads of agreement. In terms of our planning we have been looking at the lessons from the Barwon trial sites, so clearly we have been talking to participants, to the agency and to advocacy and other groups around some of the issues from Barwon. I have got to say, though, that Barwon, despite a somewhat rocky start as happens with trials, has gone well. I think in the final 2014–15 quarter 4392 people had approved plans in Barwon, which was roughly in alignment with what was predicted for that trial. And about 30 per cent of people were new to receiving disability supports, so that also confirmed what we thought — that there would be around about three-quarters existing and about 25 per cent new, so it is slightly more than that.

During 14–15, we were obviously making sure that the Barwon trial was working, but our work in 14–15 was basically around developing the basics for the bilateral agreement with the commonwealth, which was signed in September 2015, as you would be aware. But during 14–15 we were working out the details of that bilateral and what would happen, and that is basically the agreement around transition to the full scheme. During 14–15, based on the experience of Barwon, we were estimating the types of areas that would roll in to begin with and also the numbers that would be in each of those areas and when we would do that. So during 14–15 we basically were finalising — it is called phasing, so how many in 16–17 and beyond. So that was done and that is

now in the bilateral. The bilateral contains that phasing schedule of the new participants coming to the scheme and when, and obviously associated with that is the funding contributions from the state and commonwealth.

I think during the heads of agreement discussions before, obviously, 2015 that the total amount envisaged for the full scheme cost for Victoria was $5.1 billion, and that is enough to accommodate the phasing schedule of everybody we think will go in the scheme, which is about 75 000 existing clients and about 30 000 new clients. So that funding that is now in that bilateral, the 5.1 billion, is enough to accommodate that, based on an assumed average cost for the client. When I say 'assumed', it is based on the Barwon experience, so we are aware of what the experience is and what the average costs are.

The average costs going forward are roughly in accordance with what we have learnt from Barwon. The 5.1 billion consists of 2.6 from the commonwealth and 2.5 from Victoria, obviously both jurisdictions putting in a lot more money than they currently do. That will accommodate the phase-in schedule for the participants into the scheme over the next three years. In terms of the funding arrangements, the bilateral signed by the Premier and the Prime Minister sets the funding requirements for each jurisdiction, so I think that is locked in.

In terms of also preparing for the transition, the bilateral sets out the phase-in schedule. Members would be aware that north-east Melbourne is the first area to start, and that will be in July of this year, followed by each of the other DHHS areas — Central Highlands early next year and so on. We have been basically working with our colleagues in north-east Melbourne, in the northern division, and with the sector based on the Barwon learnings from up to 15 around how we might prepare different groups to be ready for the scheme — the current sector obviously in terms of disability services providers, community mental health providers and HACC providers. We are working with these groups — sorry, and early childhood intervention services through the department of education. We are also working with advocacy groups and directly with people with a disability and their families to give them information about the scheme.

For the sector it is about them understanding how the scheme operates, and that is quite a lot different, as you would know, from how it is funded at the moment — quite remarkably different. We have been working with National Disability Services Victoria so that they can make sure their members are aware of those differences based on the learnings of the providers in Barwon. And we have been working with advocacy groups around how they will talk to their members and people with a disability and their families about how they can be good consumers of the scheme to get the best out of the scheme when it operates in that area, and that has been done through a number of different forums and meetings, and community forums as well.

Dr CARLING-JENKINS — Can I just ask a follow-up there? You mentioned the average cost per person as being something you have learnt from Barwon. Was that higher than was originally anticipated?

Mr ROGERS — It is broadly in line with what the Productivity Commission anticipated, as it has turned out — not quite the same; I think it might be slightly higher, but very marginally higher.

Dr CARLING-JENKINS — Only marginally higher.

Mr ROGERS — Only marginally higher. The predictions around the number of people and the costs of the scheme for Barwon are around about where we thought they would be. We have to monitor that as it is rolling out through other areas, because Barwon is not — as you know, in Geelong and surrounding areas it might be different in different areas, so we will have to monitor that and understand how the scheme costs are going.

Dr CARLING-JENKINS — Of course. Thank you.

Mr DIMOPOULOS — Just a quick follow-up. You may have given the answer to this when I was occupied with other things. In relation to sector readiness I note that there was a figure of about 10 million given in 2015, but in the reporting period 14–15, prior to that 10 million, were there any funds given from the department for sector readiness for the NDIS?

Mr ROGERS — In 14–15 there was around, I think, $600 000 provided to peak organisations in the sector for readiness, and the year before about $900 000 was provided.

Mr DIMOPOULOS — In 14–15?

Mr ROGERS — In 14–15 it was $600 000.

Mr DIMOPOULOS — It was $600 000, and then the 10 million came with the election of the new — —

Ms PEAKE — Subsequently.

Mr ROGERS — That was late last year, the 10 million.

The CHAIR — A question from me in relation to immunisation. I note that the whooping cough vaccine program was reinstated in the 14–15 financial year after funding for it had been ceased, I think, in 2012. From the department's perspective, what impact did you see in 13–14 in terms of the prevalence of whooping cough and what take-up did you see in 14–15 in terms of parents having their children immunised and what did you see in terms of the prevalence of whooping cough as a disease in the 14–15 year as a consequence of the reinstatement of this program?

Ms PEAKE — My colleague Ms Cattermole has just joined us at the table, so I will ask her to step you through that.

Ms CATTERMOLE — Chair, I am sorry; I do not have it immediately to hand, but I will be able to get you some detail around the first part of your question in relation to changes in what we saw in relation to whooping cough in that 13–14 period. What I can say, though, what I do have to hand, is that when the commitment was made to reintroduce a whooping cough vaccine it was brought into being on 1 June of last year, a month ahead of schedule. We have seen a strong uptake, and that has been averaging about 9000 doses a month almost immediately, so it has scaled up really quickly and it has been maintained at that level pretty well since that time.

The CHAIR — So it is about 108 000 doses per annum as a consequence of the reinstatement of the program?

Ms CATTERMOLE — That is right.

Mr MORRIS — Could I just, on a point of clarification before I move to the next subject, going back to the public holiday issue, part of my question which Mr Wallace in the end did not address was the quantum of payments to each health service.

Ms PEAKE — I think it all gets tied up in the answer that Mr Wallace has given about the estimates that we provided which were then subsequently funded; they are the subject of a budget-in-confidence process which we are not authorised to disclose.

Mr MORRIS — Again; all right. Thank you. I understand the constraints you are under, so I will not push the point. Can I move to page 26 of the annual report. You do not need to check it; you will immediately, I am sure, recognise the reference. It refers to a formal independent evaluation to measure the impact of the approach of joining up the human services system. Can I ask, when will that evaluation be completed, and will it be available publicly?

Ms PEAKE — I might just ask Mr Clements to join the committee. Sorry, this is an evaluation of Services Connect — is that the question you are asking, the integration of human services?

Mr MORRIS — The annual report refers to, and it is on the top right-hand column under the heading 'Joining up the human services system'.

Ms PEAKE — Yes.

Mr MORRIS — It does not actually say anything about an evaluation of Services Connect.

Ms PEAKE — Yes. That was the program name of the integration of services. So, Mr Clements, just the timing of the evaluation of Services Connect.

Mr CLEMENTS — Hello. Thank you for the question. The Services Connect partnerships, which are community-based partnerships in operation currently, are scheduled to wind up their operations at the end of October, or the current funding at least ceases in October. So the evaluation is a live process underway at the moment, and it will be completed around the time of the completion of the current phase trial in October.

Mr MORRIS — And will that be available to the public?

Mr CLEMENTS — I would believe so, yes. I think it has been — it is a very open process at the moment. Obviously all organisations are involved in providing data, outcome data and throughput data and that type of thing. So, yes, it is a very open process, with about 110–115 community organisations involved.

Mr MORRIS — Obviously this is the same subject, but page 31 of the questionnaire talks about a refinement in the scope of the Services Connect program. Can you outline what was funded but did not go ahead regarding Services Connect?

Mr CLEMENTS — There was nothing really that was funded that did not go ahead. There was some initial work done on scoping an IT program in effect. We referred to that as a single-client use. Some initial scoping was done around the breadth of what that would require. The scoping ceased; it did not then move into further production. But in terms of the actual trial, for example, of the partnerships that I mentioned before, that funding that was provided/announced in late 2014 has been provided and it has continued to be provided.

Ms PEAKE — I might add for the benefit of the committee that there is obviously a significant body of evidence that has been provided to the Royal Commission into Family Violence around what might be necessary to have more personalised services that meet the needs of not only victims and survivors of family violence but relevant to other members of the community that have complex needs. So the learnings that come out of the royal commission will be relevant to inform our thinking about the approach to social services moving forward.

Similarly there has been a significant engagement of social service providers over 2014–15 and through the remainder of the year around child protection, out-of-home care and housing services, all of which, combined with those trials, will inform approaches into the future.

Mr MORRIS — On just a quick point of clarification regarding the IT aspect, the scoping work that was done, the project then did not go to tender, I gather.

Mr CLEMENTS — That is right, yes.

Ms PEAKE — That is correct, and really relevant to the comments I have just made, that also in the context of other evidence that has been led at the royal commission and the work that has been happening around sharing of information around common clients, we are really looking to bring all of that work together to look at what is the package of information-sharing legislative and IT changes that will be necessary to support joint ways of working going forward.

Mr MORRIS — Chair, with your indulgence because this feeds into what I would like to ask. The response has sort of raised the issue of re-prioritisations and changes. You have provided us with some information with regard to question 21 — and I am talking sort of department-wide now. I am wondering if you can provide to the committee, on notice of course, a list of re-prioritisations at initiative or line item level, what was allocated in the 2014–15 budget in the forward estimates, how much has been reallocated and what it was reallocated to. On notice is obviously desirable.

Ms PEAKE — Happy to take that on notice.

Mr CLEMENTS — Yes. We will supply you with a little bit more detail than is provided in the question.

Mr MORRIS — Yes, thank you.

Ms WARD — I have still got some questions on ambulances. We know that in the 14–15 year in the ambulance EBA an agreement was reached and the ongoing dispute ended. What I am interested to know is what were the costs that were associated with the resolution of the EBA. What were the costs incurred by the department during 14–15?

Ms PEAKE — Again, I will ask Mr Wallace to furnish that information.

Ms WARD — Thank you. Additional costs.

Mr WALLACE — I think the committee members are aware that the settlement of the ambulance EBA involved a number of features: a $3000 sign-on bonus, 6 per cent from 1 January 2015, then subsequently 3 per cent from 1 July 2015 and a further 3 per cent from 1 July 2016. The things that I have in front of me of additional funding for, or the cost for, the 14–15 year is approximately $25 million. What the committee would need to understand is that the previous agreement had expired on 16 November 2012. Under the department's funding model we receive funding in each financial year related to salaries and wages indexation, so the department had some of the funds available as carryover funds.

Ms WARD — So some of the 25 million additional cost had already been accounted for in previous budgets.

Mr WALLACE — That is correct. Because the department receives indexation of about 2.5 per cent under government indexation policy, the department did not need to commit those funds in the prior financial year because no new enterprise agreement had been struck. So when the first initial payment of 6 per cent was made, the department was able to access carryover funds from prior budgets that had been made available for general indexation to offset the costs.

Ms WARD — And how much were the carryover funds?

Mr WALLACE — The mathematics of it would have been from 16 November with the expiry of the EBA until 1 January 2015 when the funds were there. So at about 2.5 per cent of the salary base of the ambulance workers.

Ms WARD — So was there much of a gap between the carryover funds and the actual amount — the 25 million?

Mr WALLACE — Not a significant gap in that the agreement — —

Ms WARD — So more or less we broke even?

Mr WALLACE — Not completely break even, but the total funding of the ambulance agreement was about 12 per cent over four years, which is about 3 per cent annualised. The department's funding model is about 2.5 per cent annualised, so there was a small gap that needed to be provided.

Ms WARD — 0.5 per cent.

Mr WALLACE — Consistent with the government's view on relative wage improvement that they wanted to make in that particular area.

Ms WARD — Great, thank you.

Mr DIMOPOULOS — Can I just confirm something, a follow-up to Ms Ward's. So the department had the money, had the majority of the money to put to bed — well, it is not your decision, but to put the paramedic dispute to bed. The government at least had the money already in the budget to put the paramedic dispute to bed in the 14–15 financial year?

Mr WALLACE — It is definitely correct that the department does have indexation funding of around 2.5 per cent sitting in the budget.

Mr DIMOPOULOS — As a normal course of business?

Mr WALLACE — That is correct, and so those funds were available to assist with any settlement which was reached.

Mr DIMOPOULOS — That is incredible. So, we kept the population in Victoria waiting for 12 months when the money was already there. Anyway, thank you.

Mr D. O'BRIEN — I want to go to the issue of ice now. On page 10 of the 2014–15 annual report it refers to the *Ice Action Plan*, and it says the $24.6 million package will, among other things, expand treatment services. My question is whether that has led to the establishment of more public residential rehabilitation beds or if there is an intention to do so?

Ms PEAKE — I might just ask Ms Congleton to step that through.

Ms CONGLETON — Just a few comments on the *Ice Action Plan*. There were a number of components to the *Ice Action Plan* that was announced towards the end of 2014–15, and there was, as part of that, the introduction of some new therapeutic day rehabilitation services across regional Victoria and outer metropolitan Melbourne providing treatment and support services for drug use, and links to a number of families — I think about 500 per year in terms of links to families and clients across that period. So there were a number of elements, but part of that was around some new therapeutic day rehabilitation services.

Mr D. O'BRIEN — Can I just ask where they are? Are they in hospitals? Are they in private operators?

Ms CONGLETON — I will just have to see if I can find that information for you, but if I do not have it, we can certainly provide that.

Ms PEAKE — We can provide that additional information.

Mr D. O'BRIEN — Yes, that would be useful. Your understanding is there are no overnight beds if you like — it has been restricted to day therapeutic situations?

Ms CONGLETON — This was a gap that was deemed in the service, so it was deemed to be a really good addition to the range of services that were provided because there were bed services. As well as then this is a community approach, so for people then to get support in their community without having to relocate to where those services were. That was the gap that was perceived to be in service delivery. That is the nature of the service, so it is different to other services that had been provided. This was a gap that was identified by families and people that needed support.

Mr D. O'BRIEN — Yes, and I understand there is that, and I believe there have also been some community corrections facilities. Do you know are there any plans for any further not day beds but permanent beds?

Ms PEAKE — We cannot comment on future decisions.

Mr D. O'BRIEN — Sorry, I do not mean future decisions, but are there any in the pipeline as a part of the *Ice Action Plan*?

Ms CONGLETON — Not that I am aware of. The commonwealth government has also made a big announcement around ice, and I think as part of that looking at additional treatment and support as part of the commonwealth announcement. You would expect that some of that would be allocated to Victoria, so we will be looking at conversations with the commonwealth about what their plans are as well.

Mr D. O'BRIEN — Excellent. That would be great if we could get the detail of those day therapeutic beds and their location and everything. That would be great, thank you

Mr MORRIS — Chair, just very briefly while we are on this subject, can I just ask: there is the ice action task force and there is the specialist workforce advisory group. I am just looking for a bit of clarity there. Which one is the authorising body? How are any potential conflicts managed, that sort of thing?

Ms PEAKE — They had slightly different remits as well. The workforce group obviously looked at a set of issues about the thinking about different workforces and the training and development needs of those workforces. That resulted in new training materials that were released outside of this period as well as an agreement to look at developing an accredited qualification as well versus the group that was looking more broadly at services, gaps and what mattered to families and communities about the whole raft of initiatives or interventions that a state government might make to try and address drivers for use of ice and the effects of use of ice.

Mr MORRIS — Thank you.

Mr DIMOPOULOS — A slight change of pace, women in sport. On page 56 —-

Mr D. O'BRIEN — They are getting faster, don't you think?

Mr DIMOPOULOS — On page 56 of your annual report there is reference to the community facility grants. I understand that that came into your department on 1 January.

Ms PEAKE — Correct.

Mr DIMOPOULOS — I am just wanting to get a sense of the types of grants that were paid out, the recipient organisations — were they councils — and also specifically in the 14–15 year what was provided in capital grants for women in sport.

Ms PEAKE — Certainly. If we start with just the broader question of grants that were provided in 2014–15, the sporting uniform grants program provided grants of up to $1000 for purchase of uniforms essential to participation. That program, I am pleased to inform the committee, was delivered on time and on budget. There were also community sport and recreation awards, which were really about showcasing the achievements in community sporting events and design of community sport and recreation facilities. There was also funding — a bit over $3 million was allocated to 53 state sporting associations and state sporting and recreation bodies in 14–15 to improve sport and recreation outcomes for people with a disability.

Mr DIMOPOULOS — Do you know, were they capital grants or a mix?

Ms PEAKE — No, these were grants to actually just improve participation.

Mr DIMOPOULOS — Capacity-building grants?

Ms PEAKE — Yes. And there was 100 per cent growth in participation as a result of that output funding being made available. Other uses of that funding were really around workforce development, enhanced sort of reach out and involvement of people with a disability to participate in school sport programs and other community programs. There was also the Premier's Active April as an annual campaign that encouraged Victorians to undertake 30 minutes of physical activity a day during April. That saw 103 020 Victorians register for Active April, with an allocation of $800 000 to support that activity. I might then just ask Ms Congleton to take you through the capital.

Ms CONGLETON — In terms of the infrastructure, annually there is funding that is provided to local government — they are the predominant recipients of the infrastructure grants — sporting clubs. There is also funding for significant sporting events; for example, the Australian National Skydiving Championships and so forth. So annually there is funding that is allocated for infrastructure and events. As I mentioned, the bulk of the funding goes to local government, and that is generally part contribution. That leverages then funding in the local community as well and other sources to make sure that we provide good infrastructure that supports community participation and of course including women's participation. There has been some subsequent work on women in sport in these last few months, so that is an active piece that the government is considering.

Mr DIMOPOULOS — Thank you. Understanding that there is a third party involved, councils — government, councils and then the sporting clubs — tangibly can you trace any of that capital money back to, for example, tangible things in terms of the capital side, women's change rooms or that kind of stuff? What was the size of that pie, and do you know what proportion or what money went to specifically women's participation in a capital sense?

Ms CONGLETON — I know that there was an allocation for women's change rooms. I am just not identifying that at my fingertips, but that is something that we certainly can provide to you.

Mr DIMOPOULOS — Thank you. I will just make my question clear. I just want to know how much in capital grants went to women's participation in sport, whether it be for change rooms or other modifications to existing club pavilions, in the 14–15 financial year.

Ms PEAKE — We will come back with that.

Mr T. SMITH — Secretary, on page 22 of your annual report, the paramedic work value case, can you please outline the position the government has put to the Fair Work Commission regarding an increase in pay for paramedics based on work value as part of the work value case before the commission, and can you provide the committee with a copy of the government's submissions?

Ms PEAKE — Through the Chair, that is actually not within the 14–15 — —

The CHAIR — That is out of scope, I think, Mr Smith. If you would like a moment just to rephrase that question, I am happy to throw to Dr Carling-Jenkins, if you would prefer. Would that be useful?

Mr T. SMITH — Thank you.

Dr CARLING-JENKINS — I actually have a very specific question around employee expenses and something that the committee has picked up in looking at DTF's financial report and the questionnaires that have been supplied to the committee. I am just going to read it so I make sure I get it right. In the Department of Treasury and Finance's 2014–15 financial report it states that the salaries for the general government sector were 392 million, or 2.1 per cent, higher than originally estimated, due to 'higher actual salaries in health agencies and hospitals to meet higher than expected hospital activity'.

This does not seem to be backed up by what the committee saw in the general and specific questionnaire, where it states that the six largest health agencies reported salary expenses falling within 1.1 per cent of their initial 2014–15 budget. I just wonder if you can provide some clarity around that, perhaps some further information on which agencies might have been responsible for the higher than budgeted salaries that DTF speak to and what might have caused that increase?

Ms PEAKE — I will ask Mr Wallace to respond.

Mr WALLACE — The first thing I need to say is that I suppose due to the machinery of government change some of the comparative financial information does not actually give you a true view of what is actually happening. This has got to do with the legal constructs, so what is happening in both the department's annual report, and also if you are quoting information out of the latest budget papers, is that due to the machinery of government change what physically happened was the Department of Health was the ongoing legal entity, the Department of Human Services was abolished as a legal entity and the Department of Human Services joined the renamed legal entity, the Department of Health, from 1 January 2015, to create the Department of Health and Human Services.

Under the accounting rules, what happens is that financial statements are for the legal entity, and the legal entity of the Department of Health and Human Services included full-year transactions for the Department of Health, the ongoing legal entity, but only half-year transactions for the Department of Human Services, which was abolished. So the first thing is that when you both look at annual report figures or budget paper figures, you need to do a reconstruction of those figures. For example, if you go to the department's annual report, you will not only see the department's financial figures but at the rear of the annual report you will see the half-year Department of Human Services financial transactions. To actually make meaning of employee costs, you need to add the two reports together and do a reconstruction.

Similarly with the budget papers, if you go to the BP5 budget paper tables, the same thing occurs. The comparative information — when you look at the information, because of the accounting rules, it is for the legal entity and the comparative information can mislead unless you add additional data.

Perhaps what might be best, rather than me trying to on the spot give you an analysis of that reconstruction, is if we can provide you with a little bit of information on the reconstructed data, and then I think it will be easier to see the movements and explain the movements.

Dr CARLING-JENKINS — That would be fantastic, Mr Wallace, if you could take that on notice. I have some sympathy for what you are saying around the machinery of government changes and how it can appear to be misleading. If you could also, in taking this on notice, have a look at the part of my question around whether there were higher actual salaries in health agencies and hospitals to meet higher than expected hospital activity and what that might mean.

Mr WALLACE — That is correct, and I think you will find that when the data is regularised, the movements are easier to explain, and I am happy to take that on notice.

Dr CARLING-JENKINS — Thank you very much.

The DEPUTY CHAIR — Can I ask a question about staff numbers? The annual report says the new department also provides administrative efficiencies to enable more of the available resources to be directed towards service delivery and innovation. When we go to the questionnaires and we look at page 72 of the DHHS questionnaire and page 38 of the DHS questionnaire and do a comparison between financial year 14 and financial year 15, we see that when you combine the numbers there total staff numbers appear to have gone up by 172.

Ms PEAKE — Yes.

The DEPUTY CHAIR — And there appears to be five more executive officers and 89 more VPS 5s and 6s. I am just wondering why there are now apparently more senior executives, or executives and senior staff, than there were prior to the merger.

Ms PEAKE — Actually I was all geared up to give you an answer about the 172, but I might ask Mr Wallace on the specifics around the executive.

The DEPUTY CHAIR — I might come to that.

Mr WALLACE — I do not have the numbers straight in front of me, but my understanding is that — —

The DEPUTY CHAIR — They are straight out of the questionnaire.

Mr WALLACE — Yes. The executive officer positions by comparison year to year are fairly flat from the annual report. That is my memory. The government has committed to a further reduction in executive officer numbers, and we have a target to reduce for the department of nine in the current financial year and then we have a further reduction of two in the following financial year. The department currently has in place an executive officer reduction strategy which is in line with the government's reduction.

If we are talking about aggregate staffing numbers overall, there has been a small increase in aggregate staffing numbers 13–14 to 14–15. I think people will be well aware that the department delivers a lot of direct services — that is, frontline child protection workers, frontline housing workers and frontline disability workers — so it is not unexpected with the department's growing budget and service expansions and demand characteristics that Ms Asquini mentioned before, but you can see some modest growth of those staff numbers.

The DEPUTY CHAIR — I would appreciate whatever further information can be provided, but I would be particularly interested if we could get a breakdown of staff by VPS level, both in Lonsdale Street and in each of the regions.

Ms PEAKE — Certainly I can inform the committee that of the additional staff there were 40.5 extra FTE in child protection, 19.5 in disability development and support, 33.1 in youth justice, so 93.1 FTE that was additional was related to those direct services that Mr Wallace referred to. Another 79.6 FTE was really related to the bringing in of the sport and rec staff to the department, so that is the major explanation.

Mr MORRIS — Is that information that I asked for available? Or if not now, can we take it on notice?

Mr WALLACE — Yes, we are happy to provide that information.

The CHAIR — Just a question from me about inclusion. Jesuit Social Services and the National Australia Bank have a partnership for the African Australian Inclusion Program whereby Jesuit Social Services receives about $5500 per person who is placed within the NAB. Most of these are young Horn of Africa graduates who go into graduate entry positions in the NAB. They do two intakes a year, and there are about 50 people in the next intake. I have got a very large Horn of Africa community, many of whom live in public housing and many of whom I am very keen to see leave public housing and get off welfare and get into work and into good, long-term, viable positions. I am just wondering from DHHS's perspective what inclusion programs were in place in terms of 14–15?

Ms PEAKE — Certainly. I might take the question in two parts. There is inclusion in what we do for our own employees and how we encourage people to join the public service, and then there are obviously programs that we run that are about supporting members of the community to participate more fully.

The CHAIR — I am probably more interested in the former aspect rather than the latter; that would probably be my focus.

Ms PEAKE — It is a really key focus for the department, and across a number of categories, so Indigenous inclusion, people with a disability, LGBTI people, gender diversity, support for flexible work arrangements and cultural diversity. I will take those quickly going through.

In terms of Indigenous inclusion, we have got a number of employment strategies — for example, CareerTrackers internships, graduate programs and scholarships to increase actual participation in key areas such as child protection and youth justice.

We are also really focused on career development and employee retention. We have got a program which is called the Wirrigirri messenger program as part of Moondani, the Aboriginal inclusion action plan, which has had some really positive results. We have promoted many Indigenous staff to senior levels, so 50.6 per cent of Aboriginal staff employed by the department are in salary brackets over $80 000 a year. We have a high proportion of Aboriginal employees, 47 per cent of whom are employed in rural and regional Victoria, and we have a special measure applied for Aboriginal-specific roles to attract candidates. We make sure that we have an Aboriginal panel member so that there is appropriate candidate care through the recruitment process, as well as providing a staff support network, which has an annual conference and three forums a year, one of which I am attending in a couple of weeks time to provide that sort of peer support, professional development and networking for our Indigenous staff.

For people with a disability we have our Stepping Into internship program, which commenced in the last calendar year with five interns working with the department and reasonable adjustments in the recruitment process and the workplace.

In terms of gender diversity, we are a bit different than many other departments, so 68.5 per cent of our staff are female, and 59.6 per cent of our executive-level roles are filled by women.

In terms of our flexible work arrangements, I am also pleased to inform the committee that we have a higher use of flexible working arrangements than other VPS departments, utilising flexible arrangements such as purchased leave and recreation leave on half pay in particular. We find that purchased leave between two and four weeks is the most popular.

For lesbian, gay, bisexual, transgender and intersex people in DHHS we have recently established a pride network. I was really pleased to see that over 120 staff participated in its launch in September last year. I think we had the most staff who participated in the Midsumma Pride carnival march recently.

We also work closely with the new commissioner for gender and sexuality on a range of initiatives to really support access and inclusion and are managing the health and human services working group of the government's LGBTI task force to really improve the orientation and support for health and human service workers and embed accountability around meeting client needs, so that is a bit more about the outward facing.

In relation to cultural diversity, finally, we are just in the process of finalising our cultural diversity plan with a four-year commitment to really enhancing language service provision, really improving — Chair, the issue you raised — the opportunities for internships and for participation in our department. We will be looking to really provide more detail about the sorts of initiatives in that space in months to come.

The CHAIR — Anything you can do to get some of the young Horn of Africa people, particularly those living in public housing, into internships would be very welcome.

Mr T. SMITH — Secretary, in May 2015 the secretary of Premier of Cabinet told this committee that the public sector commission was undertaking a capability review for DHHS. Has it been completed, can we have a copy, what were the key recommendations and what has changed as a result?

Ms PEAKE — Certainly. The capability review is publicly available on our website, so I certainly can make that available to the committee.

Mr T. SMITH — All of it?

Ms PEAKE — Yes, it is. I am happy to step through the key recommendations.

Mr T. SMITH — Yes. We would appreciate that.

Ms PEAKE — The capability review, with the department's functions coming together, indicated that there was a need for us to really look at our strategic directions and provide coherence to staff about priorities and plans, that there needed to be governance arrangements that were clear about how those strategic priorities would be taken forward across the department and that there was the need to really build capabilities in terms of technology, the use of data and analytics and to continue to invest in our strategic policy capabilities. Finally, the capability review really pointed to some of the discussion that we have had here today about NDIS readiness and how the department organised itself in order to ensure that we were supporting clients and the workforce in gearing up for transition into the NDIS.

So in terms of the steps that have been taken, we undertook right through last year a review of the governance arrangements within the department. We have released this week the outcomes of that review, which establishes clarity around the role of the executive board — which are the members of my executive that you have heard from today — as well as a set of subcommittees that are really focused on those the big service improvement initiatives around health and community services and NDIS readiness, as well as committees that really go to the stewardship of the department, so looking at issues around staffing and people and culture, as well as looking at the quality and performance of the department.

Those governance arrangements are operational, and there are terms of reference and advice on the composition of each of those subcommittees, which again is available on our website. The organisational structure, as I mentioned earlier, has been really designed to ensure that we do have that clarity of role and responsibility and that there is integration and cross-fertilisation of health and community service — for example, around infrastructure planning and project delivery as well as around looking at our strategic policy capability and really bolstering the resources that are put to that.

And finally, in terms of the technology piece, there has been a significant body of work which we are, through our governance board, working through. We have made investments over the last 12 months to better support our staff in terms of information technology, and that will be a continuing priority for us.

Mr DIMOPOULOS — Can I just ask you about the Monash Children's hospital helipad. It is really the only major hospital next to my electorate. I know that there was an election commitment in 2010, from memory, for a range of things but including the helipad at the children's hospital. Just going back to the reporting year 14–15, what advances were made or moneys provided for that? I will give you some context. What I see from the outside looking in is that it seemed to be quite behind schedule, if in 14–15 we were still providing resources to it. I would have thought that that would have been earlier. Can you just explain? I may have it wrong.

Ms PEAKE — Certainly. I might just ask Ms Diver to respond.

Ms DIVER — Sure. People will be aware that the new Monash Children's hospital is being built where the original Monash Medical Centre helipad was situated. The helipad was used about three times a week to transport critically ill neonatal, paediatric and adult patients to the hospital, as well as for urgent transports of patients from Monash to other hospitals. With the agreement of Monash City Council, the helipad has been temporarily relocated to the Fregon Reserve to allow the construction of the new Monash Children's hospital to proceed. The 15–16 state budget provided additional funding of 3.8 million to provide a rooftop helipad that was not previously included in the scope of the Monash Children's hospital.

Mr DIMOPOULOS — Just on that, my understanding was that it was actually in the scope and that it was an election commitment in 2010–11 for 11–12. I think that is on the public record.

Ms DIVER — My understanding is that the business case that was funded in the original business case funding for Monash Children's hospital did not include a helipad.

Mr DIMOPOULOS — Can I just clarify through the Chair and the secretary, so the original business plan, because there were two — this crosses over two periods of government — so the original business plan under the Baillieu government?

Ms DIVER — Correct. The scope for the funding of Monash Children's hospital did not include a helipad.

Mr DIMOPOULOS — Well, that is a surprise. Okay. That genuinely is a surprise. I thought that was always part of the Baillieu plan, but obviously not. With 14–15, though, what was provided in 14–15 for it?

Ms DIVER — The funding for the helipad was not provided in 14–15. It was provided in 15–16.

Mr DIMOPOULOS — Okay. Thank you.

Mr D. O'BRIEN — Can I just ask on the Monash Children's and the early-in-life mental health facility, do you know if that is going to moving into the new hospital?

Ms DIVER — The early-in-life mental health facility: there are a number of parts to the Monash Children's development. There were what were aspirations and then there was what was able to be funded. I guess that is perhaps where some of the confusion around the helipad occurred. There was an aspiration for a helipad, but it was not actually funded in the original business case. The early-in-life mental health beds: there was funding provided in the original funding for refurbishment of that area in its existing location. There is still an aspiration to relocate that into the main new building, but that is currently not funded.

Mr D. O'BRIEN — Not yet funded?

Ms DIVER — It is not funded, but there is funding available to refurbish it. It is a self-contained small unit that currently operates that will remain in its place, but there is funding to refurbish it.

Mr D. O'BRIEN — Do you know if that is happening? Or is that on hold in case they can use it to move?

Ms DIVER — I am not sure of the exact timing of the works, but Monash Children's is not finished and by the time it is finished the refurbishment of that will occur.

Mr D. O'BRIEN — I just want to move to sport for a moment. The community facility funding program previously had around generally about $20 million per annum. I think it was actually folded into, though, the Community Sports Infrastructure Fund of the new government. Is that correct, that it was folded into that as part of that funding?

Ms PEAKE — I understand so.

Mr D. O'BRIEN — That is part of the question. Continuing on from that then, there are quite a number of commitments that were either, I think, election commitments or program stream commitments made out of that infrastructure fund, and I think they tally around $72 million. Would that accord? Does that sound correct? It was for things like the female change facilities, the cricket program et cetera.

Ms CONGLETON — Not about the major facilities, but other infrastructure?

Mr D. O'BRIEN — The community ones. There was previously a program, and the annual report on page 31 refers to the community facility funding program. As I said, I understand that was folded into the new Community Sports Infrastructure Fund.

Ms CONGLETON — I believe that is the case in terms of the community infrastructure program.

Ms PEAKE — That is correct.

Mr D. O'BRIEN — My question was: how much of that was effectively committed in 14–15, either through election commitments or, as I said — out of that fund the government had committed that it will fund 10 million for female change facilities, 10 million for cricket, 2 million for the country football netball program. Would it be right that that left only about $28 million in that fund over the next four years?

Ms PEAKE — We are going to have to take that question on notice and come back to you.

Mr D. O'BRIEN — Okay. Good. Thank you. A related issue on sport: in 14–15 there was a $300 000 integrity in sport program announced. That was about assisting, I think, particularly some of the less

professional sports to deal with issues around gambling and that sort of thing. What was the outcome of that program, and has it continued?

Ms PEAKE — We might need to take that one too.

Mr D. O'BRIEN — Okay. For your reference, it was in the budget 14–15, budget paper 3, page 56.

Ms PEAKE — Thank you.

Ms WARD — I am hoping to get some clarification around PPPs. In budget papers, including for 14–15, we have some line items which tell us what we believe they will cost and what will happen. But there is not any information provided to us either in 14–15 or previous budget papers that tells us what has actually happened at the completion: what were the costs, what were the costs incurred by the private partner and how that all worked. Are you able to give that information to us?

Ms PEAKE — I must just ask Ms Price to come up and comment. Before we do — sorry to the committee — I might just refer you to the annual report where there is information that is provided about commitments for expenditure.

Ms WARD — That is commitments for expenditure, but what was actually spent?

Ms PEAKE — But not the actuals; correct.

Ms WARD — Yes, that is what I am interested in: what is actually spent, what the role is by the private partner, what the private partner has spent and what it has been spent on.

Ms PEAKE — On this process is there anything you want to add?

Ms PRICE — If I could just introduce myself, first of all: Leanne Price; I am the director of infrastructure planning and delivery in the department. With PPPs, at the time of entering into a contractual close — entering into the arrangement with the private sector party — there is a detailed project summary that is actually produced. They are all published on the DTF website for each and every project, and they go through the full reconciliation of all the costings and the estimates. Then on an annual cycle the Auditor-General's office does a detailed assessment of the expenditure to date, on an annual basis, of those projects still in completion. For the department that includes both the Victorian Comprehensive Cancer Centre and Bendigo Hospital.

Ms WARD — That is the department's component. What about the private partners' component. Is that also included, and is there a running summary of reconciliation so that we know what they have actually spent in the course of the project?

Ms PRICE — There is the component that relates to the construction, which eventually government effectively pays. Their added value, we do not have that visibility; that is not current policy within PPPs.

Ms WARD — So is there any way of knowing what private providers actually spend or what their input is into a project, at the end of the project?

Ms PRICE — Currently I do not believe we have that level of detail, and that is probably a related DTF question.

Ms WARD — Do you think it would be useful to have that level of detail so that you know what your partners are providing and what they are paying for so that you could work out efficiencies?

Ms PRICE — We certainly know what they are providing. That is part of their original bid process.

Ms WARD — Sorry; you know what they are providing. When I am talking about providing I am talking about what they actually spend and how they work through what they have provided in their tender.

Ms PRICE — Certainly in terms of the construction costs, there is a fair degree of visibility of those construction costs. In terms of their other costs associated with delivery, we do not have that access, although there is access to their financial accounts.

Ms PEAKE — I think one of the things, I guess, that is a characteristic of PPPs is that the contract really sets out what needs to be delivered. What actually then is spent year on year is less, I guess, material — less germane — to ensuring that the delivery has actually happened. I think we are getting into the territory of a broader policy question for the Treasurer.

Mr MORRIS — Just a quick point of clarification on that capability review document. It does not seem to be on the DHHS website.

Ms PEAKE — It is; it has been released, so we can certainly make it available to the committee.

Mr MORRIS — It is not under 'Publications'. It may be — —

Ms PEAKE — It definitely is on the website because I have recently released it.

Mr MORRIS — If someone could send us a link, that would be helpful.

Ms PEAKE — Certainly; we can do that.

Mr MORRIS — Can I move to the bushfire appeal money. **In** the annual report, at page 232 'Note 28. Trust account balances …', the 2009 bushfire appeal trust account as at 30 June had 6 million remaining in the account. I am just wondering how that is travelling and what is happening with it.

Ms PEAKE — I apologise; we do not have specifics today. Certainly I am happy to take that away and get you further information.

Mr MORRIS — That would be good; thank you.

Dr CARLING-JENKINS — I would just like to address the issue of performance measures. The committee has had some concerns — and this is across departments, not in any way targeting your own — around some of the performance measures and the need for review. Particularly a number of them, we have identified, lack clarity, lack meaningfulness or lack robustness. I have got one specific example here, so I would like some general comments on that, if I could. I would also like to just point out a specific example around client satisfaction with advice provided, which is a performance measure for the Office for Disability.

The reported result for this measure just put some red flags up for me. It has been reported as '100 per cent satisfaction' for many years now, which means that every client of the Office for Disability for the last, well, six years actually, when we trace it back, has been completely satisfied with the agency. That has just got red flags for me in that that appears to be unrealistic. I suppose I would like someone to address the possible subjective aspects of such a measure — how that has been investigated and how the department defines that level of satisfaction — and just some general comments around performance measures, please.

Ms PEAKE — It has been the case that with the two departments coming together, or three functions really coming together, that in and of itself required us to really look at our performance measures. Also really to your point there has been commentary from the Auditor-General across the board about the relevance and utility of performance measures, so we have been undertaking a review of our measures in the past 12 months. That is a body of work that is underway and will be completed in coming months, and I am happy to take your particular example on notice to have a look at that.

Dr CARLING-JENKINS — Thank you.

The CHAIR — Secretary, if I could refer you to the questionnaire for DHS for 13–14 and 14–15 and particularly the bottom of page 19, under 'Other Income'. The 14–15 budget estimate was 396.5 million, the actual for 14–15 was 610 million and the explanation is:

> The variance is mainly driven by higher than expected hospitals' own source revenue from miscellaneous non-operating activities.

My question is: could you outline to the committee what this is, what are some of the key drivers for this and what options there are to, I suppose, expand this into the future?

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

Mr WALLACE — Again I just refer to my earlier advice that some of the information and comparisons are affected by machinery of government changes. Again I think it would be best for the committee if we did a reconstruction of that particular line and provided some additional details of it on notice.

The CHAIR — Yes, that is fine. Thank you.

Mr MORRIS — The annual report, page 17, talks about a new focus on hospital performance, and on the bottom of page 20 there is a reference to the Victorian health care experience survey, indicating that it will be available in late 2015. I am wondering if it is available. If it is not, can we get a copy of the survey statewide results for each question? But I would also be interested in knowing how the survey is being used to improve performance.

Ms PEAKE — Through the Chair, I think a specific question around material released in the second half of 2015 is not within the scope of today's, but I am very happy for us to give you general information.

Mr MORRIS — The annual report says it was going to be released, so I am asking you has it been.

Ms PEAKE — I am certainly happy to give you the general information.

Mr MORRIS — I know how financial years work.

Ms DIVER — The Victorian health experience survey is a new survey that is being developed that is now completed by each health service in Victoria, and approximately 40 000 patients are written to each quarter to ask them to participate in the survey. The results of the survey are then fed back to each health service so that they can see the results on a range of, from memory, about 70 questions. They can see their own performance and they can also benchmark their performance across similar care agencies, and that provides the opportunity for services to identify where there are significant gaps or variation in their performance and it also provides the opportunity for services to identify who has got better performance and go and learn from those services.

We have had two quarters of data available now to services where they have received that information, and they are using that information themselves to improve performance. The department also includes the results of that survey in its performance assessment score of services, so the way we monitor the performance of health services has a range of indicators. One of them is the health experience survey, and that is part of an aggregate score that we use to determine how well a service is functioning. That information is used both by health services in terms of improving their performance and as well it is used by the department in terms of providing an assessment of their overall performance. The government has committed to public release of data in the context of the transparency-in-government policy and so there is further development of a comprehensive range of data to be provided in the public domain, and when that occurs the health experience results will be provided as part of that redeveloped website with a broader range of indicators available for the public.

Mr MORRIS — So the answer for today is that we cannot get a copy of the survey statewide results for each question.

Ms DIVER — It has not been released publicly. It will be released as part of transparency in government in the redeveloped website in future.

Mr MORRIS — Which is a bill that provides absolutely no obligation on the government to release anything.

Ms DIVER — Well, there are plans to release that data as part of the — —

Mr MORRIS — Certainly no obligation, but I mean —

Ms DIVER — Sure.

Mr MORRIS — that is not a point that we need to argue about. By way of supplementary, Chair, I understand that the Victorian palliative care satisfaction survey is not being continued, and I am just wondering why that is the case.

Ms DIVER — Sorry? I just missed that.

Mr MORRIS — The Victorian palliative care satisfaction survey — I understand that is not being continued, and I am just wondering why. Was it not useful?

Ms DIVER — I will need to take the question on notice.

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

The CHAIR — Okay. I would like to thank the witnesses for their attendance: Ms Peake, Mr Wallace, Ms Diver, Ms Congleton and Ms Asquini. The committee will follow up on any questions taken on notice in writing. A written response should be provided within 21 days of that request. All recording equipment must now be turned off. Thank you for your time.

Witnesses withdrew.