STANDING COMMITTEE ON ESTIMATES AND FINANCIAL OPERATIONS

2020–21 ANNUAL REPORT HEARINGS

TRANSCRIPT OF EVIDENCE
TAKEN AT PERTH
WEDNESDAY, 23 MARCH 2022

SESSION ONE
DEPARTMENT OF HEALTH AND
NORTH METROPOLITAN HEALTH SERVICE

Members
Hon Peter Collier (Chair)
Hon Samantha Rowe (Deputy Chair)
Hon Jackie Jarvis
Hon Nick Goiran
Hon Dr Brad Pettitt

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Hearing commenced at 10.38 am

Hon SUE ELLERY
Minister representing the Minister for Health, examined:

Dr DAVID RUSSELL-WEISZ
Director General, examined:

Dr ANDREW ROBERTSON
WA Chief Health Officer, examined:

Mr ROBERT ANDERSON
Assistant Director General, Purchasing and System Performance, examined:

Mr ANTHONY DOLAN
Acting Chief Executive, North Metropolitan Health Service, examined:

Mr JORDAN KELLY
Executive Director, North Metropolitan Health Service, examined:

The CHAIR: Thanks very much for coming, everyone. On behalf of the committee, I would like to welcome you to the hearing. The committee acknowledges and honours the traditional owners of the ancestral lands on which we meet today, the Whadjuk Noongar people, and pays its respects to their elders, both past and present.

[Witnesses introduced.]

The CHAIR: You will have signed a document entitled "Information for Witnesses". Have you read and understood the document?

The WITNESSES: Yes.

The CHAIR: These proceedings are being recorded by Hansard. A transcript of your evidence will be provided to you after the hearing. To assist the committee and Hansard, please quote the full title of any document you refer to during the course of this hearing for the record. Please be aware of the microphones and try to talk into them. Ensure that you do not cover the microphones with papers or make noise near them. If you make adverse allegations during the evidence, the committee may release that information to allow the other party a chance to respond. Please try to speak in turn. That is it. Do you have any opening statement, minister?

Hon SUE ELLERY: No, I do not. I do not know, chair—perhaps you could guide us on how you want to do this because we have two annual reports.

The CHAIR: We have.

Hon SUE ELLERY: I do not know if you have thought about how you want to do it.

The CHAIR: What if we try with the annual report from the department first. Are you happy with that?

Hon SUE ELLERY: Okay

The CHAIR: Then we will go to the north metro. I will introduce the committee first: Hon Jackie Jarvis, Hon Samantha Rowe, Hon Nick Goiran, Hon Dr Brad Pettitt and Hon Martin Aldridge. The first five are the committee—we are the important ones—and Marty is the interloper who has come in from the Council.

Hon NICK GOIRAN: The Chair of Committees.

The CHAIR: The Chair of Committees, of course! Andrew Hawkes is from the committee. I have just a couple of questions. First of all, can we go to page 30 with regard to the impact of COVID-19 on Health. What is the proportion of elective surgery that is actually undertaken in private hospitals? Do we have any answer to that?

Hon SUE ELLERY: Are you able to answer that one?

Dr RUSSELL-WEISZ: Yes, I think so. Is the question how much public elective surgery is undertaken in private hospitals?

The CHAIR: Yes.

Dr RUSSELL-WEISZ: It is very little in this state. Occasionally, we do purchase specific public elective surgery from private hospitals but it is usually on an ad hoc basis. There are other states that do procure quite a lot of elective surgery from private hospitals, such as Queensland. We do so when we need to but the majority of public elective surgery is in public hospitals. Just to check I am absolutely right, I might ask Mr Anderson to comment.

Mr ANDERSON: That is correct. We do, from time to time, enter into contracts with private hospitals, particularly when we are doing something like an elective surgery blitz, for example, to catch up on activity. We have not done that for a while but we have other contracts with private operators for specific services but generally it is a capacity thing. We do not have standard elective surgery in private hospitals.

The CHAIR: You can take your mask off if you like. What is the criteria to determine whether a public patient has elective surgery at a private hospital?

Hon SUE ELLERY: It is more about the purchasing really, as I understand it. It is not about making a decision patient by patient. I do not know if the director general can add any more to that. I understand that we can take our masks off. We are very close and I do not feel comfortable taking my mask off, so I am not going to.

The CHAIR: That is fine.

Dr RUSSELL-WEISZ: I will follow the minister on that. With the private, what determines it, if a patient comes in as an emergency, does not need an operation immediately and has private health insurance and wants to move to a private hospital, then we will facilitate that. That would happen on a reasonably regular basis if they come in during the night and they actually have private health insurance and they want to be transferred. That does happen. What would determine it? It might be that we want to clear a proportion of say gastroscopies or colonoscopies or those diagnostic procedures. We might purchase it off a private hospital but, chair, it is very rare. We basically try to do our own and, even when we have an elective surgery blitz, we obviously do that and we try to do our own as well. We try to do that blitz in the public sector. It has been like that for years and for one very good reason is that the private sector here in WA is very busy and does not have a lot of capacity.

The CHAIR: Thank you. I have a few more on that but I might come back to that one. On page 4 of the annual report, “Response to outbreaks” and COVID, with regard to the RATs, which of course we are all familiar with now, when were the RATs ordered?

Hon SUE ELLERY: Chair, I think government has made statements already that it was in early December. I am going to try to be as helpful as I possibly can to the committee. You would appreciate that we have been invited to assist the committee in consideration of the annual report and that the annual report is for a reporting period. While I will try and be as helpful as I possibly can and make sure that the officers are able to assist you, government has answered that question a number of times and I have nothing further to add on that.

The CHAIR: Okay, can I just explain something with regard to the format of the annual report hearings. The annual report hearings, of course, are confined to a particular period in time but they do have an impact. Decisions that are made through the annual report have an impact and this is very clearly one of those instances where a decision with regard to RATs or any decisions with regard to COVID are going to have an ongoing impact. In that instance then, it cannot have been a decision that was just made in December. There must have been some preliminary discussions with regard to RATs. When did that commence?

Hon SUE ELLERY: I appreciate your line of questioning. Government has provided an answer to that on a number of occasions and I have nothing further to add to that.

The CHAIR: So what is the answer—what is the government's answer?

Hon SUE ELLERY: It was early December. That has been said publicly a number of times.

Hon NICK GOIRAN: On what date?

Hon SUE ELLERY: I have answered the question.

The CHAIR: It was early December.

Hon SUE ELLERY: Correct.

The CHAIR: Did they come from South Korea?

Hon SUE ELLERY: Somebody can probably assist me with that.

Dr RUSSELL-WEISZ: I cannot answer exactly where they came from but there were a number of different suppliers and we do it through PathWest who will order the appropriate RAT because it has to be rapid antigen and it has to be TGA approved. There are a number of different ones that we ordered at the time.

The CHAIR: Do you have a list or any more details on where the RATs came from?

Hon SUE ELLERY: I probably cannot add any more than that if the director general cannot. He obviously referred to PathWest so it might be that the committee considers—we could take it on notice. PathWest is not here so we could consider if we could do that.
[*Supplementary Information No A1.*]

The CHAIR: I am conscious of the fact that we have a number here today and I have a pile of questions but I will give someone else a bat.

Hon JACKIE JARVIS: When we last met with Health back in June, we discussed some ongoing recruitment drives. I notice in "Significant issues" in the annual report it was noted that COVID has hindered efforts to attract staff from outside WA. I am wondering if you have any follow-on from what we discussed in June about what we are doing around recruitment. I am also interested in whether there has been the capacity to give exemptions for people to come into Western Australia if they are working in the health sector?

Hon SUE ELLERY: Yes. I might be able to get both the director general and north metro to talk about that because recruitment obviously occurred in both. There was a general campaign of TV and print advertising to recruit health workers. Bear in mind that, all around the world, health systems are

keenly trying to recruit additional health staff. Certainly, over the year January 2021 to 2022, I have numbers about the health workforce increasing by 1 018 FTE in nursing and midwifery, 423.9 FTE in allied health and health science professionals, and 129 FTE in the medical workforce. The Chief Health Officer provided I think in excess of 700 exemptions for health workers in 2022. If I can start perhaps with the director general and then we might go to north metro if that is helpful, chair?

[10.50 am]

Dr RUSSELL-WEISZ: Thank you, minister. As the minister said, there has been an increase in the numbers the minister has just said in relation to nursing, allied health and medical. Obviously, it has been one of the issues that has affected all jurisdictions in Australia. It has also affected all jurisdictions in the world. There are shortages in the UK, all over Europe and in Australia. We have had particular shortages in theatre nurses, midwives and also in some of our WA country areas, which we have put a huge amount of effort into recruiting. Where we have been able to recruit from over east or overseas, exemptions, safely, have been put in by the Chief Health Officer. The chief executives and the health service providers work very closely with the Chief Health Officers to make sure we do attract those people who can get in.

We have had a concerted campaign over the last year, basically with a huge focus on nurses and midwives. We are looking to recruit from all over the world. We are looking to recruit nationally and we have seen that increase. We have also had graduate initiatives. There was a ministerial election commitment to recruit an additional 200 newly qualified registered nurses and midwives, and also an additional 200 enrolled nurses. Health service providers have made 885 offers of employment from the GradConnect's most recent intake and are actually providing further offers after that. We have many more graduates across the system, which will play out very well in the years to come. The private hospitals, our PPP partners and the aged-care sector are also looking at workforce as well. We are obviously working with them because we want them to remain viable and they have their own challenges, as you would know from the aged-care royal commission.

The eligibility for GradConnect has been expanded to include international students who have studied at an Australian education provider and those who have completed their studies within the last two years and have not previously undertaken a graduate program. As the minister said, there is the Belong campaign, which was launched on 22 October. We have had 11 883 web hits with 227 applications. The WA Health YouTube site has had nearly 1.5 million views and the search page nearly 1.2 million views. The other thing is a return to practice. The refresher program was launched in mid-August 2021. As at 11 February, 56 eligible applications had been received for the refresher programs and that is a mixture of RNs, ENs and midwives as well. The mental health workforce is a significant focus for us as well. Between December 2021 and January 2022, there were 177 mental health appointments: 102 medical, 34 allied health and 41 nursing. The dedicated mental health "Make a difference in mental health" recruitment campaign was launched in September 2021. We have also had a focus on allied health and health professions workforce, and also on the medical workforce as well. I am not saying that we have cracked this nut—we have not and no system has. We are seeing what happened over east with COVID in relation to the furlough of staff and also the pressures on private, public, aged-care and community sectors. The health service providers continue to recruit. We continue to try and attract from overseas and we will continue to do that through this year and, obviously attracting more graduates into the workforce.

Hon SUE ELLERY: I might get Tony from north metro to talk about that.

Hon JACKIE JARVIS: The north metro one, specifically I was interested in your secession planning framework that you implemented, and how that ties into your recruitment.

Mr DOLAN: Thank you, minister. To add to what the director general said, the Belong campaign has been very useful in regards to a process of how we can assess applicants. From a north metro viewpoint, as the director general said, nursing and midwifery is our highest issue at the moment with the most vacancies. We have been fortunate that we are very attractive for graduate midwives to come and work within north metro, particularly with a focus on King Edward Memorial Hospital and we have taken an additional 30 to 35 graduates this year that started last month. That has been fantastic. The other focus we are looking at is part of what the minister mentioned—the career pathway. That is not just about how we get volume but how we set a pathway for our staff to stay with us along that journey. Part of the graduate programs is about transition to practice and getting them comfortable with the practice and then looking at second, third and fourth year how we can provide a variety of experiences within that specialty. As an example, the director general mentioned mental health. We look at mental health and in that we look at inpatients, community mental health, domiciliary—home visiting services and forensics and give them an opportunity for the staff to rotate around that to get a different exposure with the view that we would hope to keep them within mental health for a longer period of time.

The succession planning framework is really looking at about how we encourage the promotional opportunities within the health service. We are looking at it from a middle management viewpoint. That is about creating a pathway of how people can get additional exposure to other opportunities that come up through supernumerary times. As an example, I have two staff that work with me for periods of time to get an exposure to the role of the chief executive. We then, through their annual performance development, set objectives that those individuals can meet to get those opportunities. It is a framework. It is available across all employees within north metro. We are just completing the executive development succession planning framework as well for those wishing to move into an executive role.

Hon SAMANTHA ROWE: The WA health system has experienced unprecedented demand and pressure, especially over the last 12 months. I am referencing page 2 of the Department of Health's annual report under "Significant issues". I suppose it is for the Department of Health and for the north metro health service. What are you doing to invest in system capacity to handle this record demand?

Hon SUE ELLERY: I might get the director general to make some comments about that. I guess I would just make a couple points. A perennial problem that states have had in Australia in managing their health systems has been those patients who come into the state-run public hospitals and then, because they need aged-care placements, stay much longer than they need clinically to stay in hospital because they cannot be found a place. That has long been a point of contention between state governments and the commonwealth government. It remains a point of contention now and is a significant issue that the states have to manage beyond the point which really that patient should be the clinical responsibility of the state. That is one of the pressures. I will ask the director general perhaps to make some comments about that.

Dr RUSSELL-WEISZ: Thank you, minister. Yes, there has been a trend of not only increasing demand coming through our front door but also increasing patient acuity. The types of patients have increasing complexity. Quite staggeringly—this is not just in WA—in triage ones, the sickest patients, we have seen nearly a 14 per cent change over three years; in triage twos, nearly 19 per cent; triage threes, nearly 16 per cent; and actually a reduction in triage fours and fives. Obviously, if you are seeing sicker patients coming in and ambulances have increased by about 36 per cent over that period, you are seeing much sicker patients, they need much greater care in the emergency department and actually greater care on the wards. We formed an emergency access response program. We have always had a very diligent emergency demand response program in relation to

how we address this emergency demand. We were the leaders in the four-hour rule; we still are. We are still the best performing state in the four-hour rule performance, looking at every state. We have seen some drop-off in performance, like every state has during COVID. It would not be realistic to think there would not be.

[11.00 am]

Where we have focused on is—I will come to that in a minute—the beds, but also just to pick up on the minister, what the minister said was on long stay. With long stay, 130—sometimes much greater than that—patients in our hospitals are highly complex. Staff have to navigate multiple bureaucracies, potentially at a commonwealth level, NDIS, and also a state level where they might have an NDIS package, they might have a community package, they might need a bit of housing, or they might need support for housing. So we put together a long-stay committee. That long-stay committee was not just to oversee what was being done, but to roll their sleeves up and look at individual patients and work with the health service. For example, Graylands, one of the hospitals that Tony runs, has got many long-stay patients who might need housing; they might need an NDIS package. These things are quite difficult to navigate. We actually have seen a reduction, but as soon as you have a reduction, then you see an increase in those long-stay patients.

One of the major focuses for ED to mind—I think people do look at the front door always, but actually the front door would work better if the back door—if patient flow was better through the hospital.

Hon SAMANTHA ROWE: Moving more quickly.

Dr RUSSELL-WEISZ: Our focus the last year, it will be this year, it will be next year, I think it will be in two or three years' time. I can tell you from my other colleagues in other states, we are working with the commonwealth and NDIS to say, "How do we make this easier? How do we actually, bar individually looking after every patient?" We have put additional social work in and other services in for long stay. We have actually put additional capacity in, so we have put additional beds in, and that goes along with the workforce as well. The government announced two packages of beds—332 and 270. I think that that takes us up to about 530. We have made good progress on those. Out of the 332, we currently have 212 open. I will not go through all of those, but as an example, we said we would open eight beds at Perth Children's. Eight beds are open. We said we would open 36 beds at Royal Perth. Thirty-six are open as part of that. Just as an example, on the beds to come online, there are 24 at Sir Charles Gairdner that were due to come online later this year. They are still due to come online. We expect those 332 beds to come online. There were 40 mental health beds at an Aegis facility in East Victoria Park, which will be a huge boost to the system. There were 270 beds announced mid–last year and out of the 270 beds, already 73 are open. Some are what we would call the modular beds at some of our other sites and they are coming online.

There is a huge focus on capacity, but it is really on three things: it is on capacity, it is on workforce and it is on long stay. There is also the other end—the prevention, working with St John Ambulance, working with GPs, who are also busy. They were busy pre-COVID. We are planning. People talk about post-COVID. I am not sure there is a post-COVID. Whatever the new normal is, after that, there will be additional pressures on every health system in the world in relation to mental health, in relation to long COVID and in relation to bed capacity and workforce, and that is why the focus is on all three.

Hon SAMANTHA ROWE: Is the increase in bed numbers going to then, in your view, have an impact on the pressure on our emergency departments?

Dr RUSSELL-WEISZ: Yes.

Hon SAMANTHA ROWE: Is that going to ease some of the pressure there?

Dr RUSSELL-WEISZ: It will. It takes time to come through. Obviously, if the increases still continue coming through with the ambulances and coming into our emergency departments, our emergency departments have to be ready. We have noticed an increase of mental health patients in emergency departments who are taking up longer time. That is not a criticism of the patient; the patient needs to be there. But, obviously, I have talked about the back end in some of our hospitals, so focusing on mental health will be critical in the months to come. I think it absolutely will, but it is not the whole story, because for beds, as I am sure Tony will say, you need staffing and for this staffing, we have a huge focus. We gave the area health services approval to recruit those staff—getting ready for those beds. We also know that a lot of our staff have done a tremendous job in the last two years and they are doing a great job at the moment. They will need to take some leave. They will need to have some downtime and therefore we need other staff to come in and relieve them. But Tony may have some other thoughts.

Hon SUE ELLERY: I do not know, chair; I am in your hands. I am just conscious of time and there are other members who want to ask questions.

The CHAIR: I just have a quick one before I pass on to Nick. Just with regards to the elective surgery, what is the proportion of elective surgery in terms of the total surgery figures—elective as opposed to non-elective?

Dr RUSSELL-WEISZ: I would have to take that on notice. We have elective surgery and we have emergency. We can give you that, but in the elective, there are two components of it. They are very clunky words; one is called "reportable" and one is called "non-reportable". It is how the commonwealth judges it. The non-reportable are all our "oscopies"—our gastroscopies, colonoscopies. They are all the diagnostic procedures. They are short and sharp but critical because they diagnose cancers and all sorts of things. Then there are the reportables, which are the category 1s, 2s and 3s—hip replacement, joint replacement, cardiac surgery. We can probably get you a proportion of all of that—how much is emergency versus elective.

The CHAIR: That would be excellent.

I am not sure what the level of information that you have is with regard to the private sector as well—the private hospitals.

Dr RUSSELL-WEISZ: We do not have much. We could ask them what is their proportion of emergency come elective, although emergency is small and there are only a couple with emergency departments.

Mr ANDERSON: Are you talking about private work in privates or the public work in privates?

The CHAIR: Private work in privates.

Hon SUE ELLERY: I think it is worth noting that they can ask, but it does not mean that the private sector will choose to provide.

The CHAIR: Thank you for that.
[*Supplementary Information No A2.*]

Hon NICK GOIRAN: Minister, if I can draw your attention to page 4 of the Department of Health's annual report under the heading "Response to outbreaks", where it says —

> Agile public health advice to the State Government from the Chief Health Officer enabled us to successfully 'ring fence' outbreaks in the Perth and Peel regions, giving contact tracers valuable time to identify all close and casual contacts, isolate cases, allow time for rapid and extensive community testing, and ultimately, eliminate the virus in the community.

I also note it says —

> Throughout the last year, Western Australia has responded swiftly to COVID-19 outbreaks which threatened the health and wellbeing of our community.

Can you inform the committee on how many occasions public health state of emergency declarations were made during the reporting period?

Hon SUE ELLERY: I might have actually provided that to the house in a PQ, I think, in the last week. I can check if the Chief Health Officer would have the number here, but I do not know that he would. So it might be something we have to take on notice as to the actual number so that we get it right. Would you have that?

Dr ROBERTSON: We can get it, minister. I do not have it with me.

Hon SUE ELLERY: We will take that on notice.
[*Supplementary Information No A3.*]

Hon NICK GOIRAN: Without being precise, is it fair to say that there were multiple declarations made during the reporting period?

Hon SUE ELLERY: I think that is accurate.

Dr ROBERTSON: Yes. They were made in accordance with the act, which is every two weeks.

Hon NICK GOIRAN: Thank you. You have taken that on notice and will provide the information. When you provide that information through the minister, can we also be provided information as to how many public health state of emergency declarations have been made since the reporting period?

Hon SUE ELLERY: Yes, again, I think I answered a question in the house in the last week about that, but for that precise period, we will take that on notice.

Hon NICK GOIRAN: Can we have a separate number for that please, chair?
[*Supplementary Information No A4.*]

Hon NICK GOIRAN: Minister, through you, on how many occasions were such declarations made based on the advice of the Chief Health Officer?

Dr ROBERTSON: Every one of them was made on either my advice or the acting Chief Health Officer's advice. There were a small number of occasions when I was on leave, so the acting Chief Health Officer would have made that advice.

Hon NICK GOIRAN: Would you be able to take on notice how many occasions the advice was provided by the Chief Health Officer and on how many occasions it was provided by the acting Chief Health Officer?

Dr ROBERTSON: Yes.

The CHAIR: Again, that is A4.

Hon NICK GOIRAN: Minister, through you, is that advice able to be tabled?

Hon SUE ELLERY: I think all the public advice—I will ask the Chief Health Officer.

Dr ROBERTSON: That advice was provided to the minister. I think there have been previous requests for that advice. At the moment, I am not aware that the minister has released that advice.

[11.10 am]

Hon SUE ELLERY: If you express your question as succinctly as you want it, the best that I can do is to give you an undertaking I will raise that with the minister. She will make the decision about how she chooses to answer that.

Hon NICK GOIRAN: Before a number is given to it, in response to the minister's request for a precise question, my question is: with respect to all the occasions where declarations for a public health state of emergency were based on either the advice of the Chief Health Officer or the Acting Chief Health Officer, will that advice be tabled?

Hon SUE ELLERY: I will place on the record: I will give an undertaking to raise that with the minister. I am not giving you a guarantee to provide it.
[*Supplementary Information No A5.*]

Hon NICK GOIRAN: Minister, did the Chief Health Officer also provide any advice with respect to state of emergency declarations as distinct from public health state of emergency declarations?

Hon SUE ELLERY: I think this has been canvassed publicly before. The state of emergency is the one that is renewed fortnightly.

Hon NICK GOIRAN: They are both done fortnightly.

Hon SUE ELLERY: But by a different minister.

Hon NICK GOIRAN: That is correct.

Hon SUE ELLERY: My understanding is that the Minister for Emergency Services is briefed directly by the State Emergency Coordinator, who is also police commissioner Dawson. The State Emergency Coordinator is in frequent discussions with the Chief Health Officer. I am not sure, Andy, whether you can add anything to that.

Dr ROBERTSON: I can, minister. On all occasions the State Emergency Coordinator has requested advice from me as to whether I would support an extension of the Emergency Management Act state of emergency. So either myself or the Acting Chief Health Officer has provided advice back to the State Emergency Coordinator on all occasions and he has obviously provided that advice to the Minister for Emergency Services.

Hon NICK GOIRAN: That advice from you is separate to the advice that we were referring to earlier?

Dr ROBERTSON: That is correct.

Hon NICK GOIRAN: Minister—this will evidently need to be taken on notice—can we find out on how many occasions the Chief Health Officer provided such advice? I will wait for a number for that first.
[*Supplementary Information No A6.*]

Dr ROBERTSON: It was provided fortnightly, so we can obviously work out how many were done during this period, but also in total.

Hon NICK GOIRAN: Further to that, whether that advice can be tabled.

Hon SUE ELLERY: I am in a bit of a tricky position here, because I am not here representing the Minister for Emergency Services, which is where that advice goes. You can ask me, but I am not sure that, sitting here right now, I am in the position to provide an answer on behalf of a minister I am not representing.

Hon NICK GOIRAN: No; and I am not asking for that advice. I am asking for the advice that was provided by the Chief Health Officer. I appreciate it might be distributed to more than one person, including the minister who you do not represent, but the question that is being taken on notice is whether the advice the Chief Health Officer has written, provided, can be tabled. I appreciate that requires some consideration by government.

Hon SUE ELLERY: It does require consideration by government, so I give you an undertaking the government will consider it; I do not give you an undertaking that I can provide it.

Hon NICK GOIRAN: Understood.
[*Supplementary Information No A7.*]

Hon NICK GOIRAN: Minister, during the reporting period did the Chief Health Officer provide advice to any other government department other than Health, the Department of the Premier and Cabinet, and the emergency services coordinator?

Hon SUE ELLERY: I can say yes, wearing my other hat as the Minister for Education and Training. I will allow the Chief Health Officer to elaborate. But if I give you the examples that I am familiar with, when an agency is trying to make sure that the guidelines, if you like, or the instructions they provide to their various business units, be it schools or whatever, they may well ask the Chief Health Officer for advice on how that particular framework advice should be operationalised in a school setting, on a train station, wherever. I will ask the Chief Health Officer.

Hon NICK GOIRAN: Before you do that, minister, I do not need any elaboration on that. Your answer is more than adequate, because the answer was yes. But if you could take on notice the number of occasions where such advice —

Hon SUE ELLERY: No; I cannot. I will not. Honestly, I can appreciate what you might be seeking, but the volume of that —

Hon NICK GOIRAN: Would be too much?

Hon SUE ELLERY: It would be huge.

Hon NICK GOIRAN: I am happy to withdraw that, but thank you for the clarification. Would it be possible to at least get the advice that was provided by the Chief Health Officer to Tourism WA?

Hon SUE ELLERY: I can take that on notice and government can consider whether or not we will provide that advice.
[*Supplementary Information No A8.*]

Hon Dr BRAD PETTITT: Mine is a little bit of a different tack. It starts with some of the figures on page 88 of the North Metropolitan Health Service. The question I am going to go to is around energy costs and those kinds of things. The context of this is when we met with south metro health, I understand that they report through the national greenhouse energy reporting scheme. But my reading of it, through this annual report, is that north metro looks like a bigger consumer of electricity and a bigger greenhouse gas emitter as a result, but it does not report through that scheme. I was wondering why was that. That is one question. What is captured on page 88, is that an accurate representation?

Hon SUE ELLERY: Which bit are you looking at on page 88, honourable member?

Hon Dr BRAD PETTITT: I am looking at the energy costs—I assume they are the energy costs, under "Patient support services", where it talks about "Fuel, light and power".

Hon SUE ELLERY: Okay; thank you.

Hon Dr BRAD PETTITT: It has "Other supplies and services". That is actually part of my question there because I am not sure. Is that an accurate representation of the total energy costs for the health services in the north metro region? It was not quite clear trying to find it through this. Then I am interested in what kind of plans there are for reducing those costs.

Hon SUE ELLERY: I will ask Tony if he can make some comments on that. If we cannot provide an answer today, maybe that is something we can take on notice.

Mr DOLAN: I will come back to you around the specifics in regard to whether they are total energy. I am convinced that the information within that is inclusive of north metro around that.

In regard to energy, we are just looking at lots of options at the moment within the health service around sustainability for the future. Part of that is looking at our government fleet and conversion of government fleet from hybrid to electric. We are looking at different options around how we can look at our workforce taking some accountability for that. That is energy consumption around making sure lights are off, PCs are turned off at the end of the day. This is a very enthusiastic committee within north metro over the last 12 months—that sustainability is extremely important to the staff. We are running that through small groups at each of the local sites, and that rolls up into a north metro committee. There are a lot of pledges at the moment. We have a campaign there at the moment asking our staff to pledge what they would be working on over the coming months around how to support sustainability as a health service. We have had awards that have been won through theatre around the wrapping of theatre instruments, and they have won some national awards around the efficiencies that they have done around making sure that we are actually doing it in a sustainable way. It is a focus of the health service, but we are pledging our staff to really participate in it and really are allowing some of our lead clinicians to lead some of this in the local area. I can provide specifics around the energy consumption if that is what you want.

[11.20 am]

The CHAIR: Did you want to take that on notice?

Hon Dr BRAD PETTITT: If you do not mind. The question is: what are the total energy costs? There is another question I asked, too, which is probably a technical one around the reporting through the national greenhouse —

The CHAIR: So are we clear on what we need?

Hon SUE ELLERY: I am not, but let us get it on *Hansard* so that everybody is.

Hon Dr BRAD PETTITT: There is a question around, one: Why does North Metropolitan Health Service not report through that scheme? I think it is something to do with the Corporations Act, but I am kind of interested because —

The CHAIR: Can we just keep it to exactly what you want?

Hon Dr BRAD PETTITT: Sorry. The question is: does the North Metropolitan Health Service report through the national greenhouse and energy reporting scheme; and, if not, why not?
[*Supplementary Information No A9.*]

Hon Dr BRAD PETTITT: What are the total energy costs of the North Metropolitan Health Service? Are they what is printed on page 88?

The CHAIR: Yes, over a period of time?

Hon Dr BRAD PETTITT: Over the annual reporting period.
[*Supplementary Information No A10.*]

Hon SUE ELLERY: Chair, it might be helpful to the honourable member, in the Department of Health's annual report is reference to the Climate Health WA inquiry. I might just get the director general to make some comments on that because that set out a 10-year plan.

Dr RUSSELL-WEISZ: Basically, this was part of the sustainable health review that was released by the government in 2019 and it is on page 27 under "Strategy 1 — Commit and collaborate to address major public health issues". This was a Climate Health WA inquiry under the auspices of the Chief Health Officer, but was conducted by Professor Tarun Weeramanthri. That set out a blueprint, a bit like that we have on a digital strategy, but on a sustainable health strategy in relation to climate change and how to better protect the health of the community. The first thing that we wanted to do on that was to set up a sustainable development unit, which we have done. It is in its very early

stages. I would have liked to have set it up probably six months earlier, but COVID slowed us down slightly.

We have seen a quantum change over the last five years with some really passionate clinicians—I mean, doctors, nurses and allied health professionals—in the health services who really are passionate about this and want to make a difference and are leaders. We have actually had people stand up and lead the whole approach to reducing our environmental footprint. Health are an emitter and, therefore, anything we can do, we should be doing as a system. Through the sustainable development unit, we hope to lead that and steward it, but we also want to allow health services to innovate, and health services have different parts to their journey.

We have actually got a very good blueprint from the climate change inquiry and we will probably be able to report on that more in the next 12 months about the inroads that we are making. But we are encouraging all health services—not just north metro health service—to take a lead on this and be the best corporate citizens they can be environmentally.

Hon Dr BRAD PETTITT: That actually answers my question.

Dr RUSSELL-WEISZ: Are you sure?

Hon Dr BRAD PETTITT: Yes, thank you.

Hon MARTIN ALDRIDGE: I would like to start asking some questions —

The CHAIR: We still have that one question, though, the first one, on the —

Dr RUSSELL-WEISZ: Yes.

Hon MARTIN ALDRIDGE: Can I ask some questions at page 29 of the annual report in relation to responding to COVID-19 using digital technology and particularly the way in which digital technology has enabled efficient contact tracing? During the reporting period, there was a lot of investment in developing our contact tracing capability. I know that that was deployed on a number of occasions to assist other states and territories in Australia because at the time we had very little community transmission of the disease. What is the level of contact tracing capability that was developed and how does that compare to currently?

Hon SUE ELLERY: I will ask the director general to start and then maybe the Chief Health Officer can add to that.

Dr RUSSELL-WEISZ: To start with, if you go back two years, we started with the Public Health Emergency Operations Centre and then the State Health Incident Coordination Centre. SHICC has just had its second birthday. It has been in place now for two years. We never thought this would go for two years, but we still have to have that there. Contact tracing is a critical element of our public health response. We started with a small public health team that we grew over time. Over the last six months, we have grown that contact tracing team quite significantly. It is not all around about contact tracing officers, but we have around 200 FTE. If you want exactly how many FTE and staff we have working in the team today, and where it was, I could provide that on notice, but we have grown it. As the member has said, we have actually responded to other states. We have a contact tracing team that has surveillance officers and we have other parts of the team. We have a complex care team. When you have a patient with COVID that has some complex needs—they might be social needs, they might be health needs—they look after those needs as well. You would be aware that when we get to a level of community spread that contact tracing does fall off. The efficacy of contact tracing does throughout the world, and therefore we concentrate on certain elements of not only high-risk venues but high-risk cohorts.

At this stage, we are not reducing our contact tracing. I should also say that we have trained other people from the Department of Health—I think between 80 and 100 other people—who then can be redeployed into contact tracing throughout the public sector through other departments. We have trained staff in other departments who have been deployed into being contact tracers at times of need. That is exactly where we are at the moment. But I might ask —

The CHAIR: Did you want the response to that question—the numbers?

Hon MARTIN ALDRIDGE: Yes, that would be good if we can get some precise numbers.
[*Supplementary Information No A11.*]

Dr RUSSELL-WEISZ: In relation to how many we have had?

The CHAIR: Yes.

Dr RUSSELL-WEISZ: How many we had in this reporting period and then maybe today?

The CHAIR: Yes.

Hon SUE ELLERY: I will ask the Chief Health Officer to make some comments in a minute, but I think that thing about being public sector–wide is worth noting as well. All agencies with asked to identify people that they could put into that system to be trained in the event that it needed to be scaled up. But I will ask the Chief Health Officer to make some comments.

Dr ROBERTSON: Thank you, minister. I think part of the question the honourable member was asking was around how we were using data in that sense. We developed the PHEOC system, which is the public health system. That enables us to obviously bring in all of the cases, rapidly identify their contacts and to also use other sources, including QR code data, and to then identify—at that stage, we were still identifying close and casual contacts. During this period, it was used extensively to identify the people who were either close contacts because of family or close social contacts in high-risk venues. That enabled us, as outlined in the response earlier, to rapidly get on top of those Alpha and Delta outbreaks.

Hon MARTIN ALDRIDGE: Dr Robertson, just on this point, I think to 8.00 last night we recorded nearly eight and a half thousand new active cases and we have somewhere between 200 and 300 contact tracers, if you include all of the public sector surge capacity. Have we not already outstripped our contact tracing capability?

Dr ROBERTSON: We knew that with our TTIQ—testing, tracing, isolation and quarantine—that we would initially start early on, as we did through February, and we would be able to identify almost all contacts. That managed to supress the Omicron outbreak through the end of January to the beginning of February. But we knew that it would get to a stage where the contacts—and we have obviously changed the definition for close contacts—would need to be changed and that we would need to focus primarily on household and high-risk settings. That is basically what we are doing with those 200 or so people each day. They are actually targeting the high-risk settings, whether that is schools, prisons, residential aged-care facilities or remote Aboriginal communities. That is where the target has moved to. Obviously, we have moved away from identifying every venue that somebody has attended. That was always part of the plan because we knew that no system can actually do that once you start getting up to these kinds of numbers.

Hon MARTIN ALDRIDGE: Sure, and I think that was reflected in the answer that the Leader of the House gave to the Council yesterday with respect to the positive cases having an obligation now to do their own contact tracing, except for those high-risk settings. If I can come back to this digital technology and the SafeWA app, as well as the physical registers, what utility do they now provide, given this shift in contact tracing?

Hon SUE ELLERY: I will ask Dr Robertson to make some comments. It is around high-risk venues in particular. That is, as I understand it—that is the value of them—but I will ask Dr Robertson to make some comments.

[11.30 am]

Dr ROBERTSON: They still have some utility in identifying people who may have been in high-risk settings, whether that is into residential aged-care facilities, hospitals and those kinds of settings where we may want to identify people we cannot identify by other means. They have less utility now for venues and other settings.

Hon MARTIN ALDRIDGE: My personal observation is that I am the only one who is doing the SafeWA sign-in when I walk through the door.

Hon SUE ELLERY: No, it is you and me!

Hon MARTIN ALDRIDGE: So I do wonder whether or not, particularly given the change in family case numbers, our limits on contact tracing, the shift, which I understand, whether the directions need to be amended to reflect those high-risk settings and not every public venue as it now applies.

Hon SUE ELLERY: I will ask Dr Robertson to make some comment. I would make the point as well though that part of getting it right is having it simple and having something where people do not have to think, "Do I do it here but not there?" That is literally part of the thinking, but I will ask Dr Robertson to make some comments as well.

Dr ROBERTSON: Look, I think probably the comment I can make is that we are out looking at this actively. We are reviewing this and we will provide further advice to government on this.

Hon MARTIN ALDRIDGE: So that advice has not been provided yet?

Dr ROBERTSON: No.

Hon MARTIN ALDRIDGE: It is something that is under active consideration?

Dr ROBERTSON: It is under active consideration.

Hon MARTIN ALDRIDGE: In the answer that the leader gave to the house yesterday, she mentioned that resources are being provided to enable positive cases to do their own contact tracing. Could you perhaps explain what resources are being provided to positive cases for them to do that?

Hon SUE ELLERY: My recollection is that this was the answer to the question about Esperance.

Hon MARTIN ALDRIDGE: Correct.

Hon SUE ELLERY: That was an answer provided by the Minister for Health. I think I would have to take it on notice to make sure we are giving you the answer that she understood she was giving. I am happy to take that on notice.
[*Supplementary Information No A12.*]

Hon MARTIN ALDRIDGE: Okay, so the Chief Health Officer or the Department of Health are not aware—of the 8 500 cases that have been notified as of 8.00 pm last night, is there a little package or brochure that we send them? Is there a "how-to" guide of how to identify close contacts, and call them and contact them?

Hon SUE ELLERY: I can tell you that there are in certain settings. Schools have been provided with advice on the sorts of things they need to check. I am not sure; are you able to add anything?

Dr ROBERTSON: I can probably add a couple of things, minister. Each of the cases are sent an SMS that seeks further information and it provides some advice and some links to our data. On our websites we have quite a lot of information that people can look at. In cases that are high risk, we

will look at what settings they have been involved with, whether that is residential aged care or remote Aboriginal communities, for example. If they are lower risk, we will obviously ask them to notify any family members or people they have been in contact with. Some of that information is provided by SMS; some of it is done by information that we provide on various websites.

Hon MARTIN ALDRIDGE: Are you able to provide by supplementary information examples of the resources that are provided to positive cases for them to undertake that responsibility?

Hon SUE ELLERY: We can take that on notice.
[*Supplementary Information No A13.*]

Hon MARTIN ALDRIDGE: Just on the shift in contact tracing, I understood from some public messages—I think from the Premier—that the tipping point, if you like, would be when the number of daily cases was equal to or greater than the number of contact tracing capacity that we have. Is that correct, or is it a bit more scientific than that?

Hon SUE ELLERY: I think there was a combination of factors. Perhaps the Chief Health Officer might be able to elaborate a little bit.

Dr ROBERTSON: It probably is a little more complex. That is very good guidance, but it will depend on the mix of the cases. For example, once we identify the people in schools, we know the close contacts and we work closely with the principals in those schools to notify out to close contacts in those classes. If we are working in industry, many of the industries obviously know their workforces and they provide support out to those people. All of that will take time. As I said, we use an SMS system. We get about 50 or 60 per cent come back on that SMS system. Depending on that workload, we do have to go out and identify particularly people in regional areas or in high-risk areas as to what their exposures might be. It will vary, almost on a daily basis, depending on where that case load is coming from.

The CHAIR: I refer to page 4, with regard to the response to the outbreaks and ring-fencing Perth. Through you, minister, to the Chief Health Officer, with regard to the preparedness, particularly for the Omicron outbreak, vaccination rates needed to be at a particularly high level. The Chief Health Officer has said publicly, I think in the past couple of weeks, that the peak would be delayed or pushed back a couple of weeks. When do you anticipate that peak will be and, when there is a drop-off, will it be a substantial drop-off or will levels be kept at a fairly moderately high level?

Hon SUE ELLERY: I am certainly happy for the Chief Health Officer to provide you with advice on that, but I think this is a good opportunity to put on the record that because of the efforts of this Chief Health Officer and some of the other people sitting around the table here, Western Australia is in a unique position because of our incredibly high vaccination rates. We went into Omicron in a much better position than pretty much any other jurisdiction around the world. He is a very humble man, but that is in no small part due to Dr Robertson's advice. I will now invite him to make some comments about your question.

Dr ROBERTSON: Thanks, minister. As you are aware, we have provided some modelling on that. That modelling looked at us getting towards a peak towards the end of March. We have also looked at the real-life experiences in other jurisdictions, particularly with the Omicron variant. That has led us to make some predictions. The issue here is that the modelling is not a forecasting tool. I know you have probably heard that said a few times now. It is not exact. We are obviously at the highest level we have been at today with the 8 400 or so cases, but whether we have reached our peak or not is hard to judge, and it may be a number of days before we can judge that. It may be that the peak will be over the next week or so. We are still working on that and obviously we use all the tools that we have in our armoury to try to calculate when that is likely to happen.

To answer the second part of the question, we suspect that it will not be straight up and straight down. That would be unusual if you look at what has happened in other jurisdictions. It will probably remain at or near the peak for a period of time and then obviously will drop down. The complicating factor at the moment is BA.2, which, as you are probably aware, is now causing major outbreaks on the east coast. I think as we have already said, most of our disease in this state would appear to be BA.2. We obviously have to factor that in to our calculations as well. That is not more severe—I should make that point—but it would appear to be more transmissible, and how that works out, we have to put into our calculations.

[11.40 am]

The CHAIR: And the advice re the level 2 restrictions, which is based on the particular levels of Omicron, is that at a particular level or when it comes off the peak?

Dr ROBERTSON: We are currently considering the advice on that and we will, obviously, be providing that to government.

Hon SUE ELLERY: The Premier has made some comment about that. He is very keen that those level 2 restrictions stay in place for the shortest amount that it is publicly healthy for us to do that. So I guess it is a matter that is under current consideration when the Chief Health Officer provides advice.

Hon JACKIE JARVIS: You have already mentioned earlier about the blockages with the aged-care system, getting people moved through the hospital system into aged care. I have certainly experienced this in my own family where my elderly father was approved for a certain amount of commonwealth funding for aged care and then got told, "Oh well, the bucket's empty. You can't have that level of in-home service." North metro has the Frailty Rapid Access Clinic and it says in the report on page 57 that it is an outpatient service offered by the department of rehabilitation and aged care. Does that mean you are able to access a separate commonwealth funding bucket to offer that aged-care service? How does it work with regard to what resources the state puts into it versus the commonwealth?

Hon SUE ELLERY: Good question. Are you able to make some comment on that, Tony?

Mr DOLAN: As it is a health service—it is an additional clinic. It is an outpatient clinic. The activity that goes through that will attract activity funding through the Department of Health with that. It is a multidisciplinary approach. So, it is led by a geriatrician. It has occupational therapists; it has physiotherapists; it has nursing staff in there; and it has access to psychological services depending on the condition of the individuals. It has two functions. One is about early supported discharge, so trying to get people out of hospitals sooner and through that assessment and then connecting them into the community services. It is also about our hospital substitution, so where someone is deteriorating from a physical viewpoint in the community rather than coming through the ED system and then getting admitted, there are options to then refer into this clinic and get the full assessment and then access the packages that way. We use it as both. We use to support people to leave hospital earlier than planned but also to avoid people coming into hospital.

Hon JACKIE JARVIS: Is it fully funded then by the commonwealth?

Dr RUSSELL-WEISZ: Yes. There are certain programs that are sometimes fully funded by the commonwealth or partially. Our transitional care placement—TCP—program is funded 67 per cent by the commonwealth 33 per cent by the state and there are other ones that are funded by the state in totality. What we have done through our long-stay program is actually go out to providers here and say, "How can we actually get patients out appropriately and into more appropriate clinical settings." We funded things this year, or the last financial year, and just before that as well, where

normally it would be the responsibility of the commonwealth. Our responsibility is to improve patient flow. So, we have a really good relationship, which I think has been improved with the aged-care providers over COVID. It is one benefit; we are really a lot closer than Canberra. They have really come together and provided us with some options for moving some of our most complex patients out. And they have the expertise. But we have fully funded those. We will all seek recompense from the commonwealth but we might not get it.

Hon JACKIE JARVIS: Is that kind of clinic available in regional areas? I am thinking of retirement hotspots like Busselton and Peel.

Dr RUSSELL-WEISZ: Yes. We have expanded—they are. Actually the one area you just mentioned, Busselton, has a specific issue with transitional care placement patients who are in our hospitals. We have actually sought additional places from the commonwealth and they will go to regional areas. We also run some of our own aged care, as you know. In Port Hedland, as an example, we run the aged-care facility there, not the commonwealth.

Hon SAMANTHA ROWE: My question is for North Metropolitan Health Service through the minister. I refer to page 49 of the annual report around Aboriginal health and employment. You talk about as at June last year the proportion of staff identifying as Aboriginal or Torres Strait Islander was 0.7 per cent, increasing from 0.6 per cent the previous year. I want to find what you are doing to engage Aboriginal staff?

Hon SUE ELLERY: Good question. I will ask Tony to make some comment about that.

Mr DOLAN: Currently, we are still sitting at around the 6.8 to 7.7 per cent on that. We have started to look at in our focus groups about what makes us attractive and not attractive as a health service to come and work for. We have also got a resource within our workforce team that focuses on Aboriginal employment and opportunities. We previously had a cadetship where we have brought some Aboriginal staff in and they work with inpatient support services, and that is a supported program to allow them to transition into working within Health.

Hon SAMANTHA ROWE: Has that been successful?

Mr DOLAN: It has been successful. We had I think about 17 out of the 21 employed afterwards; some have moved on and some have moved within the health service. What we have been trying to grow across the sites and services in north metro is the Aboriginal liaison officer support, particularly focused within mental health and women's health. It is really about how we can support Aboriginal people who use our services for early supported discharge or, more importantly, if there are other issues that happen socially, how we can get involved within that. We have staff of Aboriginal liaison services on site so they are available across business hours. We have just recently extended that into support at the weekends and in emergency departments so that it is easily accessible. We have also done a lot of work around access to interpretation services or access to staff for whom English is not their first language. That is really about having that accessibility, using technology more than using in-person.

Hon NICK GOIRAN: Is Sir Charles Gairdner Hospital part of north metro?

Hon SUE ELLERY: Yes.

Hon NICK GOIRAN: There has been some reporting about what is referred to as a *Legionella* cover-up. During the reporting period, on how many occasions was legionnaire's disease identified?

Hon SUE ELLERY: I am not sure that we would have that number here now but certainly one of the original reports was within the reporting period. Will you just bear with me because I do have some information in my file, so I am just going to see if I can find that. If I can answer it now for you, I will.

Hon NICK GOIRAN: To assist, what I am looking for is the number of occasions during the reporting period and then how many occasions since the reporting period.

Hon SUE ELLERY: I think what we might need to do for accuracy purposes —

The CHAIR: Can we take one on notice?

Hon SUE ELLERY: I will take that on notice.
[*Supplementary Information No A14.*]

Hon NICK GOIRAN: Do I at least take from the answer that there is at least one occasion, because if there had been zero occasions, I presume people would know that.

Hon SUE ELLERY: I am just a bit anxious about saying a number. My recollection is that there was one. I will just take the question on notice,; that is the safest thing for me to do.

Hon NICK GOIRAN: When you are taking it on notice—I think a number has already been allocated.

The CHAIR: It is A14.

Hon NICK GOIRAN: For A14, are we taking just identified cases in north metro or across WA Health?

Hon SUE ELLERY: That is what you asked for. I understood you were asking about north metro. You are asking about Charlies; that is what I understood.

Hon NICK GOIRAN: My first question was Sir Charles Gairdner Hospital, part of north metro, yes. At the moment, you are understating the question is just for cases identified at Sir Charles Gairdner Hospital?

Hon SUE ELLERY: Correct.

Hon NICK GOIRAN: Okay. So that is I think A14. For A15, Mr Chair, could we then identify any other instances?

Hon SUE ELLERY: I can take that on notice.
[*Supplementary Information No A15.*]

Hon NICK GOIRAN: With regard to the other instances, we would like to know the locations. Further to that, minister—no doubt you will have to take this on notice—is data available with regard to how quickly families were notified in each of the instances?

[11.50 am]

Hon SUE ELLERY: I might ask the director general to make some comments. I note that that issue, I guess, has attracted a certain amount of notoriety in the media report today, for example. In a general sense I will say this: patients specifically identify next of kin. The health service provider's obligation is to deal with the identified next of kin. Now, obviously, we all have wider families than perhaps just the person we might nominate, if we go to hospital, to be our next of kin.

Hon NICK GOIRAN: Other interested family members.

Hon SUE ELLERY: Correct. But the hospital's obligation is to deal with the person notified as the next of kin. I just provide some context there.

Hon NICK GOIRAN: Thank you for that. We just need to know when the families were notified. If the response is going to come back that it was just the next of kin, then that will be the response.

Hon SUE ELLERY: We will take that on notice.
[*Supplementary Information No A16.*]

Hon MARTIN ALDRIDGE: There were some questions earlier about the advice that the Chief Health Officer provides to government. I understand that there is a website that not too many are familiar

with called "COVID-19 Coronavirus: Chief Health Officer advice". This page contains the Chief Health Officer's advice to the Premier outlining the latest expert health advice on COVID-19. The last record on this website was 8 March, which was more than two weeks ago. Can I ask: is all advice provided to the Premier in relation to COVID-19 uploaded to this website as it suggests; and, if so, why has the Chief Health Officer not provided advice to the Premier in the last two weeks?

Hon SUE ELLERY: I might get the Chief Health Officer to make some comment. I am not familiar with the particular website that you are referring to, but, certainly, my understanding is that the advice that is provided to the Premier is made public. But I will ask the Chief Health Officer to make some comment about that.

Dr ROBERTSON: The website that you are referring to is a webpage on the wa.gov.au website.

Hon MARTIN ALDRIDGE: Correct.

Dr ROBERTSON: All the advice I provide to the Premier is all considered. When they have finished consideration, my understanding is that they will put it up on that website. There may be advice that is still under consideration that has not been put up on that website, but all of the advice, once considered by government, is placed there.

Hon SUE ELLERY: It is not the Chief Health Officer or his office who puts it on that website; it is the government.

Hon MARTIN ALDRIDGE: The last piece of advice was from 8 March, "Transitioning to very high caseload settings". Would you have an understanding of how many pieces of advice you have provided since 8 March to the Premier?

Hon SUE ELLERY: I will ask the Chief Health Officer to make some comment on that but I think you need to take note of the point he just made: that he may well have provided advice that is still under active consideration.

Hon MARTIN ALDRIDGE: I understand.

Dr ROBERTSON: Look, I would need to check. There may have been one other piece of advice provided in that period, but there has not been a lot of additional advice. All of the settings were actually largely in place by 3 March. The 8 March advice around the very high case-load settings was probably the last piece we put in place in response to the current outbreak.

Hon SUE ELLERY: Because if you think about all of the things we had to change—all of the settings that had to change—there is nothing beyond very high case load. That would be consistent with that.

The CHAIR: Do you want to take that last one on notice to check?

Hon MARTIN ALDRIDGE: No, that is fine.

Hon NICK GOIRAN: On how many occasions was SafeWA data accessed for contact-tracing purposes during the reporting period?

Dr ROBERTSON: We might have to take that one on notice, minister.

Hon SUE ELLERY: It is not top of mind.

Hon NICK GOIRAN: Sure. You usually come with a massive file so I thought it might be in there.
[*Supplementary Information No A17.*]

Hon NICK GOIRAN: Can you also indicate on how many occasions SafeWA data has been accessed since the reporting period?

Hon SUE ELLERY: I will undertake to ask the minister that. What she answers will be up to her.

The CHAIR: That will be part of the same question.

Hon NICK GOIRAN: As a separate question, on how many occasions was SafeWA data accessed for any purpose other than contact tracing?

Hon SUE ELLERY: I can give you an undertaking, but I do not know that —

Hon NICK GOIRAN: Is SafeWA data being used or provided for any reason other than contact tracing?

Hon SUE ELLERY: Not that I am aware.

Dr ROBERTSON: Not that I am aware of, not since the original —

Hon SUE ELLERY: There was that.

Hon NICK GOIRAN: There was the incident.

Hon SUE ELLERY: Do not talk about the war, but there was that, but that has been fixed.

Hon NICK GOIRAN: That is what I am trying to confirm: that under no circumstances there has been any further provision. Does that need to be taken on notice or are members currently confident?

Hon SUE ELLERY: To the best of the knowledge of the people sitting at this table, no.

Hon NICK GOIRAN: All right. Obviously, if people think at a later stage that the committee needs to have some further information, they will.

The CHAIR: If it is found to be inaccurate, you can let the committee know.

Hon NICK GOIRAN: On how many occasions did WA Health access G2G data?

Dr ROBERTSON: Again, we would have to take that on notice. It is used quite commonly.

Hon NICK GOIRAN: Frequently?

Dr ROBERTSON: Yes. For example, for people in home quarantine and people who are coming into hotel quarantine. It has been used quite frequently.
[*Supplementary Information No A18.*]

Hon NICK GOIRAN: If the question that is taken on notice can be: how many times has G2G data been accessed by WA Health in the reporting period and since?

Hon SUE ELLERY: Again, in the reporting period, I am happy to take that on notice; beyond the reporting period, I will undertake to raise that with the minister.

Hon NICK GOIRAN: Further questions?

The CHAIR: You have probably got one minute.

Hon NICK GOIRAN: With regard to adverse effects of COVID vaccines, is that type of data collected and maintained by the Department of Health?

Dr ROBERTSON: It is maintained through our own vaccine safety system and also, obviously, the commonwealth has its own system.

Hon NICK GOIRAN: Is the Department of Health data publicly available?

Dr ROBERTSON: Some of it is available. I would have to get back to you.

Hon NICK GOIRAN: Rather than coming back to us as to whether it is publicly available, can what can be provided publicly be tabled?

Hon SUE ELLERY: I will give you an undertaking that we will raise that with the minister.
[*Supplementary Information No A19.*]

Hon NICK GOIRAN: Do any of the witnesses know what the mortality rate in Western Australia is as a result of any adverse effect of a COVID vaccine?

Dr ROBERTSON: Any potential or any sort of suspected deaths that may be related to the vaccines are passed to the commonwealth for consideration. As of the latest report I have seen, of the 54 million doses of vaccines that have been given across the country, the commonwealth had identified 11 cases.

Hon NICK GOIRAN: Yes, but are any Western Australian? That is what I am interested in.

Dr ROBERTSON: I think there is at least one, but I can get you the figures for those.
[*Supplementary Information No A20.*]

Hon SUE ELLERY: I will put that in the context of far more deaths from COVID than from vaccination.

Hon NICK GOIRAN: I could go for a few more hours, Mr Chair.

Hon JACKIE JARVIS: As much as we would all enjoy that!

The CHAIR: No, it is time. Thank you all for attending today; it is very much appreciated. A transcript of this hearing will be forwarded to you for correction. If you believe that any corrections should be made because of typographical or transcription errors, please indicate these corrections on the transcript. Errors of fact or substance must be corrected in a formal letter to the committee. There have been some questions on notice, so when you receive your transcript of evidence, the committee will also advise you when to provide your answers to questions taken on notice. If you want to provide additional information or elaborate on particular points, you may provide supplementary evidence for the committee's consideration when you return your corrected transcript of evidence. Thank you once again for your time today.

Hearing concluded at 11.59 am