STANDING COMMITTEE ON ESTIMATES AND FINANCIAL OPERATIONS

2021–22 BUDGET ESTIMATES

TRANSCRIPT OF EVIDENCE
TAKEN AT PERTH
TUESDAY, 19 OCTOBER 2021

SESSION ONE
WA HEALTH

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 10.00 am

Hon STEPHEN DAWSON
Minister for Mental Health representing the Minister for Health, examined:

Dr DAVID RUSSELL-WEISZ
Director General, examined:

Dr ANDREW ROBERTSON
Chief Health Officer, examined:

Dr DUNCAN JAMES WILLIAMSON
Assistant Director General, Clinical Excellence Division, examined:

Mr ROB ANDERSON
Assistant Director General, examined:

Mrs ELIZABETH MacLEOD
Chief Executive, East Metropolitan Health Service, examined:

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

Mr JEFFREY MOFFET
Chief Executive, WA Country Health Service, examined:

Dr ARESH ANWAR
Chief Executive, Child and Adolescent Health Service, examined:

Ms KATE GATTI
Acting Chief Executive Officer, South Metropolitan Health Service, examined:

Mr CHRIS DAWSON
Commissioner of Police/State Emergency Coordinator, examined:

Ms RUTH O'TOOLE
Principal Policy Adviser to the Minister for Health, examined:

The CHAIR: Welcome to today's estimates hearings. The Standing Committee on Estimates and Financial Operations acknowledges and honours the traditional owners of the ancestral lands upon which we meet today, the Whadjuk Noongar people, and pays its respects to their elders, both past and present. Can the witnesses confirm whether they have read, understood and signed a document titled, "Information for Witnesses"?

The WITNESSES: Yes.

The CHAIR: There was a collective nodding of heads.

Your testimony before the committee must be complete and truthful to the best of your knowledge. This hearing is being recorded by Hansard and broadcast live on the Parliament's website. The committee will place the uncorrected transcript of your evidence on the internet a few days after the hearing. When the transcript is finalised, the uncorrected version will be replaced by the finalised version. This is a public hearing, but the committee can elect to hear evidence in private. If for some reason you wish to make a confidential statement, you should request that the evidence be taken in closed session before answering the question.

Members, before asking your question, I ask that you provide the relevant page and paragraph numbers. For those members who are not here yesterday, we will allow for members to have follow-on questions from other questions this year, if you are interested. With the number of members here, can I get an indication of anyone not intending to ask questions? I assume everyone here today will be asking questions. Good. Given that, we have a large number of members. Can I please ask that your questions be succinct and to the point, and then we will get through as much as we can. The committee will get the first options and then the shadow representative and everyone will get an opportunity to ask questions.

Minister, would you like to make any opening statements or will we get straight into it?

Hon STEPHEN DAWSON: No, thank you, chair.

The CHAIR: We will move straight into questions. First, we will move to the committee.

Hon JACKIE JARVIS: I refer to page 308 of budget paper No 2, volume 1, and the line item "Women and Newborn Service Relocation Project", under "New Initiatives". I have a question about that. The eighteenth dot point on page 310 states —

> The Government has committed to the establishment of a new Women and Babies Hospital …

I am interested whether that "Women and Newborn Service Relocation Project" relates to the new women's hospital. Could we have an update on what that does? What is the status of that?

Hon STEPHEN DAWSON: I am happy to start off. There is $1.8 billion that has been locked in to construct what will be a new world-class women's and babies' hospital here in Perth. That will support women and newborns on the Queen Elizabeth II Medical Centre site. It will involve the relocation of services currently operating from King Edward Memorial Hospital to QEII or other purpose-built accommodation in the community. It will include replacement accommodation for existing services impacted by site selection for the new hospital. For example, that may well mean the PathWest laboratories—I am not sure whether you know that the Queen Elizabeth II Medical Centre site now is outside the hospital itself to the left on the side—and services from the J block, which potentially might include the state mortuary if the south location is selected, or the SCGH outpatients department if the north location is selected. So there is money in there to move. It might need to be moved depending on the site location. Then there is funding for critical acute clinical services that currently operate from Sir Charles Gairdner Hospital—so ICU, emergency theatres and radiology services may need to be expanded and, where clinically suitable, integrated through the enabling of shared governance and common facilities. I am happy to ask the director general whether he can elaborate on where we are at.

Dr RUSSELL-WEISZ: The minister has covered most of the salient points. This is obviously an exciting period for women's and neonatal health services in WA. We have a steering committee in the department overseeing this. I chair that steering committee, and it has representatives from Treasury and Premier and Cabinet on that committee, which is consistent with what we have done before with major health projects such as Fiona Stanley Hospital and the Perth Children's Hospital.

As the minister said, there is a lot of preliminary work now going on in relation to where the best location on the Queen Elizabeth II Medical Centre site would be. It is an operating site. We are looking basically north or south of G block, which is the main Sir Charles Gairdner block, but taking into consideration the key areas of integration on the site. There are other considerations we are looking at as well—planning considerations, car parking and movement through the site—because obviously by 2029, it will have three very busy tertiary hospitals on the site with Sir Charles Gairdner Hospital, PCH and also the new women's and babies' hospital. The work that is being done at the moment is really on the business case and the project definition plan, with a view to have a recommendation to government in relation to the location of the site in the next four to five months.

[10.10 am]

Hon JACKIE JARVIS: So, with that planning, are there any plans specifically around the fact that a lot of regional women utilise that facility or come to Perth early when they have high-risk pregnancies?

Dr RUSSELL-WEISZ: Yes, absolutely. This is a hospital for all of WA and as King Edward Memorial Hospital does now, it serves the population of all of WA. We have around about 100 neonate beds that are actually on the King Edward Memorial Hospital for Women site that we would have to move and that is tertiary–quaternary service for WA. I did not cover this in my first answer, but there is a huge amount of clinical planning going on. There are a number of clinical planning groups that have been set up through the current hospital with clinicians and also the consumers involved. We do have the time to do this really well and really properly. It will look at each service, what services need to be in the new hospital, what services do not need to be in the new hospital, but with a view that it will serve rural and remote patients and it will have a blueprint that serves WA well for the future not just for the next couple of decades.

Hon SAMANTHA ROWE: Minister, I am referring to budget paper No 2, volume 1, so we are still on page 308. If you go down to the line item where it has got "Other: Future Health Research and Innovation Fund". I am just wanting to find out if you are able to outline the status of that fund, but specifically regarding governance arrangements and also the disbursement of funds in the first year.

Hon STEPHEN DAWSON: I will hand over to the director general, please.

Dr RUSSELL-WEISZ: The future health research and innovation fund obviously was established by the state government and has now considerably much more funding for research and innovation. More recently, talking about governance, an advisory council has been appointed by the state government with an independent chair, which, basically, oversees the strategic plan of the future health research and innovation fund and recommends that to the minister. Over about 18 months ago, before the advisory council was appointed, there was work done with a number of stakeholders within WA, both on the research and innovation front, to actually set the strategic plan for the next couple of years and set those strategic priorities. That now has passed over to the advisory council with the Department of Health supporting the advisory council. The Department of Health purely supports. It does not mandate; it may influence strategy, but the strategy is set by the advisory council, which has a number of eminent people on board that advisory council. For the specifics, if I can, through the minister, I might pass on to Dr James Williamson, who might be able to talk more about the specifics of what the FHRI is doing at the moment.

Dr WILLIAMSON: So, in its first year of operation it established the advisory council, as the director general has indicated. That took until about November of 2020. So, the time in which we could establish the programs and initiatives and actually disperse the funding was somewhat compressed in that first year. There was also the requirement that we expend, I think it was, up to $6 million on COVID-related research, so that was an important priority that was legislated.

I can give you an indication of the sorts of programs and initiatives that were funded in that first year. I do not have the exact amounts allocated to each of them, but a lot of these were actually carryover initiatives from previous years. So, obviously, there was commitments to out years from those previous commitments. It is really only this year that we are beginning to see the impact of the advisory council's strategy and prioritisation. Recently, we have posted on our website the programs and initiatives which we are going to be funding over 2021, acknowledging that, as I say, there is some residual out years to come from previous programs and initiatives. I am quite happy to give you some indicative titles for some of the programs that we are developing. Would that be helpful?

The CHAIR: Is there anything specific that you are looking at?

Hon SAMANTHA ROWE: That is fine.

Dr WILLIAMSON: Is there any other specific question that you had?

Hon SAMANTHA ROWE: No; thank you.

Hon STEPHEN DAWSON: Can I give a plug, just quickly. Myself and the Minister for Health last week were able to announce an innovation challenge, which would improve mental health outcomes for Western Australian children and young people. So, the announcement was a child and youth mental health innovation challenge that will see the brightest minds locally, nationally and indeed internationally put forward projects to develop and implement innovative solutions to address significant child and youth mental health issues in Western Australia. There are up to 10 amounts of $50 000 available for researchers to work on a project and then the one that is picked as deemed the best, would be able to access up to about $1.5 million to innovate. It is perfect. I am very pleased that the advisory council were the ones who suggested that we should be looking at spending in the mental health space as well.

The CHAIR: Was that from additional funding or existing funding?

Hon STEPHEN DAWSON: This was out of the fund. It is out of the existing fund, but it is an allocation from the existing fund.

Hon Dr BRAD PETTITT: It is a nice segue into my question which refers to point 1, "Prevention", in the Mental Health Commission service summary, page 342, budget paper no 2, volume 1. Of the funds allocated to prevention, how much of this is for mental health primary prevention and how much —

Hon STEPHEN DAWSON: Honourable member, I might stop you there. This hearing today is actually the Department of Health. It is not the Mental Health Commission.

Hon Dr BRAD PETTITT: There are no mental health questions?

Hon STEPHEN DAWSON: No, it is a separate agency. That particular issue is the responsibility of the Mental Health Commission. So, it is not as if a health department person —

Hon Dr BRAD PETTITT: I was expecting to have representatives from the Mental Health Commission as part of this.

Hon STEPHEN DAWSON: No, the agency was not called. Perhaps you may wish to submit your questions as part of the estimates after-process to get an answer to it.

Hon Dr BRAD PETTITT: I understand. I am getting clarity from the chair here.

The CHAIR: Just some clarification. With regard to the budget papers, page 319, where it talks about mental health services —

Hon STEPHEN DAWSON: What the honourable member is asking for is the spending of the Mental Health Commission's money on prevention. This is not the agency. So, with the greatest of respect, the Mental Health Commission themselves would have this information, not the Department of Health.

The CHAIR: No; thanks for that, minister. I think, though, that the honourable member may have the wrong page. What page are you referring to?

Hon Dr BRAD PETTITT: Are you suggesting 319—mental health services?

The CHAIR: Yes.

Hon Dr BRAD PETTITT: Thank you. In terms of those services, what I am certainly trying to get an understanding of, so I do refer to page 319, paragraph 4, as printed, "Mental Health Services", it seems to me—I mean, I guess what I am trying to understand here is how we get that right mix around community support for mental health and prevention.

The CHAIR: No, I think I get your point, honourable member, but I think that is specific to mental health.

Hon Dr BRAD PETTITT: So, your advice is that I put these in writing?

The CHAIR: That is right. You can put those as questions following this hearing to the Mental Health Commission and I recommend you do that. Have you got any other questions?

Hon Dr BRAD PETTITT: Not at this stage.

Hon NICK GOIRAN: Minister, I want to refer to a couple of budget papers, budget paper No 3, 115 refers to the response to COVID-19 and likewise in budget paper no 2, volume 1, at page 311, there is an indication there under the heading "Continuing the COVID-19 Response". It is not really apparent to me in the otherwise fairly comprehensive list that there is reference to the SafeWA app. Is that still part of the response to COVID-19?

[10.20 am]

Hon STEPHEN DAWSON: The answer to that is yes.

Hon NICK GOIRAN: There was a bit of controversy about that app prior to the election and during the last financial year, particularly in January and February. At any time during that period, January and February, was the director general on leave?

Hon STEPHEN DAWSON: I ask the director general.

Dr RUSSELL-WEISZ: For a period in January, yes.

Hon NICK GOIRAN: Was Professor Williamson ever asked to act during that time?

Dr RUSSELL-WEISZ: That is correct.

Hon NICK GOIRAN: Did Professor Williamson during that time when he was acting as director general ever have cause to attend meetings with the Premier?

Hon STEPHEN DAWSON: I am not sure we would have that information with us today.

Hon NICK GOIRAN: Is Mr Williamson present?

Hon STEPHEN DAWSON: He is.

Hon NICK GOIRAN: Can he recall if he attended any meetings with the Premier during that short period of time that the director general was on leave in January?

Hon STEPHEN DAWSON: Assistant Director General Williamson.

Dr WILLIAMSON: It is Dr Williamson, just for the record, rather than professor. Yes, I believe I did. I do not have my notebook with me, but I believe I did. The reason I am not 100 per cent certain is because I covered over various periods for the director general while he was on leave. But I do believe that I attended a meeting with the Premier present.

Hon NICK GOIRAN: Would it have been one or more meetings?

Dr WILLIAMSON: I would have to go back and look at my notes to be absolutely sure about that.

Hon NICK GOIRAN: At any of those meetings, did you ever raise concerns about WA police having access to the data from the SafeWA app?

Dr WILLIAMSON: I do not believe so.

Hon NICK GOIRAN: Not at one of the meetings? Would you have ever raised those concerns with people who attended the meetings?

Dr WILLIAMSON: I did, but not one of the members of the group that was meeting. It was someone who attended as an observer.

Hon NICK GOIRAN: Who did you raise the concerns with?

Dr WILLIAMSON: It was a member of the SSO.

Hon NICK GOIRAN: From the State Solicitor's Office—you raised a concern?

Dr WILLIAMSON: Yes. I sought advice as to what I should do.

Hon NICK GOIRAN: Quite understandably; it was a serious matter. The Premier had promised the people of Western Australia that their data would be kept safe and WA police were seeking to access it, albeit lawfully. So I can understand why you might want to seek some advice.

Hon STEPHEN DAWSON: Honourable member, I am struggling. This may well be within the remit of the Standing Committee on Estimates and Financial Operations to have a hearing with a public officer at another time, but I am struggling to see the link in your questioning to the budget papers that are before us today.

Hon NICK GOIRAN: "COVID-19 Response", minister. I have given you two pages in the budget where the department has listed "COVID-19 Response". I asked you at the start if the SafeWA app was still part of that and you indicated yes.

Hon STEPHEN DAWSON: And it is, but you are asking questions about meetings that happened some months ago where somebody was filling in for somebody else, and he has indicated that he has filled in on multiple occasions. I do not want to put the witness at risk of giving false testimony to the committee before us now because he is relying on recollections of meetings some periods ago. I think that this line of questioning, to make sure that you get to ask your question and an appropriate answer is given, is perhaps better done at a different time, perhaps as after questions.

The CHAIR: Minister, as you will be well aware, these hearings do have a fairly broad approach in the Legislative Council. There is a very clear identification of the response to COVID-19. At this stage, if Dr Williamson cannot respond to the questions, we can certainly take them on notice. If you do feel uncomfortable, Dr Williamson, that is fine.

Dr WILLIAMSON: Yes. I think there has been a response to this given formerly, and I know that some emails were produced. I think it would be better if I took any additional questions on notice and then I can ensure that they are accurately responded to.

The CHAIR: Did you want to put some questions on notice, Hon Nick Goiran?

Hon NICK GOIRAN: I am very happy with the responses provided by Dr Williamson today. I think that he has been most candid in his response and I have absolutely no concerns about the accuracy of any doctor. If I might continue with this line of questioning, Dr Williamson, when you returned to your substantive position and the director general had returned from leave, did you raise these same concerns that you had escalated with the State Solicitor's Office to his attention?

Dr WILLIAMSON: I believe that I had been in discussion with the Chief Health Officer in our internal daily meetings about this. I also believe that I had an informal verbal response back from the SSO by that stage, which essentially confirmed what subsequently transpired—that the seeking of that information was legal. To answer to your question, I believe that there was a handover, although I cannot remember the exact terms of the handover.

Hon NICK GOIRAN: But the handover would have involved you and the director general being present in person?

Dr WILLIAMSON: Yes.

Hon NICK GOIRAN: At any time during that time that you were acting did you raise concerns with the Commissioner of Police?

Dr WILLIAMSON: I do not believe, because I did have reason to go back through my notes. So, I had some conversations with the Commissioner of Police. I do not have recorded in my notes and I do not have any recollection of having raised that specific issue with the Commissioner of Police at that time.

Hon NICK GOIRAN: Right. You were sufficiently concerned to raise the issue with the State Solicitor's Office to seek advice, but at no stage raised the concerns directly with the most senior police officer?

Dr WILLIAMSON: Well, I think the important thing is that I raised it with—I thought it was a public health issue. I thought by accessing the information, whether or not it was legal, there was a risk to public confidence in the system. That is why I raised it through what I thought were the appropriate channels, which was through the public health response.

The CHAIR: Are you finished?

Hon NICK GOIRAN: I have a different line of questioning.

The CHAIR: Dr Williamson, just for your benefit, you will get a copy of the *Hansard*. Once you go through the *Hansard*, if you would like anything clarified with any of your responses or have any questions, feel free to provide that clarification.

Hon MARTIN ALDRIDGE: I want to go to the issue of surge capacity arising from the COVID-19 response. If it is helpful, there is a reference in budget paper No 2, volume 1, on page 308 under "Spending Changes". We know from the budget and also the media statement issued by the government with respect to this $1.9 billion boost —

Hon STEPHEN DAWSON: Honourable member, just to help me navigate the file, is there a mention on page 308? What happens is that the notes correspond with the pages, so if you have a line that you can point to that might help us navigate the file, that would be helpful.

Hon MARTIN ALDRIDGE: It was just a COVID-19 response spending change. My question was about this $1.9 billion boost for health and mental health services in the state. That media statement, and I think the director general in the other place's estimates hearing, made reference to these 332 new beds that are going to be created. Can I ask where are these beds going to be created? Do they require, for example, expansion of public and/or private hospitals or is it simply hospitals that have capacity within them to make operational these 332 beds?

Hon STEPHEN DAWSON: I am very happy to ask the director general to respond to that one.

Dr RUSSELL-WEISZ: Thank you. The honourable member has referred to the 332 beds. I can break these down. Some are open and some are not open yet because some need work. For the original ones, there were 118 beds that were opened. Thirty-six of those were at Royal Perth, 26 were at Osborne Park, Sir Charles Gairdner Hospital had 22 and Fremantle Hospital had 24. The majority of them are now open. There were, at the time, 10 private beds under contract through the East Metropolitan Health Service, but the majority of those beds are now open. It does fluctuate.

[10.30 am]

Hon MARTIN ALDRIDGE: Is that 118 in total, did you say?

Dr RUSSELL-WEISZ: That is 118 out of the 332. Then there were 20 beds, which were in relation to Perth Children's Hospital. There were eight medical, two oncology and 10 in the high-dependency unit. The two and the eight—that is, the 10—are open. The high-dependency unit is being opened incrementally up until December 2021. Then there are 85 beds that were announced during the budget, and this is part of the 332. There were 10 at South Perth Hospital due to be opened in October 2021; Sir Charles Gairdner Hospital, 24; Armadale Health Service, six; Bentley, 11; Fiona Stanley Hospital, 16; and Fremantle Hospital, 18. That gets us to 85. Then there were a further 78 announced in relation to mental health. There were 40 in relation to a transition care unit and then 16 in relation to Royal Perth and Selby Older Adult Mental Health Service. Then 22 which relates to 10 at Rockingham hospital and 12 at Fremantle Hospital. Those are due to open in February 2022 and March 2022 respectively. Also, new beds were announced, which were 12 at a secure unit in Bentley, nine at a mental health emergency centre at Armadale and Rockingham mental health emergency centre. That makes 31, and they are likely to be opened in the future. They need capital works.

So that is the table of the 332. I have not worked out how many of those are actually open because it fluctuates, but at least about 150 of those are open as we speak and the rest are all planned, with the last three that I mentioned likely to be further out. This is in addition to the beds that were already announced by government previously, which was an additional 314 beds. They were announced, obviously, over the last two to three years, but they are actually in addition to the 332. So it makes around 650 current beds.

I would say that the other critical aspect of this that we are working on is not just beds; it is staffing. Every jurisdiction around Australia has struggled with health staffing, specifically in certain areas, but to have the actual beds available and to staff them is our main aim. Obviously, we have had some challenges, and we are not different to any other differential jurisdiction around Australia, but the focus is on those beds opening and also the staffing, plus also trying to get some of our long-stay patients out of current beds to free up the capacity.

Hon MARTIN ALDRIDGE: Thanks, director general. That is a lot of numbers there, so I will reflect on the transcript and maybe contemplate further questions after that.

You mentioned previously with respect to our ventilator capacity that we have about 250 or so ventilators. Is that in the public and private systems, or is that just public?

Dr RUSSELL-WEISZ: I may have to take that on notice, but, at the time, going back to March, we bought around about 300 additional ventilators. We just went and bought—which we have in stock. We have around about 111 public beds that we have at the moment. Those can be surged. As you have heard these two terms—acute surge. You can surge up to additional places where you have ventilators, you have equipment and you can look after intensive care patients. As you would be aware, member, when we were looking in March 2020 and April 2020, we were seeing what was

happening in Italy and France and we needed to free up as many spaces that could take beds, ventilators, and could look after the very sick. Now, we have obviously seen—due to the strength of the response here but also what has happened with vaccinations recently—it is obviously apparent that we will not need that sort of level of response when we did not have vaccinations. It is surge capacity in relation to where you would put the ventilators, but we bought around about 350 to 400 ventilators.

The CHAIR: Can we just get some clarification with regard to the state public and private—you said you were not sure?

Dr RUSSELL-WEISZ: Yes.
[*Supplementary Information No A1.*]
Hon STEPHEN DAWSON: Keep asking; we might be able to give it to you today.

Hon MARTIN ALDRIDGE: My understanding is that we have operational capacity of about 250 and surge capacity of a further 363 ventilators that are in storage.

Dr RUSSELL-WEISZ: That is correct.

Hon MARTIN ALDRIDGE: If we need those 363, where and how will they be deployed within the hospital system? Will these be wards that are converted to, for want of a better phrase, temporary critical care units or high-dependency units?

Dr RUSSELL-WEISZ: I might ask Ms Elizabeth MacLeod to just talk about exactly how we went through that, and talking maybe from a specific hospital, how they plan for what that surge capacity would be; it would make it more real.

Mrs MacLEOD: Thank you. Through the minister, so for the surge capacity for ventilated bed capacity, we looked across the system and at a hospital-by-hospital basis, at our intensive care beds, other critical care beds and then other beds that could be used for critical care service provision. That included areas such as, it might be, post-operative recovery areas, noting that at a time of activity surge we would likely be reducing our elective surgery, so we would have that availability of those spaces. So we worked it through in terms of the ease of bringing on that capacity and had a staged plan that surged up to meet about 600 beds across the system. Some of that surged planning also then looked at the private hospitals and the sequencing of when we would bring the private intensive care unit capacity in to meet a whole-of-WA health surge capacity. The ventilators would then have been deployed depending on where they were needed to be deployed and the sequencing with which we brought on the beds. So some of those spaces that we were using would have already had ventilators. Some of the spaces would not have had ventilators, and we would have been deploying out the ventilators prior, obviously, to them being ready. So as we went through stage by stage, we would have been deploying ventilators for the next stages so they were ready and in use.

Hon MARTIN ALDRIDGE: In the early part of the COVID-19 response—this might be a question for the Chief Health Officer—I think that the number we were aiming towards was 600 ventilated bed capacity. I think the director general just mentioned that there has been some rethinking, particularly out of the New South Wales and Victorian outbreak responses, that perhaps our early expectations around ventilated bed capacity is not as high as we had once thought. Is there some current assessment of what our ventilated bed capacity ought to be based on other Australian experiences?

Dr RUSSELL-WEISZ: We are consistently looking at that. I think at the time, going back to March, it was not just ventilators that we had struggles with. We had struggles with PPE and our whole supply chain, so our main aim was to show our staff that they were safe and we got in a whole lot of PPE.

Some of our PPE, I have two to three years of stock; if not much, much more. As Ms MacLeod has said, on that 650 figure, we would never want to get to ventilating that many patients, but without vaccinations, clearly that was where we could have got to if we had not put constraints on both movement—the lockdown that happened at that time—and also other public health social measures that happened over the course of the year. Vaccination has changed that.

We are constantly looking at what New South Wales and Victoria are seeing with their hospitalisation rate, also their ICU rate. Also within ICU, just because somebody is in ICU, it does not mean they are ventilated; it can mean that they are just very critically unwell but do not need a ventilator. We are certainly seeing hospitalisations fall with higher vaccination rates, and it is a disease of the unvaccinated. Yes, we are constantly updating our figures, but we are not going to get rid of any of those ventilators because we have gone to our standard ventilator and we would more than likely swap out some of our current ventilators should we need them. I would not be complacent to be giving those ventilators away; it might end up that we have more than we would ever need, but I would rather just keep us there for the moment.

Hon MARTIN ALDRIDGE: My question was: in the current environment, based on the modelling and all the other information available to you, what is the optimal ventilated bed capacity for Western Australia?

[10.40 am]

Dr RUSSELL-WEISZ: I will ask the Chief Health Officer to comment on the different vaccination rates. Obviously, we look at different vaccination rates and for 70 per cent, 80 per cent and 90 per cent, you would need more beds—that is sort of obvious; you would need more beds and more intensive care unit beds. We believe with the surge capacity that we have at the moment—111 plus the initial surge, not getting up to the 600—that we would have for intensive care between 80 and 90 per cent, we would have plenty of ventilator capacity. However, I do need to add that we need to consider business as usual. So there is a business as usual out there; people still need intensive care for their cancers, for their heart disease, for whatever they come in for. We are consistently looking at what those numbers are allowing us to do in relation to ventilators. We know that if we get to the highest vaccination rate, we know that we will reduce the amount of ventilators, or ventilated spaces, that we require, but we believe with our surge capacity, plus our other ventilators in stock, we should have enough if we get the vaccination rates up with intensive care.

The CHAIR: Dr Robertson, do you want to comment?

Dr ROBERTSON: Yes, thank you. Obviously, a lot of our modelling is really based on what has happened in other jurisdictions and also some of the national modelling that is around what actually happens at 70 or 80 per cent. The original decision was made where we had no way to manage the outbreaks, so it had to be just done on clinical grounds at the time. But what we have seen played out now in New South Wales and Victoria is that as the vaccination rates get to 70 or 80 per cent, the demand on both hospitalisation and on ICU use has dropped dramatically because of those vaccination rates. For example, in New South Wales compared to the outbreak last year, we have seen a halving of the people who are actually ending up in ICU, and halving the people ending up in hospital and it is about a third for those going into ICU. The other thing that has occurred is that in the initial stages there was a lot of ventilation; a lot of the patients coming in were ventilated. The clinical practice has changed over time, and obviously while some people still require ventilation and some require even more extensive support, we have been able to address it by using introduction of a number of new medications including things like sotrovimab. Introduction of other medications to support them means that we have not had to put as many people onto ventilators. That meant that our 600 that we originally planned and purchased is probably not going to be

required. We are now at 73.2 per cent of all of those over the age of 12 having their first dose, 54.7 per cent, nearly 55 per cent, have had their second dose. As we get closer to those figures, the ongoing requirement for ICU and ventilated beds reduces. Against that background, we have actually moved back down towards the 300 or so things that we think is a reasonable place if we were to get a substantial outbreak based on national modelling, and it is doable given both our workforce and our equipment needs.

Hon MARTIN ALDRIDGE: If I can just finish on this issue that both you and the director general have mentioned, which is workforce. Under your surge capacity plan for intensive care, how are you upskilling that workforce or how is that workforce available to work in those critical care environments where they may not traditionally have worked in?

Hon STEPHEN DAWSON: Chair, I will ask the director general to respond to that.

Dr RUSSELL-WEISZ: I might ask one of the chief executives to talk to how they have done it in the acute surge when we thought, and we still think, as Dr Robertson says, if a major outbreak came and we did not put anything in place to stop that, which would be highly unlikely. We would potentially need more ICU beds than we think we do now at that vaccination rate. I will ask Liz MacLeod to talk how they have done it at, say, Royal Perth.

Mrs MacLEOD: Thank you. From a Royal Perth example, we have got obviously an extensive recruitment process underway at the moment. We are increasing our recruitment to 25 per cent above what our baseline is, to give us some additional staff. That is across the whole system in high priority areas. We have got staff recruited and on board in readiness for when we get an increase in activity. We are going through as well having a number of upskilling programs for those areas such as ICU. We have an upskilling program underway at the moment. We have tranche 1 that has started, and we will start tranche 2 at the end of the year and upskilling a number of nurses, particularly in ICU, as a part of the net readiness program.

The CHAIR: In terms of bed capacity, are you able to provide total bed capacity in the metropolitan area and regional Western Australia for the last four years?

Hon STEPHEN DAWSON: Can I just clarify, are you just asking just general beds in hospitals?

The CHAIR: Yes. You can take it on notice.
[*Supplementary Information No A2.*]

Hon STEPHEN DAWSON: To clarify that again—total beds in our hospitals regionally and in the metropolitan area for the last four years.

The CHAIR: Yes.

Hon DONNA FARAGHER: If we could turn to budget paper No 2, volume 1, page 311 regarding continuing the COVID-19 response. Specifically, I will ask in and around 21.4 regarding the COVID clinics. Minister, I asked a question on notice through you to the Minister for Health regarding the redeployment of school nurses to COVID-19 vaccination clinics. I received a response to that last week. It was specifically around how many schools have had access to school health nurses reduced as a result of redeployment. The response provided to me actually only provided for WA Country Health Service. I am just seeking some clarification, and I am happy for it to be taken on notice if required. I am presuming that there would also be some redeployments from metropolitan schools; and, if so, that might have just been missed from the answer. But if I could get that information that would be appreciated, for the same period of time to which the answer to question 253 was provided to me. I am happy for it to be taken on notice.

Hon STEPHEN DAWSON: I will ask Dr Aresh Anwar to make a comment on that.

Dr ANWAR: Thank you. CAHS has been providing support with the immunisation program in the school-based immunisation. Nursing staff have been supporting it. The numbers have fluctuated and I will provide the member with how that has changed over time, on notice, if that is okay?
[*Supplementary Information No A3.*]

Hon DONNA FARAGHER: Thank you for that. For the benefit of the question, the answer that was provided to me was from 9 March 2021 to 8 September 2021. Perhaps if we can have it through that range then it will be consistent with WA Country Health Service. If I could now turn to the same budget paper, page 321, under "Public and Community Health Services", I think this is the best place for me to ask a couple of questions specifically in relation to the metropolitan child development service. My first question relating to that is with respect to the metropolitan child development service. Can you please advise, and again you might need to take this on notice, the total appropriation allocated to this service, or what is the estimated allocation for the 2021–22 financial year, and what was the actual appropriation in the 2020–21 financial year?

Hon STEPHEN DAWSON: I am happy to throw over to Dr Anwar, but I suspect it may well be that we will have to provide this at a later date.

Dr ANWAR: Yes, can I take that on notice? We have been looking at increasing investment in the child development service in order to make sure that we ask address the wait times within the CDS, but I can come back with the exact quantum of the moneys you have asked.
[*Supplementary Information No A4.*]

Hon DONNA FARAGHER: Thank you. I think you have precipitated my question that is coming. I am aware that earlier this year, additional funding of $1.6 million was reallocated from the Child and Adolescent Health Service budget for additional paediatrician allied health staff between January and November 2021 to help reduce wait times to access services. I understand that was to employ some additional paediatricians and allied health staff. Can you please advise whether or not new funding has been provided in this year's budget to allow for the continuation of these additional staff beyond November 2021?

[10.50 am]

Dr ANWAR: I apologise. Through the minister, a business case, as you know, has been submitted for the quantum of $2.5 million, but the Child and Adolescent Health Service anticipates reallocating budget in order to bolster services and for the enhanced service to continue beyond November 2021.

Hon DONNA FARAGHER: In the business case, the funding was for $2.5 million, was it?

Dr ANWAR: It was.

Hon DONNA FARAGHER: Thank you; the minister did not provide me that, but I appreciate that you have now. With that, you are suggesting that that would not be new funding but a reallocation from the broader Child and Adolescent Health Service budget? Is that correct?

Hon STEPHEN DAWSON: If I can clarify, I think what Dr Anwar said was —

Hon DONNA FARAGHER: I just want some clarification.

Hon STEPHEN DAWSON: — it was part of the budget process, or in the budget process, seeking extra resourcing to keep those services past November this year. However, should that not be successful, regardless of whether or not it is successful, funds will be provided to ensure those services can continue.

Hon DONNA FARAGHER: No. That is not quite the way I understood the answer provided there. Could we just have that answer provided again, so that we are all clear?

Dr ANWAR: Yes, through the minister. I apologise; the minister provided greater clarity than I did. We have submitted a business case to enhance the CDS, but if the business case is not successful, we plan to reallocate moneys internally to ensure that the service is maintained at the enhanced rate.

Hon DONNA FARAGHER: So, the business case is still being considered?

Dr ANWAR: As I understand it, yes.

Hon DONNA FARAGHER: And that is through the Department of Health?

Dr ANWAR: It is through the budget process, as I understand it.

Hon DONNA FARAGHER: We are now dealing with the current budget. I appreciate the response, so, perhaps, through you, minister, can we get an indication as to when a decision will be made as to whether that new funding will be provided this financial year?

Hon STEPHEN DAWSON: I cannot, honourable member, because we are in a budget process and obviously I cannot comment on future considerations.

Hon DONNA FARAGHER: I am talking about this financial year, so this year's state budget. So, you cannot tell me whether that business case will be supported with new funding or not?

Hon STEPHEN DAWSON: I cannot prejudge what might happen as part of the budget process. But what Dr Anwar has indicated is that the services will continue and they will be funded internally until such time as funding is found from another sources. It is in a budget process. You know, having been a former minister, that that goes through agencies first —

Hon DONNA FARAGHER: Sure.

Hon STEPHEN DAWSON: — and it would go to Treasury through an ERC process, cabinet and out the other end.

Hon DONNA FARAGHER: I just want to be clear as to what we are talking about. Are we talking about now the 2022 budget—the 2022–23 budget? I am talking about the 2021–22 budget, because my understanding is that this business case was actually put to government and this is a response from the minister in the Parliament that you kindly provided prior —

Hon STEPHEN DAWSON: You know I aim to please.

Hon DONNA FARAGHER: You are a very good minister, as I often say.

The CHAIR: He has his moments.

Hon DONNA FARAGHER: The question that I asked was prior to the tabling of this budget, so I can only presume that the funding of the $2.5 million, the business case, was presented prior to the tabling of this budget. Therefore, we are talking about this budget, not 2022–23. Can I get some clarification? I am not talking about a future budget. I am talking about now.

Hon STEPHEN DAWSON: In terms of when it was submitted, I am not sure.

Hon DONNA FARAGHER: You answered a question in Parliament previously.

The CHAIR: Can we seek clarification on when the question was asked?

Hon STEPHEN DAWSON: I remember answering the question. What I was going to say, chair, was it is in a budget process. Without me talking out of school, you know what budget process happens towards the end of the year, every year, between budgets. It is in a process at the moment; it is being looked at. The services are being provided. They are very important services. I say that as the parent of a seven-year-old who needs to access those services. We are in a budget process at the moment. Dr Anwar has indicated that the services are funded now until November this year as part

of the previous allocation. The commitment is to continue those services past this date, and obviously a business case has been submitted to receive the funding from elsewhere, namely, through Health and through Treasury and through the budget process; regardless, those services will continue, because the reallocation will be done by the agency.

The CHAIR: That is fine. It might have been helpful in terms of trying to establish a time frame.

Hon DONNA FARAGHER: If we get time, I will find when that question was put because I think there is a lack of clarity in relation to that. Can I absolutely confirm that you will ensure that those additional staff will continue beyond November 2021?

Hon STEPHEN DAWSON: I think that is the indication.

Dr ANWAR: Yes; we have made a verbal commitment that we will continue the enhanced service beyond November 2021, and we have communicated that to patients as well.

The CHAIR: And it is now in *Hansard*.

Dr ANWAR: And it is now in *Hansard*.

Hon DONNA FARAGHER: Good.

Hon TJORN SIBMA: My line of questioning concerns page 311 of budget paper No 2, particularly the COVID-19 response, with a particular concentration on paragraph 22. Before I get there, I would just like to pick up on a piece of information given by the Chief Health Officer, Dr Robertson, which suggested that presently we are on the precipice of about 55 per cent of the eligible population receiving two vaccine doses. I want to confirm that I heard that correctly.

Dr ROBERTSON: We are currently, as of this morning, at 54.7 per cent of the eligible over-12 population. I can give you the figure for over-16; it is 57.6 per cent.

Hon TJORN SIBMA: Maybe if we concentrate on the over-12s, Dr Robertson. At the current rate of progress, when do you anticipate us reaching thresholds of, say, 70 per cent, 80 per cent or 90 per cent of the population vaccinated?

Dr ROBERTSON: At the current rate of progress, we are looking to reach the fully vaccinated 70 per cent towards the end of November, and 80 per cent would be by the end of December. Now, that will vary depending on, obviously, the uptake of various mandates that may increase that uptake and, obviously, the general population's hesitancy or lack thereof. A number of factors come into play here, so this literally varies on a daily basis and I cannot comment beyond that.

Hon STEPHEN DAWSON: Chair, if I may, I might ask Commissioner Dawson, as Vaccine Commander, he probably has —

Hon TJORN SIBMA: I have a series of questions for the Vaccine Commander which I have prepared, but I am more than happy to —

Hon STEPHEN DAWSON: It is your bailiwick at the moment, so I am not sure whether you have anything to add, noting, of course, that the honourable member has some questions directly for you.

Mr DAWSON: Through the chair, thank you. As Dr Robertson outlined, the variability depends on whether, in fact, the cohort we vaccinated was, one, mandated; and, two, we have seen at least 10 separate work areas, commencing with residential aged-care workers, hotel security et cetera. But as we branch out and, you will have seen a recent announcement by the Premier and Minister for Health in respect of FIFO resource sectors, while those dates have not yet been arrived at, in previous mandated workforces we have seen a rush, if I might put it that way, immediately before the imminent date. So, in our projections, what Dr Robertson has outlined is still on track in respect

of both the November and December dates that Dr Robertson has already expressed. I would only be repeating what he has already outlined.

Hon TJORN SIBMA: That leads into my next series of questions, both to you, Vaccine Commander, and the Chief Health Officer. Effectively, yes, this is a variable process and your modelling changes on a daily basis. You seem, however, to focus on the demand side of this equation rather than the supply side of the equation, so should I ascertain that there is sufficient supply of vaccines available to achieve those targets within the deadlines?

[11.00 am]

Hon STEPHEN DAWSON: If I can ask the Vaccine Commander to respond to that.

Mr DAWSON: Through the chair, members would be aware that in the initial procurement of vaccines, it was heavily predicated on the AstraZeneca in the first iteration. The reality of that now is that, in my words, it has got such sufficient lack of confidence in the public's mind in terms of that particular vaccine—although, all research and the advice I have received from the clinicians is that it is a very effective vaccine—in the public's mind, they are opting not to take it up. In fact, we are getting a dozen or so a week. It is as small as that, which is regrettable on the advice I have received. However, the procurement of additional Pfizer vaccines, which is by far the dominant vaccine, has resulted in the commonwealth procuring additional doses such as 70 000 from Poland, an additional 21 000 from Singapore—these are commonwealth procured—and further reallocations from the United Kingdom, which has allowed WA, as, obviously, a recipient, to receive a higher dosage.

In terms of planning our rollout for vaccines, we only get a runway—if I might express it that way—of two to four weeks in advance notice, generally in the order of about a fortnight, in which the state puts in a submission to the commonwealth. We then can plan the vaccine accordingly. That is in the order of approaching now around 100 000 to 120 000 per fortnight, and, with that allocation and based on what we understand in our discussions with the commonwealth, we believe that there will be sufficient vaccine of the Pfizer. In addition, there has been a recent allocation of Moderna—although that is being dispensed through pharmacies. And the other variable that impacts on this is that WA as a state, primarily through the WA Country Health Service and locally through the various hospital service providers and vaccination efforts at mass clinics by the state, prior to basically the last several weeks, has been exceeding that that is provided through the commonwealth through primary care, GPs and pharmacies. What we have seen in the last fortnight is that the primary care and pharmacies and GPs and the Aboriginal medical centres, for instance, are now starting to vaccinate more people than they were proportionately, which is pleasing. It means, then, that more of the population are getting it.

The CHAIR: Well, I hope that AstraZeneca is okay, commissioner, because I've had it!

Mr DAWSON: I have been double vaccinated myself, chair. So it is a very good vaccine as far as I am concerned.

The CHAIR: Good to hear.

Hon TJORN SIBMA: So, essentially, you remain confident about supply? Logistics and distribution channels are sort of, effectively, changing and broadening out as you go through the progress. Vaccine Commander, I think there are some comments attributed to you yesterday concerning about 300 000 people in Western Australia who were reluctant or late or hesitant. Are you in a position to identify actually what the root causes of slow take-up, reluctance, actually are, and are they predicated on any research that the government has undertaken?

Hon STEPHEN DAWSON: Vaccine Commander.

Mr DAWSON: In respect of the modelling that both reflects the take-up in Western Australia and the observations that were drawn down from the outbreaks in the community that have occurred in New South Wales and Victoria, there has certainly been some research that I have been briefed on that provides that in the order of four per cent to five per cent of the population are estimated to be not ever intending to be vaccinated. But amongst the eligible cohort at the moment, as has already been expressed here, we have got 73.2 per cent of the over-12 population presently on the first dosage. I am presently not overly concerned about the second dose coverage because, statistically, most people, by the vast majority, who have had the first will take up the second.

What is of concern is those 15 per cent or so who have yet to receive the first dose, and it is a mixture of both information, hesitancy and in some cases regular access to what we might say is the existing health service that is provided. I explain this by way of a long conversation I had with the Aboriginal community child health providers yesterday afternoon where they have a trusted relationship with, for instance, a remote Aboriginal community. I have also had discussions with the Royal Flying Doctor Service and other providers and of course WA country health have community and public health nursing posts in those sorts of areas. However, there is a differentiation between what one community might have confidence in, both through relationships and/or misinformation that may have entered into a particular group of people. So it is not an easy answer for me to provide you because while you might have remote and regional areas, in the city, of course, you do not have such high visibility on one suburb or a group of people against another.

Hon TJORN SIBMA: Minister, through the Vaccine Commander, dealing with this 15 per cent cohort, how much of your actual mission brief or operational focus, which stems from being the Vaccine Commander, is now dedicated to—in fact, I will put it in a colloquial term—cracking this nut, and what tools do you have available to do that?

Hon STEPHEN DAWSON: Commissioner.

Mr DAWSON: Through the chair, the approach that has been taken to date has been to ensure that the COVID vaccine centres—and I might describe them as "mass vaccination centres", such as at the Perth Convention and Exhibition Centre. There are, though, over 100 sites around the state. We have adopted, basically, two approaches. Up to date, the mass vaccination centres have done the bulk of the first and second doses, and, in the regional centres, a one-town approach working with resource companies, local providers and indeed some commonwealth-contracted providers. By way of example, at South Hedland and Port Hedland, WACHS, the commonwealth-provided contractors and the AMS have all combined. There is no competition per se. But in that approach, you can invite not only existing workforce, but also those community residents.

What we are now migrating to with this last 15 per cent, which I think is what your question is centred at, is that we have got to do more bespoke targeted efforts, and you have seen that with what the Minister for Health and I announced yesterday morning at some of our culturally and linguistically diverse suburbs, such as Mirrabooka and Armadale; they were both opened yesterday. We have smaller bespoke centres. For instance, I attended a mosque in Gosnells last Friday, and several hundred people have been vaccinated at those sorts of iterations. So we are targeting that, and I am taking all of this advice from the Chief Health Officer, because we know from Western Sydney that certain demographics are more prone because of congregate living, because of the nature of their work and their movements, that we need to target those as opposed to invite people to large vaccination centres.

Hon TJORN SIBMA: I might then ask the question which I think is on everyone's lips, certainly one advocated by—this might be for the minister, but I would be interested just in the government response. Is there a plan being developed at the moment that would permit the Western Australian

border to come down and the economy to open up at a 70 per cent or an 80 per cent or a 90 per cent vaccination threshold; and, if so, when might that plan be released?

The CHAIR: Minister—good luck with that one.

Hon STEPHEN DAWSON: Thanks, chair. Thanks, member. Obviously, honourable member, life in WA is already open —

Hon TJORN SIBMA: The border is not, though.

Hon STEPHEN DAWSON: No, but it is a furphy. We are hearing of "freedom days" in New South Wales or other places.

Hon TJORN SIBMA: That is not my question.

Hon STEPHEN DAWSON: I am answering the question.

Hon TJORN SIBMA: Are you planning to reopen the borders and what are the conditions?

Hon STEPHEN DAWSON: I am answering the question. Let me put this on the record. So we are hearing about "freedom days" in other places. What that means for those other states or cities is that they can now congregate. They can have family over—of five or 10. They can now stand up at the pub and have a drink rather than sit down. We have been very open for the last 18 months, and, yes, we have had to close down a few times. Life in Western Australia has been more normal than the case in many places around the world.

In terms of where to next, obviously a great deal of planning continues to be undertaken by government. We continue to make sure that we can get vaccines to people as close to home as possible. I think the commissioner spoke about Mirrabooka and Armadale this week. There are some innovative things happening right across the state. If I think of my own electorate in the Kimberley, there is a "vaxathon" in Broome, with Aboriginal medical health services, the state and community getting together. Getting the vaccine to as many people, as close to them as possible, will mean that we can open the state sooner. In terms of is there a plan, there is lots of planning going on at the moment.

[11.10 am]

The CHAIR: Thanks, minister. I am going to have to move on, Hon Tjorn Sibma. You might get another chance later. Thanks very much for that. That was very helpful, I have got to say.

As a matter of clarity, I guess, more than anything and picking up on something that Hon Tjorn Sibma said, one of the biggest issues you have at the moment, commissioner, is getting through that mindset with regard to the jab in the first place. But just with clarification from perhaps Dr Robertson in particular, regardless of whether we get to 80 or 90 per cent, one of the other issues that we are going to have to deal with as a state, of course, is getting to this notion that zero tolerance is not going to happen. Ultimately, there are going to be cases of COVID in Western Australia, regardless of whether it is 80 or 90 per cent—would that be correct?

Dr ROBERTSON: Yes, it is. Obviously, depending on at what stage—whether it is 70 per cent, 80 per cent or 90 per cent—will really impact on the size of an outbreak, when that outbreak is likely to arise, and, more critically, how many people are likely to be hospitalised and require the use of our ICU services. That will occur. We have seen that, obviously, play out and we will see it play out, I suspect, in many other jurisdictions over the next six months. As for the size of that, it is very dependent on the modelling and what that actually looks like. Part of any of our planning needs to look at exactly what that would look like.

The CHAIR: Precisely. Thanks, doctor. As I said, it is getting that mindset away from zero tolerance. We are going to have to live with it eventually, so thanks for that.

Dr ROBERTSON: Yes.

Hon NEIL THOMSON: I refer to page 310, "Targeted initiatives to increase WA Health's workforce", and I also refer to the international and national nurses' recruitment campaign announced by the health minister in April. My first question is which nurse recruitment agencies have been contacted?

Hon STEPHEN DAWSON: Honourable member, sorry, which?

Hon NEIL THOMSON: Which nurse recruitment agencies have been contacted?

Hon STEPHEN DAWSON: I can start off. Obviously, as we know and as you alluded to, the campaign started in April and there was an initial amount of approximately $350 000 towards an international campaign. That has subsequently been boosted by an announcement in the budget, I believe, of about $2 million extra to help that. Advertising has been run in a range of places; so places like the *British Medical Journal*, for example, MedJobsWA, the WA jobs board, and Seek. What happens at the moment is HSPs, hospital service providers—for example, north metro and east metro—they do their own recruitment. They recruit their staff, but what has happened with this campaign now is the whole system is actually recruiting together. The health department themselves, rather than leaving it to the HSPs to do alone—they still do it—the health system as a whole is doing this stuff across the board. It is important to remind ourselves that when COVID came earlier last year, what we saw was clinicians—doctors, nurses and others—from around the world go home, essentially. I know in the case of Ireland, the Irish consul to Western Australia, he helped organise a charter flight. I think there was probably 60, 70 or 80 medical professionals who went home to Ireland. They went home for a variety of reasons; partly because they wanted to help their own country in a time of need. We saw an outflux of staff. We are now trying to get those people and others back into Western Australia to do it. In terms of which agencies have been used, I am not sure if we are in a position to say which agencies. Dr Williamson?

The CHAIR: Is that information that can become available?

Dr WILLIAMSON: We could try to obtain that information.
[*Supplementary Information No A5.*]

Hon STEPHEN DAWSON: The director general has got some other information on what we are doing. It is probably prudent to put it on the record.

Dr RUSSELL-WEISZ: For the member's question, I think it is also prudent, whilst there is a national and international campaign and everybody is looking for staff, everybody is looking for workforce, be it looking internationally, we bring in around about 150 doctors, for example, from Ireland and generally from Europe each year. There is an ongoing recruitment. As the minister said, health service providers are recruiting themselves. They are recruiting to their specific areas. If you look at the North Metropolitan Health Service, it runs the tertiary maternity hospital for the state. They have had a massive focus on recruiting midwives. We have given health service providers the ability to go over their staffing base, so if there are more intensivists, for example, who are able to be recruited through a recruitment pool, or more theatre nurses, which is one of our areas of shortage, if there are more who can be recruited, we recruit as many as we can—obviously because there are different pressures.

Just to give you some figures. The question was about nursing and midwifery, particularly on the campaign, nursing and midwifery FTE between January and August this year: assistants in nursing is up 84; enrolled nurses, 78; registered nurses are up 671 people; senior registered nurses, 50; clinical nurses, 126; and midwives, only 15. However, we have seen more recruitment opportunities and

more people coming in to our midwifery recruitment. The campaigns are always ongoing. We have got graduate initiatives. This government has allowed us to take more graduates in than at any time before, so up to 1 270, and some will be in our vaccination program. Also, we have a return-to-practice program. We are also attracting back the nurses that we sent in collaboration—obviously, they were keen to go to the Grampians in Scotland. This is over, I think, two to three years ago where we had nurses who went to the Scottish Highlands, because they had shortages. Some of them are now returning to WA.

In addition to that, we are obviously running a mental health nurse workforce recruitment program. This is ongoing from the centre—from the Department of Health—but the health service providers know this best. They know what they need best. They are all collaborating together, but also specifically looking at what they need themselves.

Hon NEIL THOMSON: Thank you for that information. In relation to regional recruitment in particular and the claims of imminent service failure in towns like Wyndham and Fitzroy Crossing, can you elaborate on how many you have been able to recruit into the regions and particularly those two sites?

Hon STEPHEN DAWSON: Can I ask Mr Moffet if he can respond to this, please?

The CHAIR: Certainly.

Mr MOFFET: We have got a significant range of strategies in place to maintain service delivery across country WA. We have around 4 000 nursing staff, in broad terms, servicing the state, so it is a very large workforce. We have more nursing staff now than we had a year ago. Some of that is a result of overtime increases as well. Many of those are also deployed to vaccinations, COVID management and COVID clinics et cetera. In some parts of the state, as you indicated, Halls Creek and Fitzroy, where there are other small towns, from time to time, where we have very thin workforces, sometimes only two nurses on a shift, where we have short-term vacancies, they are very hard to cover. We are using a lot of our internal capability to deploy nursing staff and other staff, but primarily nursing staff, on a weekly basis from our district towns or our regional towns to smaller towns to support service delivery. We have a whole emergency management structure set up to deploy staff around the state.

From time to time we seek support from SHICC, the State Health Incident Coordination Centre, as well as other metropolitan HSPs to provide staff as well. In fact, we did that in relation to both Wyndham and Fitzroy Crossing. This has been going on since the onset of the epidemic. We have had a lot of challenges around immigration and access to nurses from interstate. Country WA relies more than any other HSP, certainly in this state but across the nation, on overseas doctors and overseas nurses and also interstate recruitment.

[11.20 am]

The borders and the controls that are in place, as well the departure from some professionals back to home base, have impacted us, so a large part of our emergency response is focused on workforce stability. We have stabilised services in Wyndham and Fitzroy. We obviously continue to plan and respond each and every week to exigencies and unplanned things that arise, whether that is shortages of staff through family relocating homes or staff sickness. In the instance of Wyndham and Fitzroy Crossing, I think some of the violence that we are seeing and the security issues in staff accommodation are impacting our ability to attract and maintain staff in the Kimberley. There are strategies in place locally, but that is a concerning trend for us. Currently Fitzroy, Halls Creek and Wyndham are covered, but it is a week-by-week proposition to ensure we maintain stable services in our small towns around the state.

Hon NEIL THOMSON: In relation to the recruitment issue, safety and quality at the child and adolescent health service and the Perth Children's Hospital, I wonder whether you could give us any numbers on resignations since April this year?

Hon STEPHEN DAWSON: It would be a question for Dr Anwar, but we could take it on notice.

Dr ANWAR: Can I take resignations on notice? I have got new staff who have joined us, but not resignations.
[*Supplementary Information No A6.*]

Hon JAMES HAYWARD: I refer to page 113 of budget paper No 3 and "General Hospital Services". As part of the spending increases over the forward estimates, are there provisions to expand the capacity of staffing at Albany and Bunbury hospitals; and, if so, to what extent?

Hon STEPHEN DAWSON: I will ask the director general to comment first of all.

Dr RUSSELL-WEISZ: Just going back to my previous comments, we have given all health service the ability to go up above their full-time equivalent base, just to give them that flexibility, because this year we have seen a lot of staff sickness. Be aware that it is not COVID, it is not flu; there have been other respiratory illnesses around—RSV, metapneumovirus and also a thing called paraflu. That has put a lot of people away from work. We obviously want to make sure that we have got buffers in our staffing to make sure that as that possibly will happen next year, we have got enough staffing. We have said that right across the board. We are treating country exactly the same as we are treating metro. Bunbury, which I think was one of the sites you mentioned, is obviously an extraordinarily busy site in the country health service, specifically in relation to the staffing to those two sites. I might see whether we can ask Mr Moffet.

Mr MOFFET: We generally staff in those particular sites of Albany and Bunbury to activity through our activity-based funding framework—so as our activity goes up, we respond either in a linear or a stepwise fashion, depending on the service type, to increases in demand. Both of those sites have been under significant demand and growth pressure for a number of years now, particularly at the moment, so we are increasing nursing through the nursing workload regulated program—we increase our nursing numbers automatically. That is the system has been in place for quite some time. We are also stepping up some specific services, so our critical care capability in Bunbury in particular we are growing, consistent with government's announced investments into both the service and the capital at the Bunbury site. Similarly, whether it be palliative care, surgical services, general medical, mental health, there is staffing growth. I do not have the specific numbers, but there is staffing growth commensurate with activity happening in Bunbury and, to that extent, Albany. Albany also has particular paediatric and general medical services growth at the moment as a result of demand and the service plans to increase the range of capability, particularly in paediatric and neonatal capability down in Albany. So in general terms, yes, there has been quite significant growth aligned to activity over the last several years in both Albany and Bunbury.

Hon JAMES HAYWARD: I just want to touch on the culture of the workplaces of those two places—Bunbury and Albany. We know that Albany is under a WorkSafe order to fix its toxic culture. I have a two-part question. Has that ever happened before in Western Australia where WorkSafe has put an order in a hospital because of the workplace culture? Albany has also had some very poor results in terms of its internal survey, which shows that they are struggling as well. I am just wondering what you are doing to rectify those problems?

Hon STEPHEN DAWSON: I might ask Mr Moffet to respond. Honourable member, I am not sure that the WorkSafe notice is about toxic culture. They might be your words rather than WorkSafe's words. Anyway, generally in relation to the cultural issue you asked about, I will ask Mr Moffet to respond.

Mr MOFFET: I cannot comment specifically on whether this is the first time WorkSafe has ever issued such a notice, so I do not know to be honest. They would probably be a question for WorkSafe themselves. It is the first time we have received one as a country health organisation. The issues in Bunbury all span back a long way, really. It has been a hospital under a lot of pressure for quite a period of time. It has gone through service changes, status changes, accountability and governance changes over quite some years now, so it is fair to characterise the service as being under a lot of pressure, particularly in the last few years and currently. There was an independent review around two years ago, 2019, that was initiated by our board in relation to concerns that had been raised by management and clinicians at the site, which gave us a whole program of work, so we have been engaged for around 18 months now on a program of work around cultural improvement, service investment and resources investment into some key areas. That program is continuing and has gained a lot of momentum. WorkSafe themselves gave us positive feedback about that program. Essentially, they appear satisfied that the program of work that we are undertaking at the moment, if it goes through to completion and is successful, is the right course of action in terms of cultural measurement and improvement. There is a significant range of work going on around workplace safety as well at the site. That is a specific issue. We have obviously got the service growth happening at the same time, as services grow to meet government selection commitments, and our planning for major capital expansion is around $200 million, so there is a lot going on at the site. We have put in place extra capability in terms of the leadership team. There is a restructure going on to the clinical streams to make sure that senior clinical leadership capability is developed at the site as well, commensurate with the sort of activity that it is experiencing now.

In terms of the broader survey, I do not have Albany-specific results with me, but we are aware that there are a number of sites around the state where you have hotspots, if you like, and Albany nursing has been one of those. We have had a plan in place beyond each survey, so there is a plan being developed right now by the local management team and the regional leadership team around better understanding and responding to some of the survey results across the state. In general terms, I would say that over the two years that the survey has been running, we have had a two-point reduction in staff engagement during really what was seen as the most challenging time as a health organisation in our history. In the last 18 months, it has been extraordinarily challenging. Our staff have been amazing in the way they have responded to their country communities and to management, but it is fair to say that we have asked the extraordinary of them. That has come at a price at this point in time, so we are very focused on staff wellbeing and supporting staff in terms of fatigue and making sure that they feel supported in continuing to deliver care, particularly as we move through the vaccination program. At some stage we will see COVID enter the state, as has been commented on. We are very focused on making sure our staff feel supported, but it is a very big job.

Hon JAMES HAYWARD: Just picking up on the fatigue, I understand the director general said that one of the approaches to make more staff available is to increase overtime available to the staff. It is clear also that you have said that there is money in the budget to spend more money, and one of the ways to do that is to increase over time, but surely that is just making the situation worse, is it not?

[11.30 am]

Hon STEPHEN DAWSON: Just to clarify, I do not think the director general said “overtime”. He said “over base”, so hospitals can recruit up to 25 per cent above their base rather than 25 per cent overtime.

Hon JAMES HAYWARD: It is not the case that overtime limits have been increased?

Dr RUSSELL-WEISZ: We really leave that to health service providers. Some health service providers will use less overtime, but have more staff. We also do not dictate anymore. We want health service providers to stick to budget, but we do not dictate really on staffing, how they actually organise themselves. They are the experts; it is up to them. So, in relation to your question about Albany or Bunbury, I think that would be an issue that the local management would actually make a call on, but maybe Mr Moffet can comment on overtime as opposed to base staff.

Mr MOFFET: Obviously, our preferred response is to have no overtime as an organisation. The less overtime the better in terms of staff fatigue, but the reality is that we operate in 200 sites across the state and in approximately 100 of those we provide 24-hour services and we are quite thin, so overtime is a normal part of what we do in order to provide emergency care, anaesthetics, obstetrics, and a whole range of acute service responses. We have seen some increase in overtime, not extraordinary, but more significant than we would like to see, in the last 18 months. That is in response to staff shortages and extra demands now being placed on people. Our preference is to have a good stable salaried or contracted workforce and to really minimise overtime.

I cannot comment specifically on Albany at the moment. I just do not have that data with me. I certainly know we have had staffing growth over the last year, as you would expect, of between 400 and 500 staff, many of them deployed specifically to COVID-related functions, as we know, but around probably 200 just as a broad estimate to respond to activity increase. We would like to see more. It is accurate to say that we have had approval to staff up to 25 per cent more in some key areas. Our executive team and senior management teams are working through how that might work. Getting additional nursing and medical staff is not easy. We are experiencing that already. It is more likely that we will have to have place-based, so individual towns and individual service streams will look at what might work for them and that might be a clinical support resources. It might be some administrative support to free up nursing staff, for example. There will be a range of things that we will need to do to support our staff to keep going, but there is not an open tap of supply of doctors or nurses available at the moment.

Hon JAMES HAYWARD: Finally, if I may, are you confident there will be an improvement in the workplace culture in the WA Country Health Service moving forward?

Mr MOFFET: Are you referring to the whole of country or Bunbury specifically?

Hon JAMES HAYWARD: Port Hedland, Bunbury, Albany—the hotspots that we know of.

Mr MOFFET: I would say, based on our previous experience, definitely. I guess when one listens closely to what staff are saying, and bearing in mind there are a lot of extraneous pressures at the moment, and try to as quickly as we can respond to the pressures that staff are feeling, adjustment in management approaches, resourcing, all sorts of strategies that we have deployed over many years, we will definitely see improvement, absolutely. We are totally committed to that. Can I turn things around immediately in our current environment? No, it is going to take some time and some solid commitment, but that commitment is absolutely there from our organisation to continue to work, particularly with those hotspots. You mentioned the three hotspots that we have.

The CHAIR: Thank you. As a matter of interest, are there any nursing shortages or doctor shortages in the metropolitan area or the regional hospitals?

Hon STEPHEN DAWSON: I will ask the director general to respond.

Dr RUSSELL-WEISZ: Yes, chair, there are. We have got doctor and nursing shortages, but they are generally confined to specific specialties so midwives, for example, theatre nurses, intensive care unit nurses —

The CHAIR: Where are they most profound? In the regions or in the metro?

Dr RUSSELL-WEISZ: Both in the regions and in the metro. Mostly what I mentioned there is metro, but there would be shortages of midwives in rural areas as well. There are general shortages in every jurisdiction of those particular cohorts.

The CHAIR: As a former education minister, you could quite easily quantify where the shortages were and the numbers that were short. Can you do the same in the health portfolio?

Dr RUSSELL-WEISZ: We can. Obviously, things do fluctuate, but if you take King Edward Memorial Hospital as an example, we can tell you on a monthly basis how many midwives we are short of and how many we are recruiting, too. I cannot tell you off the top of my head.

The CHAIR: Can you provide that information for each of the hospitals? I do not want you to take up an enormous amount of time on this, but I would be very, very interested to know where the shortages are and what they consist of. What is the best way that you can provide that information to the committee?

Hon STEPHEN DAWSON: Can I clarify? Is it vacancies you want?

The CHAIR: Yes, situations that are—that is why I asked first of all: how do you quantify it? In education it is very—we need a teacher in science in Meekatharra, but in health I would be interested to know if there are positions vacant and available, and do you do it on a monthly basis or how do you quantify it? You can do it, I understand.

Hon STEPHEN DAWSON: I will ask the chief executive because each HSP will have a different set of circumstances. So, I might ask Ms MacLeod to give you the information.

Mrs MacLEOD: Conferring with my colleagues, I think we would be able to provide you with that. The critical areas would be—we can get you some numbers and present it in a consistent way—but medical, there will be some specific specialists such as psychiatry but otherwise junior medical officers are generally an area of shortfall. There are some key areas within nursing; intensive care theatres and midwives and mental health are examples. So, we can give you those numbers and then other general where we are short and we can provide that.

The CHAIR: That would be great. I would appreciate that. Thank you.
[*Supplementary Information No A7.*]

The CHAIR: Now we will move on to Hon Dr Brian Walker, who is very keen on this portfolio.

Hon Dr BRIAN WALKER: I am, of course, as you know, a practising medical practitioner while also an MP. A quick mention here, I was listening with great interest to the comments across the chamber here and noting that it does not actually gel with my experience as a doctor throughout WA. Mind you, I left hospital service a year and a half ago. The hospital there, 100 per cent of the nurses stated that they would be happy to leave; they were that distressed at how they were being treated. I see that reflected in quite a number of hospitals where the satisfaction expressed by staff in closed doors does not match the glowing representation by the CEOs of the organisation. I will leave that one just floating in the chamber.

I refer the minister to budget paper No 2, volume 1, page 318, and the first table on that page detailing the public hospital emergency services. I have spoken in the chamber a few times about the FTEs and I am wondering if I could direct your attention to that, which on the face of it with the increase in numbers seems very good. But the question I have for the minister, and for anyone else, is how many of those 2 951 listed for this financial year are frontline staff and how many are administrators?

Hon STEPHEN DAWSON: I will ask the director general to make a comment and then we might have to take it on notice.

Dr RUSSELL-WEISZ: I would have to take it on notice just to break it down. There has been a huge focus on recruiting the workforce in frontline, both nursing, allied health, and medical, and the vast majority would be frontline staff. Now, I do not mean just emergency department staff. I am talking about ostensibly clinical staff in our hospitals and our health services through WA. We have put on additional administration staff in the areas of, say, the state health incident control centres. They do not necessarily come up as clinicians. When we set up a response to the pandemic, there is a disaster response that we follow that comes under the Chief Health Officer, and we have had to supplement that to have a very robust core like every jurisdiction has done. We call it SHICC here. It is called SHEOC in New South Wales. That would be comparatively small numbers. Our focus has been on clinical staff, and we would have to come back on this.
[*Supplementary Information No A8.*]

[11.40 am]

Hon Dr BRIAN WALKER: Also, we were looking recently at the east metropolitan budget cut putative of a $10 million reduction and the claim that there would be no reduction in frontline services, which I thought was quite interesting.

I will move on to the next one here, because one of my interests, of course, is the efficiency of the health services there and one major part of that is going to be the electronic health records. I notice on page 314, items 43 and 44 make mention of "in an increasingly digital world". I looked for some figures and I found none. I am assuming this is because the EHR is actually a federal scheme.

Hon STEPHEN DAWSON: I will ask the director general to respond.

Dr RUSSELL-WEISZ: Can I just confirm, member, that you are referring to the electronic medical records system?

Hon Dr BRIAN WALKER: Indeed.

Dr RUSSELL-WEISZ: Through the minister, we were very fortunate to receive funding for a business case for an electronic medical record in the previous budget, and we have been working extraordinarily hard on this business case. WA Health generically has not put in an electronic medical record over many years. We have seen what has happened in our eastern states colleagues' jurisdictions and seen, I have to say, the good, the bad and sometimes the ugly and we want to learn from that. We know that an electronic medical record will improve safety and quality outcomes for patients. It is also supported by junior and senior medical staff. The one thing I can say is we do have a couple of digitally enabled hospitals; we have Fiona Stanley Hospital and Perth Children's Hospital. We have a system called BOSSnet, which was put in during the commissioning of Fiona Stanley Hospital as a digital medical record, and that has been enhanced and rolled out, some just read-only, to other hospitals. The $8 million that came from government was recognising that WA Health needs to get on the journey of an electronic medical record.

There has been a huge amount of work done in the last year during the pandemic by the team around me and also by the team in the department and the health support services about doing a very robust business case in relation to an electronic medical record, noting it is a journey. I think if there is anything we have noted from electronic medical record rollouts that have happened in other jurisdictions, it is that if you go for the big bang approach, sometimes you have to abandon that approach. We want to be noting that we are in pandemic, but we want it to be incremental. One of the things—as you can probably hear, I am very passionate about this—we have pushed in this is that we leave no-one behind. We leave no hospital; we do not have one hospital that ultimately is hugely digitally enabled under an electronic medical record and we have another hospital that has nothing. We know this is a changed management process; this is not just an ICT

process. It is not purely about the actual system. We have seen the success, for example, of rolling out an intensive care unit electronic medical record at Fiona Stanley Hospital, and that is now just about to be rolled out at Royal Perth Hospital in their new intensive care unit. That is basically a standalone system that we want right across the board for all intensive care units. We also have gone through a number of review processes with this business case. This has been a very robust business case and we will be presenting that to government shortly. It is a journey over the period.

I would say we are on a better platform now. We have successfully transitioned all our applications from our old service—so, our old infrastructure—to the cloud. That was called GovNext or, for us, HealthNext. That has been a huge achievement for Health, to move off dated infrastructure, and it now allows us to be able to actually put in an electronic medical record, should it be funded.

Hon Dr BRIAN WALKER: I am delighted to hear that. I would like to hear some sort of figures that might be associated with that to get an idea of that. But is it fair to say that the current electronic health record as used in general practice is not working out? I certainly have had no success with that. I have looked at the Kimberley, the communiqué for which I found was actually quite difficult to use. I am looking at the ED, where the nurses are standing there trying to input data and not being accepted by the system and spending unconscionable amounts of time trying to get this registered, which, when it is done, as can be seen in other hospitals, is quite nice. But the time it takes to navigate the difficulties of that program actually impairs the ability of nurses to move on. These are things which I have noticed in my own clinical experience. I now take it these are reflected in your desire to get things coordinated in one robust system and that is in the future and there is no funding plan available for that yet.

Hon STEPHEN DAWSON: The director general.

Dr RUSSELL-WEISZ: We have had funding for individual systems. Currently, there is a brand new imaging system and this is not an ICT system; it is a clinical support system—so, for X-rays CTs, MRIs. It is a whole suite as a new system of imaging that we are putting in place. PathWest this year has put in a brand new laboratory information system for the whole state. There are a number of new systems that will not be usurped by an electronic medical record. An electronic medical record should be able to take those systems and make it work. It is not really a one size fits all.

I would say, and I might be corrected by my colleagues, that most of the junior medical staff are very au fait with using electronic medical records, and the ones who go to Fiona Stanley Hospital who are using BOSSnet would say, "Please do not go back to paper; we want this enhanced." I think, member, you are talking about potentially what you use in general practice. It has been a long time since I was in general practice and we certainly had paper then. I do not know if you are talking about the usability of that service in general practice. If a patient has a My Health Record, certain things get uploaded from the hospital system, as it does from general practice. What we are trying to do is again keep this to an implementable practical solution and deliver something for the health system that hopefully in the future will be integrated into general practice, but not try to bite off too much in the first go.

Hon Dr BRIAN WALKER: I have one last question, and we are going to go back to COVID now. In paper 2, volume 1, page 309, paragraph 2 says that we continue to experience service pressures. I think we can all accept that. The question I have is actually more a look at the potential in the near future—perhaps to the Chief Health Officer just now. At what point do we anticipate our emergency services and ICU reaching breaking point should the floodgates open?

Hon STEPHEN DAWSON: Dr Robertson.

Dr ROBERTSON: Through the minister, that is a very hard thing to predict. We have a very good idea of what our current position is. We also have a very good idea of what our surge capacity is. We also know that as we increase our vaccination rates, from the modelling we have seen, the number of cases that are likely to end up in hospital or the number of ICU cases continue to fall. We have seen that starting to play out and we have seen it actually play out in a number of other jurisdictions.

What we are looking at is getting up to between 80 and 90 per cent. Certainly by 90 per cent, we will be very comfortable that we will have the capacity to deal with any outbreaks that may occur, for a number of reasons. First, by that time, obviously the number of cases we are likely to end up with who require hospitalisation or ICU is going to be a lot less and they also will be spread out over a greater period. Certainly, we are starting to see some real impacts from 70 per cent onward, but to ensure that we have that capacity, we are really looking at between 80 and 90 per cent to be comfortable.

Hon STEPHEN DAWSON: Just on that, the director general just wanted to supplement that.

Dr RUSSELL-WEISZ: Your question was about reaching capacity. I think we were concerned last March when we saw what was happening around the world because we thought that we certainly would reach capacity. I think as Ms MacLeod outlined, there were very good plans to say we have these intensive care beds, these areas can become intensive care beds or high-dependency beds and all these spaces up to about 650 spaces can be used. That was at that time. We also have—I think this is something that has been nationally discussed—this acute surge and then when you do have COVID here and high vaccination rates, a bit more normality comes into it. We still have a very, very robust acute surge plan and that acute surge plan, if it did—you have seen this in New South Wales and Victoria—get away from us, obviously we would do our best that it did not. When New South Wales had its first case, which I think was on 16 June, they were only at 33 per cent first dose and 16 per cent second dose. Today, we are at 74 per cent first dose and 55 per cent.

So the whole environment would change, but we still have an acute surge capacity. If we had a large outbreak, exactly like you have seen in Victoria and New South Wales, you would work with your private partners as well. The private hospitals have been involved with us from the very, very beginning. In very, very acute surges, as you have seen in Victoria and New South Wales, you would have to take down some elective work. You would have to respond, but, as Dr Robertson says, if you get to the best vaccination rate you possibly can, you are then able to work with COVID in the community.

The CHAIR: What I intend to do now is just have a five-minute comfort break for everyone and I will go an addition five minutes after one o'clock.

Hearing suspended from 11.50 to 11.57 pm

The CHAIR: Welcome back.

Hon WILSON TUCKER: My line of questioning is related to COVID modelling and vaccination rates in budget paper No 2, volume 2, part 5, which continues on a similar line of questioning to Hon Tjorn Sibma's. I asked a question before the hearing about what COVID modelling WA Health relies upon to formulate health advice. The answer I received was that WA Health did not identify a particular model but considers various models and conducts its own internal modelling. Given this response, my question is: what is your modelling telling you is the risk of COVID to the community at an 80 per cent vaccination rate?

Hon STEPHEN DAWSON: I can start off. Obviously the state considers modelling from a range of places in terms of its decision-making. You would have seen in Victoria, for example, they have the Burnet Institute. The Doherty Institute is referred to quite regularly in terms of the commonwealth.

We model as well. Modelling is a point in time, honourable member. Obviously we look and see what is happening in Victoria or New South Wales on a daily basis, and the learnings we get from that we take into consideration in the things we model—so it is not a static piece of work. You cannot say, "Well, that's stuff we did yesterday; we will rely on that for the next few months", because, quite honestly, you cannot. Thankfully, we have been very fortunate in WA to this point, but the learnings tend to be from other states and territories around the country and indeed around the world.

In terms of any modelling, in terms of the decision-making process for the state, we do have a state emergency committee of cabinet, so this stuff goes to that committee of cabinet and then it will go to cabinet. It is cabinet that makes decisions in terms of where we go to from here, but obviously it is based on the advice from the Chief Health Officer. We have relied from the outset on the medical advice and it has served us well until now. We do not propose to deviate from that. But the professionals tell us that you cannot rely on just a piece of modelling from Western Australia alone; you need to learn from those other states and territories that are actively on a daily basis living with COVID—living through COVID. What we are seeing is that it constantly evolves. The short answer is that we get our modelling from everywhere. We have our own consideration as a state, but those learnings come from elsewhere.

Hon WILSON TUCKER: Given the modelling, as you mentioned minister, is dynamic, it changes based on a number of inputs, do you have the rate that you would expect for hospitalisations—this could be a range or a percentage—given the current modelling today?

Hon STEPHEN DAWSON: I am told that there would be, honourable member, but I am told by the director general that it is cabinet-in-confidence so I am not at liberty to release that at this stage. I am trying to be helpful. I will ask the director general what he can provide in relation to that.

Dr RUSSELL-WEISZ: I would properly ask the Chief Health Officer to make a comment, but I would say that the minister is right: we rely on Doherty. Doherty is the start. Doherty was obviously at national cabinet. Then there is a range of other things. You look at exactly what is happening in real-time in New South Wales and also what is happening in Victoria. That is in real-time. As the Chief Health Officer has said today, the rates of hospitalisation are probably less—I do not want to put words into his mouth—than maybe what would have been expected, even at the original time, as the minister said, when you look at the Burnet modelling in Victoria. So you take all of those. There are two other parameters that we are very open about, which people have talked about, which is what they call TTIQ—it is another health acronym: tracing, testing, isolation and quarantine—and then public health social measures or PHSMs. Those are all taken into account. What has happened then is WA Health with its modellers has looked at all of that. It is dynamic because we are seeing what is happening in Victoria. I think Victoria today had 1 600 or 1 700 cases. They obviously have had quite high cases. Obviously, our modellers then look at what Doherty predicted, what Burnet predicted and seeing what that actually looks like at certain vaccination rates. That actually informs where we think we will be in relation to the vaccination rates. But what every state has said is we need to get vaccination rates as high as possible.

[12 noon]

The CHAIR: Can I get some clarification on what your question was, Hon Wilson Tucker? What were you seeking?

Hon WILSON TUCKER: Any modelling around the expected number of hospitalisations at an 80 per cent vaccination rate. If we did 80 per cent and the borders are open, how many hospitalisations, how many cases is the government expected to see in that scenario?

The CHAIR: Can I just get some clarification; that data is cabinet-in-confidence, is it?

Hon STEPHEN DAWSON: Firstly, I am told it is not finalised, so the considerations are ongoing, and secondly, it would go through that cabinet process before government makes a decision to release it.

The CHAIR: Can I get some clarification myself from this? Does cabinet make the decision what is going to happen, or is it based on specific data?

Dr RUSSELL-WEISZ: The modelling that is done by the department and informed clearly by the Chief Health Officer's advice—it has always been informed by the Chief Health Officer's advice—is that the Chief Health Officer and others and I would look at that modelling and then that is actually informed through the State Disaster Council. That modelling at the moment is taking into account—I have said it again, today we are at 75 per cent, 55 per cent vaccination rates. We know that we want to get as high as possible. That modelling has then informed the Chief Health Officer's advice. I might ask Andy to comment.

Dr ROBERTSON: Obviously, as the director general said, the Doherty data has formed the basis of a lot of the national modelling, and that is readily available. That gives you an idea of the likely number of cases you will get, the hospitalisation rates and ICU rates at a 70 per cent and 80 per cent level, and lower levels than that, but obviously at 70 and 80, which are of the most interest. Then we obviously look at modelling that also takes into a number of parameters. It is not a matter of just modelling the rise of cases, but it is how effective is our testing, our contact tracing, our isolation and our quarantine. Obviously, if that is optimal, that will have an impact on the spread of the disease. If we can actually reduce the size of the epidemic, just by the testing, contact tracing and subsequent isolation and quarantine, that is part of the thing we would need to model. The other things that we would need to model is what impacts would different public health social measures have. If we were to lockdown for a period of time, whether that is a short lockdown or a long lockdown, that will have an impact on what the model is and the number of likely cases. What happens if we do not do a full lockdown—we use lesser restrictions, for example? What happens if we had capacity limits and density limits at certain levels: what would be the impact of that? They are all the kind of things we need to model to consider in a model going forward. They are the factors as well as the vaccination rate and exactly what the vaccination rate is and what the vaccination rate is in different subgroups. For example, if we have an outbreak in an Aboriginal community with a very low vaccination rate, we may have a lot more cases than if we have it in a highly vaccinated part of Perth. That is all part of the modelling process. Those factors come into play and it is quite complex, but that gives us the basis for us to look at what the next steps might be.

Hon WILSON TUCKER: Thank you for that answer. How long do you expect it to take to achieve the hospital capacity to handle the expected number of cases identified in your modelling? Given the modelling is a black box—there are a few different inputs here, the Doherty, I think there is the Milan as well—I am curious if there is forecasting done around the amount of time it will take to have hospital capacity to handle those expected number of cases in a scenario where we open up.

Hon STEPHEN DAWSON: I will ask the director general.

Dr RUSSELL-WEISZ: Through the minister, the honourable member asked about—it is dynamic because it is now. If something happened now, it would probably be what I would call an acute surge phase, what Ms MacLeod talked about earlier during this estimates about how we would respond. We are not at that level yet. We only have 55 per cent of people double vaccinated. How we would respond to an outbreak? The Chief Health Officer, as he has done since early March 2020, has given advice to government about what certain measures you would put in place. At times it has been lockdown, at other times it has been, as the Chief Health Officer just said, it could be going to a two-

square-metre rule. Those are public health sector measures, and making sure our testing and tracing—so, whenever we have a major outbreak, make sure our testing is good. You have seen all the queues, but we have a good testing response and we have a good tracing response. That is as we are today.

I can say today, if we got a major outbreak—you are really asking me to probably say that we did not respond, we got into a New South Wales–type situation, which I would obviously have to say that we would do our best, I think all three of us and everybody in this room, not to get into that stage, and we have not in the past. But we would make a call then about, well, if we have an increased number of cases in hospital, we have a very defined acute surge plan. We have talked about if we went over our normal intensive care unit beds, where we would go for additional beds, and we have got those beds, we have got the ventilators. In an acute surge capacity, you would pull certain levers. You would pull public health sector measures, you would make sure your testing and tracing kicks into action, as it always has over the last 18 months. You saw exactly what the contact tracing did for the truck driver who was positive just recently. Initially, we thought there were very few contacts, and that expanded to a lot more contacts. That was the tracing going straight into action. Testing went into action to a lesser extent than when we have had lockdown.

[12.10 pm]

That happens at the moment. The point you are getting to if you have high vaccination rates, is that you are trying to cause least disruption to the health services as possible. But at the moment we have seen in the acute surge phase, both Victoria and New South Wales have had to take down elective work and they have had to use private capacity. That has always been what we would do as well, if we got into that situation. As Dr Robertson has said, if you can get your vaccination rates very high, you have less cases, less ICU, less deaths, less hospitalisations, but you are going to have to respond and you want to, as we have always said from the beginning, flatten that curve. With high vaccination rates, we want as least disruption to the system and to be able to cope within our intensive care unit capacity that we have now, or be able to minimally surge—just use a little bit of the surge capacity that we have actually planned for in the last 18 months.

Hon WILSON TUCKER: Minister, I am just curious to dig into this modelling a little bit more, and I appreciate you mentioned it is dynamic. Are you able to table a snapshot in time, say today, of the current modelling that the Health Department is using and relies on; and, if you cannot do that, are you able to provide the details of the methodology or process that is used to determine this modelling?

Hon STEPHEN DAWSON: No, I am not, honourable member, as I said. Any modelling, as I explained, it is a constantly evolving process, so any learnings would be shown to the Chief Health Officer and, based on that, he would recommend a course of action to the State Disaster Council. That is what happens. I do not have a document that I can provide to you, but we learn on a daily basis, based on what is happening elsewhere in the country, about how they are dealing with COVID-19, how it is spreading et cetera, and what we would likely need to do should it arrive in Western Australia—or when it arrives in Western Australia. So it is a constant process, but I do not have a document to table.

Hon WILSON TUCKER: Just the final question here. The Premier has previously mentioned opening up at around the 80 to 90 per cent vaccination rate. Is there any expected announcement to give Western Australians a hard vaccination target to open, rather than an ambiguous percentage? So, really, what is the actual target whereby we would open up?

Hon STEPHEN DAWSON: Can I say, through you, chair, I cannot presuppose decisions or announcements the Premier may make in the days, weeks or, indeed, months ahead; that is a question you will have to ask him at some stage.

The CHAIR: Will it be based on medical advice?

Hon STEPHEN DAWSON: What we have done thus far, for the last 18 months we have relied on medical advice, so I do not see us changing course.

Hon KLARA ANDRIC: I refer to budget paper No 2, volume 1, page 307, under the heading "Appropriations, Expenses and Cash Assets", the line item "Delivery of Services". Can the minister provide advice as to the concerns in relation to long-stay patients in WA hospitals and what is being done to address these concerns?

Hon STEPHEN DAWSON: I can ask the director general to make comment on that. This is a very real issue and I have to say that it has been in the mental health portfolio too. There was a snapshot, I want to say, in August now. At that stage, there were 152 people in long-stay mental health beds who could be somewhere else, if there was somewhere else for them to go; that is, they should be in more appropriate settings and getting more appropriate services had there been somewhere else for them to go. There is a body of work that Nicole O'Keefe, who is one of the assistant directors general at the Department of Health; she is leading on behalf of Health, but other agencies are involved. I will ask the director general to comment.

Dr RUSSELL-WEISZ: Through the minister, this is one of the key strategies to reduce the demand in our hospitals. If we can free up current beds and get these patients more appropriately treated in the community, it is not discharging these patients inappropriately. We have had some patients in our hospitals waiting many years. We discharged one recently who had been in the hospital for five years. They have gone to appropriate accommodation with wraparound clinical services. Some of these people need very complex wraparound services. We have now had a team established in the department working with our health service providers to navigate a myriad of different agencies and, on many occasions, the commonwealth. Just incidentally, we met with the NDIA recently. We have very good engagement with them. At the moment, we have normally 130 long-stay patients in our hospitals who could be somewhere else—somewhere appropriately cared for, either in housing or supported housing, with clinical wraparound services, and sometimes they are very complex.

We know that some of our NDIA partners—those people who provide NDIA services to complex patients—are finding the funding that they actually receive from the commonwealth is not as high as they would like. We work with them very closely. What we have done is try to get away from this sort of commonwealth–state divide. We have said, "Look, we need actually to intervene on these patients." Over the last six months we have moved 115 long-stay patients to more appropriate accommodation. That could be NDIA or aged-care accommodation, but it is actually freeing up capacity. Unfortunately, those beds have now been filled by more long-stay patients. But the issue would be, if we had not done this intensive work, we would have ended up with probably 250 patients in our beds. A lot of these patients would have mental health issues that need to be treated both in the community and in the hospital, but I can say that all the agencies are working well together. You need Communities, the Department of Health and the Mental Health Commission.

The NDIA are being extraordinarily cooperative. We are working really closely with them and also we are looking at whatever opportunities we have outside Health. We are working with an aged-care provider at the moment, who also can provide disability services, and we are going to try and send between 12 and 24 patients out from our hospitals to those sites. It is trying to fill this missing

middle. It is trying to fill from the complexity of a hospital stay to community, about where you actually place these patients. As part of our emergency access response program, which is looking at the demand in our hospitals, this is one of our critical three. I mentioned to one of the other honourable members: workforce, capacity and also with the beds that we are opening, but also long stay. I cannot emphasise enough the effort that needs to go in here, because this is something that will stay with us. As we age, I think this issue will become greater and we are going to have to break that divide down between community providers and hospitals, and between the commonwealth and the state.

Hon STEPHEN DAWSON: If I can add, just briefly. Just in terms of the project, the Department of Health, the Mental Health Commission and the Department of Communities have been working together, as the director general said, trying to do it on a person-by-person basis, so trying to find a solution for that person. It is not about discharging, as the director general said; it is about transitioning to more appropriate services. The issue of bed blockages is an issue that transpires in each of our states and territories. I know that recently health ministers from around the country have written to the federal government on this issue to seek their support and some funding to enable state and territory jurisdictions to actually help find more appropriate settings for these patients. I think for some of these beds, I heard anecdotally, some of the long-stay mental health beds, for example, if you get a person out of a long-stay bed who has been in there for a period of time, you can have about 20 to 22 patients who would ordinarily use that bed throughout a year, so it is significant. To be able to deal with these issues creates a lot more capacity in the system: better care for the patient, first of all, but capacity in the system to deal with the other issues that we have to deal with.

[12.20 pm]

Hon STEPHEN PRATT: I just wanted to come back to the COVID response and vaccination. I refer to budget paper No 2, volume 1, page 308, and the line item "COVID-19 Spending" under "COVID-19 Response". The Chief Health Officer gave us the current statistics around double vaccination. I am hoping that the minister can expand on some of the initiatives that are underway in promoting vaccination.

Hon STEPHEN DAWSON: Sure. I may actually ask the Vaccine Commander to make comment. Honourable member, I am not sure if you were here and apologies if you were. I had previously mentioned some of the innovation that is happening around the state. The state has been working with, for example, mining companies, and so I think in places like Paraburdoo, Tom Price and other places, we have actually worked with them to get mass vaccination happening in those communities. There were recently a couple of "vaxathons" in Broome—again, a collaboration of the state, private and non-government sector all working together to try and get to people as close to home as possible to make it as easy as possible for them to be vaccinated. But I think the Vaccine Commander is living this stuff on a daily basis, so perhaps he can provide some further information on that.

Mr DAWSON: Thank you, minister. Through the chair, I will comment first on the metropolitan mass vaccination clinics. We have seen in the recent week the bookings start to tail off in terms of full utilisation of the available doses. I have authorised and conferred with the Chief Health Officer to make all of the metropolitan vaccine clinics available on a walk-in basis. We did open that up for the Claremont and the Joondalup vaccination centres, but today I have in fact authorised for full walk-ins. That, then, allows people to go at their own convenience as opposed to a particular set date. We also brought forward, by emailing, each of the future vaccinations—for example, either for first or second dose—for people to come in earlier, based on the available vaccines and vaccinators.

Within the metro area, we have the Claremont, Kwinana, Joondalup, Perth and, as I mentioned in an earlier answer, Armadale and Mirrabooka centres. Aside from those, we have also, in this current month, got vaccination clinics underway in Albany, Broome, Bunbury, Busselton, Carnarvon, Derby, Geraldton, Hedland, Kalgoorlie, Karratha, Kununurra and Newman, by way of example. And there are other ones, for example, at Katanning, and I could keep going right through the south west—for instance, at the Pilbara and other places.

For specific cohorts such as schools, we have already commenced four agricultural colleges in the country, education support schools—again, based on health advice—because of the vulnerabilities of those particular student cohorts. Four such education support schools have already been the subject of their first dosage, and six schools are scheduled for next week. We have nine residential colleges and a further 18 education support centres already scheduled. We are working with what is termed an "in-reach model", attending specific schools, and with the 75 metro secondary schools and 35 regional secondary schools, we have a mix of buses to transport children from the school to a vaccination centre for efficiency purposes. In other cases, depending on the socio-demographics, we got advice from the Department of Education, and are working very closely with them, that in order to address specific cohorts that may be in a lower socio-economic demographic, we know from the learnings in New South Wales and Victoria that they are more vulnerable because of the nature of the settings in which they live.

Aside from that, there are, as I mentioned earlier, specific faith groups. They will range from Muslim and Christian to all sorts of faiths. We have converted a number of the buses previously utilised by police, because they have got refrigeration and they have been adapted for transporting both vaccinators and the vaccines to specific places of worship or specific cultural groups. So, with that, the engagement with cultural leaders is very important. Translating Aboriginal, Creole or specific cultural groups in language has been most important. The Chief Health Officer and I have addressed, for example, African faith groups, Sikh and a whole bunch of different cohorts in order that we can both engage and get confidence with the community leaders who are also assisting us not only with interpretive services, but also by encouraging their own particular community members to come in. So we are now at this phase of specifically targeting those areas that we see under-represented, and there is no greater concern than the Aboriginal cohorts and communities. Again, we have extensive interaction there at the strategic and the face-to-face level. Aboriginal people, myself, the Chief Health Officer and others have specifically sat down with community leaders to, one, explain to them and, two, get their assistance and cooperation.

Hon STEPHEN PRATT: Through the chair to the Vaccine Commander, about Aboriginal and more around the remoteness of that, what techniques are we using to get the vaccine to communities?

Hon STEPHEN DAWSON: Commissioner, if I may, I might just start before you do. I just want to place on the record my thanks and our government's thanks to the Aboriginal medical services and particularly the Aboriginal health council who have been tremendous in terms of their capacity and ability and want to work with us. Even from the early days, kind of from early last year, they were trailblazers, I have to say. They were out there, ahead of most others, in terms of actually pushing government, it would be fair to say, to actually respond appropriately. So to Vicki O'Donnell and to those teams, thank you.

There have been some issues with AIR, and I will let the commissioner add to it. The reporting system that the commonwealth uses is called "AIR", and someone can tell us what it stands for. The data from Western Australia is influenced from some of our remote communities. So what we know from on the ground, and how some of the communities have been vaccinated or high numbers of

vaccinations, has not actually appeared on AIR as it should have, or there has been a lag for a period. But if the commissioner does not mind answering that as well.

Mr DAWSON: I can. Thank you, minister. Through the chair, to extend on the minister's comments just then, by way of example, several days ago through the Aboriginal advance council, the AACC—Vicki O'Donnell heads up the Kimberley Aboriginal Medical Service. The difficulties we have got in getting specific and precise data is because AIR, which is an acronym for the Australian Immunisation Register, is inputted by data from pharmacists, GPs, AMSs and the state health vaccine centres. It has difficulties in reconciling data because, for instance, it is done on postcodes. So if you use the example of the Kimberley for instance, the Halls Creek postcode may cover smaller communities such as Mulan, Bililuna, Balgo et cetera and we cannot get specificity in terms of the exact numbers of people who have received the vaccine because the postcode could cover as many as 40 different localities. I have spoken to the federal Aboriginal affairs minister, Ken Wyatt. He has undertaken to provide, through his efforts, further data. We have put additional analysts to work with our epidemiologists, and I have bought in another four analysts last week to add to what the epidemiologists do to write further code, to try and get that specific data so we can be more precise in where we target the particular vaccines. But I would add to what the minister said, the AMS, the private providers and the pharmacy guild et cetera and the WAPHA, which is the Western Australian general practices, are all working very collaboratively, as much as we can, despite the data difficulties.

[12.30 pm]

Hon SANDRA CARR: I refer to budget paper 2, volume 1, on page 310 under the broad heading "Significant Issues Impacting the Agency" but more specifically under the subheading "Critical Infrastructure and Capital Projects". Can you please detail some of the investment in specific infrastructure in capital works particular to regional Western Australia?

Hon STEPHEN DAWSON: I can start; the director general might supplement. I think it has been alluded to previously today that we are seeing significant investment in this year's state budget in the mental health space. As part of that, we are seeing a range of regional hospitals upgraded over the next few years. We will see an investment at Meekatharra hospital, for example, in your electorate—actually, it is in my electorate; outside of your electorate—of $48.5 million. That is to consolidate health services at that hospital site. That includes the expansion of acute care, emergency services, mental health, community aged care, and other primary care services. In your electorate, a redevelopment is scheduled to happen at Geraldton Health Campus; that is $82.3 million. That will deliver an expanded emergency department, a new intensive care unit and an expanded high dependency unit. It will also deliver an integrated mental health unit and also includes essential engineering service upgrades. There is money for expanded car parks for a new ambulance entry and to reconfigure the main entry. There is further money, $2 million, for detailed planning and scoping works for stage 2 of the redevelopment, which is to co-locate St John of God private hospital on the Geraldton Health Campus site.

There is an investment in Laverton hospital; $23.47 million towards a new Laverton Hospital project. There is funding for the Tom Price hospital. Again, this is a facility that is probably long overdue for upgrading. That will provide a fit-for-purpose hospital with a modern emergency department, private interview rooms and consulting rooms, visiting services. It will provide new medical imaging equipment and digitally enabled telehealth services, and a new four-bed inpatient ward. There is a significant investment of $61.4 million for a redevelopment at the Newman health service. This, too, will include an expanded emergency department, inpatient beds, an outpatient centre, purpose-built GP consultation spaces, and two dental chairs. We are investing more than $1.3 billion over

the next four years into significant health infrastructure and it is happening right across the state. I am not sure whether the director general has anything to add.

Dr RUSSELL-WEISZ: No, minister, you covered everything. From a Department of Health perspective, we are working very closely with WA Country Health Service in relation to the Bunbury redevelopment. Obviously, that is a $200 million commitment from the government. It is a complex redevelopment that is in its early stages. The project definition plan is being finalised. There are natural complexities on the site that needs collaboration between the department and WA Country Health Service. Maybe Jeff needs to add if we have missed anything.

Hon Dr BRAD PETTITT: Maybe the chair can advise me before I go down this route; I want to make sure that it is appropriate. In terms of questions that relate to annual reports, is now the appropriate time?

The CHAIR: No.

Hon Dr BRAD PETTITT: Okay. I will not do this one either. My staff provided me with questions to ask that are probably not appropriate at this point.

The CHAIR: You will get an opportunity. As you know, on the committee, we will have a specific hearing for annual reports.

Hon Dr BRAD PETTITT: I will pass on my turn.

Hon NICK GOIRAN: I want to refer to budget paper No 2, volume 1, page 312, at line item 26 where it discusses the implementation of the Voluntary Assisted Dying Act 2019. How many applications have been made since the scheme came into effect on 1 July?

Hon STEPHEN DAWSON: I will find the right page in the notes.

I will ask Dr Williamson, who may be able to provide information. It is how many applications have been received since 1 July?

Hon NICK GOIRAN: Yes.

Dr WILLIAMSON: That information would be provided to the board. We would have to seek permission to release that information from the board.

Hon NICK GOIRAN: Sorry, I missed that—you would need to get what?

The CHAIR: Need to get permission from the board.

Dr WILLIAMSON: That information would be provided to the board and then the board would report on this. This is the number of people who have applied?

The CHAIR: Applications; yes.

Dr WILLIAMSON: Yes.

Hon NICK GOIRAN: Who has possession of the applications at the moment?

Dr WILLIAMSON: Sorry, who has possession of them?

Hon NICK GOIRAN: Yes, of the applications. Who is in possession of them?

Dr WILLIAMSON: When an application is made, it is managed through the board secretariat.

Hon NICK GOIRAN: The board secretariat?

Dr WILLIAMSON: Yes. The individual applications are managed by the statewide care navigator service. The information about the use of the substance et cetera is reported to the board.

Hon NICK GOIRAN: Is the navigator service funded by the Department of Health?

Dr WILLIAMSON: Yes.

Hon NICK GOIRAN: How many applications have they received?

Dr WILLIAMSON: I would have to seek advice about releasing that information. If you would like me to take that question on notice, I would be prepared to do that.
[*Supplementary Information No A9.*]

Hon NICK GOIRAN: Are you in a position to tell us how many deaths have occurred as a result of the applications?

Dr WILLIAMSON: Again, I would take that on notice.

Hon NICK GOIRAN: Because?

Dr WILLIAMSON: Because that information is not in the public domain at the moment.

Hon NICK GOIRAN: Is that not the whole point of an estimates committee hearing?

Dr WILLIAMSON: The way that it is intended to work is that the board will produce a report and that information will be released through the report.

Hon NICK GOIRAN: That might be the desire of individuals, but this is a parliamentary committee hearing. The government has provided a large amount of money to WA Health including for the facilitation of this scheme.

Dr WILLIAMSON: As I say, I am happy to take the question on notice.

The CHAIR: We will include that with the previous question, A9.

Dr WILLIAMSON: Can I just clarify what the question is; would that be all right? There is a question there about —

The CHAIR: It is the number of applications and the number of the deaths.

Dr WILLIAMSON: To what date?

Hon STEPHEN DAWSON: From 1 July to today's date.

The CHAIR: 1 July to today's date; and then the number of deaths.

Dr WILLIAMSON: Again, can I clarify: is that the number of deaths through administration of the substance or the number of deaths and those who have applied?

Hon NICK GOIRAN: No; as a result of the substance being taken.

Further to that, Dr Williamson, are you aware of reports of any complications?

Dr WILLIAMSON: No.

Hon NICK GOIRAN: You are not aware of any. Is the director general aware of any?

Hon STEPHEN DAWSON: Director general.

Dr RUSSELL-WEISZ: Honourable member, no, I am not.

Hon NICK GOIRAN: Mr Chair, perhaps the minister could ascertain whether any of the witnesses present today are aware of any complications that have arisen as a result of a Western Australian taking a VAD substance.

Hon STEPHEN DAWSON: I have to say that I rely on the director general and the assistant director general, neither of whom are aware. Honourable member, that is not to say it has not happened.

Hon NICK GOIRAN: It most definitely has happened. I am trying to find out whether our most senior health officials in Western Australia are aware of it or not.

Dr RUSSELL-WEISZ: I am not aware of any. I cannot recall whether I have seen a briefing note on any adverse events from it. I would rather give you a very accurate response and just check my records over the last three to four months, which I am happy to do. But as I sit here today, I am not aware of any—I used the word "adverse" events, you used the word "complications".

The CHAIR: We will take as A10 confirmation as to whether or not there have been any complications.
[*Supplementary Information No A10.*]

Hon NICK GOIRAN: Further to that, Mr Chair: director general, I absolutely accept that you are not aware of it; you have said so today and that is enough for me. But who will you obtain this information from in order to inform the committee whether there have been any adverse events or complications?

[12.40 pm]

Dr RUSSELL-WEISZ: Through the minister, I might ask Dr Williamson to comment, but they would be notified to the Voluntary Assisted Dying Board.

Dr WILLIAMSON: The statewide care navigator service would usually be made aware of any issues that have arisen. We will take that question on notice and we will inquire.

The CHAIR: Yes, we have that one already. That is the one with the complications. Just to clarify, what was that last one seeking clarification on?

Hon NICK GOIRAN: I think the director general is clear that he is going to ascertain whether there have been any complications or adverse outcomes as a result of the taking of the substance.

The CHAIR: We have already done that. That is supplementary information A10. We have already got that.

Hon STEPHEN DAWSON: The extra question that the honourable member asked about who we find out from has been answered.

Hon NICK GOIRAN: Can we ascertain how many doctors have been involved in this process since 1 July? That may come in two forms. One is how many have been trained, because if they have not been trained in the process, they are not lawfully permitted to be involved in the process. Secondly, how many have actually been involved in the administration of the substance?

Hon STEPHEN DAWSON: I can advise you that there are currently 41 practitioners across Western Australia who have completed all components of the voluntary assisted dying approved training, and that figure was from 15 October. I am further advised that there are 163 practitioners who have registered for access to that approved training, although half have not yet submitted their documentation to the Department of Health to verify their eligibility, so they not have been able to progress to the training or they have realised that they are not eligible to access the approved training. In terms of how many practitioners have been involved in the process, we have to take it on notice.

The CHAIR: That would be available?

Dr RUSSELL-WEISZ: Yes.

Dr WILLIAMSON: We can certainly provide that information. Obviously, some practitioners have only been involved with one patient; others have been involved with more than one patient. We can give the total number of practitioners who have been involved with at least one patient.
[*Supplementary Information No A11.*]

Hon DONNA FARAGHER: I would like to go back, if I may, to page 321 under "Public and Community Health Services". I want to get a bit more clarity about the funding for the metropolitan child development services. I have now had the opportunity to go back and look at *Hansard*, and on 18 August, in an answer to a question in this house, I was advised that with respect to the business case the matter was subject to cabinet consideration as part of the 2021–22 budget process and therefore currently subject to cabinet confidentiality, which is understood. I just want to be really clear, based on the answers that have now been provided by the minister in the earlier estimates period. Can I confirm that the $2.5 million business case was either not approved or was held over and will now be considered as part of the 2022–23 budget process?

Hon STEPHEN DAWSON: I cannot confirm that; however, the director general has indicated that we are happy to provide an answer to that by way of supplementary information, because he does not know.
[*Supplementary Information No A12.*]

Hon DONNA FARAGHER: Further to that, can I also confirm that the $2.5 million is for one year only?

Dr ANWAR: There is obviously a desire to make sure that the funding is for a sustainable service going forward.

Hon DONNA FARAGHER: Thank you. Further to that, again perhaps on notice, can you advise with respect to that $2.5 million, because that is obviously more than the $1.6 million that has already been provided, how many additional FTE staff would be able to employed through that extra funding? I will take that on notice as well.
[*Supplementary Information No A13.*]

Hon DONNA FARAGHER: The final question, to allow others to ask questions, is: I understand that the last workforce analysis was undertaken with respect to the metropolitan child development services back in 2015, and that was in response to an answer provided to me also in the house. Can you advise when the next analysis is expected to be undertaken?

Dr ANWAR: We are currently just re-looking at the CAHS workforce and systematically working through that at the moment. I can come back out of session for a date at which CDS would be embraced and the date at which it would be completed.

Hon DONNA FARAGHER: Could we take that one on notice then, please?
[*Supplementary Information No A14.*]

Hon TJORN SIBMA: I would like, if I can, to pick up previous line of questioning, but first I want to establish the fact, for full disclosure, because it has been a topic of interest, that I am double-vaxxed. The whole incentive behind this is so that I reduce my chances of contracting COVID; reduce the severity of the symptoms I acquire, should I acquire the disease; and obviously reduce the chance that I am either hospitalised, put in an ICU unit or develop long COVID or die. It also obviously reduces my capacity to transmit the virus to other vulnerable populations within the state, one of whom, the largest group, is children under 12, who I think rarely get the oxygen in the debate. It is an oversight in our public health messaging Australia-wide. Therefore, I ask a question on the basis of health advice. Could I understand the risk that is presented to the Western Australian community by the arrival of somebody who is double-vaccinated and tests negative for COVID upon arrival? What are the chances of those people transmitting the virus throughout state?

Dr ROBERTSON: If somebody is double-vaccinated, assuming they have had at least two weeks past the second vaccine, which would give them maximum protection, there are a couple of things we know. It depends a little bit between vaccines, but their chance of getting the disease—there are

various figures depending on the vaccines—is around 65 to 70 per cent less than an unvaccinated person. Similarly, their chance of transmission is also reduced. If they get the disease, their chance of transmitting it further on is also reduced, and the estimates are around a 65 per cent reduction. So if you combine those two together, your chance of getting the disease and then transmitting it is considerably less—in the 80 to 90 per cent less. However, it is not zero. Somebody coming in has one test. The issue with one test is that it is a point in time, so if they become infected—and we have had a number of people like this, including a truck driver reasonably recently, where they were initially tested—some of them may have had testing before they travelled and were negative on arrival, and then we have picked them up and they have then become infected two to three days later and potentially were infectious in the community. Yes, they are a lot less likely to spread it, but that is not to say they cannot spread it. Obviously, with no community cases at the moment and a very susceptible society, if you look at what our susceptibility is, because we have no restrictions at the moment, because there is a lot of movement around, there is no mask wearing and a lot of mixing from non-household groups, the chances are that if they get into the right environment, they will spread it and it could spread rapidly in a susceptible population. Unfortunately, a significant proportion is still either unvaccinated or only partially vaccinated.

Hon TJORN SIBMA: May I ask a follow-up question? Has there been any modelling done, and if not any extensive modelling, could you in layperson's terms quantify the character of risk presented by a traveller from Queensland who is double-vaccinated and tests negative for COVID-19 compared with the risk presented by a similar individual at a similar demographic level travelling from New South Wales or Victoria? What I am trying to understand is: is there an incremental increase in the risk profile presented? For example, the Premier made an announcement that travel between Queensland and Western Australia will be normalised very soon. What is the difference in risk between a traveller from New South Wales and a traveller from Victoria if they have both been double-vaccinated and tested negative at a single point in time compared with their Queensland counterpart? Is there a significant difference in risk?

[12.50 pm]

Dr ROBERTSON: At this stage there is. Obviously, in New South Wales we are seeing a reduction in the number of cases, but there is still a lot of disease circulating in the community. Even with the figures today from New South Wales with 273 cases, there are still literally thousands of cases circulating in the community. Similarly, with Victoria with 1 749 cases, probably the risk is even higher. And the case positivity rates that we see in some of those states indicate far above what we would expect. What that is saying is that there are still undetected people within that community. The case positivity rate in Victoria, for example, dropped from around three per 100 down to around 2.3, so it is getting better, but it still means that there is a risk that you as an individual will come in contact with somebody who is infected in those communities, as opposed to Queensland where they have had no community cases in the last, I think, 18 days.

Hon TJORN SIBMA: I appreciate that argument, but there is not necessarily a hard quantification of the probability that an individual presents a greater risk of transmitting COVID-19 in Western Australia who is coming from a state with a higher daily rolling average compared to a—would it be in the order of 10 per cent more likely, 20 per cent more likely, 30 per cent more likely, or is it wrong for me to sort of conceptualise it in those terms?

Dr ROBERTSON: It is very hard to conceptualise in those terms. It really depends on whether you are mixing within the broader population. It will depend on whether you are meeting with non-household members. It depends on the size of the crowd. If you are in a larger audience, it depends on your physical distancing from that crowd. So, there are a number of factors that will make it

either more or less likely. It depends whether you are wearing a mask and all the other people are wearing a mask. They are all factors that will determine whether you are more or less likely to be infected.

Hon TJORN SIBMA: Do these kinds of considerations feed into the characterisation of riskier destinations that I see on the wa.gov sort of map of Australia and you have the black states with the red lines—the extreme risk destinations? Is that determination of risk predicated solely on the number of daily cases plus other factors; and, if so, is there also a countervailing argument that those states are surpassing us in terms of vaccination enrolment? Will that start de-escalating the risk profile of those states? When they are approaching 80 to 90 per cent of their population double vaccinated, at what point can the risk argument be sustained for keeping the borders closed?

Dr ROBERTSON: The risk argument, yes, it is calculated on, obviously, the caseloads that are occurring in those states—that is part of the calculation—but it is also calculated on the susceptibility of if that disease was introduced into Western Australia. Given our current situation in phase 5, where, basically, we are an open society and people can go to any number of events, including without any protective measures, what the flow-on effect might be from that if you got an epidemic. Now, as they get higher, what we will see is that, yes, it is likely that we will see a continued fall. Victoria is probably at or near its peak now. New South Wales is definitely falling now. We are seeing the exponential fall in New South Wales, and that will improve with the vaccination rate. Has that improved their vaccination rates? Without a doubt. Unfortunately, it has been the incentive to get vaccinated. What we have seen however, though, is that if you look at the number of people in hospital, for example, taking a figure from last week, around 60 per cent of people in hospital were unvaccinated; around 33 per cent had one dose; and about seven per cent were double vaccinated, and they were almost invariably over 70 with comorbidities. The problem is the 33 per cent. A lot of people are getting vaccinated when the disease breaks. It is too late to be getting vaccinated because you could end up in hospital with serious disease or, unfortunately, dying with one dose. It is not as protective as two doses, and that is where, I think, it is playing out. That is the message that the Vaccine Commander and I have been trying to get out—that not only do we need to get up to that, and although it would help those states, we need also to be looking at our vulnerable communities within our own state and getting up to that 80 to 90 per cent.

The CHAIR: That gets me to the point that I raised earlier, Dr Robertson, and not to labour this point, but, fundamentally, short of this massively successful herd immunity that we can have with this pandemic, unless we keep our borders closed ad infinitum, forever, and do not let anyone else in the state, ultimately, we have to learn with live with this virus, do we not? Because at some stage it is going to come into Western Australia, so we are going to have to learn to live with it.

Hon STEPHEN DAWSON: Chair, if I may, I make the point we are ripe for infection while the vaccination rate is low.

The CHAIR: I am totally aware of that.

Hon STEPHEN DAWSON: And so the focus at the moment is on getting people vaccinated. The lower it is, the more risk associated with it. Are we going to be closed forever? We are not. Without kind of point-scoring—I know you are not—the takeaway message has to be: vaccinate, vaccinate, vaccinate. Get vaccinated early, because as we heard from Dr Robertson, even when you have got one vaccination, you are not home and hosed.

The CHAIR: I am not arguing with you, minister. I agree. I am vaccinated and I encourage everyone to be vaccinated. All I am saying is that, ultimately, at some stage, we as a society are going to have to change our mindset to say that this notion of zero tolerance we cannot live with. Ultimately, we

will have to get to a point in our society where we accept that COVID is part of our community. Would you agree with that, doctor?

Dr ROBERTSON: Certainly, I agree. We are anticipating that at some stage we will get disease within this community, but what we are doing as part of that is trying to make this the best outcome we can get for this state. To do that, if we can get up to those 80 or 90 per cent vaccination rates and we do get an outbreak, then we will be able to manage that outbreak, we will have minimised the hospitalisation and serious disease and deaths, and we will be able to open up, you know, more broadly across the country.

The CHAIR: I applaud the work that has been done. I promise you. I really do.

Hon NEIL THOMSON: I go back to the questioning I had on page 310 in relation to the targeted initiatives about increasing the workforce. We have heard from the committee that staff are quite thin and there are extraneous pressures. These are some of the words that were used. We also know that we currently have problems in relation to elective surgeries being cancelled, and people deferring visits to doctors and others for standard treatments because there has been a reluctance while the COVID issue has been around. We have heard about the surge capacity options, and that is very welcome news to know that we still have surge capacity if we need it, if COVID suddenly erupts in a part of our state, but I ask this question: is the department confident that it has the sufficient clinical staff for both ongoing COVID responses—this is in a situation when COVID is here; this is in the long term—and regular health services over the long term, both metro and in the regions? Do we have simply enough staff, particularly clinical staff, in this state, and at what quantum is that?

Hon STEPHEN DAWSON: I will ask the director general to provide a response.

Dr RUSSELL-WEISZ: Honourable member, we have been concerned for some time about the pocket of those particular cohorts where we have struggled and we have put huge efforts into them. Your question goes to when COVID is here. Let us hope, as we had the previous discussion, that vaccination rates are very, very high. Our aim, and the department's aim and the health service providers' aim, is to cause the least disruption as possible to what I am going to call business-as-usual health services. We have seen the massive disruption over east to elective surgery, to elective work, to delayed care.

[1.00 pm]

I think one of the things that we may be talking about in years to come is about what has happened to patients about the delayed care, not the long COVID, because they have not sought care during very, very protracted periods of lockdown. The critical thing to that is workforce and capacity. We are doing everything we can to target, and we are in a better situation than we were potentially one month ago or two months ago.

You mentioned the elective surgery and how that has been affected by some of the demand we are seeing at the moment. We did an elective surgery blitz last year, as you would be aware, where we did a lot of elective surgery and some of that has remained at historically high levels. We are doing more elective surgery, bar the times that we had to cancel elective surgery, than we have ever done before in the public sector. We obviously apologise to every patient for any disruption caused by cancellations, and cancellations and deferrals do occur when we are in a business-as-usual environment. Pre the pandemic, they did occur because some patients needed an intensive care bed where there may not be that specific intensive care bed or they needed a couple of surgeons to do the operating. Health services respond on a daily basis to this, but we try to keep it to a minimum. Our aim—the department's aim and the health service providers' aim—is to have the

workforce that we require in all the most difficult specialties to recruit for when we have COVID in the community. We have vaccinations high so it does not—we aim not to disrupt our business as usual. But it might be that if we have a small outbreak where we have a number of patients—let us say we have unvaccinated patients that are in ICU—it might need the cancellation of the occasional elective surgery. But we are trying to make sure, through the opening of the 332 beds that were announced, by focusing on those areas of workforce that we will have the workforce to cope with business as usual and, hopefully, a small and manageable amount of COVID in the community.

Hon MARTIN ALDRIDGE: My question does follow on from that point around elective surgery. I understand that elective surgery was suspended for the month of September. What date did that cancellation lift? Was it contained just to the calendar month of September or did it extend into October?

Hon STEPHEN DAWSON: I will ask the director general to respond. He might just need to get his notes, so give him a second.

Dr RUSSELL-WEISZ: We did suspend it for September and we asked health services to ramp up in, I think, the first week of October. We have not put any of the same restrictions on elective surgery we had in September in October, as of today. However, health services will respond to the demands that they are seeing at their hospitals, as they would have done in August and July, and they will have to marry up their elective surgery capacity along with their emergency demand. We certainly said from 1 October that elective surgery can be ramped up. I cannot answer today whether one health service has exactly the same as it did in August, but in August we had a significant emergency demand on our health system which caused some cancellations during that month. We will be able to report at the end of October what our elective surgery performance was like.

Hon MARTIN ALDRIDGE: If I can get this right, what has happened is there was a deferral of elective surgery through the month of September, but HSPs are taking decisions themselves as to when those surgeries will be rescheduled based on clinical demand within their area.

Dr RUSSELL-WEISZ: No. We did not take down all elective surgery. We only took down non-urgent category 2s and some category 3s, and we made the category 2 all clinical decisions. That was for September. As of October, health service providers could go to their previous levels. But with those previous levels, they work on, like they would have done in April, what is their bed capacity, what is their workforce capacity, and how many of their workforce are sick. For a lot of what we have seen, some of the cancellations relate to our staff who we do not want to come in if they are unwell and therefore, unfortunately, some elective surgery is cancelled. Health service providers basically should have gone back to their previous levels depending on what they saw in demand as of 1 October.

Hon MARTIN ALDRIDGE: So have they? Do you have any intelligence from the health service providers? Are they just continuing September through October or are they back to normal operating levels?

Hon STEPHEN DAWSON: Perhaps we might ask Ms MacLeod to respond and perhaps Mr Dolan who has not had a chance to talk.

Mrs MacLEOD: We did go back and we would be at our levels roughly at the moment. The two weeks immediately after the shutdown were school holidays and we would normally see lower elective surgery during school holidays anyway just because of staffing levels during the school holidays. But we will now have returned to our normal elective surgery levels prior to the four-week hiatus, noting that on a day-by-day basis we balance emergency and elective demand for that day and the following days as well, so it is something that we balance on an ongoing basis.

Hon MARTIN ALDRIDGE: Can you tell me how many surgeries were cancelled as a result of this decision to defer in September?

Mrs MacLEOD: I can take the question on notice. I do not have the numbers with me. We did track through that.

Hon MARTIN ALDRIDGE: Sorry; I was referring not specifically to your health service, but across the hospitals—the public and the private–public hospitals that were impacted.

Hon STEPHEN DAWSON: I can tell you. The total of category 2 was 130 and the total of category 3 was 455, for a total of 585 surgeries cancelled.

Hon MARTIN ALDRIDGE: And they were the ones directly related to this decision?

Hon STEPHEN DAWSON: Yes.

The CHAIR: We are going to have to finish up there. Thank you very much to everyone for attending today.

Members, you can still submit any remaining questions that you have through the electronic lodgement system, and that will close at 5.00 pm on 29 October, so you still have a little bit of time.

For the witnesses, the committee will forward the uncorrected transcript of evidence, with questions taken on notice highlighted, as soon as possible after the hearing. Responses to questions on notice are due by 5.00 pm on 17 November 2021. Should you be unable to meet the due date, please advise the committee in writing as soon as possible before that due date. The advice is to include specific reasons why the due date cannot be met.

Once again, I thank you very much for attending. That was a very worthwhile hearing.

Hearing concluded at 1.07 pm