PUBLIC ACCOUNTS AND ESTIMATES COMMITTEE

Inquiry into the 2024–25 Financial and Performance Outcomes

Melbourne – Friday 28 November 2025

MEMBERS

Sarah Connolly – Chair
Roma Britnell – Deputy Chair
Jade Benham
Michael Galea
Mathew Hilakari
Lauren Kathage
Aiv Puglielli
Meng Heang Tak
Richard Welch

WITNESSES

Jenny Atta, Secretary,

Catherine Rooney, Deputy Secretary, Budget, Finance and Investment,

Naomi Bromley, Deputy Secretary, Hospitals and Health Services,

Pam Anders, Deputy Secretary, Mental Health and Wellbeing,

Siva Sivarajah, Chief Executive Officer, Hospitals Victoria,

Professor Zoe Wainer, Deputy Secretary, Community and Public Health,

Nicole Brady, Deputy Secretary, System Planning, and

Ryan Phillips, Deputy Secretary, People, Operations, Legal and Regulation, Department of Health;

Jordan Emery, Chief Executive Officer, Ambulance Victoria; and

Priscilla Radice, Chief Executive Officer, Victorian Health Building Authority.

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

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

On behalf of the Parliament, the committee is conducting this Inquiry into the 2024–25 Financial and Performance Outcomes. Its aim is to gauge what the government, the courts and Parliament achieved in 2024–25 compared to what they planned to achieve.

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

All evidence given today is being recorded by Hansard, and it is broadcast live on the Parliament's website. The broadcast includes automated captioning, and members and witnesses should be aware that all microphones are live during hearings and anything you say may be picked up and captioned, even if you say it quietly.

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

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

I welcome the Secretary for the Department of Health Jenny Atta as well as other officials who have joined us here today. Secretary, I am going to invite you to make an opening statement or presentation of no more than 10 minutes, after which time committee members will ask you some questions. Your time starts now.

Jenny ATTA: Thank you, Chair, and committee members. I too would like to acknowledge the traditional owners of the land we are meeting on today, pay my respects to elders past and present and extend that respect to any First Nations peoples who are with us today.

Visual presentation.

Jenny ATTA: Our vision at the Department of Health is a simple one: that Victorians are the healthiest people in the world. In 2024–25 nearly 2.7 million patients accessed state-funded public healthcare services,

and these services rely on close to 169,000 public healthcare workers, who make a difference every day and support Victorians at every stage of their life.

Victoria's health system continues to perform strongly across the department's output expenditure priorities. Total expenditure in 2024–25 was $30.5 billion. In terms of Victoria's health system performance, our health system continues to perform strongly, including compared to other Australian jurisdictions. Productivity Commission data shows Victoria performs better than the national average on a wide range of key measures. For 80 per cent of reported public hospital performance measures, Victoria performs better or equal to the national average, and that includes, for example, the median wait time for planned surgery, which in Victoria is the lowest in the country. It is the second highest performing state on emergency department patients treated in recommended timeframes. For 87 per cent of ambulance services performance measures and 82 per cent of mental health service measures, Victoria is better than or equal to the national average.

The department supports four ministers across six portfolios: health, ambulance services, mental health, ageing, children and health infrastructure. In terms of the health portfolio, health services achieved a record-breaking year for planned surgery, with 212,000 surgeries delivered, and there were almost 4.2 million specialist appointments through the public health system, an increase of 350,000. There has been a big focus on diverting pressure from our very busy hospital emergency departments through the work of the Victorian Virtual Emergency Department, which responded to more than 254,000 video calls and prevented 209,000 avoidable ED visits. And we have had more than 800,000 people visit urgent care clinics in Victoria since 2022. We have also opened new services for women and delivered more community-based care options. This includes five dedicated women's health clinics, enabling more than 11,000 women, girls and gender-diverse people to get the care they need, and 20 women's sexual and reproductive health hubs. In 2024–25 the community pharmacy pilot operated, enabling more than 36,000 consultations and improving care access for Victorians. Continuing significant investment in our dedicated health workforce across the state provided greater support through training, development and capacity building. We also saw, through Victoria's landmark inquiry into women's pain, more than 13,000 women and girls share their stories.

Staying with the health portfolio, also in the reporting period we launched the safer digital healthcare program to safeguard Victoria's health services against cybersecurity threats and undertook extensive consultation and development to be ready to stand up 12 local health service networks on 1 July this year to improve collaboration, drive service improvements and deliver care closer to home. Hospitals Victoria was also established within the department to strengthen oversight and management of financial performance across the sector to achieve sustainable operating results.

In ambulance services, ambulance transfers within 40 minutes improved by 14 per cent from February to June 2025. This really significant improvement was off the back of the implementation of the standards for safe and timely ambulance and emergency care, which enshrined best practice based on clinical leadership and international evidence. There was also an expansion of the video-assisted triage across Ambulance Victoria, 229 new paramedics were recruited and 30 mobile intensive care ambulance interns commenced their on-road training, the largest ever MICA intake.

In the mental health portfolio, mental health and wellbeing locals supported more than 15,400 people, contributing to a total of 24,600 Victorians seeking help since the service began in October 2022. We also opened Ngamai Wilam in Armadale, Victoria's first publicly funded 12-bed residential eating disorder service, and established Victoria's first public dedicated youth mental health service. For the first time more than 1500 people accessed free and confidential drug checking at mobile pill-testing sites operating at five festivals. There were more than 6700 instances of support through our expanded drug harm reduction outreach program, and the CBD health clinic delivered more than 890 appointments to people facing barriers to mainstream care.

In the aged care portfolio we delivered more than 1.5 million bed days through Victoria's public sector residential aged care services. Those services continued to deliver high-quality care for Victorians, achieving an average 4.18-star rating, above the national average of 3.79. There was also investment of $6 million to upgrade Aboriginal Community Elders Services, and construction was completed on further new aged care facilities at Rutherglen, Camperdown and Cheltenham.

In our children's portfolio more than 100,000 callers were supported by the 24/7 maternal and child health line, and we implemented the second year of the $86 million More Support for Mums, Dads and Babies package,

delivering a range of key deliverables including longer 'key ages and stages' consultations; more maternal and child health and lactation support for families right across the state, including at 15 Aboriginal maternal and child health services; 25 multicultural story times; 18 dads groups; and baby bundles to more than 35,000 first-time Victorian parents. In 2024–25 the department also opened two new early parenting centres: Bendigo early parenting centre and the Baluk Balert Barring Aboriginal dedicated early parenting centre in Frankston.

You go to health infrastructure, and there was a total investment of $1.7 billion in health infrastructure across 2024–25. Importantly, this forms part of a $15 billion health infrastructure pipeline, including the new Footscray Hospital, Frankston Hospital, Ballarat Base Hospital and Northern Hospital. In terms of broader infrastructure projects, there were 138 grant-funded infrastructure projects completed across Victoria in metropolitan, rural and regional areas, valued at more than $150 million. There were also important upgrades to ambulance branches in key areas – in Manor Lakes, in Maribyrnong, in Ocean Grove, Euroa and Yarram. We installed more than 1200 kW of rooftop solar capacity, continuing that program across health facilities.

In closing, Chair, the work of the department is ambitious, it is really important, it is delivering impact. Through continued investment and reform, we are continuing to work to deliver a health system that meets contemporary challenges and works toward our vision of Victorians being the healthiest people in the world.

The CHAIR: Thank you very much, Secretary. I am going to throw first to Mr Welch.

Richard WELCH: Thank you, Chair. Thank you, Secretary. Thank you, staff. The Royal Melbourne Hospital has, through the RMH Foundation, invested:

> … in a Security room which will come online soon. Whilst offsetting some cost, significant challenges will remain.

How much additional funding is required before it becomes operational?

Jenny ATTA: Sorry, Mr Welch. I just missed the first part of that. You are referring to the control centre?

Richard WELCH: Yes.

Jenny ATTA: I do not have the detail of exactly the cost of that project that the Royal Melbourne is delivering.

Richard WELCH: I can take that on notice if you are happy.

Jenny ATTA: I can certainly see what information we could provide on that.

Richard WELCH: Yes. When will it become fully operational?

Jenny ATTA: That project is about to get underway as I understand it. So again perhaps I could come back on what is the expected timeframe. I have not got that with me.

Richard WELCH: Thank you. How much did the foundation provide?

Jenny ATTA: The total cost of the project and the proportion of funding from the foundation, again that will be information held at the health service level. I do not have that with me this morning.

Richard WELCH: Thank you. What are the significant challenges that remain?

Jenny ATTA: This is a project, on my advice and understanding, where Melbourne Health are looking to expand and enhance their security centre, ensuring that that important part of a hospital's day-to-day operation is at best practice levels. It is clearly an enhancement on what they are already providing.

Richard WELCH: You are referring to challenges. What are the significant challenges that remain?

Jenny ATTA: Sorry, for the Royal Melbourne?

Richard WELCH: For the security centre.

Jenny ATTA: Well, I think it is about looking at taking the hospital to the best possible level of operation that they can have. All hospitals, particularly our big metropolitan hospitals, are very busy public enterprises with thousands of people moving through, including emergency –

Richard WELCH: Secretary, within the context of it, it says:

> Whilst offsetting some cost, significant challenges will remain.

In that context, what are those challenges?

Jenny ATTA: Well, that questionnaire from the Royal Melbourne Hospital – I do not have access to exactly the detail about the project, what they have got covered, what challenges remain.

Richard WELCH: Thank you. In a similar vein, could we get a list of the number of security personnel at each of Victoria's health services across Victoria? I think what would be particularly helpful would be to see what the trend is perhaps over the last five years on that dataset.

Jenny ATTA: We will not hold at a central level all of that detail, Mr Welch. Some of the hospitals will have in-house security services, some will have contracted services, so across our 74 health services –

Richard WELCH: But you would be able to aggregate it – you would be able to request and aggregate it.

Jenny ATTA: I think that that is information we would have to see if we could compile. As I said, across 74 health services, all of those health services operate with their own management, governance board. We hold a certain amount of detail that is reported through to us. There is further granular detail that would be held at the hospital level. I could see what we have; I just cannot give you an assurance that we hold it at that level of granularity.

Richard WELCH: I think a simple email to each one saying 'What are your security numbers for the last five years?' would be quite easily obtainable, surely.

Jenny ATTA: Well, Mr Welch, I am happy to see what we can reasonably provide and ask of the health services.

Richard WELCH: Thank you. I appreciate that. Now, in terms of the budget, there were two very significant Treasurer's advances this year – $1.46 billion and $1.52 billion. So how did the state health budget get its budget wrong by $3.86 billion?

Jenny ATTA: Well, I do not think it is a correct characterisation to say that they got it wrong, Mr Welch, but I am happy to talk to –

Richard WELCH: I think it is pretty accurate, because at least the $1.52 billion was ex-budget, so that was clearly on top of expected budgeting. So I think is a pretty reasonable way to frame the question.

Jenny ATTA: If I could just step you through it, Mr Welch, my advice is that it was quite a unique year. There was an unusual two-stage appropriation process in that year, which you can see through those Treasurer's advances, to settle and finalise the modelled budget, the operational budget for hospitals. The key driver for that was coming off the volatility of that COVID period, with significantly increased funding and higher costs for the hospital system –

Richard WELCH: So these things were not foreseen and you could not budget for these?

Jenny ATTA: for all the obvious reasons. What the department was seeking to settle going into that budget process and finalising hospital budgets for the 2024–25 year was to look at stabilising the funding so that we could move forward in terms of no unplanned costs. There was an initial decision of government through the budget process and funding provision from Treasury. There was then the finalisation of some modelling and analysis work by the department.

Richard WELCH: Obviously that modelling was inadequate, right, because you needed more.

Jenny ATTA: No. The finalisation of that modelling and analysis work, some further engagement with the sector and a report back and through that second stage of appropriation –

Richard WELCH: Well, maybe you can cast some clarity on this: when was each of those advances requested by the department – what specific date?

Jenny ATTA: The initial Treasurer's advance was an allocation –

Richard WELCH: No, no. I just want to know the dates. What date was each one –

Jenny ATTA: I am trying to come to that, Mr Welch –

Richard WELCH: You could start with the date then.

Jenny ATTA: It was not a request for a Treasurer's advance. Treasury and Finance allocated the funding, the first tranche – the first Treasurer's advance –

Richard WELCH: And the second tranche?

Jenny ATTA: I think it was in August – late July or August. I can see if we have a specific date at which there was further consideration by government off the back of that further work and the appropriation to finalise –

Richard WELCH: When did you first become aware you would need a further advance?

Jenny ATTA: I am trying to explain, Mr Welch, that on my advice –

Richard WELCH: I am just looking for dates. I am not looking for explanations; I am just looking for dates.

Jenny ATTA: I think I have given you the first date. It was in terms of the budget process.

Richard WELCH: How far in advance of that were you aware that you may need it? Because it is a very sizeable – you do not suddenly arrive at work one morning and there is a $1.52 billion deficit. How far in advance were you aware of this emerging problem?

Jenny ATTA: It is not the case that there was a $1.52 billion deficit, Mr Welch. Each year as part of the budget process –

Richard WELCH: Then why did you need a $1.52 billion advance?

Jenny ATTA: As I have tried to explain, it was something of a unique year in the way that the appropriation to support hospital services was finalised through the budget process.

Richard WELCH: I understand that is your explanation for the $1.4 billion advance; that is not your explanation for the $1.5 billion advance.

Jenny ATTA: I am trying to be as clear as I can that on the advice I have from the department through that budget process there was an initial allocation and a request for further work. One of the key issues that we were trying to settle and give government confidence on was the increasing prices and costs in the system through the COVID period and the COVID recovery funding to –

Richard WELCH: Could we see that analysis and modelling, please? Could you provide that?

Jenny ATTA: I cannot provide analysis that was provided through cabinet in confidence.

Richard WELCH: But you must have internal budgeting analysis.

Jenny ATTA: What I could do, Mr Welch –

Richard WELCH: In the course of your own governance of the budget there must be governance information – in your normal, ordinary course of government management reporting – that would give you an explanation of your foresight of this blowout.

Jenny ATTA: Mr Welch, I am very happy to ask Mr Sivarajah, CEO of Hospitals Victoria, to talk to some of that detail around the costing analysis.

Richard WELCH: Could you provide that to the committee, please?

The CHAIR: Mr Sivarajah.

Siva SIVARAJAH: From what I understand – I was not in the department at that stage – the first component, the $1.52 billion –

Richard WELCH: I am sorry; I just cannot hear you. Would you speak into the microphone a little bit more? If you were not there at the time, can we please have a copy of – in your own governance, your own management reporting – your analysis and modelling linked to the Treasurer's advance?

Jenny ATTA: Mr Welch, I am happy to look at what we could provide. What I cannot provide is the information provided into the cabinet-in-confidence budget process.

Richard WELCH: Could we ask for perhaps your committee minutes, your meeting minutes?

Jenny ATTA: I am not sure what meeting minutes you are referring to.

Richard WELCH: Surely this came up at your own board meeting, the need for a $1.52 billion advance.

Jenny ATTA: Mr Welch, the department every year will bring a business case into the budget process for hospital funding, and that was no different in that year. The final appropriation off the back of that business case was settled in two stages in that year. The mechanism of using a Treasurer's advance –

Richard WELCH: So you are only doing the budgeting actually within the financial year. You are not doing the budgeting before the financial year, you are doing it in real time; is that what you are saying?

Jenny ATTA: No. You are talking about the two Treasurer's advances that supported hospital budgets for the 2024–25 year.

Richard WELCH: The second advance was ex-budget, so how can that be? That does not make sense.

Jenny ATTA: The department has always worked to settle budgets for hospitals with an initial draft model budget and then a final budget that, as I understand it, is usually settled in July–August.

Richard WELCH: We cannot rely on this year's budget, so how reliable are your budgets now?

Jenny ATTA: What we have been able to do –

Richard WELCH: No, no. If that is your practice – that you make up your budgets as you go through the year – how can we rely on your budget in any financial year?

Jenny ATTA: Mr Welch, we do not make up the budgets as we go.

Richard WELCH: Well, to my ears, that is exactly what you have just said.

The CHAIR: Excuse me, Secretary. Excuse me, Mr Welch. It is very early in the day for me to have to remind members to please take caution and not put words into the mouths of secretaries and witnesses before us today. Ms Atta is trying to answer your question, Mr Welch, but you appear to be asking lots of questions on top of the previous ones you have asked, which is perhaps some of the reason why members here at this table, including those to my left, are getting confused. Secretary, did you have an answer to Mr Welch's question?

Jenny ATTA: In fact this year, having done that work across the previous year to understand where those cost movements, coming out of COVID, and where those price changes were settling, and which of those had settled, where we had seen embedded cost change for the hospitals, we have been able in the 2025–26 year to –

Richard WELCH: Nothing you have told me gives me any confidence you have a clue what your budget is.

Jenny ATTA: if I could just finish Mr Welch – deliver those budgets to hospitals at the start of the financial year. That work has really allowed that change.

Richard WELCH: Thank you, Secretary. Fine. We are not going to get any greater clarity. In terms of the national health reform agreement with Victoria – it is on page 184 of the questionnaire – you say Victoria is concerned it may not optimise financial and reform outcomes for our health system. Given our poor performance outcomes in a number of critical areas of service delivery, what assessment has the department done on the total amount of funding that will be required across the state?

Jenny ATTA: Mr Welch, there is an enormous amount of work that goes into supporting the negotiations that are very live at the moment around the *National Health Reform Agreement*, which was rolled over for one year and is now the subject of negotiations, so I do not think there is a simple answer to your question.

Richard WELCH: But have there been any cuts to service delivery identified? Will you require any cuts to service delivery?

Jenny ATTA: Mr Welch, we are seeking to negotiate an improved *National Health Reform Agreement* –

Richard WELCH: Which you are concerned about.

Jenny ATTA: with additional funding from the Commonwealth. That is absolutely the intention. There has been no contemplation of any reduction in service.

Richard WELCH: Right. Okay. In your questionnaire you are saying you are concerned about it – it 'may not optimise financial and reform outcomes'. So what are the concerns? What will not be optimised?

Jenny ATTA: Well, we would, as a key element of these negotiations, seek for a significant lift in Commonwealth funding to reflect the costs across our health system.

Richard WELCH: What if you do not get it?

Jenny ATTA: If we do not get it, we will have to calibrate to where we are able to land that agreement.

Richard WELCH: So how will that manifest in reality?

Jenny ATTA: So there is no risk of not having maintenance of effort. We are starting from a position of, as we have said, trying to optimise the outcomes, as the state would on every occasion through these negotiations.

Richard WELCH: Can you provide us with a copy of the department's accountability agreement?

Jenny ATTA: The department's accountability agreement? Sorry, Mr Welch –

Richard WELCH: Your annual accountability agreement.

Jenny ATTA: The acquittal with the Commonwealth?

Roma BRITNELL: You do not have an accountability statement for the department? That is not something you have?

Jenny ATTA: I am just seeking to understand whether you are talking about an acquittal agreement with the Commonwealth government or something else.

Richard WELCH: The *Age* reported that your department spokesperson is reported as saying:

> … it was normal for some financial measurements to change each year to reflect a health service's annual accountability agreement …

Jenny ATTA: I think you might be referring to the statement of priorities agreements. There is one agreed with every health service in the state, and that is the accountability agreement between the department and each of our health services.

Richard WELCH: Okay. Yes. So that, yes.

Jenny ATTA: Well, there are 74 of those. We could certainly provide the link. They are published on the department's website.

Richard WELCH: The annual report previously used to report cash on hand. That is not in the latest annual report. Why is that?

Jenny ATTA: The measures in the annual report, Mr Welch, follow and adjust for the measures that are reflected in those accountability agreements with each of the accountability agreements with each of the health services and –

Richard WELCH: No, I am just simply asking why it has been left out of the annual report. I am not asking for an explanation of it, I am asking why it is no longer in the annual report.

Jenny ATTA: But I am answering your question, Mr Welch. There have been a series of changes to the range of measures in the statements of priorities with health services, which are then reflected in the annual report. As part of trying to reduce the burden on reporting and focus on the most important measures –

Richard WELCH: Cash on hand is not exactly a high-burden accounting measurement.

Jenny ATTA: we moved to three financial measures in the statement of priorities.

Richard WELCH: It is the most fundamental measurement any organisation has.

Siva SIVARAJAH: Secretary, can I answer that question?

Jenny ATTA: I will hand to Mr Sivarajah.

Richard WELCH: No, that is an extraordinary answer. Secretary, can you guarantee –

Jenny ATTA: Mr Welch, cash at hand is very carefully monitored by the department.

Richard WELCH: No, I am happy with the answer. I do not need any further information.

The CHAIR: Excuse me. Mr Welch, you ask these questions, and I have to say the Secretary is giving you a comprehensive answer – evidence that goes to the very heart of the inquiry that is before us and the report that will be tabled in the Parliament of Victoria. If you ask a question, you can afford the Secretary the opportunity to respond. Did you have another question?

Richard WELCH: I do.

The CHAIR: I do hope you are listening and hoping for an answer.

Richard WELCH: Thank you, Chair. Secretary, can you guarantee that all contract staff are being paid within normal payment terms?

Jenny ATTA: All contract staff for the department, Mr Welch, or –

Richard WELCH: In hospitals – are being paid within normal contract terms.

Jenny ATTA: Obviously management at the health service is responsible for that. Of course it is expected that health services are appropriately paying all contract staff in line with those contract terms. I do not have any information that they are doing other than that.

Richard WELCH: How many health services had difficulty paying creditors? This again comes back to cash on hand. That is why it is an important measurement. And how many had difficulties paying their staff – which ones?

Jenny ATTA: Let me ask Mr Sivarajah if he can assist with that.

Siva SIVARAJAH: Every health service was able to pay their bills on time – pay their salaries, wages and debtor payments. Where there were difficulties, they did advise Hospitals Victoria, and we provided them with additional cash so that they could meet all their obligations.

Richard WELCH: Given that there are difficulties, why isn't cash on hand not a critical measurement?

Siva SIVARAJAH: Cash on hand is reported on every annual account. It is audited by the Auditor-General, and it has –

Richard WELCH: But did not go in the annual report.

Siva SIVARAJAH: No, it did go in the annual report. It sits under two areas: one as part of the balance sheet, and then the second one is the cash flow statement. They are mandatory. It is in every annual report. It is expected to be reported. The Auditor-General checks it, and they sign off on the audit papers.

Richard WELCH: Thank you. I will go to page 42 of the Melbourne Health questionnaire. It explains that the emergency department continues to experience –

The CHAIR: Apologies, Mr Welch. Don't worry, we will be coming back your way. Mr Galea.

Michael GALEA: Thank you, Chair. Good morning, Secretary and officials. Thanks for joining us today. Secretary, I would like to start by talking about the Victorian Virtual Emergency Department, or VVED. Over the 2024–25 financial year what impact has this had, particularly on reducing the pressure on emergency departments in their physical form across the state?

Jenny ATTA: Thanks, Mr Galea. I will ask my colleague Ms Bromley to perhaps talk a little bit more about the VVED. It has been a really important initiative since it was first launched, I think in 2020, and it has grown significantly since then and been a very important innovation for the health system. Since it was launched in October 2020 it has supported over 592,000 calls and to the end of September 2025 more than 670,000 consultations. In 2024–25 the VVED responded to more than 254,000 presentations, making it busier than many physical emergency departments. If it is useful, we could talk just a bit about the way it operates, because it has been an important new addition to the health system. Ms Bromley.

Naomi BROMLEY: I can talk to that. As the Secretary said, it was established during COVID, and as we all remember from that time virtual care was really important because physical care was incredibly difficult during that time. Northern Health established the VVED, actually under the leadership of my colleague Mr Sivarajah. It is a 24/7 statewide access virtual consultation. It is like an emergency department in many ways. People go through the administration process online, and then they will be triaged by a triage nurse, and the triage works in much the same way. Then, depending on the category, if they are categorised as being quite urgent, they will probably see a doctor very quickly – again online through that video consultation. Or if they are categorised as being able to wait, they might wait a little bit longer, and there is a call-back function that can be used as well.

We know that the VVED has really had an impact on reducing physical emergency department presentations, and obviously it can also negate the need for an ambulance transfer, which means that we are saving our precious ambulance resources. But also for many patients it can be challenging to travel to the emergency department. They might not have transport; they might have young children at home, for example. So it is a really important way of accessing care when people are feeling like they cannot wait for a GP, they cannot wait for the next day, whatever it might be. It is very heavily utilised by parents, for example, where they are just not 100 per cent sure what might be happening with their children. So 83 per cent of VVED patients are avoiding

that unnecessary physical emergency department visit – that was in 2024–25 – and that equates to 210,000 emergency department presentations. In that same year in-field referrals from paramedics were a significant part of that; around 74 patients a day were having that sort of in-field presentation facilitated through AV. Again, they are not requiring a transport. Some of them still do require a transport, but it is that ability to have that sort of interface with the doctor that is really useful.

The workforce of VVED is really important. It is comprised of emergency trained nurses, nurse practitioners and then physicians that are registered to practise. So it is the same workforce that you get in a physical emergency department, it is just the mode that is different.

We monitor the virtual emergency department in a whole range of different ways. We monitor the wait times and we monitor patient experience feedback – that is a really rich source of data – and then there is the usual sort of incident management data and quality oversight.

There are escalations in place as well during that process. As can sometimes happen, at an initial presentation to the triage nurse, for example, if a patient deteriorates, there are ways for people to escalate and for different decisions to be made. The emergency department physicians that work in VVED work very much, obviously, in collaboration with the patient, but if there is a referring healthcare professional, they are looking at the patient – obviously the physical presentation, but also the circumstances that the patient will be presenting in, because that is obviously really relevant when we are looking at whether or not the patient needs to come into the hospital.

There are also really important mechanisms and protocols around those decision-making processes that the VVED physicians are trained in to triangulate the information, because it is a little bit different to if the patient turns up in the emergency department. It is a controlled environment, whereas when the patient is at home, it is not necessarily a controlled environment.

One of the really important parts of it is the interface with aged care. Residential aged care providers being able to leverage VVED has been a really important pathway for them to be able to get that advice and support, if something has happened at the residential aged care facility, to be able to make the right decision for that patient, because it is often not a great outcome for an aged care resident to unnecessarily travel to an emergency department. It is very disruptive, and often that care can be provided in their home, which is the residential aged care facility.

In terms of patient experience, there is also really important consumer representation embedded in the governance structures to ensure that there is real lived experience that informs continuous improvement in the VVED, because it is a new and novel way of providing emergency care, and so there is a real focus on continuous improvement and learning.

A couple of other things I will just mention from a diversity, equity and inclusion perspective: there is an interpreter service as well, so we are really trying to make sure that everyone can get the same access to that service. If they need an interpreter, then that can be arranged, and from memory it is part of the registration process right up-front – 'Do you need an interpreter?' – so that can be arranged through the process. There is a dedicated health equity lead and First Nations nurse support service and access for priority populations and for the First Nations community. As I said, the VVED tracks patient experience very closely, using that really to drive that continuous improvement.

Michael GALEA: Thank you very much, Ms Bromley. I know the annual report says that in the last financial year 254,000 presentations, or just over, presented to the VVED. As you have mentioned as well, there was around 209,900, I think the questionnaire says, that were deemed as averted visits to the ED. I would imagine part of that figure is also reflected in the people that have accessed the VVED who otherwise would not have gone to an ED and therefore could have had a potentially worse health outcome that might not have been found for much longer?

Naomi BROMLEY: That is right.

Michael GALEA: Thank you. Those figures, the 254,000 presentations in the past year: how does that compare to a typical physical ED as we know it?

Naomi BROMLEY: I think, as the Secretary said, from a data perspective, this is actually our busiest emergency department in the state now. Emergency departments are all obviously different sizes and have lots of different volumes. Off the top of my head, St Vincent's, for example, sees about 150 people a day. So you can see the quantum and the volume that the VVED is able to accommodate and support, because it is this really novel service delivery model. I would add to that by saying that the feedback that we hear is that the clinicians love working this way. Many of them will work in the VVED but they will also work in a physical environment, and it has really been fantastic for staff engagement and staff retention, because it is a different way of working but they still report feeling supported and having the supervision et cetera available to them. But it is a different level of intensity, I guess, to working in those physical emergency departments. We know that over time staff find that challenging to maintain, and for some people being able to mix it up with a virtual care model has proven to be really good for staff retention and engagement, as we see in other parts of health care as well.

Michael GALEA: Thank you. I note that in the 2023–24 budget funding was provided to effectively double the capacity of the VVED from being able to deal with 500 patients per day to about 1000. Based on the figures in the 2024–25 financial year, you can see that is demand that is already being seen to. Can you tell me about the impact of that over the past financial year and how that progress is going?

Naomi BROMLEY: Yes. Obviously the VVED was quite small when it started and really quite contained, but what we have seen over time is that, as the systems and processes have bedded down and progressively – and it is very progressive – that funding has been increased, therefore the targets and the number of people we are seeing through the virtual emergency department are progressively increasing. The funding that was provided in the last state budget will continue that trajectory of increase. What that means is that more and more people across Victoria can access VVED, and that is the really important thing. While it is located at Northern Health and it is delivered by Northern Health, and we do see very high utilisation by that local community, this is actually a service that is for everyone in Victoria. For regional Victorians and for people who live a long way from physical emergency departments, this is a really important way for people in those communities to have another option that is available to them. Of course there are things like Nurse-on-Call, after-hours GPs, those kinds of things, but we know this is filling a gap. Similarly, when we think about, as I said, the residential aged care facilities out in regional Victoria, again it is really providing another option rather than immediately having to revert to 'We'll have to call an ambulance; the patient will probably have to go to hospital'. This is an in-between step that can sometimes – not always, obviously – mean that that person can stay at home. Again, if you think of people in regional Victoria, with long distances to travel, people who have got children at home, it is really, really challenging, and I think that this is a really important service for those kinds of communities as well.

All we are really wanting to do is continue to promote it to sectors like aged care but also to all the communities across Victoria, and ideally we will get to a point where we see that uptake really evenly spread across Victoria. That will without a doubt give us the kind of increased demand that the additional funding lays out. As I said, we are very much progressively building slowly towards that.

Michael GALEA: Thank you. That is interesting in particular in relation to the aged care side of that, how that would be. It makes a lot of sense as to why that would be the priority. I note there have been recent advertisements as well for urgent care clinics, for the VED, for all the measures, and of course physical EDs, explaining that triaging system. I know from previous inquiries in the Parliament this year that even some MPs have learned about the virtual EDs in these hearings too, which has all been good to raise awareness of what has been implemented. But over the financial year what else has been done to increase that awareness of the VED?

Naomi BROMLEY: There is a campaign that talks to this ecosystem, which is called Right Care Right Place, and that is the overarching campaign. But we see a lot of individualised and community-based promotion as well. Even things like within physical emergency departments, there is a lot of information about the VVED, and in fact some emergency departments have what is called a VVED pod. You might go in, and then the triage nurse might say, 'You could use the pod, and you'll get seen faster by a doctor using that.' My local emergency department in Williamstown has one of those, for example. But even that kind of information that is provided there is a way that we are progressively building more and more awareness. As you said, it is an ecosystem, so we have got VVED, and we have got the 29 urgent care clinics across the state now, again, in locations where accessing primary care is very challenging for communities and there is that kind of grey space

between what is primary care, what is emergency care, what is acute care. Urgent care clinics are providing that, but they are also free, and the opening hours provide additional access.

The other piece that I would touch on that I think is a really important part of this ecosystem is the Ambulance Victoria secondary triage model. Again, this is something that is quite innovative. It has been in place for a very long time, but it continues to grow in sophistication. This is where someone rings 000 – they think they might need an ambulance – and the call taker works through a protocol and identifies that they might be eligible for what is called secondary triage. I note Mr Emery is in the room, and he is obviously the expert on this, not me. But what secondary triage does is direct that person to a set of clinicians, and they will do a more detailed assessment with that patient about what is happening for them. And then there might be a whole range of referrals that the secondary triage can provide. It might be that they get to the point of saying, 'We think you're okay to go to your GP, so let's work through that.' Sometimes they are actually social referrals; some people do ring 000 because they are lonely and for lots of other social reasons, so it is a way of managing that. Again, this is a way that people can get access to expert health care. Obviously they have called 000 for a reason; they do need help, they do need advice, they need assistance, but they do not necessarily need an ambulance to come to their house or indeed to take them to hospital. So secondary triage has been a really important way to, again, protect our precious, precious ambulance resources out on the road, but it is also often a better outcome for patients, because the fact is an ambulance is not really what they need; they need something else. So the ambulance coming to them probably is not going to lead to a helpful outcome. Certainly they do not need to then be taken to a physical emergency department. So getting that local referral in their community – what the service is that they actually need and how we can help them are also really important parts of that kind of ecosystem there.

Michael GALEA: Thank you very much. It is good to see obviously the different levels of triage coming in there as well. Speaking of the urgent care clinics, obviously these were formed in Victoria and in New South Wales, as priority primary care centres originally, in response to that primary health challenge that you identified and indeed the primary health challenges that were left as a result of the former federal government. They are now urgent care clinics, and many of them are now co-branded – or they may all be co-branded – as Medicare. I understand that as of July 2024, 17 of them are now fully co-funded, with the Commonwealth paying half and the state paying half. My understanding from these FPO hearings last year was at that time there were 12 that were still solely funded by the Victorian state government. Is that still the case?

Naomi BROMLEY: I will either defer to the Secretary or my colleague. The Secretary might be able to answer that.

Jenny ATTA: We should have those numbers here, Mr Galea. There were 19 urgent care clinics originally funded. Of these 19, seven have subsequently transferred to Commonwealth funding under the Medicare urgent care clinic program, and there are other Commonwealth-funded urgent care clinics as well.

Michael GALEA: Thank you. And there are still some that are still fully state funded?

Jenny ATTA: There are.

Michael GALEA: Thank you. So we are still doing a bit of the Commonwealth's work for them in that primary healthcare space, punching above our weight again?

Jenny ATTA: We are in continued discussions with the Commonwealth to advocate for them to take on that role fully for primary care.

Michael GALEA: Terrific. Thank you. I would like to turn to planned surgery now. I am not sure if this might still be you, Ms Bromley. The questionnaire at page 16 discusses planned surgery performance. Can you talk to me about how this this performance metric has been performing across our hospital system in the 2024–25 financial year?

Naomi BROMLEY: Yes. Thank you. Obviously, at the end of the pandemic, off the back of COVID, the waitlist had grown considerably because surgery had been paused during that time. So there was a huge push, referred to as the COVID catch-up plan, to increase the number of surgeries that were happening all across the system and to bring the waitlist down to a manageable level but also, really importantly, to improve the timeliness of treatment. They are kind of the three measures for surgery: how much are we doing, how big is

the waitlist, but perhaps more importantly, are people being treated within clinically recommended timeframes? There are three categories for surgery, and that will dictate what the clinically recommended timeframe is.

Michael GALEA: Thank you.

The CHAIR: Thank you, Mr Galea. I am going to the Deputy Chair.

Roma BRITNELL: Thank you. Thank you, Secretary and officials. My first question is about workforce – nurse shortages in particular. You have invested in training and offered free courses to nurses in the 2024 period that we are discussing. Many of those nurses are due to graduate. Why has the government failed to provide graduating nurses with midwifery places for 2000 in the next financial year?

Jenny ATTA: Deputy Chair, the graduate nurse program – and I will go to Ms Bromley in a moment for some detail on this – is just finishing stage 2 of that matching process. Not all graduate nurses have immediately been matched. Over the last couple of years, in a pleasing sense, we have seen much greater rates of retention in our health services.

Roma BRITNELL: I am actually asking about the ones graduating and being placed, which you have just mentioned. Can you give me the number of how many of those graduating nurses will not be placed in 2026?

Jenny ATTA: We do not have a final number on that because we are still doing work to –

Roma BRITNELL: So these were trained during 2024–25?

Jenny ATTA: I will just go to Ms Bromley to give you that detail.

Naomi BROMLEY: There are two stages to the nurse match, and we have seen about 3000 nurses placed through the grad match this year.

Roma BRITNELL: It is the 2000 that have not been matched yet. I am just wanting to know if there is a guarantee that they will be placed, and if not, why not?

Naomi BROMLEY: It is not quite 2000. I think there are about 1700 people who applied for the graduate program and were not placed. There are still some vacancies in the graduate program, mostly in rural and regional areas, so we are working to try and get those people placed there. But it is really important to note that this is not the only way that a university graduate can get into nursing. The graduate program is highly desirable, and that is demonstrated by the number of people who apply to do that. But –

Roma BRITNELL: Do we have enough nurses in the public health system where those graduates are hoping to go?

Naomi BROMLEY: Well, I guess one of the reasons why we have less graduates this year is that we have seen a real pattern over the last couple of years of the significant vacancies that we had in the system after COVID, and this was the same in lots and lots of sectors. We had a lot of vacancies, and that has gradually decreased. In fact some of our metropolitan health services are now saying that they do not have vacancies. In rural and regional Victoria there are still vacancies, but even that is coming down.

Roma BRITNELL: So if there are vacancies, will you guarantee that these nurses will be offered positions, particularly if the metropolitan areas are full? The regions are begging for staff to go out there and need assistance perhaps to put them out in the regions – some sort of incentive, as was discussed in other inquiries that I have been part of. Is that something that you are looking at?

Naomi BROMLEY: We are seeing even less vacancies in rural and regional areas now. This is coming down as well, but there are still vacancies. Now, as this –

Roma BRITNELL: Perhaps you could just give me a breakdown of the vacancies and the placements. Could you take that on notice perhaps?

The CHAIR: Ms Bromley is trying to answer the question, Deputy Chair. Give her a couple of moments to answer it.

Naomi BROMLEY: We are working through making sure that all of the graduate positions are promoted and advertised to that candidate pool, because what we would love to see is every single one of those graduate positions – and there really are a very small number now. But it is important to note that we cannot just put a graduate in any vacancy, because there is an important balance between entry-level, mid-career and experienced nurses. If you think about a –

Roma BRITNELL: Thank you. I do understand that; I understand that quite well actually. Can you give me a breakdown of how many vacancies there are in the regions then? Would that be possible?

Naomi BROMLEY: I will see what we can provide in terms of vacancies for 2024–25.

Roma BRITNELL: Thank you. Now, on workforce shortages, the union secretary Danny Hill said on 3AW just last Tuesday that Victoria has a shortfall of 1500 paramedics. Why has that been allowed to happen?

Naomi BROMLEY: I do not know that that is correct.

Roma BRITNELL: Well, there definitely are vacancies, and I know there are trained paramedics that are not working that want to work. So why has that been allowed to happen?

Naomi BROMLEY: We could potentially bring Jordan –

Jenny ATTA: Look, I might ask, Deputy Chair, Mr Emery. We have got the CEO of Ambulance Victoria here. He might be best placed to answer your question.

Roma BRITNELL: While he is coming to the table, I might move on – and he can come back to that – because this might be of interest to this gentleman as well, to occupational violence. The government introduced mandatory minimum sentences for assaulting emergency workers, including frontline doctors, nurses and, obviously, ambulance officers, supporting emergency care. Given the rising incidence of violent attacks – I think we saw 24,000 reported in the last financial year – do you have data on how many perpetrators of assaults in public hospitals have been prosecuted and have received the minimum six-month jail term? And probably ambulance as well, because obviously that falls into that category.

Naomi BROMLEY: Can I just clarify the question? You want the –

Roma BRITNELL: How many people have received the mandatory jail term? Of the 24,000 in the last financial year that were assaulted in the workplace, in hospitals, that figure is. Do you monitor that, and if not, why not?

Naomi BROMLEY: I do not think we would have that data available now. We could go away and see what we –

Roma BRITNELL: So you are not following up and tracking these violent assaults and giving –

Naomi BROMLEY: You are asking specifically – sorry, just to make sure I understand – about the prosecutions as opposed to the incidents?

Roma BRITNELL: Yes. These are your workers, who have been probably on WorkCover and I imagine still are, who I am sure you are very concerned about. Surely you are following up on whether they are getting any significant consequences to the assaults on the staff. 24,000 is a lot in one financial year.

Jenny ATTA: Deputy Chair, just to clarify, we have got reporting of more than 25,000 incidents of occupational violence in the 2024–25 annual reports, but we cannot characterise them all as assaults.

Roma BRITNELL: Okay. Well, 'violence' is a pretty strong word. Incidents of violence are significant, I would have thought, in anyone's language.

Jenny ATTA: Sorry, in terms of any prosecutions and court processes, I do not have outcomes like that with us here today.

Roma BRITNELL: Thank you. I will move on – unless you have any mandatory jail terms that you are aware of and want to share with the committee.

Members interjecting.

The CHAIR: Excuse me, members.

Roma BRITNELL: Okay. I am just giving the opportunity. If you do not have that, that is fine.

The CHAIR: Excuse me. Deputy Chair, do you have a question?

Roma BRITNELL: Yes.

The CHAIR: Ask your question, please.

Roma BRITNELL: I will move on. The latest data on planned surgery waitlists was released last week – three weeks overdue, I might add – and shows the statewide list surging to nearly 61,000 patients. The lists are not improving, so why not?

Jenny ATTA: Well, I will ask Ms Bromley to talk to the detail. Of course we have seen significant improvements in different elements of the surgery waitlist, but Ms Bromley might go to that detail for you.

Naomi BROMLEY: I think the data you are referring to is for this financial year. But I understand the nature of your question, and it does go to that relationship between those data sources that I mentioned earlier. The waitlist is one measure and the activity is another really important measure, but timeliness of treatment is perhaps, if I can say, the most important measure of all. Certainly from a patient perspective, that is the thing they care about. It does not matter how many people are on the waitlist for individual patients, it matters how long they are going to wait for surgery. As I said, there is those three categories for category 1.

Roma BRITNELL: I am aware of the categories: category 1, category 2, category 3. I am aware of that. What I am actually wanting to know is why the waitlist has surged to 61,000 and why that list is not improving. I mean, these are people in pain, needing hip replacements and getting addicted to opioids. It is a fairly significant situation. I know the Alfred hospital's waitlist is up by 13 per cent since the last quarter and it is using Cabrini Health to perform some of the category surgeries. Is that right?

Naomi BROMLEY: Some of our public health services do subcontract surgeries to the private system – it is called the public and private model – and that is something that is negotiated directly between the public system and the private system. It is often for lower complexity surgeries and certainly lower complexity patients, but it can be a really successful way.

Roma BRITNELL: Can we find out, please, if Cabrini is being paid? It is taxpayer money that is being paid from the public system to the private system. Even though you are saying it is negotiated privately, it is still public money. Is Cabrini being paid the COVID rate of NWAU or the current rate of NWAU?

Naomi BROMLEY: Current.

Roma BRITNELL: Current rate. Okay.

Naomi BROMLEY: The specifics will be negotiated between them, but no private provider is being paid a premium to do public surgeries.

Roma BRITNELL: Okay. While I have the representative from Ambulance Victoria here still, I will just ask: what is being done to address the 1500 vacancies that Mr Hill quoted last week? And if it is not 1500, it is still a valid question. What is being done?

Michael Galea interjected.

Roma BRITNELL: I am sure you are aware of it.

The CHAIR: Excuse me, Deputy Chair.

Roma BRITNELL: This is actually my time. I do not think responding to a question from the person to my right –

The CHAIR: Excuse me, Deputy Chair. I would also like to remind members –

Roma BRITNELL: No point of order has been called.

Michael Galea interjected.

The CHAIR: Excuse me, Mr Galea, I would also like to remind you to tie it back to the terms of reference that are before the committee.

Roma BRITNELL: Was there a plan put in place last financial year to address the ambulance shortages that we are experiencing in Victoria?

Jordan EMERY: Thank you, Deputy Chair. We have a range of processes and procedures in place to manage recruitment across our workforce. Last year we brought on 229 graduates as part of our graduate recruitment pathway. We will bring on a further 294 this financial year. I would also say, Deputy Chair, at present we have over 1200 individuals through various phases of our recruitment process. We are always actively working to ensure our rosters are covered based on short-term vacancies and then have a very healthy pipeline of individuals coming through our ordinary recruitment.

Roma BRITNELL: So you are confident that you will meet your numbers required in this financial year?

Jordan EMERY: Yes, I am very confident, Deputy Chair. It is a wonderful profession that draws a number of very capable individuals –

Roma BRITNELL: It most certainly is.

Jordan EMERY: and we are very lucky here in Victoria for that.

Roma BRITNELL: I have worked in the ambulance with your capable people; I can attest to that. I will move on now to health infrastructure. Infrastructure Victoria estimates that upgrades to the Alfred, the Royal Melbourne and Austin Hospital alone could cost up to $8 billion over the next decade in addition to the $150 million to $300 million needed for community health facilities. What is the department's assessment of the total cost of all infrastructure requirements across the state? We do hear the Minister for Health saying in Parliament frequently $11 billion. Given that the $8 billion extra is needed, how are you feeling about the infrastructure needs in the state and meeting those?

Jenny ATTA: Thank you, Deputy Chair. I might ask Ms Radice, who heads up the health infrastructure delivery arm, to speak to that. Thank you.

Priscilla RADICE: Good morning. In terms of the Infrastructure Victoria report, we are doing a lot of investment across the state in those three facilities that they pointed out, currently. We have current investments in the Austin. We have the major $2.33 billion investment in the RMH, which is on top of the ongoing investment and refurbishment money that we do put into acknowledging our ageing facilities. We are also undertaking almost $300 million worth of refurbishment work in the Alfred. Some of that work was delayed during COVID. We had done a major part of decanting and getting ready to do those works, and then all of that area needed to be reused for COVID. We have had to work through the decanting and keeping that facility open and operating for patients. We have just successfully worked through and tendered for the fit-out of a location at St Kilda Road for outpatients and for administration. Now we can go in and refurbish those really important IPU and ICU rooms.

Roma BRITNELL: Isn't it a fact that the first phase of the redevelopment is not expected until 2032? Of the Royal Melbourne, sorry.

Priscilla RADICE: It is a very major redevelopment for the Royal Melbourne and the Women's on the Parkville site. We are right in the middle of working through the design of the demolition of the materials handling building. That has to be demolished to make way and space for that redevelopment.

Roma BRITNELL: Is it 2032? Is that correct? That is my question.

Priscilla RADICE: The date for the major RMH redevelopment is tracking to the BP4 date.

Roma BRITNELL: What is the annual cost of the large capital and engineering teams required to ensure safety compliance across the Royal Melbourne Hospital, please?

Priscilla RADICE: I do not have the asset maintenance data for the Royal Melbourne; that is not part of my portfolio. But I do run the administration of the grants capital program for the Department of Health when it is grants. I know that they also receive other funding from other sources. The RMH has received numerous grants, and all of that is available on our website, our guidelines and who receives funding.

Roma BRITNELL: Hospitals across the state that have scopes done and projects that are underway, such as Warrnambool Base Hospital, that now have got increased costs due to COVID increases and building cost increases, will they be guaranteed the funding they need – that hospital in particular – to be built to scope? Or will Warrnambool Base Hospital have to have less pathology areas and other areas cut so that that build will be completed?

Priscilla RADICE: We are working through on the Warrnambool Base Hospital right now. We have just finished more than 4 kilometres of pipes and relocating critical services –

Roma BRITNELL: I understand that. But will that building be built to scope, or will they be having to have the scope cut?

Priscilla RADICE: The Warrnambool Base Hospital will deliver all of the critical scope that is in the business case, and we are working through with that contractor to move from stage 1 to stage 2.

Roma BRITNELL: So we will get a pathology department as was scoped?

Priscilla RADICE: The Warrnambool Base Hospital has a current pathology department, and that will stay at the hospital.

Roma BRITNELL: No, in the original scope it was to be done up. It is not going to happen or it is going to happen?

Priscilla RADICE: We will work through the final details of the scope as we work through to main construction.

Roma BRITNELL: The details of the scope were done a long time ago, and that was the original scope. Are we going to be getting the facility according to the original scope or not?

Priscilla RADICE: The Warrnambool Base Hospital has a pathology department now, and as we work through that development –

Roma BRITNELL: Thank you. I will move on. St Vincent's Hospital triage policy: Secretary, under St Vincent's Hospital's triage policy Indigenous patients who have otherwise been characterised as categories 4 or 5 are allocated a minimum category 3. It was reported on the ABC on 12 November that the policy had no negative impacts on ED access and patient flow. However, the director of the emergency department Jonty Karro was quoted as saying:

> I want to be absolutely clear that this policy has not resulted in any increased waiting times for any non-First Nations patients …

Could you provide the data that confirms no-one has waited longer for treatment because of the hospital's policy to triage all Indigenous patients as cat 3 or above?

Jenny ATTA: Deputy Chair, I think it is important to say and to just reiterate that any patient presenting with serious or life-threatening emergency, regardless of background, will always be seen first at our emergency departments. The program that you are referring to is part of a suite of improvements that St Vincent's have been designing for their emergency department that is seeing improved outcomes for all people presenting at emergency in quarter 1 2025–26. St Vincent's have improved median waiting times by 8 per cent.

Roma BRITNELL: But I am asking specifically about the Indigenous policy that St Vincent's has. Can you please guarantee that this policy will never result in non-Indigenous people waiting longer?

Jenny ATTA: You have asked me for data, and I can talk to that, Deputy Chair.

Roma BRITNELL: So you said 'all people'. I am talking about the Indigenous policy specifically.

Jenny ATTA: I think what I am trying to say is that the data is showing that from the suite of initiatives that St Vincent's have introduced, reflecting on the busyness and the high demand in their emergency department and looking at where they can enhance and improve throughput, they have achieved improved –

Roma BRITNELL: I am not talking about the suite of policy changes.

Jenny ATTA: But the initiative you are talking –

Roma BRITNELL: I am talking about the cat 3 that has been developed for Indigenous people in front of others. Is that something you can guarantee – that people will not wait any longer if they are not Indigenous? I mean, surely if you bring someone to the front of the queue somebody falls behind.

Jenny ATTA: I was really going to the data that shows the overall improvement for everyone in there –

Roma BRITNELL: Can you just provide that data in the interest of time? I have got some other questions.

Jenny ATTA: Very quickly, Deputy Chair: they have improved median waiting times by 8 per cent to 23 minutes. They have improved ambulance to ED transfers –

Roma BRITNELL: I am not talking about the average across the department. I am talking about the effect that your director actually quoted. The emergency department director quoted that no-one will be disadvantaged. I am just simply asking: can you determine that non-Indigenous people will wait longer?

Jenny ATTA: I do not have information about anyone waiting longer.

Roma BRITNELL: I am asking can you guarantee that they will not?

Jenny ATTA: I will let St Vincent's manage that program and talk to that granular –

Roma BRITNELL: Okay. Is any other health service doing a similar thing?

Jenny ATTA: There are similar programs in major hospitals in other parts of the country. There is a similar program operating out of Sydney.

Jade BENHAM: No. Victorian hospitals.

Roma BRITNELL: In Victoria specifically. We have seen 64 per cent of people presenting to ED in Echuca – it has gone from 64 per cent down to 59 per cent. Is that as a result of a similar policy, or why are these waiting periods getting worse?

Jenny ATTA: I am not aware of this. All of our health services will look to tailor service improvement strategies to their local circumstances, and to best support their local community there will be different strategies adopted across hospitals. This particular initiative, I am not aware of whether it is being picked up in other hospitals.

The CHAIR: Thank you, Secretary. Ms Kathage.

Lauren KATHAGE: Thank you Chair, Secretary and officials. I have some questions around ambulances to start with, please. The questionnaire on page 28 has information about the initiative supporting our ambulance services. Can you explain how that program has led to Ambulance Victoria exceeding inpatient measures around quality and care – what impact that program has had on the measures?

Jenny ATTA: Yes. Thank you. I might ask Ms Bromley to speak to that.

Naomi BROMLEY: Thank you. In 2024–25 we saw a 4 per cent improvement in ambulance offload times compared to the previous year. There is a whole range of work happening in this space. One of the programs that has been in place for quite a long time is what is called the timely emergency care collaborative. But more

recently – in fact in February of this year – we introduced the standards. The standards cover off both emergency departments and ambulance. The *Standards for Safe and Timely Ambulance and Emergency Care for Victorians* – it is quite a mouthful. I think the Secretary actually mentioned this in her presentation, from memory. Since we introduced those standards in February, what we saw through to June – the end of that financial year – was a 14 per cent improvement in those five months, which is really, really encouraging.

Lauren KATHAGE: It is massive.

Naomi BROMLEY: And I can share that we continue to see those improvements in that transfer time. The standards and the timely emergency care collaborative work together. They are complementary initiatives. But what the standards really do is bring together what we know – what the evidence base says both internationally and interjurisdictionally, but really importantly, based on actual real-world experience here in Victoria, very much reflecting the insights and the wisdom of the people who actually work in emergency departments, those real leading clinicians. We have had significant input from those clinicians in the development of the standards. They lay out a template or a blueprint, if you like, for how emergency departments and ambulances can work together at that interface to really get the best outcomes for patients. But it is not just about the emergency department, it is really patient flow and having a high-functioning, high-performing emergency department – it is a whole-of-hospital proposition. It is so important to have the patients flowing through the hospital. It is about discharge. It is about moving them from the emergency department into the inpatient setting, if that is what is needed. That is what frees up the emergency department and then enables that more timely transfer. That is why we focus on it as a really important indicator of overall improvement and the overall health of that system that links together the ambulance and the emergency department.

Really importantly, this is how we tackle ramping. This is what ramping is – when we have these transfer times that are blowing out. The target is 40 minutes. We are really working hard to try and increase the proportion of those transfers that are happening within 40 minutes, because that gets our ambulances back on the road and then that translates into better ambulance response times and better ambulance availability over time. The standards tackle things like clinical leadership, patient flow throughout the hospital – really bringing to life the kinds of practices, processes and procedures that have been shown to work, and often shown to work in our own health services here, and then sharing them and getting everyone to pick up on those. These are the things that work. Getting that consistency across the system, we have seen, as I said, some really extraordinary impacts. One of the health services that I think the Secretary spoke to was St Vincent's and some of the impacts that we have seen around their improvements. Peninsula Health is another one that really has quite an extraordinary story, reducing the average ambulance handover time from 24 to 8 minutes.

Lauren KATHAGE: Yes, I read that in the paper.

Naomi BROMLEY: That is a two-thirds reduction. They have really done an exceptional job out at Peninsula. Since February – since the introduction of the standards – they have been maintaining a 90 per cent or above average of their ambulance transfers happening within that dedicated timeframe. The kind of thing that they are doing: they have increased their capacity – they have had quite targeted increases in capacity. They are supporting the patients to safely transition from the ambulance to the ED wait room where that is appropriate – it is kind of a 'fit to sit' approach, which obviously is not appropriate for all patients. Some patients need to stay with their ambulance crew – they need to be on the trolley – but some patients can transition into the wait room, so there is a way of assessing that, and then of course they are monitored within the wait room as well. Another one is creating an ambulance off-load nurse role, which has really helped to expedite that handover. There are obviously a couple of stages to all of this, and one of them is that there has to be a handover between the paramedics and the nurse that will be taking over that care. So having a dedicated nurse role in the emergency department that is assisting with that and expediting that again means that that transfer can happen more rapidly.

Lauren KATHAGE: I really like hearing that you are putting faith in our experts, the hardworking emergency department and ambo workers, and trusting them to be the ones to know how to fix parts of the system, and I guess we extend that respect for their expertise to triaging people and understanding if they need to take into account cultural indicators of morbidity or other factors which might impact the health of, for example, Aboriginal Victorians. So it is great to hear you have got that faith in our workers. I would like to move on, if I can. Still on that workforce, page 4 of the questionnaire has information about investment in that

workforce. Can you talk a little bit about the rural side of that, the embedded nurse practitioner roles, and how that is making a difference for people who are looking to access health services in rural areas?

Naomi BROMLEY: Yes, sure, I can. Nurse practitioners are obviously a fantastic addition to the healthcare workforce, and I suppose in some ways what they do is fill a gap between nurses and doctors. They have got additional skills, additional training, and they can work quite autonomously. Obviously, they are not doctors, so they cannot do all of the same things that doctors can do; they cannot necessarily prescribe the same medications or initiate the same treatments. But within a defined scope – and a lot of work goes into defining what that scope is, what is appropriate and what is safe – nurse practitioners can fill a really important role, particularly perhaps in rural and regional areas, where again access to doctors, access to GPs can be quite challenging, either because of distance or because of availability, sometimes because of cost. So having nurse practitioners in the system – in community health settings, for example, and also working alongside GPs in their practices – provides another layer of access. It is also a great initiative for our nursing workforce, providing a career pathway for nurses who might love their profession but who might be looking for something else – they might be wanting to do a little bit more. So going through that training and finding a placement as a nurse practitioner gives them that opportunity to really use their full range of skills but also to learn new skills and to be able to apply those in their communities.

Lauren KATHAGE: That learning of new skills: we see the nurses and midwives – I am thinking particularly of Kilmore, where I had a baby at the start of the year. They are a formidable bunch who run the show, basically. There is obviously a lot of upskilling that has gone on, but also linking in with the Northern more recently gives them an opportunity to practice down at a busier hospital. I actually had a midwife who had recently graduated through a scholarship, Cassie, who was there to catch my baby. If you will indulge me, she was supported by Arti, Shannon, Nicki, Maddy, Jasmine, Roslyn, Sarah and Tania of course there at Kilmore and doctors Greta and Nicole, and I cannot forget Sharon, who made the best salad sandwich of my life after I had given birth. Those nurses and midwives up in Kilmore are a fantastic group of people. I can see that there is a system for placements at larger health services. Can you talk a bit to that?

Naomi BROMLEY: For nurse practitioners?

Lauren KATHAGE: For regional and rural midwives, for upskilling.

Naomi BROMLEY: Oh, okay. What I might do, if it is okay, is pick up on that but acknowledge the work of the Victorian Maternity Taskforce, which was obviously initiated by the ministers and has done a huge amount of work to bring to life the report, which was launched quite recently. What that report, and the work of the taskforce, does is pick up on some of the things that you are referring to around how we think about maternity care a bit differently and how we make sure it is meeting the needs of community – all different communities, whether in rural and regional Victoria or in our very, very busy growth corridors. Midwives and nurses are a really important part of that. So while obviously many women will need to be supported by the medical workforce at some point during their pregnancy, their birthing experience and postnatally as well, we know that midwives can and do play a really important role there. I think, as you have, often women will express a greater experience and greater satisfaction from having that relationship with a midwife on that journey, and where it is safe and appropriate to do so, having a midwife-led birthing experience is something that we know many women want for that really important journey.

The taskforce has looked at models of care, it has looked at the workforce and it has looked at different ways of configuring the workforce to think about how we build on what is a great, safe maternity system here in Victoria, but also think about how we meet the needs of the community going forward. In rural and regional areas, for example, where sometimes there are workforce shortages, how do we reconfigure the workforce differently? How do we have different models of care so that no matter where they live in Victoria, women and families have got the right options available to them locally but also the right access where they do need more intensive care or where they might need more intervention, with really clear pathways for those things to be identified and then accessed?

With that report, I think a couple of the recommendations have already been accepted. One of them is to have a chief midwife. Another one is to initiate the My Surgical Journey product, which is a really important way to support women on that journey and give them some autonomy and provide them with information so that they can kind of really engage in that process. We will be progressively looking at all of the recommendations of the

taskforce report and working through how to prioritise and how to stage those and then progressively roll them out across the system.

Jenny ATTA: I might just give Ms Bromley a quick break. But going to the rural and regional specifics of some of the programs there, we are supporting pathways. The maternity connect program supports nurses and midwives from rural health services to complete clinical placements in higher acuity settings, enhancing their skills, networks and confidence for improved care upon their return to local communities. In 2024–25, 68 nurses and midwives were supported through that program. The postgraduate midwifery incentive program offers registered nurses employment-based postgraduate studies in midwifery, providing financial support and supervised practice, and 65 scholarships were granted to rural and regionally based nurses in 2024–25.

A couple of others: the rural urgent care nurses capability development program supported almost 350 registered nurses in regional urgent care centres in 2024–25, and 34 small rural health services have been funded to embed nurse practitioner roles in priority areas – and Naomi has talked about that role – all with the objective of improving access to care closer to home.

Lauren KATHAGE: I guess one of the other elements to that for a rural or regional area – another piece of that puzzle – is the community pharmacy program, which is now no longer a pilot but a program because it worked. Chemist Care Now, I think it is called. Care at the chemist now, I think is the actual –

Jenny ATTA: Yes. Chemist Care Now.

Lauren KATHAGE: Chemist Care Now. Thank you, I will get my wording right. How is that tracking in terms of people accessing that? I guess I am particularly interested in rural or regional and what that slice looks like.

Jenny ATTA: Sure. Chemist Care Now supports women's health by delivering care that specifically benefits women, including resupply of the oral contraceptive pill and treatment for uncomplicated urinary tract infections. Eighty-four per cent of services delivered in the pilot phase were received by women. Regional and rural patients, who in particular can face delays seeking an appointment with a GP, now have the opportunity through Chemist Care Now where pharmacies can provide an alternative option for treatment in some of those categories, with 27 per cent of authorised pharmacies that are participating located in regional and rural Victoria.

Lauren KATHAGE: Thank you. It will be interesting to see how that additional Medicare bulk-billing funding coming through the system changes things in that sort of ecosystem, but I guess that will be a topic for next year's outcomes process. The funding for the community pharmacy program – we are predicting more conditions to be added. Is that right?

Jenny ATTA: Yes. The 2025–26 state budget committed $18 million to support the operations and expansion of the program over the next four years and ongoing.

Lauren KATHAGE: Thank you. I might go on to ask a little bit about mental health now, if I can?

Jenny ATTA: Absolutely. I might invite Ms Anders to the table, who might be best placed to answer your questions.

Lauren KATHAGE: In particular, in the mid-year budget update it lists funding there for the pill-testing trial. Are you able to let us know how the trial over the previous summer festival period worked? Can you give an overview of that?

Pam ANDERS: Yes, I can. I think on 25 June last year the Victorian government announced an 18-month pill-testing implementation trial, and in November 2024 legislation was passed which provided the legal framework for both what was mobile pill testing and also fixed-site drug-checking services. We have a consortium of three different organisations that deliver those pill-testing services, and that is Youth Support and Advocacy Services, the Loop Australia and Harm Reduction Victoria. This is the consortium that is delivering the trial, and as I said, it includes both fixed-site service and mobile service. It will run over 18 months and will include 10 music festivals. Last summer we did the first of those five festivals, which operated both at multiday festivals and also single-day events, and these included Beyond the Valley, Hardmission, Pitch Music and Arts

Festival, Ultra and the Warehouse Project. I can tell you a little bit more about what we found at those five different sites. Over that season we had a total of 1500 people who accessed the service and tested around 1400 samples. We had 10 onsite drug notifications that were issued, with two of those escalating to a statewide advisory notification. I think really importantly and impactfully –

Lauren KATHAGE: Sorry, could you explain what that means?

Pam ANDERS: It means effectively where a substance has been detected as a risk – that is, it is not the substance that the consumer thinks it is and what is more it could have a harmful effect on the individual – onsite drug notifications are issued, either through SMS or through social media channels of the local festival, to try and share that alert out to people who are at the festival. But if it is a particular high-risk substance that has been found, it kind of gets escalated to a statewide notification, so it gets amplified through different channels, particularly through the consortia and also through the Department of Health's channels.

Lauren KATHAGE: After the festival notification, did more people come and get their pills tested?

Pam ANDERS: I am not sure in terms of what the correlation was at the time, but I think what is really promising about what we are finding at these mobile sites is that where people came forward, indeed of those 1500 people who presented to get a sample tested – we have a health professional onsite – there were around about 743 health conversations that were delivered alongside.

Lauren KATHAGE: Thank you.

The CHAIR: I need to be a ruthless timekeeper. The committee is going to take a very short break before resuming the hearing at 11:15 am.

The committee will resume its consideration of the Department of Health. We are going to go to Ms Benham.

Jade BENHAM: Thank you, Chair. I have some questions about the mental health and wellbeing levy, referring to the Department of Health annual report, page 126. Can the department provide a full line-by-line breakdown of how much in mental health and wellbeing levy appropriations has been spent on each royal commission recommendation, noting that there is no such breakdown appearing in the budget papers, annual report or PAEC evidence?

Jenny ATTA: Ms Benham, I might ask Ms Anders to speak to that.

Pam ANDERS: Sure. Can I just get you to repeat the question, please?

Jade BENHAM: Sure. Referring to page 126, the appropriations page in the annual report, the mental health and wellbeing levy appropriations – can we get a line-by-line breakdown of each royal commission recommendation, noting that there is no breakdown of how those appropriations are being spent on each of the 65 recommendations?

Pam ANDERS: Okay, I understand. Thank you. The mental health levy is an appropriation, as you said, and in 2025 the actual amount that was collected was around about $1.259 billion.

Jade BENHAM: And that is what is listed in the report. We need how that is being spent on each of the recommendations.

Pam ANDERS: That is right. The *Mental Health and Wellbeing Act*, section 743, actually enacts the provisions to provide for the ongoing appropriation of the Consolidated Fund to enable the equivalent funding to be spent on the provision of outputs that are consistent with and promote the objectives of the Act and also the mental health and wellbeing principles. What that means is that we look at the total output expenditure for mental health in 2024–25.

Jade BENHAM: So is it not broken down?

Pam ANDERS: It is broken down at output level.

Jade BENHAM: Okay. Are we able to get a breakdown of those outputs?

Pam ANDERS: We do publish the output estimates in the budget papers, and we publish what was spent on those outputs in both the Department of Health's annual report and also the chief mental health annual report.

Jade BENHAM: So how do we see how they relate to each of the recommendations from the royal commission?

Pam ANDERS: Appropriations are not at royal commission recommendation level; they are actually aggregated up into output initiatives and output costs.

Jade BENHAM: But that is why the levy was introduced, isn't it?

Pam ANDERS: The levy was recommended by the royal commission to provide a sustainable revenue stream into mental health investment, so it goes into the system and the system is initiating the reforms. The reporting and the appropriation is at the output cost level. We report the output costs, so total output expenditure for mental health in 2024–25 was $2.988 billion, which you can see is far in excess of the dollars that were raised from the levy that year.

Jade BENHAM: Has any of the levy revenue been used for purposes that are not directly link to the royal commission implementation?

Pam ANDERS: The appropriation, as I said, is linked to the output costs. Those output costs are what we purchased through mental health clinical care and mental health community care.

Jade BENHAM: Even the Mental Health and Wellbeing Commission are needing the report and waiting on this data, which is really critical. Are you able to supply that data for us?

Pam ANDERS: As I said, the appropriation is at output cost and output initiative, so it is actually rolled up. We do report each year around the progress of royal commission recommendations – indeed I think the minister provided that report earlier this year at PAEC estimates – and we report through the chief mental health and wellbeing officer's annual report. We talk about what was delivered for the output initiatives, some of which include royal commission recommendations. For example, the provision of new beds and the commissioning costs for new beds would be part of the mental health clinical care output.

Jade BENHAM: You said the total amount spent in 2024–25 was $2.98 billion. How much of the levy funding remains unspent as of 30 June 2025?

Pam ANDERS: If I understand your question, the amount of the funding that is raised from the levy is fully expended, because the output costs are greater than the levy. The output costs, as I said, have been reported at $2.988 billion, and the levy was at $1.259 billion.

Jade BENHAM: We really just want to know where that levy money is going and what exactly it is being spent on. I get the outputs, but where is the money going?

Pam ANDERS: Well, I can give you some examples of what was delivered as part of those output initiatives for 2024–25 – for example, $16 million to open the 20 new beds at the YPARCs, youth prevention and recovery beds, in delivering new and better services. It included the service rollout and the commissioning dollars for the existing local mental health and adult and older adult local services.

Jade BENHAM: Does the department maintain an internal ledger which maps the levy dollars to the royal commission recommendations?

Pam ANDERS: As I said, the royal commission recommendation for the levy was for it to be a sustainable hypothecated revenue stream into the investment and expenditure for mental health.

Jade BENHAM: So how then do we assure Parliament that the levy is being used as it was intended?

Pam ANDERS: This is where, as I said earlier, the *Mental Health and Wellbeing Act* requires that the chief officer for mental health and wellbeing reports on the surcharge as part of the annual report on mental health and wellbeing services. Amongst other things, the Act provides for the amount appropriated under section 743 and how the proceeds have been spent on the provision of mental health and wellbeing services.

Jade BENHAM: Okay, I am going to move on to the overdue recommendations – page 9 of the Department of Health annual report. The mental health and wellbeing department is leading the implementation of the recommendations by the royal commission. How many of those royal commission recommendations are currently behind their original implementation timelines, and why has the government never published the overdue count?

Pam ANDERS: The number of recommendations total around about 74. We have recommendations from both the interim report to government, which had nine, and 65 recommendations in the final report. The progress to date has included that of those 74 recommendations, 11 have been completed, 57 are in progress and six are yet to commence.

Jade BENHAM: So those six – is the department planning to abandon those?

Pam ANDERS: The royal commission itself in its guidance to government – and they were not implementation timeframes that were recommended; the royal commission said they act as a guide. I think the main objective, the royal commission said, for providing that guidance was to give government a sense of the sequencing of those 74 recommendations: which ones were the priority ones or the foundational ones to deliver in the first phase? That was the first phase of three phases over 10 years. We are now just at the tail end of the fourth or fifth year of royal commission reform work, and indeed some of that guidance from the royal commission included not commencing some recommendations until the third phase of the reforms.

Jade BENHAM: Are we able to get a progress report on where the recommendations and the implementation are up to?

Pam ANDERS: We can take that on notice.

Jade BENHAM: Great. Thank you very much. On pages 226 and 227 of the department's report, only 43 per cent of mental health emergency department presentations were admitted within the target of 4 hours, the worst performance on record. When did the department first notify the minister that mental health ED transfer times were collapsing below 50 per cent?

Jenny ATTA: Thanks. Ms Anders?

Pam ANDERS: Okay. The department provides both to the minister but also publicly regular reports on performance, including both ED measures of less than 4 hours and also less than 8 hours. So that is a regular conversation that we have with the minister, and also through our e-health those reports are made public.

Jade BENHAM: So when exactly was the minister briefed that these transfer times were collapsing? And can we get a copy? If they are published, can we get a copy of those ministerial briefings?

Pam ANDERS: The data is made publicly available regularly, quarterly, and we can certainly provide that link to the committee to be able to access those reports. As I said, the quarterly reports are a quarterly conversation. On the indicators that you are specifically referring to, particularly for 2024–25, yes, we can see that the average mental health length of stay for less than 4 hours was 43 per cent, which was a slight improvement on the 2023–24 figure of 42 per cent.

Jade BENHAM: So when was the minister briefed about those times?

Pam ANDERS: As I said, we have a regular conversation with the minister. So off the back of each quarterly data we have that conversation about where the system is at –

Jade BENHAM: So you do not know when the minister was briefed about that? I am just after a date.

Pam ANDERS: Well, the most recently available quarterly report was in October. We always have a regular briefing with the minister around what the data is telling us ahead of it being published. But it also informs our quarterly conversations with health services.

Jade BENHAM: Okay. So it is every three months, and there was not any flag earlier than that?

Pam ANDERS: I might just clarify exactly that the measure you have talked about for 2024–25 was not a significant variance in that quarter. In fact –

Jade BENHAM: It slipped below 50 per cent.

Pam ANDERS: And it has been for a number of years. And indeed the royal commission called this out in their report.

Jade BENHAM: Okay. So how many Victorians last year waited longer than 24 hours in an emergency department for a mental health bed?

Pam ANDERS: I do not have that specific data at hand.

Jade BENHAM: Could you provide that to the committee on notice then, please?

Pam ANDERS: I am happy to take that on notice.

Jade BENHAM: Great.

Pam ANDERS: I can say that of total presentations to emergency departments each year, around about 5 to 6 per cent of them are mental health patients. Last year –

Jade BENHAM: Yes, that is fine. We just need to know how many are waiting longer than 24 hours?

Pam ANDERS: Last year that represented around about 113,000. The majority of those people are discharged after a period of treatment, care and stabilisation to home. There is a smaller percentage that goes on to access either a general medical bed or –

Jade BENHAM: But if they are not being seen in emergency, that is the data we need – how many have waited in emergency.

Pam ANDERS: I am happy to take that on notice.

Jade BENHAM: Okay. Thank you very much. Child and adolescent mental health service seclusion is more than triple the acceptable rate. Can you table the incident-level data by service and date, including root cause analysis?

Pam ANDERS: We do not publish that data at individual service level. It is anonymous, de-identified data, and the instances of the use of seclusion and restraint, particularly for children and adolescents in Victoria –

Jade BENHAM: I get that you do not publish it, but are you able to supply that data to the committee?

Pam ANDERS: No, that is not made available outside the office of the chief psychiatrist, because it can provide individual identifying information, because the denominator is quite small. In some cases we might be talking about one family with one child at a health service that may have had multiple episodes of seclusion. And so that is very clear and potentially identifiable to both the child and the family.

Jade BENHAM: Okay. So how many CAMHS beds were offline at any time during the 2024–25 reporting period due to workforce shortages, capital works or other safety issues?

Pam ANDERS: I do not have that data by age stream at child and adolescent, but I will be able to confirm what the bed numbers are across the state.

Jade BENHAM: Okay. That is great. Thank you. Can we just go back to the mental health ED presentations: has the department made any recommendations to the minister on how to improve those wait times?

Pam ANDERS: The reasons why a person may wait longer than 4 hours or 8 hours in an emergency department are multiple. For some consumers, they may be waiting in emergency because it requires a period of stabilisation, particularly for consumers who may present intoxicated or substance-affected. One of the critical initiatives that we have advised the minister on and the government has been implementing over the last

couple of years has been the opening up of what are called new mental health and AOD emergency hubs. At the moment we have 35 beds across, I think, five or six different emergency departments which provide a dedicated space inside the emergency department to effectively hold, assess and treat a person presenting with a mental health or AOD or, in some cases, a co-occurring –

Jade BENHAM: Has the department made recommendations to the minister on how to how to improve this flow?

Jenny ATTA: Ms Benham, that is one example of recommendations to the minister and initiatives that have been introduced to improve that situation. There are also a range of other improvement strategies at the emergency department level to benefit all patients presenting, including those presenting with mental ill health. Ms Bromley could quickly talk to those.

Naomi BROMLEY: Yes. So –

Jade BENHAM: Just in the interest of time – I have got a lot of questions to get through: are you able to supply any of those briefings or recommendations to the committee on notice?

Naomi BROMLEY: In terms of improvements to emergency department performance? We have certainly got a lot of information, and we could provide some of that. Some is in the –

Jade BENHAM: Yes, great. Thank you so much. I want to move on to forensic mental health now. This is referring to page 51 of the Forensicare annual report 2024–25. Only 16 per cent of acutely unwell prisoners accessed a forensic bed within seven days. How many individuals waited longer than 30 days, and what was the longest wait recorded?

Jenny ATTA: I will see if Ms Anders can assist.

Pam ANDERS: I do not have the specifics to answer your question. I am happy to take that on notice.

Jade BENHAM: Great. Thank you. That would be great.

Pam ANDERS: What I can say, though, is that there is enhanced capacity for Forensicare currently underway through the expansion of stage 3 at Thomas Embling Hospital, which will provide an additional 82 beds. They are expected to be completed towards the end of this year, and commissioning of those beds will be a priority for future budgets, as we have spoken to.

Jade BENHAM: So will that help fill the current shortfall in forensic acute beds? And how long has the department known the system cannot meet, again, the royal commission recommendation of a seven-day target?

Pam ANDERS: It will absolutely provide new capacity in the system to triage forensic clients to Thomas Embling. I mean, this is a longstanding challenge in the system, one which the royal commission wrote extensively on, and indeed the expansion of Thomas Embling Hospital is a royal commission recommendation.

Jade BENHAM: Okay. Can you also supply the daily waitlist for forensic mental health beds for each month of the reporting period?

Pam ANDERS: If we have that data, I am happy to provide it.

Jade BENHAM: Great. Thank you so much. I want to talk about the sobering-up centres now, the trial evaluation on page 13 of the department's report. The Department of Justice and Community Safety Secretary publicly stated that a further evaluation report of trial sites would be provided by August or September in 2024. So could you please supply the evaluation report for the Yarra sobering-up trial that was due to be released in August or September last year?

Pam ANDERS: I think what the Secretary may have been referring to was the justice-led evaluation. Across government we have two commissioned evaluations in regard to –

Jade BENHAM: Have those reports been completed?

Pam ANDERS: I am not aware of the justice report being released. I can confirm the Department of Health's evaluation report is underway and will not be complete until early 2026.

Jade BENHAM: Early 2026? Okay, so given that the government's own officials publicly admitted that the trial sites were delayed and not fully operational, what internal briefings or warnings were issued to the ministers about those risks?

Pam ANDERS: I cannot speak to any particular warnings, as you have characterised, but what I will say is that these services were established and the legislation was enacted on 7 November. I can also add that since 7 November, when this was operationalised in 2023, to 30 June 2025, the sobering centre, the outreach services and the places of safety, which are statewide, have supported a total of 55,041 instances of both what we call assertive and community outreach.

Jade BENHAM: Were there internal briefings, though? We know that all the trial sites were delayed or were not fully operational, so surely the department briefed the minister that there were delays and deficiencies in this service.

Jenny ATTA: There is always briefing advice to ministers as we are looking at implementation, planning and rollout. Ms Benham, we are not able to provide ministerial briefings, but I think Ms Anders has been talking to the planning and then the implementation and progress.

Jade BENHAM: Sure. I just want to go back to that number of patients – 55,000, you said –

Pam ANDERS: Yes.

Jade BENHAM: since November 2024?

Pam ANDERS: Since November 2023.

Jade BENHAM: Okay. So why has the department failed to publish the performance reports?

The CHAIR: Thank you. We are going to go to Ms Kathage.

Lauren KATHAGE: Thank you so much, Chair. Again, thank you, officials. Ms Anders, I was hoping we could continue our conversation about pill testing. I was mentally at a music festival over the summer, and you told us that there were – I think it was 750. Sorry, there were 10 drug notifications and two statewide. Can you go on to tell me more about those 750 conversations?

Pam ANDERS: That is right. As I said, around about 743 health conversations were delivered, which represented around about 65 per cent of those who accessed the service. You line up to access the service; you deposit your sample. It can take around about 15 to 20 minutes to run the test, and during that time a health professional will be available and will offer a conversation. Some festival goers politely decline, others are curious. What we have found is that about 65 per cent of those have also said this is the first time they have openly spoken to a health professional about drug and alcohol safety. As part of that, really pleasingly, more than 30 per cent of service users advised that they would take a smaller amount after talking to a health professional, and nearly 40 per cent advised that they would tell their friends about the test results and the advice following the use of the service. Since the time of the festivals last year, we have also now opened up the fixed-site service at 95 Brunswick Street, Fitzroy. This was opened up in August this year, and this service also publishes detailed, regular reports publicly, which is really important because it gives users and people working in the sector access to real-time information on to what extent hazards or dangerous substances are circulating in the drug market. It just really underscores the importance of that service.

Lauren KATHAGE: Excellent. Thank you so much, Ms Anders. I appreciate that additional detail.

Meng Heang TAK: Thank you. Secretary, I want to take you to the mental health and wellbeing levy. It is referred to in budget paper 5, on page 18, which estimates that the mental health and wellbeing levy would collect $1.03 billion in the 2024–25 financial year. Can you please explain the purpose of this levy and how it has been invested in mental health and wellbeing services?

Jenny ATTA: Yes. Thanks, Mr Tak. I will hand back to Ms Anders in a moment, who was touching on this earlier, including that confirmation that in 2024–25 actual revenue that was collected was $1.259 billion. It was a central recommendation of the royal commission – in fact the royal commission's interim report – that government introduce a new revenue mechanism to provide additional funding for mental health services. The *State Taxation and Mental Health Acts Amendment Act* was passed in 2021 to introduce the mental health and wellbeing surcharge, which has been in operation then since January 2022, and Ms Anders went to the mechanism through the *Mental Health and Wellbeing Act*. It re-enacts those provisions to provide for the ongoing appropriation. I might hand to Ms Anders. I think your question went to how that levy is being used?

Pam ANDERS: Thank you, Secretary. I can add to that by taking you through some of the important milestones that were delivered as part of the investment in mental health in 2024–25. This included, as I mentioned earlier, delivering new and enhanced services. One of the key flagships of the reform work to date has been the rollout of new mental health and wellbeing locals. Currently, as of this week, we have 22 services up and running across 24 locations. We have had these local services established in a number of tranches. What we can say is that as of 30 June the local services have supported around 24,600 Victorians aged 26 and over. These are really fantastic services. They are free. They offer us a broad front door for people whose mental health and AOD needs may be a bit more complex than what a local GP or a primary care provider can support but not quite complex enough that they need to access a tertiary service.

On other new services that we have been opening, we have established new social inclusion action groups statewide. Also, as the Secretary mentioned in her presentation, we opened up Victoria's first public residential eating disorder centre in April this year. This is run by Alfred Health. It is a 12-bed centre providing a 24/7 residential model of care for Victorians aged 18 or older experiencing eating disorders. It provides a really therapeutic, homelike environment. It was designed to really service that gap between acute treatment in a hospital setting and community care. I think another really critically important milestone, as we talked about earlier with emergency departments, has been the establishment of new mental health and AOD hubs. We have effectively six hubs that were operationalised, including at Latrobe Regional Hospital, University Hospital Geelong, Sunshine Hospital, St Vincent's Hospital Melbourne, Monash and also the Royal Melbourne Hospital. We have got another 35 beds that are currently being built, and we have got two of those hubs that are planned to be operationalised next year, both at Frankston Hospital and as part of the new Footscray Hospital.

Meng Heang TAK: Thank you. There is a vast range of initiatives there. I will come back to that a little bit later. Secretary, the mental health local workforce is referred to in budget paper 3, page 46, which details an investment of $15.8 million to continue expanding the workforce with the graduate program helping to establish a pipeline of future skilled workers for our mental health and wellbeing locals. Can you provide us an update on the rollout of this initiative?

Jenny ATTA: Yes, Mr Tak. The mental health and wellbeing locals graduate and early career program commenced in March 2025 with that objective of developing a pipeline of clinical and wellbeing graduates. The department is commissioning that program in a couple of stages or intakes. I might ask Ms Bromley to speak to that.

Naomi BROMLEY: Thank you, Secretary. As the Secretary was saying, it is occurring in a couple of tranches or stages or intakes. The first intake saw five mental health and wellbeing locals awarded roles across several disciplines. We have got allied health, for example – social workers, occupational therapy, mental health nursing of course, as you would expect – but also lived and living experience workers, which is a really important part of the local model, which my colleague can speak to in a bit more detail if you want to hear more about that actual model. For that intake there were 27 FTE commissioned, and I am really pleased to report that all of those roles were then successfully recruited to. For the second intake, that has been commissioned, and that recruitment is underway at the moment. We expect those placements to commence in February 2026. It was announced in July of this year. That will be a much bigger intake – that will be 66 FTE – and there will also be a broader number of locals that are engaged there. For the first one it was five. For the second one it is 12 locals. This is a very important foundational piece for the locals initiative, because it is quite a novel service delivery model to actually create these roles, to create the pipeline that is needed to deliver this slightly different kind of service delivery model. That is really why the graduate program dedicated to locals has been established. Because it is quite a novel service delivery model, there is also a slightly different way that those graduates are supported to the way that they would be in in a regular health service, where the support would be delivered in the health service itself.

What have also been established as part of the program are three statewide support providers. These providers support the locals and the graduates to make sure that they are getting their education, training et cetera that they are going to need on that early career journey. Those three are the Alfred, mental health and addiction health; Mental Health Victoria have also been engaged to deliver that statewide support for the clinical and wellbeing aspects of the program; and then the third aspect of the statewide support is Mind Australia. They have been engaged to deliver statewide support specifically for the lived experience graduates that are part of that cohort. What they are really doing is ensuring that best practice is being applied to the way that graduate program is being run and also that it is consistent so that the experience and the support that the graduates have will be the same and will be best practice, no matter which of those locals they are placed in.

Overall, once we commission and recruit to this second round – there will be the five and then the 12 – there will be a third and final intake, which I think commences in July 2026. That will then see that program to fruition. I do not know exactly how many FTE there will be. I think as we work through the design of that third intake it will obviously build on the 27 in the first tranche and then the 66 in that second tranche or intake.

Meng Heang TAK: Thank you. We will be looking forward to further intakes for this wonderful initiative. Moving on, Secretary, I refer to budget paper 3 on pages 46 and 50, which detail an investment of $95.1 million to reduce drug-related harm in the CBD and across Victoria. Can you tell the committee what progress has been made to date on the delivery of this initiative?

Jenny ATTA: Yes, Mr Tak. In April 2024 the government announced a $95.1 million statewide action plan in response to increasing drug harms in Melbourne's central business district and across Victoria. The CBD initiatives respond to recommendations from Ken Lay's consultations regarding a second medically supervised injecting facility in the CBD. There are a range of different elements to the plan, and I might ask Ms Anders to take us through those and the progress.

Pam ANDERS: Yes, I can do that. Since the release of the plan we have been quite busy. There are a number of critical deliverables that have either been completed or are in train at the moment. As the Secretary said, these are really around aiming to reduce drug harms, particularly in metropolitan Melbourne. A couple of those examples have been – and I think this was mentioned in the Secretary's presentation – a new healthcare clinic that has been established in Bourke Street, which to date, between the six months of January to June this year, 2025, delivered over 890 primary and mental health services, particularly to people facing really longstanding barriers to accessing mainstream health care in other places.

Delivery has also commenced for enhanced outreach services in the CBD, Footscray, St Kilda and surrounding suburbs. When you look across those outreach teams, they have delivered over 6700 critical harm reduction supports connected to over 1400 Victorians, including responding to six overdoses that could have otherwise been fatal but for the presence or the capability of an outreach team to attend. There has also been a CBD reference group established, and this is about bringing together a group of experts focused around the CBD to inform and mobilise services both for business and community in coordinating localised responses to drug harms in the city.

The statewide action plan also expanded access to pharmacotherapy, with $8.4 million of grants that have been distributed and provided to 15 community health services, and this is really around boosting really important local access points across the state. I think another really core part of the statewide action plan is elevating the expertise and the guidance of addiction medicine through the appointment of Victoria's first chief addiction medicine adviser, Dr Paul MacCartney, who really delivers expert advice on different system priorities.

What we have got a focus on at the moment through 2025–26 includes, also working with the CBD reference group, a local awareness and anti-stigma campaign around harm reduction and drug use for Melbourne CBD, the establishment of an expert AOD ministerial advisory committee and also, through the leadership of the chief addiction medicine adviser, the development of Victoria's first AOD strategy, which is really around what we need to do to prevent and reduce harms over the next 10 years.

We are also working with our colleagues in VHBA around the construction and opening of a community health hub at 244 Flinders Street. The fit-out at the hub has commenced and was begun on 30 October, and this new hub we are aiming to have established and operationalised around about the middle of 2026. It is going to be an important gateway for local health and social services, including the implementation of one of Australia's first

hydromorphone implementation trials, which is around trying to gather and build specific evidence on implementation barriers and enablers of hydromorphone treatment as an adjunct to community-based pharmacotherapy options.

We have also got a statewide overdose prevention response phone line trial that we are working on, and there is also the establishment of 20 naloxone dispensing machines – again, another Australian first – across metro and regional Victoria, and this is going to be able to provide around-the-clock access to what is really life-saving opioid reversal medication.

Meng Heang TAK: Thanks, Ms Anders. You talk about 20 machines across the state. Would you be able to talk more about how this investment is reducing drug harms outside of Melbourne CBD and into regional Victoria?

Pam ANDERS: Well, I think I have probably covered some of that. The naloxone dispensing machines – we have not quite finalised the locations of those, but we are on track to deliver those over the course of this financial year. We are working closely to finalise what is the most ideal location of those dispensing machines, and we have also had to commission manufacturers in Australia to develop those machines. So it is a priority to have that completed and rolled out in 2025–26.

Meng Heang TAK: Just to come back, you mentioned 15 community health services. Would those also be focused just in Melbourne CBD or across the state?

Pam ANDERS: No, it is statewide, and I can share with you a list of those pharmacotherapy grant recipients. I can confirm that earlier this year, in March 2025, we had 15 community health services. These are spread across metro and regional areas, including Ballarat Community Health, Barwon Health, Bendigo Community Health, DPV Health in north-west Melbourne, Gateway Health in Hume, Gippsland Lakes Complete Health in Gippsland, Goulburn Valley Health, Grampians Community Health, Latrobe Community Health, Monash, Peninsula Health in Frankston, South West Healthcare in Warrnambool, Western Health, and Your Community Health in inner-north Melbourne.

Meng Heang TAK: Thank you. With the remaining time I am also interested to ask a few questions on eating disorders. I refer to budget paper 3, page 52, 'Support and treatment for eating disorders'. Secretary, can you provide just a quick update on the implementation of this initiative?

Jenny ATTA: Mr Tak, the government is taking a systemwide approach to prevention, early intervention and treatment with a statewide *Victorian Eating Disorders Strategy 2024–2031*. It was released on 6 October 2024.

Meng Heang TAK: Thank you.

The CHAIR: Thank you, Mr Tak. We are going to go to Mr Puglielli.

Aiv PUGLIELLI: Thank you, Chair. Good morning. To start off, the Virtual Women's Health Clinic: can you inform the committee how many people have accessed the free Virtual Women's Health Clinic since it began?

Jenny ATTA: I will just see if Ms Bromley might have that information.

Naomi BROMLEY: I will see if I can locate it.

Jenny ATTA: Or Professor Wainer might come to the table and provide that detail.

Zoe WAINER: I do not have the actual number on how many have attended, but I am happy to take that on notice and see if we have that data available for you.

Aiv PUGLIELLI: Thank you. That is much appreciated. Can I ask – and this may also need to be on notice: of those people, how many accessed the service for abortion care?

Zoe WAINER: I will take that on notice, if we have that data available.

Aiv PUGLIELLI: Okay. Thank you. Can I ask: does that service collect demographic data of patients?

Zoe WAINER: It collects limited demographic data, yes.

Aiv PUGLIELLI: Okay. Obviously noting confidentiality where appropriate, is there any relevant information that could be provided to the committee?

Zoe WAINER: I do not think so, but please let me take that on notice. Obviously there is a confidentiality and identification issue there. Is there a particular area of interest?

Aiv PUGLIELLI: No, just to get a sense of a breakdown of the demographics, just to see how we are tracking on that front. Looking at the clinic's website, there seems to be little to no mention of culturally appropriate care. Can I ask: was there consultation with First Nations communities on how that service could be set up to serve their communities better?

Zoe WAINER: Yes, there was consultation, and of course we also have the Aboriginal Women's Health Clinic, which is a dedicated First Nations women's health clinic, and we are already seeing some really good success outcomes as a consequence of that work.

Aiv PUGLIELLI: Can you tell us a bit more about what that consultation looked like?

Zoe WAINER: It was obviously detailed conversation with community with both areas of the clinics, both the mobile as well as the First Nations clinic, which is dedicated to First Nations women and girls.

Aiv PUGLIELLI: Thank you. Can I ask: how much funding was used for the 2024–25 budget period to expand abortion access in Victoria other than for the free clinic?

Zoe WAINER: I do not have the specific figure for you on the dedicated services. As the Secretary has already spoken to, we have obviously opened additional sexual and reproductive health hubs and the virtual women's health clinic. These provide a range of services – including with 1800 My Options – that increase access to both medical and surgical termination across the state, with a particular focus on ensuring access for regional and rural women.

Aiv PUGLIELLI: Is there a total budget figure you would be able to come back to the committee with?

Zoe WAINER: Around access to termination of pregnancy specifically? No, because it is a range of services that include all sexual and reproductive health services.

Aiv PUGLIELLI: Thank you. I might move on to another matter. The Royal Women's Hospital has run a fundraising campaign to seek public donations. As part of this they have a wish list that says:

> Dear Santa, this year, we don't need toys or treats under the tree.
>
> All we want is life-saving equipment and care for the women, babies, and families who need us most.

It lists:

> Dear Santa,
>
> … can you … bring us,
>
> - 1 x portable abdominal probe
> - 2 x phototherapy units
>
> …
>
> - 20 x PepiPods
> - 50 x sets of Baby Bundle gift bags …
> - 200 x NICU Family Care Packs.

Why are our public hospitals having to fundraise?

Jenny ATTA: Mr Puglielli, fundraising is something that particularly our larger hospitals or health services, or certainly very many of them, do to look at opportunities to enhance and supplement their operations in different ways. We certainly do not look to restrict their capacity to do that. We are very focused on ensuring that their operations are appropriately funded and that we have, through the statement of priorities process we

talked about earlier, a strong agreement between the department and the health service around their funding, their budget, the performance outcomes that are intended and a range of other measures.

Aiv PUGLIELLI: Was there not enough funding in this budget period to cover that list of items for the Royal Women's?

Jenny ATTA: It is difficult for me to speak to that list of items. I think one of the things on that list were the baby bundle bags. Obviously, they are available universally through the children's portfolio through the maternal and child health services et cetera. Without understanding the detail of that list or whether they are talking about a volume of some things, clearly some of the things on that list are part of specialist equipment and materials that they would already hold. Without a conversation with them to understand what they are looking at with that list, it is difficult to be specific.

Aiv PUGLIELLI: That is okay. I am happy to provide more detail on notice to you if that is of use. They also list ventilator circuits for NICU transport. Surely that is critical equipment, not enhancing or supplementing.

Jenny ATTA: Sorry?

Aiv PUGLIELLI: It is ventilator circuits for NICU transport.

Jenny ATTA: I am not sure if anyone can assist with that here. I might have to take that on notice. I just make the point that they may well be talking about additional equipment on top of units that they already have. I just cannot speak to the detail of that.

Aiv PUGLIELLI: If you are bringing material on notice, of those items that I have listed, which will be in the transcript, are you able to come back to us to see if any of those items were funded in this budget period for the Royal Women's?

Jenny ATTA: I can certainly see, yes. I cannot give you an assurance about the level of granularity, but certainly in terms of regular operations and what would already be in existence or provided, we will do our best to give you a sense of that.

Aiv PUGLIELLI: Thank you. Moving on to acute mental health beds, can I ask: how many additional acute mental health beds in regional Victoria were delivered for the budget period?

Jenny ATTA: I might see if Ms Anders can assist with that.

Pam ANDERS: In regional Victoria, you said?

Aiv PUGLIELLI: In regional Victoria, yes – acute mental health beds.

Pam ANDERS: In 2025?

Aiv PUGLIELLI: For this budget period, yes.

Pam ANDERS: Can I just clarify the question: is it new beds or existing beds?

Aiv PUGLIELLI: It is additional acute mental health beds.

Pam ANDERS: Additional acute mental health beds. I can advise there were a number of new mental health beds and facilities that were opened during this period in 2024. Some of those included both acute and subacute beds. Funding was provided for, as I mentioned before, six new mental health and AOD emergency department hub beds, including six of those beds opening at Latrobe Regional Hospital in February 2025. I can also advise that there were planning and commissioning dollars to get ready to open up the new YPARC facility in Traralgon for young people aged between 16 and 25. They were two of the highlights of new bed facilities, both acute and subacute, for regional Victoria.

Aiv PUGLIELLI: Is there any further information, more exhaustively, that you can provide to the committee, even on notice if necessary?

Pam ANDERS: I am happy to take that on notice. I can say we do have another significant program underway at the moment which VIDA is leading around upgrades to existing acute mental health beds. This is project intensive care area, or Project ICA, which is upgrading sites right across Victoria, including regional Victoria. As of September 2025 we had refurbishments to over 16 of the planned 24 inpatient units, and, if I just go through the list, I will highlight that this included both Wangaratta hospital and a range of metropolitan hospitals.

Aiv PUGLIELLI: Okay, thank you. Just looking at numbers of beds still: of the figures that you have provided of new beds, how many were allocated to be adolescent acute mental health beds?

Pam ANDERS: I do not have that figure at hand. Can I just clarify when you say 'adolescent': we do tend to have two age groups, adolescents between 12 to 17 and young people from 18 to 25. For adolescent beds, we have adolescent beds across four metropolitan sites, and indeed at the moment we do not have any adolescent beds specifically located in regional Victoria.

Aiv PUGLIELLI: None at all?

Pam ANDERS: None at the moment. This is a particular area of reform called out by the royal commission, because they are very difficult circumstances, particularly for a young person – and their family – who may require admission to a specialist mental health bed. They will be required to travel down to metropolitan Melbourne. One of the priority projects for the department has been to co-design what that model needs to look like for regional Victoria, and indeed we talked about this work I think in the PAEC questionnaire this year, around an adolescent service development framework. What is really important about that is that it is a co-designed piece that has been led with young people and families, who have told us what a model of care looks like and what the space is they require for a therapeutic environment. We expect to finalise that framework this financial year, and that will act as a foundation to guide where we need to prioritise investment across regional Victoria to improve that access.

Aiv PUGLIELLI: When would we expect that process to be complete?

Pam ANDERS: We are aiming to complete the framework this financial year.

Aiv PUGLIELLI: Okay. Thank you. Just looking at the outcome of beds in the regions for young people, will the new mental health and alcohol and other drugs residential rehabilitation facility in Mildura include any adolescent acute mental health beds?

Pam ANDERS: No. It is an AOD facility, so there is no provision in that service for a mental health specialist acute service.

Aiv PUGLIELLI: Okay. From the department's perspective, is there any tracking that occurs of the number of young people in regional Victoria who are experiencing a mental health crisis who do not have access to a bed?

Pam ANDERS: Through the provision of the quarterly reports that I referred to before, we have particular measures that look at how many child and adolescent presentations we have to the system and also how many of those would – we have got disaggregated across age cohorts for the use of seclusion and restraint, which we spoke about before, and for presentations to our infant, child and youth mental health services, both bed based and community. I should say, and I could add this to your earlier questions around access to beds, we do have regionally based infant, child and youth mental health services that do provide community-based mental health, so trying to keep a young person in their home surrounded by their families. It is for the bed access, if that is required, that they are required to come to Melbourne.

Jenny ATTA: Just to add to it, Mr Puglielli, because we have moved a little bit between talking about adolescents, as Ms Anders said, and then young people. I think this was mentioned, but just to be clear: the youth prevention and recovery care centres are available in regional Victorian sites as well as metropolitan.

Aiv PUGLIELLI: Okay. Thank you. Moving to inpatient rehabilitation beds, can I ask: how many inpatient rehabilitation beds for alcohol and other drugs are there in the state?

Jenny ATTA: Ms Anders?

Pam ANDERS: Yes, I can speak to that. So it is rehabilitation –

Aiv PUGLIELLI: Inpatient rehabilitation beds for alcohol and other drugs.

Pam ANDERS: Adult residential rehabilitation beds total 459 across the state, and we also have 47 youth residential rehabilitation beds, which also includes provision for culturally safe Aboriginal patients.

Aiv PUGLIELLI: Okay. Thank you. Can I ask: how many health services in Victoria have dedicated alcohol and other drug addiction units?

Pam ANDERS: Sorry, how many – could you repeat the question?

Aiv PUGLIELLI: How many health services in Victoria have dedicated alcohol and other drug addiction units?

Pam ANDERS: I can reflect that one of the pieces of reform work that we have been implementing, as recommended by the royal commission, has been to ensure each of our 21 designated area mental health services have what is called an integrated care platform, so they can support people presenting with co-occurring needs, both mental health and AOD. I do not have the specific granular data around how many addiction medical specialists we have at each of these services, but we do provide funding to ensure that the pathways are integrated, which does mean bringing on a specialist workforce –

Aiv PUGLIELLI: Okay. Yes.

Pam ANDERS: to support people with co-occurring needs.

Aiv PUGLIELLI: That number I am seeking is not something you have that you could provide on notice?

Pam ANDERS: I do not have that on hand, but if that data is available, I am happy to take that on notice and provide that to you.

Aiv PUGLIELLI: Thank you very much. I will move on to another matter. Moving on to the prevalence of nitazenes in Victoria, can I ask: how many detections of nitazenes were there in the state for the 2024–25 period?

Pam ANDERS: I know we do publish that data, but I am not sure that I have it actually at hand. I am very happy to take that on notice and provide that. The information is available.

Aiv PUGLIELLI: Thank you. Just to home in further, how many of those detections occurred following presentations at drug checking services?

Pam ANDERS: Our drug surveillance takes intel from multiple points, including through emergency departments and toxicology samples that may be picked up and dispatched, as well as through discarded equipment – for example, at the MSIR site – where a suspicious substance may be detected, and also through the drug-testing service. The pill-testing service now gives us much more real-time intel as to what is available. Their samples, what they find and their detection alerts are made publicly available on a monthly basis. We can provide that link.

Aiv PUGLIELLI: Thank you. I just would be keen to know, of the detections of nitazenes for the budget period, in which settings those detections were occurring, just to understand how many were captured within drug checking as service provision.

Pam ANDERS: We can take that on notice.

Aiv PUGLIELLI: Much appreciated. In relation to drug checking, can you provide the committee with a list of substances that were found to also contain nitazenes during this reporting period?

Pam ANDERS: Again, I might need to take that on notice. We do have that information available.

Aiv PUGLIELLI: Thank you. That is appreciated. Specifically, maybe I can ask: how many presentations for drug checking were of a substance expected to be heroin prior to testing?

Pam ANDERS: Suspected to be heroin?

Jenny ATTA: Suspected or expected, Mr Puglielli?

Aiv PUGLIELLI: Expected, I should say. Thank you for clarifying.

Pam ANDERS: I will need to take that on notice.

Aiv PUGLIELLI: That is all right. I will move on. Can I get a breakdown of how the mpox transmission rates have been for the budget period?

Jenny ATTA: I will ask Professor Wainer, who may be able to speak to that for you, to come to the table.

Zoe WAINER: Forgive me for one minute; I am just finding the correct data for you. I do have data from your previous question. Would you like that now? Or I can provide that on notice.

Aiv PUGLIELLI: I am on limited time, so if you want to provide it on notice, you can.

Zoe WAINER: I am happy to provide that on notice then.

Aiv PUGLIELLI: Thank you.

Zoe WAINER: The question was about mpox?

Aiv PUGLIELLI: Yes, the mpox transmission rates for the 2024–25 period.

Zoe WAINER: Obviously we saw the re-emergence of mpox in Victoria in mid-2024. That was a rather large outbreak, but again, it predominantly impacted gay, bisexual and other men who have sex with men and their sexual contacts. We obviously worked pretty hard to raise awareness of mpox, promote testing and ensure whoever is at risk and eligible for vaccination had access to free, convenient and locally available options. In terms of the current numbers, we saw a rise in numbers in early 2025 but we have seen a decrease subsequent to that, and it is currently mainly being transmitted through people who have brought it in via international travel.

Aiv PUGLIELLI: Okay. To confirm, are the rates of transmission still increasing?

Zoe WAINER: They are decreasing.

Aiv PUGLIELLI: Okay. Thank you. How about the vaccination rates – are they increasing?

Zoe WAINER: The vaccination rates are stable currently, and as we move into the festival period, we ensure that we do increased communications about the importance and access avenues for mpox.

Aiv PUGLIELLI: Can I ask: is there still outreach and promotion to encourage people to get vaccination that is going on?

Zoe WAINER: Sorry. Could you repeat that?

Aiv PUGLIELLI: Promotion of – I have run out of time. I am so sorry.

The CHAIR: Sorry, Mr Puglielli. We are going to go to Mr Hilakari.

Mathew HILAKARI: Thank you, Secretary and officials for your attendance now into the afternoon. I thought I might start on budget paper 4, page 66, mental health infrastructure. There is a line in there that says 'Improving safety in mental health intensive care areas'. I know we have covered, somewhat, these areas in the hearing so far, but I am just hoping you can provide an update, Secretary, on the implementation of this initiative and talk through some of the consumer and staff safety elements that are involved in it.

Jenny ATTA: Thanks, Mr Hilakari. If I could just very quickly, with the indulgence of the Chair – just on the earlier evidence on urgent care clinics – for clarification, I just want to be clear that we have 20 Commonwealth-funded and nine state-funded urgent care clinics. On mental health –

Mathew HILAKARI: Can I say those urgent care clinics are excellent, by the way. My family has used those a number of times, as I know many people listening in would have too.

Jenny ATTA: I think gradually the community is really discovering them.

Mathew HILAKARI: Did the Commonwealth follow us in terms of funding those, or was it the other way round?

Jenny ATTA: I think we had to step in first, from memory.

Mathew HILAKARI: Indeed.

Jenny ATTA: Mental health infrastructure – the 2022–23 state budget provided $61.1 million to upgrade intensive care area beds and improve safety for vulnerable consumers, including enabling gender-based separations. These refurbishments form part of Victoria's broader mental health infrastructure modernisation and, importantly, align with royal commission recommendations, particularly recommendation 13, which in part calls for gender-based separation in high-dependency units. That has been a very important part of this program of upgrades. There are 24 acute mental health sites within the remit of the project. To date works have been completed on 17 of those sites, with the remaining seven sites to be completed by June 2026. Works have included reconfiguring bedrooms and ensuring access to ensuites, and there are some other important gender safety features – obviously the gender-based separation but also creating safer and more flexible layouts and enhancing visibility for staff to better monitor risks. I know Ms Radice is with us, who might be able to talk to which projects have been completed in 2024–25.

Priscilla RADICE: Certainly. Thank you, Secretary. We have completed the Royal Children's Hospital, acute adolescent; the Monash Health, Monash Medical Centre, acute adult; Monash Health, Kingston Centre, for the acute aged; Mercy Health Werribee, Mercy Hospital, mother and baby unit; Eastern Health, Maroondah Hospital, acute adult; Bendigo Health, Bendigo hospital, acute adult; Monash Health, Casey Hospital, acute adult; and Albury Wodonga at the Wangaratta hospital, again acute adult.

Mathew HILAKARI: Thank you. I might just take us to a different matter, which is the Mental Health Capital Renewal Fund, Secretary. I reference budget paper 3 from 2024–25, pages 54 and 57. I am just hoping you could outline what projects have occurred and where they are up to as well. It was great to hear that 17 of 24 projects, in the previous answer, are completed – over three-quarters of them. I am looking forward to hearing what is happening here.

Jenny ATTA: It has been a really important initiative, the Mental Health Capital Renewal Fund. In 2023–24 and 2024–25 funding of $20 million across those two years was provided through the Mental Health Capital Renewal Fund grants to health services to improve the quality and amenity of mental health and alcohol and other drug facilities across Victoria. The fund is really focused on improving the safety, quality and accessibility of mental health and alcohol and other drug services, and funded projects have included upgrades to inpatient and residential facilities, refurbishment of community-based services, modernisation of ageing infrastructure, enhancements for contemporary models of care and, importantly, technology or equipment improvements to support service delivery and consumer experience. The fund is upgrading, as I said, hospitals and mental health facilities to improve safety, accessibility and patient experience. Complementary funding for community mental health services expands local recovery-focused care, helping to shift treatment from inpatient to community settings. Together these investments are enabling the implementation of key priority reforms for government, improving care quality and creating trauma-informed, person-centred environments as envisaged by the royal commission.

Projects supported include $1 million to Monash Health's Doveton community care unit to remodel and refurbish bedrooms and bathrooms and to deliver a new consulting room and also the Austin Hospital's acute psychiatric unit – $1 million to renovate eight ensuites – while Northern Health will receive $994,000 for the refurbishment of the mental health inpatient ward. Additionally, the youth residential recovery program in St Albans has received more than $204,000 for safety upgrades and refurbishments, including bathroom renovations and replacements of other fixtures.

Mathew HILAKARI: While we are on YPARCs, I am just hoping you could talk about some of the new beds that we have in Heidelberg and Traralgon in particular and how they will help young Victorians

experiencing mental health challenges. I know they are such an important service for so many young people, so I am just hoping we could talk about those ones. They are from the 2024–25 budget on pages 46 and 52 of budget paper 3.

Jenny ATTA: Yes, certainly. I might see if Ms Anders could come once more to the table. While she is coming up to the table, the addition of the new youth prevention and recovery care, YPARC, beds in Heidelberg and Traralgon will expand access to community-based subacute mental health support for young Victorians. Further to our earlier discussion about service provision to children, to adolescents and young Victorians, all those three categories are important, and the YPARCs are very important for that younger youth cohort. The 2024–25 state budget provided $16 million over three years to open 10 beds at each of those sites in Heidelberg and Traralgon, and health services are currently finalising recruitment and model-of-care development work to support the opening of those services. There is also funding to deliver new and refreshed YPARC centres more broadly, and Ms Anders might talk to that.

Mathew HILAKARI: Ms Anders, I was hoping you might also cover off some of the services provided at YPARCS. Not everyone is familiar with their services, so I would love to hear a little bit of a flavour of that as well.

Pam ANDERS: Sure. They are a really important part of what is available for young people, because we do know that over 75 per cent of health issues begin before the age of 25. What the YPARC services provide is short-term recovery-focused treatment, care and support in a residential service. The cohort that it supports is between 16 and 25, and what it is about is providing a safe and almost home-like environment for young people so they can get the treatment, care and support they need but also, if they can, they can continue on with their everyday, day-to-day events, like if they are going to school or they are managing casual or part-time employment. They can use this as a point-in-time residential service where they have got around-the-clock treatment, care and support. They are voluntary, so young people can volunteer to come into these and access them, and they can get referred to them by a GP or by an area mental health service clinician. A young person can stay at a YPARC facility for up to 28 days, but we find the average stay is around about 19 days. Really it provides both clinical and wellbeing supports. It could be combining clinical treatment with psychosocial support, and it could extend to daily living skills or family involvement as well, just to try and build that longer term resilience to enable a really smooth transition for the young person to return to home.

Mathew HILAKARI: I am just going to take us now to a completely different topic, if that is okay, which is the public sector residential aged care facilities. Just before I get into the question, I want to give a shout-out to everyone, particularly the nurses, working in those facilities. Victoria has remained committed to public sector residential aged care in a way that other states have not, so I want to just thank them for all the work that they do. In terms of the facilities themselves, I know that Mr Tak next to me is particularly encouraged by the Boollam Boollam facility, which has been, I understand, maybe opened now, but it certainly was funded during the 2024–25 financial year. I am just hoping we can talk about where that is up to but also some of the other capital projects that are underway.

Jenny ATTA: Thanks, Mr Hilakari. I am just going to check whether Ms Bromley or Ms Radice is best placed to talk to that, so we will work that out that on the detail. Noting your comments about –

Mathew HILAKARI: The Boollam Boollam facilities in Kingston and the Rutherglen facilities are also of interest to me.

Jenny ATTA: All right. Terrific. I think Ms Radice is going to assist. I just make the point that I completely agree – amazing work is being done in those services. They are so important for Victoria in terms of ensuring, particularly in regional and rural Victoria and thin markets, that we do not have older people having to stay longer and for protracted periods of time in hospital, with better access to beds and the appropriate care in those services, as well as the important work in the metropolitan area. But I might hand to Ms Radice.

Priscilla RADICE: Sure. Our team are incredibly proud of that program. I have had the privilege of seeing a number of them, and they are very beautiful and truly residential; these are places that people are living in.

Mathew HILAKARI: People's homes, yes.

Priscilla RADICE: Those guidelines that Victoria has adopted in that infrastructure space ensure that we are delivering appropriate infrastructure in those spaces, so that program is tracking very well. Camperdown has been completed, Rutherglen has been completed, Mansfield will be completed in 2027 and is tracking, the Orbost facility will be complete in 2026 and the Cohuna facility is underway and forecast for completion in 2027, so they are all tracking along well. The Maffra facility – we have contract award now and we are mobilising onsite. The design and procurement is underway for the Numurkah facility, and construction is set to commence for that in early 2026. There have already been a brand new facility delivered at Kew as well, a 120-bed facility at Wantirna and the Cheltenham facility – 150 beds in Kingston. It is a large program of work right across the state and an area where I think Victoria does an incredible job, delivering residential aged care to the public.

Mathew HILAKARI: The Secretary mentioned thin markets in some of our regional areas. I know that as well as being a great employer in those communities, it is really important to keep people in their communities. It so meaningful –

Priscilla RADICE: Yes, care closer to home. When I was at Camperdown, there was actually a lady there who was getting her hair cut there at the facility, and she was just so chuffed, and her family were chuffed. It was very nice to have visited at that time. Regional areas do present workforce challenges, not only for health services, as you heard, but also for construction. It remains a challenge to ensure that we can get the specialist trades and workforce that we need into those regional areas. When you have a program of works something like the residential aged care, it can help us to package and sequence and for the market to prepare and understand when things are coming to market, but it does remain a challenge to get that labour construction workforce in the regions.

Mathew HILAKARI: Of course. Part of that construction work is some of the design features that are going into these new facilities. I am hoping you can talk to some of those design features that are being rolled out at the moment and how they will improve people's homes.

Priscilla RADICE: In terms of the residential aged care, we have taken the combination of guidelines, really listening to the community and the staff around what works and what people are looking for, both their family and clearly the residents – ensuring that couples can age together well in a facility, ensuring that there is appropriate gender separation and that the staff facilities are there and that there are places for their family and friends to come as well. I think more broadly, when we are thinking about design of health infrastructure, we are very focused on our role and standardising what can be standardised and not bespoking every single hospital build. That is an important part of our agenda to ensure that we are giving the best consistency and equity to our clinicians but also working with industry to streamline our approach for the things that can align to the Australian health facility guidelines and that we can roll out in terms of the big change around the internet of things. We have the building information technology, which we put in our BIMS (Building Information Model) in all of our buildings. They are able to then talk to the systems in these buildings. Frankston and Footscray, which are two major hospitals that are tracking towards their on-time opening early in 2026, are incredibly tech-intensive buildings that enable the health service to run them very efficiently and deliver operational savings over time as well.

Mathew HILAKARI: Thank you, Ms Radice. You have combined two of the things that I am going to talk about in the next question, which are older people and hospital discharge. In the questionnaire we had some responses on page 127 about the Commonwealth government and national cabinet decisions, and particularly the Commonwealth *Strengthening Medicare – Supporting Older Australians* funding agreement. I am just checking in about how this will go on to affect older people who are seeking to be discharged from hospital, and how this is going to address a well-known problem across the sector.

Jenny ATTA: Thanks, Mr Hilakari. I will just see if Ms Bromley might be able to assist with that. I just reinforce the point that it is a really significant issue at the hospital end, and we are certainly in discussions with the Commonwealth at the moment, as are other states and territories, on the growing significance of protracted periods in hospital for older people who are medically able to be discharged. That interface with the aged care sector is so important, so we really are pressing that point around what more is needed on the aged care side from the Commonwealth. Ms Bromley.

Naomi BROMLEY: Thank you. As the Secretary said, this is a huge area of focus at the moment. There has been quite a lot of public discourse on this, and this is not just a Victorian issue – many other jurisdictions are grappling with this as well, and I will come back to that in a moment. Both for aged care but also actually for people waiting for NDIS services this is also relevant. Essentially they have finished their medical treatment and their care at the hospital and they are ready to be discharged, but because they are waiting for a service that they need to go back to their home, back to their community or into a residential setting, they are stranded in hospital – that is the language that is used. In Victoria, because we have the public sector residential aged care sector and Victoria has a much bigger footprint in this space than other jurisdictions – I think it is just shy of 10 per cent of beds in Victoria that are public sector beds – this does actually help and assist with the flow. There are a couple of reasons for that. One is that the public sector facilities tend to be in those thin markets – so in rural and regional Victoria, where other jurisdictions really might have a desert, if you like, of residential facilities – and so that is incredibly useful. But it is not just locational; it is also the complexity of residents that PSRACS are in many ways better set up to support. For some of the more complex people are who are seeking a placement in a residential aged care facility, the private market might not necessarily be able to flex and accommodate them as well as the public sector is able to do, and that is because they are essentially set up to be able to do that. There are additional supports, the staff ratios are often more favourable, and they are very –

Mathew HILAKARI: I just want to ask about that. We have obviously got nurse-led care in the public sector aged care facilities, and nurse-to-resident ratios have been in place for some time. Is the private sector anywhere near catching up with that wonderful care? I just want to shout out to the ANMF and their wonderful support in bringing that policy forward.

The CHAIR: Thank you, Mr Hilakari, but we are out of time. Secretary, officials, thank you very much for appearing before the committee today. The committee will follow up on any questions taken on notice in writing and, Secretary, responses are required within five working days of the committee's request.

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

I declare this hearing adjourned.

Witnesses withdrew.