PUBLIC ACCOUNTS AND ESTIMATES COMMITTEE

Inquiry into 2020–21 Financial and Performance Outcomes

Melbourne—Monday, 8 November 2021

MEMBERS

Ms Lizzie Blandthorn—Chair
Mr Danny O'Brien—Deputy Chair
Mr Sam Hibbins
Mr David Limbrick
Mr Gary Maas
Mrs Beverley McArthur
Mr James Newbury
Ms Pauline Richards
Mr Tim Richardson
Ms Nina Taylor

WITNESSES

Professor Euan Wallace, Secretary,

Professor Brett Sutton, Chief Health Officer, Health Protection,

Ms Jodie Geissler, Deputy Secretary, Commissioning and System Improvement,

Ms Katherine Whetton, Deputy Secretary, Mental Health and Wellbeing,

Mr Greg Stenton, Deputy Secretary, Corporate Services,

Mr Chris Hotham, Deputy Secretary, Health Infrastructure,

Mr Jeroen Weimar, Deputy Secretary, COVID-19 Response, and

Dr Zoe Wainer, Deputy Secretary, Public Health, Department of Health;

Professor Tony Walker, Chief Executive Officer, Ambulance Victoria; and

Professor Christopher Michael Roberts, Chief Executive Officer, Safer Care Victoria.

The CHAIR: I declare open this hearing of the Public Accounts and Estimates Committee.

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

On behalf of the Parliament the committee is conducting this Inquiry into the 2020–21 Financial and Performance Outcomes. Its aim is to gauge what the government achieved in 2020–21 compared to what the government planned to achieve.

Please note that witnesses and members may remove their masks when speaking to the committee but must replace them afterwards.

All mobile telephones should now be turned to silent.

All evidence taken by this committee is protected by parliamentary privilege. Comments repeated outside this hearing may not be protected by this privilege.

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

We welcome the Department of Health Secretary—Ambulance Victoria I think is here as well—and all of those who have come with you today. Thank you, and we invite you to make a 10-minute presentation.

Visual presentation.

Prof. WALLACE: Thank you, Chair. Good afternoon. I, too, would like to acknowledge the traditional owners of the lands we are meeting on this afternoon and pay our respects, on behalf of the department, to their elders past, present and emerging.

The 2020–21 year for the department and for the health sector more broadly can be summarised really as a year of two stories: one, the provision of normal health care to our population; and then second, the response to the full force of the COVID pandemic that our state faced last year, with health care really at the very forefront of that challenge. We did that by rapidly expanding in some critical areas and creating space in others to create the capacity that was projected to be needed. We changed many of the ways in which our clinicians work and we asked them to adapt and embrace new technologies. Throughout last year I think we called upon their expertise, the skills and capacity of what really is a world-class health workforce to ensure that the system continued to perform well and provide care to those who most needed it.

Of course the pandemic, sadly, is not over, and indeed the modelling suggests that the next few months may be among the toughest for the health sector. Over coming months the department and the sector more broadly will remain focused on delivering the health care that Victorians need and deserve, whoever they are and wherever they are.

Just a summary of last year's budget: there was capital investment allocated of about $2 billion, which actually took the health portfolio to just over $9 billion now in total—the largest infrastructure portfolio in the history of health in this state; nearly $3 billion dedicated to respond to COVID; a large allocation of funding in anticipation of the need for catch-up deferred care; and then the first beginnings of the mental health royal commission's implementation program, so $570-odd million to respond to the nine interim recommendations that were before government at that time; and then the beginnings of funding for transformation of how we deliver care and will continue to into the future.

Despite the pandemic I think the system overall continued to meet and exceed actually most performance indicators: nearly 1.9 million hospital admissions, more than the previous year; 163 000 Victorians were admitted for elective surgery, just 7500 fewer than before despite the closure or the deferment of much elective surgery; and importantly all category 1 elective surgical patients were admitted on time within the 30-day target. Not just the volume but the quality of care was sustained, so more trauma patients received their care in a major trauma centre; patients with a suspected stroke received their treatment faster than ever before in our state's history, with 98.5 per cent of those patients arriving at a stroke unit in less than an hour; and the incidence of serious in-hospital complications—I have listed here serious in-hospital infections as an example—also fell, so central line and staphylococcus bacteraemia infections were the lowest in the state's history. So both quality and quantity were sustained just by the pandemic. Unplanned hospital readmissions fell, both lower than target and lower than the previous year. And all high-priority elderly Victorians were assessed for their aged-care needs on time, ahead of target and again ahead of the previous year. And we commenced more community-based drug treatment courses again than target and the previous year.

Now, that is not to say that the system was not under pressure last year nor does not continue to be under pressure; it is. Ambulance Victoria did over half a million emergency road transports last year, 7.5 per cent more than target. But the proportion of code 1 calls responded to on time within 15 minutes was lower than we wanted, so too was the number of patients transferred from AV to EDs on time. While all urgent ED patients, category 1 patients, were treated immediately on arrival, only 62 per cent of all ED patients cleared ED in under 4 hours, lower than we wanted, and actually much lower for those presenting with mental health issues—only 54 per cent of those patients were admitted within 8 hours. We similarly saw deferment of semi-urgent category 2 surgery such that those admitted on time were lower than target. We provided less home and community care for younger people—877 000 hours against the target of 1 million. And we serviced fewer patients through our dental services than target and 50 000 fewer than last year, all because of deferred care.

The two stories for the department were responding to COVID and then investing in our hospitals for COVID. This slide summarises the response to COVID. There was investment in a new database, the customer relationship management system, now called TREVI, that we have discussed at this committee before. And even in the past month when we have had over 2000 cases a day 99 per cent of new cases are contacted within 24 hours, an extraordinary effort. Both those cases and their close contacts, again with escalating numbers—some 17 000 close contacts are in the system at the moment—are contacted through this rapid surge expansion through our contact centres. We built the nine local public health units to provide end-to-end contact tracing locally, managing almost 18 500 cases last year. And of course we began the state-led program to the national COVID vaccination program, a network of 78 clinics. Almost half of all vaccines given in this state are given in a state-led program—over 10 million vaccines to date, of which just over 4.6 million were given in a state-led program.

In terms of the health system itself, we have had to make fundamental changes. We created streaming hospitals where we preferentially sent COVID patients, and that was to reduce risks of transmission, improve their care but also improve the care of patients who did not have COVID, protecting non-COVID streaming hospitals so they could get on with elective surgery—lessons learned from wave 2. Obviously we invested heavily in ICU capacity, including ventilators, and very early on last year with ARV the department invested in what became a national, real-time ICU bed monitoring system called CHRIS. But it began here in Victoria. There was a partnership with private hospitals to create agility. We developed a fit-testing program, testing nearly 120 000 workers. We bought the machines and we trained the staff. And there was a department-led surge in

115 000 additional clinical shifts to meet both hospital demand but also demands on vaccine and testing centres and of course to support aged care, particularly the private sector.

And we began, as I said, the first steps towards mental health reform, beginning with the building of 120 new beds in Geelong, the Northern, Sunshine and Melbourne; six new hospital outreach post-suicidal engagement sites; and a hospital in the home program, particularly with nine beds for younger people, with Orygen and Barwon Health. We began planning for an Aboriginal social and emotional wellbeing centre. At the same time, we had specific funding to respond to the mental health needs caused by the impact of COVID, and across last year there were a series of investments by the department in meeting those needs.

And I think if we learned anything from last year it was working better together for better outcomes—and I do acknowledge the important work that Safer Care and VAHI led to support not just the system more generally but dedicated support in clinical guidance and clinician support for COVID. Of course our new safe patient care amendment Act was passed in November last year, bringing better care in our public sector aged-care facilities. And what began as clusters earlier this year then continued as health service partnerships to really bed down better collaboration for future care for our health system. So we have learned things from the pandemic that we have used to help redesign and continue to evolve for better outcomes.

In that vein, lastly I will acknowledge the rapid expansion of telehealth. This September there were 86 000 telehealth video calls to patients in their homes compared to two years before, the September before the pandemic, when there were 800. We have developed a centralised supply, a statewide supply chain, for critical PPE but not just for PPE—HealthShare Victoria has been established over this time. We have bought 570 million items of PPE for supply to our health services. We have expanded our pathology system and put in place the beginnings of fundamental pathology reform. And our COVID-positive pathways, the pathways that keep patients out of hospital, are the beginnings of what look like integrated in-home care pathways for chronic disease.

Chair, I will end there and have hopefully summarised those two halves of a very challenging year for health, but a year that I think Victorians can be very proud of their health system.

The CHAIR: Thank you, Secretary. Deputy Chair.

Mr D O'BRIEN: Thank you, Chair. Good afternoon, Secretary and team. Secretary, in the presentation you said there are 515 ICU beds in the system. Is that public and private?

Prof. WALLACE: Yes.

Mr D O'BRIEN: And that there are 1493 ICU-capable bed spaces in the system, which I assume is also public and private.

Prof. WALLACE: Sorry, 400 and—

Mr D O'BRIEN: 1493 was what your presentation said.

Prof. WALLACE: Yes.

Mr D O'BRIEN: So, Secretary, can I go back then—the announcement on 1 April last year of 4000 new beds and equipment, staff and space, and $1.3 billion to be injected into the system to establish those 4000 ICU beds. Was that just a fiction?

Prof. WALLACE: No, it was not. I think at the last PAEC we touched upon this a wee bit also. Recall, if we put our minds back to that time, the modelling at that time, you might recall, suggested we were going to have 4000 ICU admissions due to COVID—so feeding that you would have expected something in the region of 15 000 or 20 000 total hospital admits. And so 4000 ventilators were procured, and the workforce planning that was put in place at that time by the workforce branch in the department was to bring people off the nursing registries and people who had recently retired and medical registries, and retrain people—in one of the slides there was the 23 500 retraining of clinical staff in critical care—so create a workforce that was capable of then staffing those beds, because it is not just about the beds.

There were three bits to it. One was the purchase of the ventilators. One was the creation of the staff and retraining of staff already in place, and part of the deferred care outcomes of course is to free up staff that might be involved in elective surgery, both perioperative and postoperative, so they are available then to staff ICU beds, so new jobs for them, if you like, and bringing staff off the nursing and medical registries et cetera. And then the third bit was—and I think we talked about this last time—about creating physical spaces within the hospital for those new ICU beds, so retooling the theatres and theatre waiting areas and so on and so forth.

Mr D O'BRIEN: So are there currently now 4000 ventilators, staff and spaces available?

Prof. WALLACE: Today, as we sit here this afternoon, there are just shy of 1600 spaces available, potentially staffed and equipped. We have another several thousand, and Jodie may give us the precise numbers—we have many thousands of ventilators in storage so that if, God forbid, we did meet that surge, then we would have the equipment, we would have the workforce and then we would revisit our hospitals to say, 'We need you to create this space'. But I think the minister at the time, Minister Mikakos, in the announcement around the 4000 beds—and I was in Safer Care at the time helping lead some of the ICU work—that is exactly what we were preparing for.

Mr D O'BRIEN: Yes. In fact it was the Premier's press release and the Premier and the minister were there at the time. So it specifically says that the money will secure the ICU equipment, staff and space. Now, you have touched on that. So can I go to the staff, and you have just mentioned 23 500 retrained critical care staff, but did we ever get to a point where we could physically staff, provide a bed, a ventilator and a space for 4000 ICU patients?

Prof. WALLACE: That is very much where we are heading. I think—

Mr D O'BRIEN: No, sorry. I am going to the question of the staff in particular. Have we got enough ICU staff trained for that announcement?

Prof. WALLACE: So did we ever train sufficient staff for 4000 ventilator beds? Well, we never got to the point, thankfully, of needing them. But that 23 700 retraining figure is not specific to ICU retraining.

Mr D O'BRIEN: So that is critical care?

Prof. WALLACE: So there was ICU, there was aged care and so on. But we were on this trajectory to procure equipment, create space, mobilise and retrain staff to continue to meet—maybe I could answer the question not in the 2020–21 financial year but this current financial year. We have developed our streaming model for our health services. Ms Geissler's team built with the health sector six acute streaming hospitals back in January–February in anticipation of—we had small numbers back then—this is how many we will need. Now, with this third wave, as numbers have gone up, Jodie's division has worked with the sector, continued to bring on more and more hospitals, more and more beds, more and more staff, provide those ventilators—so we have distributed 960-odd ventilators to 26 health services. So we have progressively built out. I think the concept of—

Mr D O'BRIEN: Can I go back to the key question?

Prof. WALLACE: Yes, yes. I am trying to answer your question—

Mr D O'BRIEN: How many beds can we open and staff?

Prof. WALLACE: 1592 or 1596 I think today.

Ms GEISSLER: 1593.

Mr D O'BRIEN: So we never got to the 4000. Can you provide me—and this is a question we asked last time, Secretary—what actually the $1.3 billion was spent on? So that announcement was significant: $1.3 billion to prepare our health system. I think last time I asked if you could take it on notice and we actually did not get an answer. What was it actually spent on? We know we did not get 4000 beds and 4000 staff. What was the $1.3 billion spent on to prepare our health system, given particularly at the moment the health system is under such pressure?

Prof. WALLACE: Yes, huge pressure. I will just take you to the numbers. In the 2020–21 budget that this inquiry is focused on there was funding of $3.95 billion for COVID to the department. It involved COVID funding and also funding for the health service response. So I think the total funding allocated in this year was $2.4 billion for the health response, so that was about hospital preparedness. It was about expanding, testing, operations and pathology, so we have had to expand pathology. There have been six-and-a-bit million pathology tests, COVID tests. There is the workforce work that I alluded to, which—

Mr D O'BRIEN: That presumably includes the $1.3 billion, then?

Prof. WALLACE: Well, there was obviously funding in the previous financial year 2019–20, but in 2020–21 there was $2.4 billion specifically for COVID health response. And included in that were ventilators; the test, trace and isolate systems; contact tracing; additional cleaning; PPE; residential services and so on.

Mr D O'BRIEN: Can I perhaps narrow it down a bit?

Prof. WALLACE: Sure.

Mr D O'BRIEN: How many additional ICU-trained nurses do we have that we did not have on 1 April last year?

Prof. WALLACE: If we have that total number—I will take it on notice. We have continued to expand our ICU beds. So today, say, we have 1593 ICU beds. We would normally operate around 450 to 500 or 515 in the public and private sectors. So we have tripled our ICU capacity today compared to before the pandemic, and those beds are staffed.

Mr D O'BRIEN: Okay, so triple the ICU capacity, but we still only have 515 open literally as at now.

Prof. WALLACE: Yes. I mean, thankfully, today—I will give you the number from today—

Mr D O'BRIEN: Can I just clarify. We will get the number of new ICU nurses since the start of the pandemic—so let us pick 1 April, given that was the date that the media release went out—and also the number of ICU specialist intensivists if you are able to provide that.

Prof. WALLACE: There is some nuance to the answer because there is a difference between an ICU specialist and retraining medical staff to be ICU competent in a situation where we are facing 4000 ICU admits, which thankfully we never got to. Again, the system has retrained clinical staff to be competent in ICU should we need them, including nurses and medical staff.

Mr D O'BRIEN: So when you say you have tripled the capacity of ICU availability you are including the staff needed to do that.

Prof. WALLACE: Yes, but—

Mr D O'BRIEN: If the worst comes to the worst.

Prof. WALLACE: Yes, and it is very much, Mr O'Brien, about the worst coming to the worst, because under normal events, in theory—and we did not do this in Victoria, but it was done elsewhere in the world. There were obstetricians and gynaecologists being trained in ICU. God forbid. In an ideal world you would not want an obstetrician looking after you and providing you basic ICU care, but those were the changes that were being made in our workforce to prepare a clinical workforce so that if we needed to, if push came to shove, then we had clinical staff to look after patients.

Mr D O'BRIEN: I get that, Secretary. I guess the point I am making with this is going back to that announcement where the public of Victoria and the Parliament of Victoria would assume when the Premier and the health minister say 'We're going to provide 4000 new ICU beds, including the staff' that that is what we are going to get. And $1.3 billion of taxpayer money to be spent on it—we did not get that. Now, whether that was overreach in a media release or not, we did not get that, whether or not we needed it. That is great, that we did not need it, but I guess the point still remains: as we have both discussed, the health system is under enormous pressure now. We got told back in April last year that this was going to prepare it, and here we are with the health system still under enormous pressure.

Can I perhaps just move on to one of those issues, and it may well have been in the quantum of funding you talked about. There was $30 million allocated to upgrade the old Peter MacCallum, which I think is now called St Vincent's on the park, run by St Vincent's. Can you tell me how many COVID patients have been treated there?

Prof. WALLACE: I do not think we treated any COVID patients there. What we used that space for was to create capacity in the system, and it goes to—on the slide I said that we made changes to create capacity in the system. We created capacity in the system at the old Peter Mac so that St Vincent's then had capacity in St Vincent's proper to look after COVID. You might recall last year there was all sorts of planning going on to create capacity in the system. But when we planned that work, I think the original intent—and Mr Hotham may want to comment—was 'Could we use those wards in the old Peter Mac for COVID?'. When we had a look at them they were not COVID fit.

Mr D O'BRIEN: Right. So is there any ICU capacity there?

Prof. WALLACE: No, we did not plan to put ICU beds there. So those beds, still in use by St Vincent's, created the additional capacity at St Vincent's proper for the expected ICU intake.

Mr D O'BRIEN: Yes. And there were 84 beds announced.

Ms GEISSLER: Yes. That is correct and they are still—

Mr D O'BRIEN: That is what is available now.

Ms GEISSLER: Eighty-four went to old Peter Mac, and all 84 are still used.

Mr D O'BRIEN: Okay. Can we just confirm: was it $30 million spent on that refurbishment?

Ms GEISSLER: I will have to—

Mr D O'BRIEN: Can we perhaps take on notice what the final figure was? Secretary, what has been the cost of the agreements signed between the department and Victoria's private health sector to manage the surge, if you like?

Prof. WALLACE: The commonwealth actually picks up the funding for the private sector, so the private hospital sustainability or viability fund is funded by the commonwealth.

Mr D O'BRIEN: Okay. But do you have that figure? Presumably you need to tell them what it is, or does it go straight to the commonwealth?

Ms GEISSLER: We would have to provide that to you on notice if that is okay, because it is constantly evolving. As you will appreciate, the private sector continues to provide services and work alongside—

Mr D O'BRIEN: Yes. If we could get it at least for the year in question, that would be good.

Can I move to another topic now, Secretary. You will recall in the hearings in December last year we asked the minister at the time about the proposed second medically supervised injecting room, and he said to us that Ken Lay's report would be finalised by Christmas. Here we are in November the following year. Has that report been finalised, and if so, can that report be provided to the committee?

Prof. WALLACE: So this is the report on a second site in the CBD?

Mr D O'BRIEN: Yes.

Prof. WALLACE: Well, we are still working with Ken Lay around a second site. So a second site, as you know, has not been finalised. And I think part of that is due to pandemic delays and so on. So a second site has not been finalised.

Mr D O'BRIEN: Okay. Has the report been finalised? Has the minister made specific reference to waiting on a report from Ken Lay?

Prof. WALLACE: I am not sure if the—

Ms WHETTON: Ken Lay has not finished his report. Partly from COVID delays, he has not been able to talk to a number of the stakeholders that he was hoping to speak to to be able to do that.

Mr D O'BRIEN: That does not really gel terribly well, given that—

Mr NEWBURY: The phones do not work.

The CHAIR: Sorry, Mr Newbury, it is hard to hear when you interject.

Mr D O'BRIEN: It was all through last year that Mr Lay was working on this, when we had COVID. The minister said Christmas, and we still have not got a finalised report. Well, not to put too fine a point, the government bought the old Yooralla building in Flinders Street. Is it going to be the site for the second medically supervised injecting room?

Prof. WALLACE: So we did buy that building earlier this year, but again, the second site for the medically supervised injecting room has not been determined by government. They have not finalised their decision.

The CHAIR: And I would remind you, Mr O'Brien, that we are considering the 2020–21 budget estimates.

Mr D O'BRIEN: And Minister Foley specifically answered questions about this at the hearings in December last year, at the budget hearing, so I am trying to get a sense of what has actually happened. This is an outcomes hearing. So despite the minister saying we would have something by Christmas, we still have not got an answer nearly a year later. What is Yooralla going to be used for then if we do not know whether it is going to be used for an injecting room?

Prof. WALLACE: So we purchased that building in April this year—I think the finalisation of sale was in late June this year—and the intent of the department is to use that for wraparound health and social support services for vulnerable communities in the city.

Mr D O'BRIEN: Has it been ruled out as a site, though, for a supervised injecting room?

Prof. WALLACE: No site has been determined by government.

Mr D O'BRIEN: Okay. Can you tell me whether the existing site, the North Richmond facility, has ever been listed as an exposure site or has ever been identified as an exposure site for COVID?

Prof. WALLACE: I think it has, actually. I think we have had cases that have attended that.

Mr D O'BRIEN: All right. I do not believe it has actually ever appeared on the public list of exposure sites, so I am interested to know then how the community was advised if it was ever an exposure site.

Prof. WALLACE: Like all exposure sites, they would be managed through—

Obviously there are some sensitivities around that site for obvious reasons, and their clients, and their clients are anonymous, but we have very strong COVID-safe practices in place at the North Richmond site, and the health service—

Mrs McArthur interjected.

The CHAIR: Sorry. Mrs McArthur, it is hard to hear when you laugh or interrupt.

Prof. WALLACE: And the staff would be sharing information with clients as they would appear.

Mr D O'BRIEN: Okay. Can I quickly put a couple on notice. We asked last time for a table updating the mental health royal commission recommendations and progress against those. Could we actually ask for that again on notice for an update?

Prof. WALLACE: We can.

Mr D O'BRIEN: That would be great.

Prof. WALLACE: And remember that 2020–21 was really around the nine interim recommendations and the 65 are in this current one, but we can provide you with an update for both.

Mr D O'BRIEN: That would be great if you could. Likewise the Minister for Mental Health announced funding in May 2021 to support 3000 jobs. Could I get an update on what the number of mental health professional jobs was originally and then how that has changed up until now?

The CHAIR: Thank you, Mr O'Brien. Your time has expired. Mr Maas.

Mr MAAS: Thank you, Chair. And thank you, Secretary and departmental officials, for your appearance today. I note that there is no appearance from the Wallace tartan face mask.

Prof. WALLACE: I am afraid there is not. I have gone with the Melbourne black.

Mr MAAS: Very stylish and on trend. If I could take you to my first question, the questionnaire spoke to about $2.246 billion that was spent on the COVID health response—I think you had a figure of around $2.9 billion up on the presentation. I was just hoping you would be able to outline for the committee the ways in which the funding supported initiatives that assisted in driving down and suppressing the COVID-19 transmission in 2020 to 2021.

Prof. WALLACE: Yes, of course. Thank you. Just bear with me while I pull up that information. In 2020 there were 20 375 cases, and sadly, 819 Victorians died last year. This year, 2021, there have been so far 72 964 cases, almost all exclusively of the delta strain, and 332 deaths. I think the difference in the case numbers and in the number of Victorians who have died is a reflection of some of the systems improvements that have been put in place this year from lessons last year. Clearly the successful management of COVID requires highly effective test, trace and isolate, and we have talked about TTI at this committee before and at the parliamentary inquiry into contact tracing. In wave 2 last year, at the beginning of the 2020–21 financial year, of course that was an environment with no vaccination. We are now managing it in the presence of vaccination, which again I think plays very strongly into why there is a differential proportion of deaths. This year we have now managed five significant waves and outbreaks, and I think that the investment that has been made in the COVID response—$2.4 billion—has gone in part to the infrastructure around contact tracing. That is a very diverse and complicated machinery.

Last year and ongoing we have rapidly built, expanded, refined and evolved capabilities in testing. The total tests to date are about 13.5 million tests overall and 6.5 million last year, and that has only been possible through some nearly 200 testing sites—a mixture of fixed sites, some very large sites like at the showgrounds and Sandown and other places, very large testing sites with drive-through testing, but also the pop-up testing. I think back to Al-Taqwa College and similar schools where we provided onsite testing earlier this year, really in very close consort and collaboration with community leaders and school leaders and really to meet the needs of the children and their families. And then at Al-Taqwa we partnered testing with vaccination—highly successful. We have also developed a call-to-test program, a door-to-door almost; if you cannot come and get a test, through disability or infirmity or for whatever reason, then we will come to your house to do it. And we established truck testing sites on the Princes Highway and on the Hume and so on.

I do not know if you recall, but last year at the beginning of the pandemic, really in wave 2, the Premier made a call for a blitz. He wanted 100 000 tests done over a two-week period, 50 000 tests a week. We are now doing 50 000 tests a day. In fact at the peak of this most recent wave we have done north of 80 000 tests a day, so it gives you a sense of what has been built with the investment in testing. Then of course you have got to do something with the tests, so we have expanded our pathology both in the public and the private sector. The pathology labs themselves have invested in faster infrastructure, so machines that return the results much faster. Then of course we have built the CRM, so-called TREVI, a database if you like, that manages the results. We have talked about that at this committee before—that as results come in it triggers SMS texts to cases. The contact information is uploaded, and then texts go to them and it identifies outbreaks. I think in some of the waves this year, the delta strains this year covered by some of the press, we were getting to third, fourth and fifth waves of close contacts within 72 hours, an extraordinary place to be compared to where we were at the beginning of the pandemic in March, April last year.

And then lying behind all this is a very agile and skilled directions and legal team, so a team that are able to respond to the changing assessments of the CHO, where he says that we need different restrictions or easing of restrictions and being able to respond agilely to that. In answer to some of the questions Mr O'Brien was asking around investment in our health system, we have built increased capacity not just in ICU. I mean, I think the ICU is the most visible, but of the 500-odd people who are in hospital today, there are only 100 in ICU. So there are four to one patients in hospital wards compared to those in ICU. So we have built increased capacity for that. We have invested obviously in our aged-care sector, and we have undergone all that workforce surge and workforce training, so I think a very diverse investment.

Now, portfolios that no longer lie with us, that now lie with our sister department—Families, Fairness and Housing—but which were critical in the responses last year and this year were around social support, so the wraparound supports that when we have an outbreak and people require support to get tested, support to stay quarantined at home safely. So a lot of investment in what was last year called Operation Benessere began with our public housing towers and public housing more broadly but really expanded out beyond that. A lot of investment in Operation Benessere was involved in that funding, so really very diverse. I think that when people look back on the pandemic and look for exemplars of responses, they will look to Victoria.

Mr MAAS: Thank you very much. That is quite an array of initiatives that you have detailed for us. If I could take you to page 20 of the questionnaire and particularly the part around the local public health units, what I am interested in hearing about is how the local public health units and their establishment assisted in improving the effectiveness of contact tracing and outbreak responses following the second wave in 2020.

Prof. WALLACE: Thank you. The public health units are a bit dear to my heart, because when I was seconded last year from Safer Care to what was CCOM, the case and contact and outbreak management team, in public health, the public health units had just been announced. The first had just been announced by the Premier, and the first, you might recall, was in Barwon Geelong University Hospital, and then we progressively built nine. We have established nine public health units across Victoria, so three in the city and then six in our five regions. We have one in Shep and one in Albury-Wodonga, so we have got two in the Hume. The intent of the public health units—and some of this was covered in the parliamentary inquiry discussions—in contact tracing was to bring contact tracing as close to the community where the cases are as possible, so as I said in one of the slides, really end-to-end contact tracing and outbreak management and to facilitate that very rapid response.

I think we saw very early on when Barwon was established—and I think Barwon is a stand-out public health unit—that they took control of the Australian Lamb Company outbreak in Colac, which you might recall, and very quickly wrapped themselves around the whole community, not just the workers in the abattoir itself but the families, the children, the schools, the whole community, and managed to control that in a way that just would not have been possible had we directed it solely from 50 Lonsdale Street.

And more recently, so this calendar year and in the last financial year and extending into this financial year, I think the PHUs have had a really important role in integrating testing and vaccination programs, so again understanding what the vaccination needs are of the local community and delivering them in a manner that is fit for purpose. Again, I think of the reasonably recent outbreak in Shepparton where the Goulburn Valley Health public health unit managed that for us. I think the public health units have been a landmark reform piece for us as a state. They have been necessary for us to be able to respond agilely to local outbreaks and ongoing. I think our work even today—I am thinking in Gippsland, in Albury-Wodonga, in Shepparton and Echuca—being led by our public health units there, always in concert and collaboration with the CHO's team and the deputy CHO's in public health here. Jeroen Weimar, our COVID commander, established areas of operation, most recently over the last three months, to bring better structure to support our PHUs. So I think post COVID the public health units will remain really important public health infrastructure for us.

Mr MAAS: Thank you. You have already spoken to the increased testing capacity. Page 67 of the questionnaire goes to testing and pathology. How effective have increases to the testing capacity and improvements to pathology processes been in suppressing COVID-19 transmission?

Prof. WALLACE: Wow! Look, there is no question that the testing capacity that Jeroen and his team have built has been absolutely fundamental. If you think back to the Finkel review—so Alan Finkel, then chief scientist, did that review of essentially contact tracing, but the bulk of it was testing and sampling different

approaches from across the country, and it was at a time that Jeroen was leading our testing development and capability. There is no question that without the systems that Jeroen and the testing team built we would not have managed to fight what were pretty significant five delta strain outbreaks that we have had this year, before this third wave. I do not know if Brett wants to comment about how many jurisdictions internationally have managed to go from zero with a delta outbreak back to zero, so I might ask him to comment on that in just a second.

But let me just take you to some of the numbers. I mean, I think the network that the testing team have built within the department really is second to none. It is highly adaptive, it is able to surge, it can move very quickly—so when we get outbreaks in Gippsland we can move rapid testing teams there in support of the PHUs. If you just look at even this calendar year, average testing numbers have increased some two-and-a-half-fold: from April–June when we were doing 20 000-odd tests a day to October when we have been doing north of 70 000. Now, it is not just the people taking swabs; it is the type of swabs. We have adjusted the swabs that we take and the workforce that is doing them. Again, I have alluded to the investments in the labs, so the labs have invested in equipment that give much faster results; and then the test tracker that Jeroen and his team built way back last year makes sure that the information seamlessly comes in from the point of testing into the lab, into TREVI, which then triggers the contact tracing team. So I do not know if, Brett, you want to comment on the successes elsewhere in the world in comparison to what we have managed to do with delta outbreaks here.

Prof. SUTTON: Thanks. Certainly delta represents a unique and really profound challenge to being able to beat it back down to no community transmission whatsoever. I think it was earlier this year when I warned of several countries that had had no community transmission for 12–18 months that were spilling into community transmission that they could not stop, and that has really been highly characteristic of the delta variant. When you have got very high vaccination coverage, it becomes easier and easier to be able to manage the single cases or the small clusters that are identified, but for us to have managed the Sandringham drycleaners and various other incursions into Victoria throughout this year has really been extraordinary.

We are well aware now that the ACT with its initial incursions and New Zealand ended up with established transmission despite being ready and scaling up very significantly with testing and with lockdowns at the very earliest sign. So it is testament to the contact tracing and to all of the engagement that is required to support that that we have been able to manage it. And the benefits are clearly that you do not initiate a lockdown that stays on from the moment of that incursion. Clearly with this wave that is the situation that we found ourselves in, and we had to have that in place until we met those national benchmarks of 70 and 80 per cent vaccination coverage, where we know that we can manage the health system and the transmission more broadly. There are just a few other jurisdictions internationally that have been able to manage a delta variant back down to no community transmission. Some provinces of China come to mind. Other than that it has really been Australia—Queensland has done it, the Northern Territory, WA, South Australia—but they are no easy task, that is for sure.

Prof. WALLACE: The other thing we should be proud of is the collaboration between both the private and the public sectors not just in testing but particularly in testing, with the private sector providing almost 75 per cent of the total tests. But both public and private have surged across the history of this pandemic. Public capacity for COVID testing has gone from about 4000 tests a day to almost 15 000 tests a day, so more than tripling over the course. Again, that investment in those pathology systems—not just the staff and the machines but the reporting systems—I think stands us in really good stead for the future. This is not an investment that is going to be cast aside when the pandemic is finished. These are fundamental changes in the way that pathology testing is provided to the state. They will serve us well for the next thing that hits us but will serve us well for business as usual.

Mr MAAS: Terrific. Thank you very much. We might leave it there. Thanks, Chair.

Prof. WALLACE: Chair, if I may, Mr O'Brien asked for a number for the private hospitals payments. For 2020–21 the reconciled payments to private hospitals were $305 million.

Mr D O'BRIEN: $305 million? Thank you.

The CHAIR: Thank you, Secretary. Mr Hibbins.

Mr HIBBINS: Thanks, Chair. Thank you, Secretary and your team, for appearing this afternoon. I want to go back to public health. At the outbreak of the pandemic it was pretty clear that there were some really big issues with the public health system in Victoria, particularly around the workforce not having the amount of trained, qualified, multidisciplinary public health staff who could actually quickly respond to the pandemic response. Now, on page 23 and in your previous answers you have mentioned the local public health units, but in terms of looking beyond the pandemic and applying some of the lessons learned, I am interested to know: is there going to be increased investment in the training, the development, the recruitment and the retention of the multidisciplinary public health staff in Victoria in the Department of Health public health teams and other public health organisations?

Prof. WALLACE: Thank you. I think your characterisation is right. I think the pandemic exposed some weaknesses in our public health system that have been rapidly corrected in the service of the pandemic but very much with an eye on the horizon. In response to Mr Maas's question I spoke rather fondly of the public health units because I was there at the beginning of building them, and there was no question when the opportunity came to build a public health unit. And I am not a public health physician. I remember having conversations with Brett and the DCHOs and CCOM at the time: 'What could and should a future-facing public health system look like, and is this something that we want to continue to build out?'. And of course the resounding answer was yes.

I do not know if Brett wants to comment, because obviously he is much closer to this than I am and is a specialist in the field, but in Victoria we have not had a rich expanse of public health training programs in the way that some other jurisdictions have, either in Australia or internationally. The intent very much was: let us build the infrastructure in our public health units. And there is additional funding in this current year's budget, dedicated funding for our public health units. Let us build the infrastructure and of course the workforce—and we have now got public health physicians, specialists, in all of our public health units. Let us build our workforce of course to service COVID, and this last 20 months has just been about testing, contact tracing, vaccination this year. But let us build the infrastructure with what could come after and what would a future public health training program be, not just public health physicians but public health officers and all that, because we have had conversations with our tertiary providers and the peak bodies in public health.

Prof. SUTTON: Thanks, Secretary, and thank you, Mr Hibbins. Certainly there are constraints in the public health workforce, especially the public health medical workforce, that have been longstanding and historical. There are something like 300 full-time equivalent public health physicians in Australia. I find that manifestly inadequate. But that is not an easy issue to solve. There are specialist training places that need to be expanded. AHPPC made a position statement that was endorsed by national cabinet about the support and expansion of the public health workforce. And, as the Secretary says, I think we need to go beyond public health medicine to incorporate health promotion practitioners—those with a masters of public health or other public health qualifications. I have certainly been in conversations with the Public Health Association of Australia, the Royal Australasian College of Physicians and the Australasian Faculty of Public Health Medicine to look at that broader workforce, but also understanding that there is a long pipeline that needs to be built and supported.

A Victorian public health medical training scheme is in place. It has been stood up in recent years, but also I think there is an opportunity for expansion. It is constrained by the number of public health physician supervisors and the opportunities to work within government, medical research and other settings in order to get those experiences and competencies across the breadth of public health. We have certainly reflected on the fantastic experience of our infectious disease physicians to support the pandemic response but have to recognise that their competencies are limited to communicable disease or infectious disease and not to the broader public health competencies. So we will look to those who are not necessarily public health physicians to be able to support our local public health units and to be able to be incorporated into our training scheme to support public health physicians.

Prof. WALLACE: Thanks, Brett. I might just supplement it. I feel very lucky we managed to recruit Dr Zoe Wainer, who is here as the new Deputy Secretary for our public health division. Zoe is a medical graduate by background, and she has been building the most recent iteration of our COVID-positive pathways—these pathways to support people with COVID in the community. But again, with Mike Roberts, CEO of Safer Care, there is a very clear vision of 'What does this look like after the pandemic?'. How can we use the infrastructures that we have developed and the expertise that we have developed and the vulnerabilities that have been exposed by the pandemic to maintain public health outreach to the most vulnerable in our

community? Of course we are working very hard in service of this pandemic to keep the numbers down, keep the community safe, but we are also looking beyond the next horizon. What does this look like for the future for Victoria?

Mr HIBBINS: Thank you. Look, you have answered my follow-up about the training scheme, so I will move on now. I want to ask about public dental. I think even in the latest data it shows that public dental waiting lists have increased again. I think now patients are waiting on average 23 months for general treatment, which I think is the worst delay in a decade. It is about 15 months to see a specialist. What actions are being taken to reduce the waiting times for public dental services as a result of COVID?

Prof. WALLACE: Thank you. There is no question that COVID has impacted dental services. Those impacts mostly have been around deferred care as we have closed our dental hospital because of the same elective surgery restrictions that we have imposed on others. There is no question that dental health services have been impacted. The other thing of course to acknowledge is that, like other acute health services, dental funding is shared between the commonwealth and the state, and that is important. I will come to that in a minute.

The total dental output budget in 2020–21 was $319 million, and that included funding for a school dental program, which started in 2019, and the funding provided by the commonwealth through this national partnership agreement. You saw on my slide that we did some 50 000 fewer dental separations, if you like, in 2021 compared to the previous year. Can I say, though, that the most urgent patients—those requiring emergency care—have not waited. Similar to cat 1 general surgery, our most urgent dental patients have not had to wait. But we have had to defer care in the same way that we have done elsewhere. Remember that Dental Health Services Victoria provides a lot of its services through community programs. It is not all done in the dental hospital. Much of that community program has continued. But we have catch-up to do, so dental health services will do catch-up like our other services.

Mr HIBBINS: Is there any data or any evidence that people have simply dropped off the waiting list and that the real waiting list could actually be higher?

Prof. WALLACE: Sorry, is there any—

Mr HIBBINS: Could people have just simply just dropped off the waiting list and taken their names off it or what have you?

Prof. WALLACE: There are some Victorians who never go on the waiting list. Our most vulnerable—some of our people experiencing homelessness, pregnant women and children—never go on a waiting list. They get their care. But once you are on a waiting list, then you are on the waiting list and the service will get in touch with you. Now, there will be some individuals who for whatever reason then, once contacted, either have had their care elsewhere or their care needs have changed and they no longer want to fulfil their appointment, that is true.

Mr HIBBINS: All right. Thank you. I want to ask now about surgical robots. I know this is a particular passion of the Member for Brunswick. The budget contained $21.5 million in the forward estimates to driving shorter wait lists and better outcomes from elective surgery. Could I ask whether this includes funding for additional surgical robots in the public hospital system to perform computer-assisted keyhole cancer surgery?

Prof. WALLACE: It does not.

Mr HIBBINS: It does not. Okay. Now, obviously a benefit of such surgery is that patients spend one week in hospital and are back at work in a week. But for those who cannot have it, it is longer—they might be off for a month and spend longer in hospital. Can I confirm that there are 16 of these robots in private hospitals but only three in the public hospital system?

Prof. WALLACE: I think—how many do we have in public?

Ms GEISSLER: I am not sure. I will have to get back to you on that, I think.

Prof. WALLACE: I do not know how many there are in private. We probably do have three in the public system. There have been randomised trials of robotic surgery. I think it depends on the disease and the

operation and the procedure that is being done. Robotic surgery has been most commonly and most frequently used for prostatic surgeries, so prostatic cancer or prostatic surgery, and then expanded out for lots of other things. At Safer Care we looked at this back in 2019 and really made our health, economic and patient outcome assessment of 'Has the case been made that robotic surgery improves patient outcomes?'. Never mind the cost, does it improve patient outcomes? And the answer is no. There was a landmark randomised trial run out of Brisbane by the Queensland group, and robotic surgery—this was for prostate—does not improve outcomes for patients, so it does not reduce impotence, it does not reduce complications. And there is very, very modest, if any, shortened hospital time, in-patient time, which is what you have alluded to, because it is not keyhole surgery by robotic surgery versus open surgery—it is robotic keyhole surgery versus keyhole surgery. Now, if there is any benefit of robotic surgery—and I am not saying there is not, but the randomised trials currently do not support it, so you certainly would not buy one. If you had the cash in your back pocket to buy one, you are better spending your money on something else. But if there is any benefit of robotic surgery, it is actually for the surgeon—the wear and tear on the surgeon—and we just do not have those data yet.

Mr HIBBINS: Okay. Thank you. Well, I do not have the cash in my back pocket. But just in relation to that, was that a formal cost-benefit analysis or a formal study undertaken within the department?

Prof. WALLACE: We looked at robotic surgery, yes.

Mr HIBBINS: Is that potentially a document able to be made public?

Prof. WALLACE: If it is, I will make it available.

Mr HIBBINS: Thank you. I want to move on now to health staff leave. Obviously the public health staff working in our hospitals have had to give up a lot of their own leave for things like isolation requirements, homeschooling, recovery from workload and what have you, and obviously this has a significant impact on burnout and staff retention. You know, this is a massive burden being placed on this staff. What plans, if any, are there to ensure that staff have got sufficient leave entitlements and they have got adequate opportunities to recharge, rejuvenate and not burn out?

Prof. WALLACE: Thank you for the question. I appreciate the question, because the health workforce, as I said on the slides, have been front and foremost in responding to this pandemic, and some of the liberties that we are now experiencing because of the changing tides of the pandemic are not being experienced in our hospitals. They are still in PPE. I have never worked in PPE, but I can imagine what doing a shift in PPE must be like. It would be absolutely exhausting. And they do not have the downtime with colleagues over lunch in the tearoom that they used to have, because the tearooms are closed et cetera, et cetera. So thank you for acknowledging the fatigue that our health workforce is facing. We are mindful of it. We are mindful that it is important that staff take leave.

Over December–January there are traditionally reasonably quiet times—if there are ever any quiet times in our health sector, those are quiet times as surgeons take leave so there is less surgery et cetera, et cetera. The challenge facing the sector, as I said in one of the opening slides, is that the modelling suggests that perhaps the greatest challenging times for the health sector of this pandemic are going to be faced in December and January. Jodie may want to supplement my answer. Jodie is working with the CEOs in the health system to help, firstly, message to the workforce and then plan leave with them.

And then the other component of course—and it was not specific to your question—is that in 2020–21 the government made an allocation of just shy of $10 million to Safer Care to establish a healthcare wellness centre, which Mike Roberts, CEO of Safer Care, now leads, really again recognising—this is not an overnight fix—that we need to be looking after our workforce. Jodie, I do not know if you want to add anything.

Ms GEISSLER: Yes. I also appreciate the question. I am very happy to add to it. Indeed, if I can just pause on wellbeing for a second, the $9.8 million in the healthcare worker wellbeing package in December 2020 indeed led to the Healthcare Worker Wellbeing Centre, also a series of healthcare worker wellbeing grants programs, mental health first aid training and peer support, and also further improvements to staff amenities, mostly in rural hospitals. I note that most recently—just last week—the government has announced further funding for wellbeing initiatives. But also important I think is the surge workforce that we have been able to deploy to alleviate some of the pressures on our workforce. That is 7000 workers, and the pool has delivered 115 000 shifts during the pandemic.

And then finally I think we have also tried to expand our workforce to ensure that all clinical and allied health workforces can be deployed, so we have endorsed wider professional groups to undertake a range of testing and vaccination roles and we have been working very closely with our public health colleagues on that. We have also put nursing students—supported them—to work in wards to their full scope of practice and improved additional support to nursing teams. We have employed 400 nursing students with our services for COVID, and final-year students are able to provide care and support to confirmed COVID cases and to be placed on wards, with safeguards in place. So I think there is a lot that has happened, recognising obviously our workforce is critical to the response.

Mr HIBBINS: Thank you. Can I ask finally whether there is enough accommodation available for staff or their families who need to furlough or isolate because of potential infection in their workplace? Does every hospital worker who wants to protect their family have a place to stay?

Prof. WALLACE: Yes, I think that was one of the really important initiatives last year. I think at the beginning it was called the Hotels for Heroes program, and it has really just been embedded as part of the standard requirement. So the accommodation does exist. I think we would acknowledge that we have had challenges in some of our rural and regional settings, where there is not quite the accommodation that we have in the city, but accommodation still exists for healthcare workers and their families.

Mr HIBBINS: Okay, thanks.

The CHAIR: Thank you, Secretary. Mr Newbury.

Mr NEWBURY: Thank you. Thank you so much. Before I get to my questions, can I just go back to something that the Deputy Chair was talking through, just to make sure that I got the figures right. Your slides earlier showed that there were 515 ICU beds prior to the pandemic. The slides then say that as of September, 1493, which I take as 978 new beds. I do not mean to be semantic, but there has been a lot of dancing around over figures so I just want to get in my mind: 978 new. Is that a fair calculation? So 1493 minus 515 leaves us with 978. I am getting a nod from—

Ms GEISSLER: You are getting a nod, noting the 515 ICU beds and the—

Mr NEWBURY: Minus the 515.

Ms GEISSLER: Minus the 515. They are included.

Mr NEWBURY: So the number we can use is 978? So out of 4000 we have got 978. Is that a fair—

Prof. WALLACE: No, I do not think that is a fair characterisation.

Mr NEWBURY: What is the number?

Prof. WALLACE: The investment that was announced not in 2020–21 but in the previous financial year around those 4000 ICU beds, and Mr O'Brien said equipment, actual space for the beds and staffing—that pathway began. In Safer Care, the then chief nurse and midwifery officer, Ann Maree Keenan, led a piece of work with—

Mr NEWBURY: I appreciate all that. I am just after: what is the number?

Ms GEISSLER: So 1493 ICU-capable bed spaces, I can talk to what that is. That includes the baseline of 515, yes.

Mr NEWBURY: So I am going to just simply take it out and say 978. I think that is a fair calculation, because 515 were there before. In my mind there are 978 of the 4000, which means 3022 were not delivered. Is there a plan to deliver more?

Prof. WALLACE: There is. The short answer is yes, if we need them. You know, on the slide—

Mr NEWBURY: Or maybe?

Prof. WALLACE: Well, no, no. The planning is all in place for them. So again on the slide, part of the COVID response of the system was we have had to stop doing things. It is not just the financial costs; there are other costs to create 4000 ICU spaces around the system, which is feasible.

Mr NEWBURY: Is that your plan?

Prof. WALLACE: Well, no.

Mr NEWBURY: Okay. So it is not your plan to deliver the 4000. Okay, thank you.

The CHAIR: Mr Newbury, could you stop interrupting and allow the Secretary to complete an answer without you cutting off the Secretary at the point that you feel the question is answered.

Mr NEWBURY: Thank you, Labor Chair.

The CHAIR: Mr Newbury, please stop interrupting me. Mr Newbury, could you allow the Secretary the opportunity to complete his answer, please, without interruption.

Mr NEWBURY: I just asked him if he had completed it, and he just said no.

Prof. WALLACE: So our plan is always to meet the needs of the state.

Mr NEWBURY: I understand. But no to 4000.

Prof. WALLACE: If tomorrow, God forbid, we needed 4000 ICU spaces, then we have the equipment and the space, and then of course we have got the staff on board.

Mr NEWBURY: But the current plan, unless there was some new need, was no. I heard the word 'No' a few times. Thank you for that. Thank you for clarifying that. I am going to then talk a bit in detail about one of the slides, and I will ask Professor Walker a couple of questions following on from our discussion in May. Firstly, I just wanted to talk through the slide and refer you to, if you do not mind, the proportion of emergency code 1 calls responded to within 15 minutes: 77.2 per cent, nearly 10 per cent below target. And ambulance to ED patient transfer within 40 minutes was 74 per cent, 17.8 per cent below target. Do those figures concern you?

Prof. WALKER: They absolutely concern me, and they represent the challenges the whole health system has been facing with the pandemic. From a response performance perspective we have been working to respond to greater demand in the community, sicker patients. So we are seeing a higher level of acuity of our patients that we are being called out to, and we are seeing longer periods of time to do a case because of both the PPE that paramedics are putting on and the challenges at the interface in the health system. The whole health system as a whole, as a system, is under pressure, so often the crunch point is the emergency department.

Mr NEWBURY: Would it be fair to say, and I know this is a generalisation, if people wait longer, the risk is higher, if they are in emergency circumstance, that there may be an adverse health outcome?

Prof. WALKER: Well, that is our job, to manage that risk. Essentially what we do is manage the sickest patient with the available resource. To give you an example, if you do not mind, will probably help explain that. If I have someone who may today call 000 because they have severe back pain, quite uncomfortable—they cannot move easily, they have called us as an emergency—we will respond with an ambulance to that patient. Then if we get another call for someone with chest pain, who potentially has a heart attack, we will divert that ambulance away. So the sicker patients are still getting the quickest response we can provide at the time. The less sick patients are waiting a longer period of time, and they are the ones that we are managing then through our secondary triage area to monitor to make sure nothing is changing in their condition by calling them back in case they do need to be upgraded.

Mr NEWBURY: One of the difficult things is when you look at figures, when you look at statistics, these are real stories of real people.

Prof. WALKER: Absolutely. Yes.

Mr NEWBURY: We spoke previously about the 30-year-old Caulfield woman who died after waiting 7 hours. These are real cases, so I appreciate your point that you redirect resources. But it would be fair to say sometimes those resources are not there to redeploy to potentially a case in need.

Prof. WALKER: And since the dreadful case of Ms Lackmann that you are referring to we have invested significantly, with the support of government, to increase our secondary triage area to monitor those patients so that we can upgrade on the basis where there is something changing in their condition.

Mr NEWBURY: Just on that point, if you do not mind me asking, about the financial investment, the financial investment has been made, but these figures say there is a really big cause for concern in terms of wait. When you look at these figures you say to yourself, 'Well, transfers are almost 20 per cent below target'—that is one in five people. I find them very concerning, and I am sure Victorians would find them concerning. So I take your point that there is investment, but at the same time these response times are going down.

Prof. WALKER: And that is because we are in a pandemic. So at the end of the day we are in the middle of a pandemic at the moment. Maybe I will take a step back. If you consider coming out of wave 2 and the work we were doing to, if you like, recover from the increasing demand we were seeing, the improvement plan basically was about getting our performance back up as close to target as possible. Then we have had the delta strain and the pandemic coming in, which has fundamentally impacted on that. So we are seeing now significant numbers of COVID patients in the system, significant acuity within the system. And again we are seeing more than 50 per cent of our emergency calls right now are actually lights-and-sirens cases. Professor Wallace may want to speak more to this, and others, but we are seeing more patients who are, because of delayed care we believe, presenting with more significant problems and ambulances being called for.

Mr NEWBURY: I know when we spoke earlier this year we talked about other people who may have died or have had adverse outcomes. Are you aware of any more recent cases?

Prof. WALKER: No, I am not. We have been working very hard to manage the risk in the system. I think as we have seen the changes coming through, we are managing that risk right now effectively, again by monitoring those patients who are maybe waiting for an ambulance through call-backs and other arrangements we have in place.

Mr NEWBURY: Thank you so much for your help today. I was actually going to ask Professor Sutton a question. Sorry to do a swap on you both. If I can go to the same slide and the point that 54.4 ED patients with mental health were admitted within 8 hours, 32 per cent lower than target—a third lower than target. Mental health over the last year is something that I have certainly spoken a lot about and I would note for the record that you have publicly spoken about, which I think has not been lost on people. I think it is something that you have spoken about clearly, and I recall you talking about the need to incorporate mental health messaging into public messaging, public press conference messaging. Former Australian of the Year Pat McGorry has described what we are seeing in terms of mental health as a 'shadow pandemic'. Do you understand that descriptor? Do you feel that is an adequate descriptor?

Prof. SUTTON: Yes. I think it is a not inappropriate descriptor. There is a parallel increase, a very substantial increase, in mental health manifestations—people becoming acutely unwell with mental health problems, some who had pre-existing issues that have been exacerbated through the lockdowns in particular, but also those who never had a problem previously who have been confronted by the loneliness and the inability to access some of the mental health and psychological support that they would outside of a pandemic. So there is no question that there has been a really significant increase in mental health challenges in Australia and globally.

Mr NEWBURY: Would it be a fair characterisation—I know I have heard you talk about this too—to accept that the restrictions actually had an impact, clearly, on that shadow pandemic?

Prof. SUTTON: Of course. And this is the awful dilemma of a public health response. I think some people have felt like there was a path where no harms were ever going to be in place, but it was always apparent to me that you just had a choice between the awful potential consequences of not having a lockdown—if Victoria had had the UK's response to the pandemic, 10 000 people would have died in Victoria. If we had had the US response, it would have been 15 000 deaths. If it were Peru's response, we would have had 40 000 deaths. So

there is no question that the public health response that has been put in place in Victoria has saved many thousands of lives. But it has come at the cost that you are speaking of.

Mr NEWBURY: I know that when I first started speaking about it, it was because of the community organically talking to me—my community talking to me—in relation to issues amongst young women, young girls and teen girls often. We saw data being released to cover the budget period that absolutely showed, in my view, a spike in that particular age group. Was that something you were aware of and thought through, that particular age group?

Prof. SUTTON: Yes, I was aware that self-harms in particular or suicidal ideation was a particular concern for young people and that it was more manifest in young girls or women in particular.

Mr NEWBURY: Did you think through or did you provide advice to the government on that particular issue?

Prof. SUTTON: No. I mean, my role is to manage the public health response. But the information on those presentations to emergency departments, to primary care and elsewhere were obviously available to the department, and it was for the mental health branch—the Chief Psychiatrist and the community health organisations and others, like Headspace, who work in this area—to look at that and to see how best to respond. Obviously the Secretary can speak to the investments that are made in response to that.

Mr NEWBURY: Because I think a lot of people, a lot of experts, I think, felt that there was almost a trade. You did not use that word earlier, but you did use a similar word. I do not want to verbal you, but you did use a similar word that there was almost a trade, that there was a health response which actually had a recognised adverse outcome. And in terms of young girls especially that was a serious outcome, and it is showing in terms of presentations to hospital which are not being dealt with in an adequate time but also just presentations more generally. You perhaps would not use the word trade-off, but would you use a similar word? I mean, was that an acknowledgement earlier of that?

Prof. SUTTON: Well, it is absolutely an acknowledgement that having public health directions that included long periods of time where people needed to stay at home other than for essential reasons would bring its own harms, would bring its own challenges, especially in the space of mental health or psychological wellbeing.

Mr NEWBURY: This is actually a bit of a tough question. I am a dad, and I have got little kids. I do not like to talk about them publicly in too much detail, but one thing that concerned me was that there was clearly a lesser impact on children and yet the restrictions were a blanket approach across age groups. So more generally the protection of adults had a disproportionate effect on kids, and for me as a dad, I am willing to take more pain if I protect my kids. I think a lot of parents would say the restrictions did not accept that. What would you say to that proposition?

The CHAIR: Sorry to interrupt you, Dr Sutton. Mr Newbury, I would remind you that the terms of reference of this inquiry are not the same as the terms of reference that this committee has previously considered.

Mr NEWBURY: I understand.

The CHAIR: Mr Newbury, could I please finish what I am saying before you choose to interrupt me again. This inquiry is into the financial and performance outcomes for 2020–21. I would ask that you keep your questions within those terms of reference.

Mr NEWBURY: Thank you, Labor Chair, and I specifically referred to the Victorian Agency for Health Information data, which covered the particular period in question, and my question related to that. So it was data and spending that was reported quite clearly in that space.

The CHAIR: Simply referencing a document, Mr Newbury, does not make your question relevant to the terms of reference.

Mr NEWBURY: Simply saying it doesn't does not mean anything other than you are making a political point.

The CHAIR: Mr Newbury—

Mr NEWBURY: Can I finish my question then?

The CHAIR: Mr Newbury, you can complete your question if you keep it relevant to the terms of reference of the inquiry.

Mr NEWBURY: Thank you, Labor Chair. In relation to the Victorian Agency for Health Information data, which showed that there was a serious adverse impact upon children, I think that it would be fair to say there was a perception that restrictions across the broader community had a disproportionate impact on children, which the data actually shows for that time period. What would you say to that?

Prof. SUTTON: The public health response has to take account of what transmission means across the population. Children can get infected. They get much more mild illness. They are less likely to become severely unwell. However, they are part of the reason why transmission occurs, and the control of that transmission in order to protect everyone, especially the most vulnerable, needed to be inclusive of everyone who could potentially transmit, and that included children. To the extent that we could lift restrictions at the earliest possible time, to the extent that we could make sure that those restrictions were proportionate to the risk for those most vulnerable individuals, we did so.

Mr NEWBURY: Thank you. Secretary, just quickly, the CHO mentioned that he did not brief the executive on the mental health impacts. Did you?

Prof. WALLACE: We track mental health impacts for the whole population across the whole pandemic, and as you have said, there was a rise in some of those measures, so ED presentations, for example, and ED presentations of adults have come back for mental health—

Mr NEWBURY: So the executive was aware?

Prof. WALLACE: Yes, and have responded. So I think across the whole pandemic there have been recurrent investments in mental health to respond to the pandemic and specifically for children. So in this current financial year, not in 2020–21, there was child-directed investment in mental health, a specific response to the pandemic.

Mr NEWBURY: And hopefully the data will one day—

The CHAIR: Thank you, Mr Newbury. Your time has expired. As we are halfway through this hearing, we may take a short 10-minute break and resume in 10 minutes. Thank you.

I reopen this hearing of the Public Accounts and Estimates Committee. Just before I pass to Ms Richards, the Secretary has some additional information to provide.

Prof. WALLACE: Yes. Thanks, Chair. We have got some information on the ICU workforce and just to confirm the robot numbers. Jodie will provide those.

Ms GEISSLER: Yes, very happy to. So in terms of critical care workforce, there were 10 730 nurses enrolled in additional training in 2020–21. 1622 nurses were enrolled in additional training in 2021–22. So the total is 12 352 nurses upskilled in critical care in the last 18 months. Between 2019 and 2020, ICU physicians increased by 8 per cent and critical care qualified staff increased by 2.6 percent, and that would be higher now because they are figures from 2020. And just in terms of robots, indeed I can confirm that there are three: one at Peter Mac, one at Royal Melbourne Hospital and one at Barwon Health.

The CHAIR: Great. Thank you so much. Ms Richards.

Ms RICHARDS: Thank you. Thanks, Professor Wallace and to the officials, for your appearance today and for all the work in the last 20 months as well. I would like to explore the elective surgery situation. From the questionnaire at page 25 I understand there was a reported $41.3 million that was spent as part of the elective surgery blitz, and I know that is noted in the Treasurer's advance as well. I was wondering if you could please explain how this funding has been spent and what impact it has had on our elective surgery output.

Prof. WALLACE: Thank you. I might ask Jodie to supplement my answer to you. As we have discussed and shared in my presentation and my introductory comments, we have across various phases of the pandemic—in wave 2 last year and in this third wave—had to make some very difficult decisions around deferring some elective surgery. It goes to some of the balance that was explored with Professor Sutton around restrictions and mental health. At all times we have been considering the risks and benefits, if you like, because every surgery we cancel is affecting an individual and her or his family. We understand that.

Now, as the committee well knows through various discussions in previous committees, we categorise elective surgery into three categories: category 1—urgent surgery, not invariably but typically cancer surgery—and then category 2 and category 3. Category 1 surgery should all be done within 30 days, and throughout the pandemic, throughout all of last year and through this year, 100 per cent of category 1 patients were treated in time. Then category 2 is 90 days and category 3 is within a year, 365 days. It is in those two categories, categories 2 and 3—and particularly last year, category 2, and this year now, category 3—that we have seen deferred care, reducing the proportion of patients admitted on time. And so the investments that have been planned and made have been around trying to catch up, if you like, on that so-called deferred care—so trying to supercharge the elective surgery system.

Now, before asking Jodie to comment on exactly what we have done in terms of that surgical blitz, both earlier this year and then proposed ongoing, one of the decisions—and again, I talked about it in my slides—that we made this year, really out of lessons of last year, was: could we prepare the system, the health system, to respond to another wave? Frankly, we were not wanting the wave that we are just coming out of, but could we prepare the system such that we could respond to the needs of people with COVID and keep elective surgery going? So one of the features of this calendar year, the back end of last financial year and now the front end of this financial year, has been our so-called streaming hospitals, where we preferentially streamed patients with COVID to initially six hospitals and then we have progressed and expanded that. We have done that purposefully, in part to improve the care of those patients and reduce risks of transmission et cetera but also so that the non-streaming hospitals could go hell for leather and really use the funding that government gave us to do the surgical blitz and try and get through as many patients as possible.

Clearly where we are now—and not in the financial year that this inquiry is about, but where we are now—we have had to defer care more broadly across the system in order to create the capacity. But I think one of the fundamentals in preparing the landscape, if you like, the sector, was to allow us to continue elective surgery blitzes even in the face of the pandemic, and for most of the third wave actually we have managed to do that. I say 'we'; our colleagues and our hospitals have managed to do that. And there are still hospitals today out in regional and rural that are very busy with elective surgery because they are not impacted.

But I might ask Jodie just to comment on the specific changes that we have made in terms of meeting that elective surgery blitz.

Ms GEISSLER: Sure, I am happy to, and thanks for the question. Just going back to the $75 million in funding that formed part of the $300 million elective surgery blitz effort, $200 million was allocated to health services based on the proposals that came through from the health service partnerships—that was $75 million in 2021 and $125 million in 2021–22. The blitz funding aims to support the completion of additional procedures reported by the elective surgery information system—the ESIS system—and non-ESIS procedures, including endoscopies, in 2021 and 2021–22. Data reported by health services indicates that 7571 additional ESIS and non-ESIS procedures were completed from March to June 2021. 5994 of the procedures were completed in public health services, and the remaining procedures were contracted to other public or private providers.

In 2021 elective surgery blitz funding has predominantly been used to address patient waiting times for both ESIS and non-ESIS procedures, including endoscopy, general surgery, orthopaedics, cataract removal and urology specialties. However, procedures will continue to be completed across all major medical specialties as the department continues to work with our health services to support the catch-up of elective surgery activity that has been deferred, as the Secretary said, as a result of the pandemic, when it is safe to do so. I think certainly due to the necessary restrictions on non-urgent surgery, funding from last financial year has been rolled over to this year, and the allocation of additional elective surgery funding across 2020–21 and 2021–22 has provided great certainty to our public health services and has enabled them to drive better value across the two years in circumstances where they have needed to establish local agreements with private providers to

undertake surgery. Further funding, including $136 million from this year's budget, which equates to around 18,000 elective surgeries, will be allocated as the department works to restart surgery.

Ms RICHARDS: Thank you. Thank you both for the response and the evidence. I am interested in exploring a little bit the partnerships between the public system and the private hospitals. I am aware that the department has been working really closely across the two sectors, it sounds like effectively as one system. Could you please take the committee through what this partnership has meant for elective surgery?

Prof. WALLACE: Thank you. Again, in one of my introductory slides I think that 'better together' theme has come through really strong. I think the partnerships between the private and public sector across all of the waves of the pandemic have been really important. The precise role that our private hospitals have played has changed, and they have been extraordinarily willing and agile in changing it. Last year during the second wave, when we had, you may remember, a very large number of aged-care facilities almost exclusively in the private sector impacted by outbreaks and had residents and staff with COVID, the private sector created capacity for us to be able to move residents safely into hospital beds and so shared that burden with the public sector and provided in-reach into the aged-care facilities themselves.

This year—Jodie and her team have really led this work—we have worked in partnership to say, a bit like building the streaming hospitals, so looking ahead, if we were to get a third wave, and we did, in those planning phases, how would we use our private hospitals? Of course it goes to Mr O'Brien's question around ICU beds. We are looking to the private sector to provide ICU capacity if we need it. At the moment the 100 or so patients in ICU are in our public system, but there are private ICU beds there which, through our partnership with them and supported by commonwealth funding, are there for us to use if we need them.

We continue to call on them for aged-care supports, and we have got a couple of very key private hospital partnerships, what we call low-acuity sites, to allow us to move residents safely from an aged-care facility into this low-acuity site. Essentially we move COVID-positive residents—with their approval of course—into a low-acuity site so that the negative residents remain negative and are not exposed. We did quite a bit of that earlier this year with some of our aged-care facilities in the north and the west. We moved those residents to Epping Private. We also use some of those private facilities, low-acuity facilities, for looking after children whose parents end up in hospital and there is no-one to look after them—so unaccompanied children, we have a safe place to look after them.

And then in this most recent phase we have been working with the private providers around, as we bring on more and more streaming sites in the public system—and we have purposely made a decision to keep COVID-positive patients, where at all possible, in the public system: could we move some care? Obviously as we create COVID beds in the public hospitals we are displacing patients, switching off surgery, so could we displace some of those patients, that patient care, into the private sector? So our private hospitals have then come on board and allowed public patients to be operated on within the private system, often with public staff—public surgeons—but working in the private system with private health service nurses. It worked incredibly effectively, and I think sadly it was mischaracterised in some of the media around 'public patients ahead of private patients'. It is genuine partnership, and it is a whole-of-state view: how do we best enable the system to look after Victorians? And the decisions around surgery that is done or not done is on clinical need and really agnostic as to whether you are private or public. I think it is highly effective.

As Jodie's team plan the next phase out of this pandemic—so as numbers stabilise, hopefully, and cool more, hopefully—how do we use those partnerships between public and private to best enable us to switch surgery back on? And we will switch surgery on across both systems, always with half an eye on what happens if we get more cases so we are not stopping and starting—a sort of staccato-like response. So that is the intent. I think one of the key partnerships, one of the key lessons, insights, from the pandemic—and I think we probably shared this at a committee last year—was the genuine benefit to the whole of the state of the better partnerships between public and private.

Ms RICHARDS: Did you want to—you looked poised.

Ms GEISSLER: I was just going to offer a couple of examples, because these are local arrangements between public and private services that are established and there are some examples of how they have worked, just to build on what the Secretary said. We have had public hospitals move entire services, such as an

oncology ward, to private facilities. We have referred urgent public patients—and again, as the Secretary said, only the urgent public patients—for elective surgery to a private hospital. We have certainly used private hospital theatres and support staff for surgical work undertaken by surgeons engaged by public health services. As the Secretary has also said, we have established those COVID streaming wards in private services, and we have certainly worked with them on ICU capacity, so it is a multifaceted partnership there.

Ms RICHARDS: Thanks, both of you, for that. I am now interested in exploring hospital performance, and I know that is a pretty complex area. In the last financial year when we were experiencing that second wave I know that there were investments made to support the health services and the hospitals to respond adequately to the COVID cases. I am interested in perhaps understanding a little bit more about what those investments were and how they were used to prevent our hospitals from being overwhelmed, and I will refer you to page 20 of the questionnaire.

Prof. WALLACE: I may ask Jodie to supplement, but as I think I discussed in response to Mr O'Brien, in the last financial year there was an allocation of $2.4 billion to hospital COVID health responses. As we have discussed across this afternoon actually already, much of that was about hospital capacity, so bringing on uncommissioned capacity. In previous questions we talked about the recommissioning, if you like, of the old Peter Mac wards in the old Peter Mac for St Vincent's. We accelerated—and Mr Hotham may want to speak as to some of the infrastructure accelerations that we did. I will mention Northern, because it is in my head, but there were others. So we accelerated some infrastructure build to create new capacity. As we have just been discussing, we used some of that funding to purchase private capacity through the national partnership agreement. And then much in service of anticipated ICU beds but not uniquely ICU beds—also some inpatient beds—we reconfigured and optimised existing space. The other thing that we have done is to continue to improve the infrastructure in our health services to be COVID safe. Then we recommissioned closed spaces like Peter Mac—I think Bendigo Hospital also and Baxter House in Geelong.

I do not know, Chris, if you want to talk about the accelerated infrastructure program.

Mr HOTHAM: Yes, very happy to, thank you, Euan. And thanks for the question and your interest. So, as the Secretary has described, from an infrastructure perspective there was the particular commissioning and recommissioning of those ICU spaces and some smaller works related to that. But pleasingly, because it was a challenge at times, as state-significant projects we were able to continue through this period. There was recognition about the importance of our portfolio in adding this new capacity to the system. There were three or four projects in particular that were able to be accelerated and completed even ahead of time. So Casey was probably the first of those: the clinical tower there, a $135 million expansion project, added 128 new multi-day beds. That was just as the first wave was taking off. It also allowed for some economic stimulus in that time. That was critical. The Northern Hospital expansion that the Secretary is referring to, we accelerated there. We came in ahead of time and under budget, and with that additional saving, if you like, we were then able to commission a 28-bed COVID ward with particular negative pressure functionality—a real input and a real upside for the sector as a whole. At Goulburn Valley we were also able to accelerate ahead of time a new inpatient tower there, adding new ICU bed space and operating theatres. And then in some of our other portfolios we brought on St George's aged-care facility in Kew well ahead of time, with 90 aged-care beds for the sector; and we have also and are even now accelerating some of our EDs, including a facility at Monash Clayton.

I might just touch on, as part of that, that the Secretary talked about the lessons of COVID in our infrastructure program, because that is really important. As much as we are fast-tracking these facilities, looking forward, with much of our Big Build, if you like, we will now learn the lessons of COVID around design and adopting some of those principles. That goes to some of the challenges that we have heard, I think, that you have talked about, in and around ED. But we will be looking at facilities that are able to deal with more flexible space for the adaptation of expansion and equally for cohorting in segregation—but I think we might be out of time.

Ms RICHARDS: Thanks.

The CHAIR: We are. Thank you. Mr Limbrick.

Mr LIMBRICK: Thank you, Chair. And thank you, Secretary and team, for appearing again today. I just wanted to start on a couple of questions around ventilators. We were talking about those before. In the

presentation there is a statement that says there were 931 new ventilators distributed. I think you mentioned earlier, maybe it was to Mr Newbury, there were 4000 ventilators purchased at one point, I think in planning for worst-case scenarios or something. So how many ventilators do we have in our stockpile at the moment to draw on in the unfortunate event that we would actually need them?

Prof. WALLACE: Several thousand we have in warehousing.

Mr LIMBRICK: So how many?

Prof. WALLACE: About 4000.

Mr LIMBRICK: Okay. So if we had 4000 in our stockpile, I would have been thinking that there were around 3000, because didn't the government announce that we were going to give a thousand to India as part of a foreign aid thing? Did that actually happen?

Prof. WALLACE: So the government did announce that, and I am not sure—we might come back to you. We will take it on notice.

Mr LIMBRICK: Because my understanding was that we were overstocked and we were going to give a thousand to India. I think that was announced on 6 May—that part of the stockpile was going to go to India.

Ms GEISSLER: I think that was intended, but we will have to get back to you to confirm. But I can absolutely confirm that just over 4000 ventilators are in our warehouse.

Mr LIMBRICK: Yes, so that would seem to indicate that a thousand did not go to India.

Ms GEISSLER: We would have to confirm.

Prof. WALLACE: Yes, let us confirm. We would not want to mislead you, so let us confirm on that point. Then the other point to make about ventilators that were purchased is that clearly we had existing ventilator stock, which was coming to the end of its natural life cycle, which we have obviously swapped out with the new ventilators. So it is not as if we have got lots of new ventilators when there is a clinical need for a replacement. So those ventilators that were deployed across the 26 services, some were in the service of creating expanded capacity and some were actually replacing tired stock.

Mr LIMBRICK: Yes. The federal government announced that there were just over 1000 ventilators sent to India the day before the state government announced that. So we do not know that they came from Victoria, or you will have to get back to me on that.

Prof. WALLACE: Yes.

Mr LIMBRICK: Okay. And what does a ventilator cost on average per unit, roughly?

Prof. WALLACE: I do not know. But again I will come back. They will obviously vary in their capacity, but I will come back with the unit cost.

Mr LIMBRICK: Thank you. Something that we have talked a lot about is emergency department capacity, and some of the emergency directions have had unintended consequences on emergency departments. I know one that I have had lots of feedback from constituents about and there has been lots of talk in the media about—I was wondering what is being done to change it—is around people who have respiratory illnesses not being able to go to a GP, because the GP will not see them, especially with children and infants, and then they turn up at emergency departments instead. What is being done to address that issue, because my understanding is that is having a severe effect on emergency departments?

Prof. WALLACE: Yes. It is a great question. I think the whole flow of patients—citizens, really—through emergency is very complicated. A bit like Professor Walker was talking about the AV demand previously, the two are intimately connected but each with their own discrete drivers. We have seen, and it is not unique to Victoria—indeed it is not even unique to Australia—profound changes in how people, our citizens, choose to access emergency care over the last 10, 20, 30 years. Thirty years ago, if you needed emergency care, you would go to your GP, because your GP was providing 24/7 care. We are in a very different environment now,

and something like 45 per cent of Victorians have come from overseas and are new to the health system. So we have got people accessing emergency departments for care that are probably better serviced elsewhere, never mind the pandemic. And then the pandemic has brought on an additional extra load, and you have mentioned one of those.

You might remember back last year it was almost a requirement that if you had respiratory symptoms, your GP would not see you. It was about protecting our GP primary care infrastructure so that they were still able to look after people who did not have COVID. So of course then for those people the only place to go was to ED. So our EDs have done a large number of things over the course of the pandemic, last year and this year and ongoing. For example, they have expanded their overall capacity. Again, Chris may want to talk about the infrastructure expansions, but we have expanded overall capacity across the system for ED. I think we have talked about this at past committees, but they have triaged the care of people attending EDs—so a rapid assessment: 'Do you have suspected COVID, or not?'—to allow them to sort of quarantine off, if you like, those people who are at high risk of COVID. And over recent months, with the introduction and availability of rapid antigen testing, EDs have been using RATs on arrival to triage patients into high risk or low risk.

And then most recently we have invested in 20 respiratory clinics really to turn the tables—not to say that all GPs should be looking after people presenting with possible COVID, but it is the primary care equivalent of our streaming hospitals. Could we create capacity in the system where people with suspected COVID ongoing—so they have got symptoms and they need health care—have got a respiratory clinic that they can go to? Probably the most visible of those examples would be the clinic that Mukesh Haikerwal has established in Altona North. It is really a stand-out example, so we have replicated it. We have taken the learnings from Mukesh from last year and replicated those. And then some of our EDs have created their own equivalent of that, so a sort of respiratory clinic off to the side of the ED—as you attend the ED: 'Why are you here?', 'I've got a cold, a sore throat', 'Okay. Can you go to our respiratory clinic?'—really to try to create a surge capacity on site. And then the team at Northern Health have created a virtual ED to provide emergency care remotely, really piggybacking off some of the lessons and expansions of telehealth.

So I think the solutions have been varied, sometimes bespoke, but the overarching response is about increased capacity, increased triaging of patients and increased availability of care in the community through the respiratory clinic. So this is going to be an enduring problem. This is not going to go away. The pandemic is not going anywhere very quickly. So we have to have an enduring solution for people who need to access urgent medical care who may have COVID, and we do not want that to displace care out of our EDs ongoing.

Within the department ourselves we established two really critical task forces: one on ED patient flow and one on AV handover, if you like. So those two task forces have been working very hard with clinicians, health services and other stakeholders, including patients, to say: what are the enduring solutions to some of the challenges that Mr Newbury was exploring with Professor Walker around AV handover, AV uplift et cetera? So there is a lot being done, and then there is some infrastructure stuff.

Mr HOTHAM: Perhaps just on that note, if it is of interest, in terms of the expanded ED capacity there are a few pillars to this, I would say. There is what is coming through in our big builds, and hospitals like Footscray and Frankston obviously have that enhanced capacity built in. We have done a couple of specific ED redevelopments, bringing on new beds particularly at Sunshine and Monash, over the last 12 months. To Euan's point about the enhancements of the model, there are also large investments around mental health hubs within EDs and paediatric-oriented EDs as well, both to help deal with those particular client bases and the differential support that they need and to some extent to avoid disruption of the wider ED but help give them the path through the system that they really require. And then I think, if I look at the kind of broader system capacity that they are building, probably the other pillar, if you like, is alleviating some of that demand at EDs through some of our other investments. That is particularly where probably the mental health beds come in, those 144 acute mental health beds that are coming online over the next year or so. They are going to be really critical to effectively finding better pathways for those clients. So it is kind of building more, enhancing what is there to be cohort specific and relieving pressure in other ways. I think it is those investments coming together.

Prof. WALLACE: And just finally, very quickly, I think Victorians should have confidence that the system always has clinical need at the forefront. So our category 1 patients in ED, those with the most urgent need—100 per cent of them have been seen within the recommended time. So again, our services have pivoted to meet the needs of Victorians as they arrive.

Mr LIMBRICK: Thank you. I might direct my next question to Professor Sutton if I may. One of the big discussions that we have had is around hospital capacity, right. There is this sort of strange balance where the pandemic restrictions are there to help hospital capacity but the restrictions themselves also cause issues with hospital capacity, such as ED self-harm presentations, for example, and what we talked about earlier, potentially some of these respiratory issues. So how do we find that balance where a lockdown, for example, is not actually causing more harm than good?

Prof. SUTTON: Yes—important question. I think it is not an easy thing to model. Our modellers have obviously tried to find the most precise estimates for the number of cases that might occur with or without lockdown or lockdown at various levels of stringency to give us an estimate of the numbers that would therefore end up in hospital and the numbers that would end up in ICU and dying. I think the thing that we recognise is that there is always some uncertainty about that, but it has been refined over time. But in almost all of the scenarios, the potential number of cases that would occur with COVID if there were not the appropriate mitigations in place could run to hundreds of thousands. So even though we recognise that there are deferred care and other acute requirements that come out of lockdown, they were not of a magnitude that was equivalent to what would be occurring with COVID, and the severity of illness that we know occurs with COVID, especially for those unvaccinated, is such that 1 to 1.5 per cent of all cases end up dying or an equivalent number are hospitalised. So those estimates can be reasonably clear and they tend to be manifestly an order of magnitude greater than those that might come out of the deferred care or other care needs through lockdown.

Mr LIMBRICK: Thank you. There has been some confusion I think about the rationale for things like vaccine mandates and passports. Some people have talked about it as if it is a workplace safety measure, some people have talked about it as if it is a way to push up quickly the number of people who are vaccinated and other people have talked about it as if it is a way to ease the burden on the public health system. Is there a simple rationale for this, because it does not seem very clear? If it is workplace safety, there are other mitigation strategies such as rapid antigen testing or recognising prior immunity through infection, which we do not recognise—which I found odd if it is a workplace safety measure. What is the actual rationale?

The CHAIR: Sorry to interrupt you, Mr Limbrick, and again Professor Sutton, but I just remind committee members to keep their questioning into the financial and performance outcomes we are here to discuss and consider.

Mr LIMBRICK: Okay. Does that mean Professor Sutton should not answer that question? It is a very relevant question.

The CHAIR: Well, I will give you the opportunity to put the question within the terms of reference, but I would ask that you keep your questions to the terms of reference.

Mr LIMBRICK: Right. I am not sure how to change that so it is within the terms of reference. Have we seen effects with regard to workplace safety improvements or the rationale for vaccination in the first place through the last financial year? What is the rationale that we are talking about here? Are we trying to ease the burden on the public health system? Is that what we were trying to do?

Prof. SUTTON: Look, it is all three. All of those considerations were in my mind in the public health policy coming to that view. Certainly there are occupational health and safety issues at play, and the consequence of having a very highly or fully vaccinated workforce, especially for the adult population, has been borne out. The healthcare sector, where mandates were introduced early, has seen very, very reduced transmission. There are still individuals who become infected as healthcare workers, but they are at a much, much lower proportion and of course they get milder illness by virtue of that. It does make a difference to the burdens on the health system and the modelling builds in what the vaccination coverage would do with respect to the hospitalisation and ICU, and it clearly demonstrates that there is a lesser pressure on the health system as a consequence of that.

The final rationale is that it pushes the vaccination coverage much faster, especially for those who were slower to get to that high level of uptake, which was especially in the 20- to 39-year age category. They were a mobile and working population in particular, and we saw a really significant change when the construction sector came back as a not fully vaccinated but very substantially vaccinated workforce. We saw a huge change in the size, number and severity of outbreaks as they returned. So I think all of those things were at play and I think all of those things were achieved.

Mr LIMBRICK: Thank you. Just finally, in the short time I have got left, when a lockdown ends we would expect case numbers to go up normally, but that is not what has happened recently. How do we explain that?

Prof. SUTTON: It is following the modelling that the Burnet and others have provided, and it does relate to the fact that we continue to increase our vaccination coverage through this period. So it often takes 10, 14 days or more for the effects of opening up to manifest as increased transmission. But in that 10- to 14-day period we are getting 14 to 20 per cent additional coverage—first dose, second dose and the immunity that kicks in by virtue of that coverage. So I think there are competing forces there, upwards and downwards, on transmission pressures. Ultimately I think the opening up will mean that we will see an increase, an uptick, but it is much less by virtue of the fact that we continue our vaccination coverage to higher and higher levels.

Mr LIMBRICK: All right. Thank you.

The CHAIR: Thank you, Mr Limbrick. Sorry, bear with me. Ms Taylor.

Ms TAYLOR: Thank you, Secretary, Professor Sutton, department officials. I was interested in exploring the innovative responses to COVID-19 a bit further, noting there was a $1.9 billion investment in COVID-19 during the pandemic and some of these terrific, innovative responses were borne through. You have already spoken a bit to it when you were talking about the streaming hospitals, so I would just like to tease that out a little further, if you could expand on that, perhaps speak to any other initiative and perhaps report on outcomes as well.

Prof. WALLACE: Thank you. It is difficult to know where to start. I mean, I have tried to discuss already this afternoon and tried to lay out that I think the effective response to the pandemic has required a whole sequence of innovations and developments from actually the very beginning to get people to come forward to get testing. Be aware that we have had a sustained advertising campaign about 'only a test can tell', really encouraging people with what might be very minor symptoms—a sore throat, sore eyes, sore head, whatever—to come forward to get tested, so to trigger people to come forward to get tested. And our own data and data from elsewhere, New South Wales and overseas, show that the average time for people to come forward to get tested from the onset of symptoms remains today longer than we would like. So there is innovation in that space and then of course the testing innovation we have talked about. I think the most important innovation in testing in addition to the increased capacity that I have already alluded to in the public and private laboratories has been the acquisition of these rapid machines where we get much higher throughput of test results, and without that it would not have been possible for us to get to 80 000-plus tests a day from where we started way back at the beginning.

The so-called 'test tracker' is something that Jeroen Weimar and his team developed way back last year, which was really capturing key information at the time the test is done. That digital information then follows the test, follows the swab, into the laboratory, and as that result becomes available it is then uploaded into TREVI so that all the information is there. Again, looking back to where the state started, indeed the whole world started, at the beginning of last year, all these were manual processes. We had a presentation to the parliamentary inquiry into COVID last year: we shaved literally three, four, five days off that whole process, which allowed us to get to a point where we were having new cases from the point of testing to being contacted within 24 hours and then their close contacts within another 24 hours. I talked earlier about some of the outbreaks earlier this year—you know, modest outbreaks but nonetheless outbreaks—where we were getting to rings three, four and five within 72 hours. None of that was possible without the innovation in testing, both at point of testing in the laboratory and then of course TREVI itself, which really automates all of our responses.

In terms of innovation across the system I did mention CHRIS, and CHRIS was funded principally by the commonwealth government. It began here in Victoria, like most good things, and it was really back in early last year, so in the previous financial year, about a need to see all of our ICU beds in real time. Working with ARV and Ambulance Victoria, I remember lifting the phone to Tony to say, 'Is it feasible?', and then lifting the phone to Professor McLachlan at the Alfred and the ARV, 'Is this feasible?'. And they said, 'Yes. We have got an existing infrastructure called REACH that we could repurpose', hence out of which was born CHRIS. As a CHRIS user now—so ICU directors and ARV—they can see every ICU bed in the country and who is in the bed and do they have COVID, so it is a really important innovation.

Last year as we were planning the 4000 ICU admits that Mr O'Brien alluded to we knew that we would have to have visibility across every single ICU in this state, public and private, to inform ARV and Ambulance Victoria on where should they be taking patients. Now, as it transpires, we did not need that full capacity, but nonetheless I think the infrastructure has continued to serve us well, and to this day every day continues to inform where a patient is best lifted to provide best care.

Not a technical innovation as such but I did allude to it in my closing slide, which is around the health service partnerships. We have regional partnerships and then three metro partnerships really aligned to our public health units. Those partnerships were envisaged actually by our predecessors, so Kym Peake and Terry Symonds pre pandemic, as a way of better health service structure and care delivery, ensuring best care possible being delivered close to home—never enacted because the pandemic came along, but repurposed, and I think back then were called clusters, so hospital clusters. But again, the intent was: could the hospitals work together in small clusters to rationalise care, to coordinate ICU beds et cetera? This year, under Jodie's leadership, we have really embedded those health service partnerships. It has been a real innovation. It serves us well for the future. And then of course the local public health units—again, brand new public health infrastructure all built in service of COVID but all ready to respond to future health needs. Jodie, is there anything you want to add?

Ms GEISSLER: Just on the point around outcomes, I think there are some really interesting statistics around care in the home. So we have seen care in the home critical to the pandemic response. As you will be aware, a Better at Home program was funded in 2020–21, $43.5 million to bring online, enable really, surge capacity in our health system and support our health services to do that remote monitoring and in-reach approaches. But startling, I guess, are some of the statistics we are starting to see come through. Admitted chemotherapy, for example, 1.4 per cent in 2019, now up to 3.5 per cent in 2021; admitted rehab, 2.2 per cent in 2019 to 6.4 per cent in 2021. The Secretary has also said we are doing a record number of 86 000 video appointments. So I think there is a lot that is going on in terms of providing care in alternative spaces as well.

Prof. WALLACE: Just on the videoconferences—and I call this out because the team at Monash Health published their outcomes in *The Lancet*, one of the world's leading medical journals—during the pandemic last year Monash Health moved 70 per cent of their antenatal appointments to telehealth. So seven out of 10 women attending Monash Health had their care delivered from their home or their workplace. Now, there are about a million antenatal appointments in Victoria every year: 80 000 births, around 12 to 13 appointments per pregnant woman.

One of the core components of their work was to ask the women themselves, 'Is this a good thing or a bad thing?', because there is an element to it where you think, 'Is it really a good thing for pregnant women?'—it is not that the woman is having all of her care done remotely, but she is having lots of appointments. So they sent out blood pressure cuffs to women, because when pregnant women go to hospital for their antenatal appointment they are essentially getting their blood pressure taken. Of course there is lots of other care around them. But much of that care around 'How are you doing?' et cetera can also be delivered at home. So it is something that Monash has sustained. It is something that we are very interested in looking at as an innovation for whole of state. It could deliver care for women at home or in their workplace. Just avoiding the parking fees alone is worth exploring.

The pandemic has challenged us to rethink: how do we deliver care and how do we deliver care into the future that has the woman, or the man for that matter, at the centre of the care? So I think there are lots of things that the department is working with health services about: 'What have you changed that we can sustain?'.

Ms TAYLOR: Very comprehensive. Thank you. I just wanted to move to boosted ambulance services. I think on page 22 of the questionnaire you reported $14.8 million in funding to increase ambulance services and improve access to care. I think it would actually be really helpful for the committee if we could unpack that further and look at how this funding was spent, how it translated to more paramedics and expanded services, you know, to meet the increased demand.

Prof. WALLACE: Yes, great. I might ask Jodie to kick off, and then we might invite Professor Walker back up, if that is okay, to give us some further information.

Ms GEISSLER: While Professor Walker is coming up I can talk to the $14.8 million investment that you have referenced. That has funded seven additional peak-period units for metro regions in Epping, Tarneit,

Mernda, Craigieburn, Boronia, Templestowe and Bayside; four new rural peak-period units in Bellarine, Eaglehawk, Churchill and Gisborne to help meet growing demand in those areas; increased resourcing at the Daylesford, Benalla, Lakes Entrance, Torquay, Castlemaine and Bannockburn branches, relieving pressure on crews during very busy periods; converting the Beechworth branch from single paramedic to dual paramedic crewing; converting the Chiltern team to a single paramedic on-call location with ambulance community officer support; adding 12 triage practitioners to the operational communications team to assist more patients with alternative care pathways to Victorians who do not require a lights-and-sirens ambulance response; and recruiting 77 graduate paramedics to fill rural and regional vacancies.

So indeed Professor Walker might want to add more detail to that, in particular maybe how the alternative care pathways work, but Mr Hotham might also want to also reflect on ambulance station openings.

Prof. WALKER: Thank you. It is interesting. If you go back to wave 2 last year and think through, we had a situation occurring where when the community opened up just before Christmas we saw a 23 per cent increase in demand for ambulance services in rural Victoria. So part of the $14.8 million was really focused—in fact the $14.8 million was largely focused—on how do we address some of the rural issues that we were experiencing. It is interesting. Bernard Salt talks about the 'Goldilocks zone' 200 kilometres out of Melbourne where a lot of people were moving to, which was profoundly impacting on our demand in areas that were historically not as busy as they turned out to be. As I said, a 23 per cent increase overall. So that led to significantly boosting, as Ms Geissler said, additional paramedics. We put 87 additional paramedics across the state, 16 into Hume region.

Because not only did we see the shift of the population, we also saw a change in behaviour of our paramedics. As with all of us in the community, being exhausted through this pandemic paramedics were deciding they did not want to work overtime. They wanted to spend time with their families and do the things that they wanted to do, and I fully respect that. So we invested heavily to ensure we had sufficient reserve staff to be able to cover rosters for training and other matters that were there. We put on the additional 13 surge cars, which again were about ensuring that we had more resources available when other resources were out, particularly transporting patients into Melbourne. An additional seven peak-period units in Melbourne—again on the outskirts of Melbourne we were seeing high population growth and high demands on our services. And the rural services importantly put in a number of peak-period units—12-hour shifts to, if you like, supplement the 24-hour rosters that are there. So we have crews in place to be able to manage that. Castlemaine—up through the highway up towards Bendigo and Castlemaine. We upgraded Gisborne. Gisborne was still operating as an on-call location in some of its shifts. We were able to upgrade that to bring on additional crewing in there. Bendigo as well—a very busy area—and through Churchill and the Bellarine Peninsula. And we brought forward some of the government's announcements into last year to essentially increase the amount of resources we had in Geelong, again a very popular place for people to want to go and live and that therefore increases demands on our particular services.

And the alternative care pathways were very much about saying if we are managing a circumstance where we have people calling 000 who need help but do not need an emergency ambulance, our revised clinical response model—which we have been working on very heavily over the last five or six years—was about: how do we match those people to the right services? So working through our secondary triage area, today in fact we are now managing close to 1000 cases a day through our secondary triage area, with more than 50 per cent of those being able to be diverted, if you like, to alternative services in the community and avoiding an ambulance service response, which means that emergency ambulance is available for someone who needs that particular level of care. The investment has been quite significant. We grew a number of referral service triage practitioners in that area and increased the number of resources, particularly to manage that 200-kilometre zone where we did see a significant population shift over that time.

Ms TAYLOR: Thank you. I was wanting to move on to capital infrastructure. If I could take you to section B of the questionnaire, which deals with asset investment. Obviously in the last 21 months we have seen how important it is really to plan for the health demands of the community and also into the future, so I think it would be really helpful to have some feedback on the progress made on our major health infrastructure projects over the last financial year.

Prof. WALLACE: Thank you. I might ask Mr Hotham to provide the precise details, and again I go back to some of my introductory slides. In the 2020–21 budget $2 billion was given for capital infrastructure, which

took our current whole portfolio to $9.2 billion of health infrastructure—the largest portfolio in the history of health investment in our state. But the precise investments in 2020–21 and progress, I will ask Chris to comment on.

Mr HOTHAM: Very happy to. Thank you. Look, it was a big year for us. Euan outlined in his initial presentation that dual challenge for the health system of the existing demand and COVID. For us it was the existing delivery and delivery for COVID as well, and we feel like we were able to stretch to that challenge. Perhaps to start with, really one significant highlight of the last year would be the construction beginning of Footscray Hospital, which is, as you know, the largest investment in the state's history in health infrastructure. That was a really significant milestone, and we are making great progress there. I have touched in earlier remarks on some of the projects that we accelerated to help with that COVID capacity, including Casey, Goulburn, Northern, St George's, some of our mental health projects as well.

In terms of homing in on the 2020–21 year, there were some really significant investments, as you know, in that year. The 2020–21 budget obviously profiled the Frankston Hospital redevelopment. I am pleased to say that the expression of interest has gone out for that. We are evaluating tender submissions and would expect a recommendation to government for early next year, so that will be a really significant milestone for a huge project there. We have made some significant inroads in Melton with the $75 million in the 2020–21 budget around land acquisition there, and we have a site identified and announced by government in Cobblebank. So in early 2022 we expect to be able to profile those master plans and broader plans for that.

There has been progress in our aged care portfolio, once again with some of the projects that have been completed but equally the money from the $134 million from the 2020–21 budget for the Kingston Centre in Cheltenham. We have made some great progress there. The design is almost complete, and we would expect to be on site coming into the 2022 financial year. So we have got very long lists, but it is that picture of both the existing portfolio that has managed to track pretty well through the pandemic period and then lifting to the challenge of accelerated projects and helping health services in their COVID response.

Ms TAYLOR: Thank you.

The CHAIR: Thank you. Mrs McArthur.

Mrs McARTHUR: Thank you. Chair. Thank you, Secretary and team. Just to correct the record, Secretary, it was not Barwon Health that solved the problem in the Colac outbreak; it was Colac Area Health and the locals. And then the same thing occurred in Warrnambool as well—so absolutely locally run; nothing to do with Barwon Health or DHHS, just to get that on the record.

Some questions on notice in relation to mental health, please, if you would not mind. How many patients that were discharged from a mental health bed prematurely subsequently presented to an emergency department for self-harm or suicidal ideation or succumbed to death by suicide? That is the first one. Page 62 of the annual report refers to just 54.4 per cent of emergency patients being admitted to a mental health bed within 8 hours, so on notice could you please provide a breakdown of this data indicating the total number of patients waiting for more than 8 hours and more than 24 hours by health services over the past year, broken down month by month? And, Mr O'Brien, the Deputy Chair, began another question on notice, so just to repeat, because I do not think it all was concluded because time ran out: in May 2021 the Minister for Mental Health announced—

The CHAIR: Sorry, Mrs McArthur, just to clarify, are you asking this question now that you believe Mr O'Brien did not have the opportunity to ask?

Mrs McARTHUR: Yes.

The CHAIR: Because we do not just repeat questions to take on notice.

Mr D O'Brien interjected.

The CHAIR: Okay, so you are asking that question. That is okay, no worries. Just so long as the Secretary has an opportunity to answer.

Mrs McARTHUR: I am not sure that he ended, Chair, so it is easier to get the whole question out. So, yes, in May 2021 the Minister for Mental Health announced funding to support 3000 jobs in the mental health

sector. Could the Secretary please provide the number of mental health workers, broken down by full-time equivalent hours, the total number of staff by classification and/or profession and the location of these positions for the time periods of the start of the 2021 year, at May 2021 when the announcement was made and the end of the 2021 year? If these figures are not available, how will the department measure how many of the 3000 promised mental health jobs will actually be delivered? Those are on notice, Secretary, if that is okay.

Prof. WALLACE: Thank you.

Mrs McARTHUR: Okay. So to go back, Secretary, you kindly answered Deputy Chair Mr O'Brien's question earlier to the effect that $305 million was spent by our public health system with private providers, so can you explain how much of this was spent on prioritising public patients for elective surgery in the private sector? Page 25 and your answer to Ms Richards referred to the additional $41.3 million provided, but how is this sum and the overall funding split between public and private providers?

Prof. WALLACE: Thank you. There is a lot in that question. First, forgive me for not acknowledging the work that Colac Health did. It was a huge amount of work. What I was really referencing in regard to Barwon was that the local public health unit, the contact tracing led out of Barwon and Geelong University Hospital and really the leadership role that Barwon has had from its establishment and ongoing. So there is no question, and I think in answer to conversations we have had this afternoon around the value of local public health units, it is exactly that local proximity—knowing and understanding the community and working very closely with Colac Health and other health partners and providers in the west—so forgive me.

In terms of the elective surgeries, that $305 million figure that I referenced is the amount, the reconciled payments for private hospitals through the private hospital viability fund, which is a shared investment between the commonwealth and the state government. Can I say—and again, I did allude to this in a previous answer—that no dollars have been spent prioritising any patient over another patient except on clinical need. So where we have worked with our private sector colleagues in them providing access to elective surgery, it has been always on clinical need, so moving public patients out of the public sector into private to have their surgery, to allow, to create space for, the public sector to look after COVID patients. So essentially we made a decision that the public sector—and again I mentioned this before—would provide care for COVID-positive patients. That necessarily displaces some care; some of that is elective surgery. And then working very closely with the private sector to be able to accommodate some of that. But no public patient has been prioritised over a private patient, or indeed through the partnership vice versa, except on clinical need, and that is really important.

Mrs McARTHUR: Well, Secretary, with respect, that does not appear to be what many surgeons are saying, who are claiming that public patients are being reclassified to more urgent categories to clear the backlog of elective surgery, and it fits with the constituent inquiries I have had, particularly from one constituent in the Geelong area, who is a private patient, a pensioner in fact, who had her crippling arthritic knee surgery cancelled for the second time. But if we are in the business, as you said, of providing health care that Victorians need for all Victorians, whoever and wherever they are, how can you justify this discrimination?

Prof. WALLACE: Look, there is no question. Like you, I am sure, and like many committee members, I too have had correspondence from Victorians whose care has been displaced. Again, can I emphasise that these are not decisions made lightly, so this is about making necessary adjustments to our healthcare provision to allow us to look after Victorians with COVID. Again, while the numbers are modest, there are a hundred Victorians in an intensive care unit today because of COVID, and 50-odd of those are ventilated. In the normal course of events we do not have a system. Our 450 or 500 ICU beds are typically utilised fully by people having elective surgery. In order to create the space in our system—400 other inpatients with COVID—we have to create capacity, so to do that we have to make hard decisions on deferring care for some.

Now, again, one of the hallmarks of this year's response, learned from insights from last year, is our streaming hospitals, where we have tried throughout most of this year, up until really the last month or so, to focus all of our COVID patients into a relatively small number of health services. In your own geography Barwon Health has come on as a streaming hospital relatively recently and Colac has not at all, so we are not impacting on local health services where at all possible. So we have tried, but we have to create the space. We displace care, and therefore we then work in partnership with private to try and absorb some of that displacement. But has that meant that some patients who were listed for surgery—and orthopaedics, I agree with you, is one of the most impacted for surgery in the private sector, for which they are paying good private healthcare insurance—have

had their surgery deferred? Well, it has, unfortunately. Those are not decisions appropriately made by the department on an individual patient basis. They are decisions that are best left to clinicians, who are perfectly placed to decide what the clinical prioritisation of the patients are. So here are the patients that we have displaced, here is the system that we have had to defer and progressively we have reduced non-urgent elective surgery across the state. There are still some services providing elective surgery almost unabated. But again, the clinical decisions are best left to the doctors. Now, like you, do I hear individual surgeons saying, 'Well, my patients'? Well, that is what you would expect. They are advocating on behalf of their patients. That is appropriate. We support them in doing so.

Mrs McARTHUR: Okay. So, Secretary, can I ask you to take something on notice? Can you provide a breakdown of how many beds in private hospitals have been used to treat public patients throughout the pandemic and how many elective procedures have been carried out on public patients in private hospitals? I will just leave it on notice.

Prof. WALLACE: In the 2020–21 year?

Mrs McARTHUR: Yes. Okay, if we go to page 20 of the general questionnaire in relation to hotel quarantine medical contracts and the department's response to the COVID-19 pandemic program, as part of the $1.9 billion I would like to ask you about the department's contracts with medical providers for the government's hotel quarantine program. So, Secretary, Onsite Doctor, an entity owned by a well-known Labor Party donor in fact, Dr Henry Pinskier, was awarded an initial $4.2 million contract to provide medical services to the government's hotel quarantine program. A deed of variation to this contract saw this figure revised to $86.4 million. Can you explain why this contract price was revised only five months later?

Prof. WALLACE: Well, in the 2020–21 year of course the department only looked after hotel quarantine until 27 July, and thereafter it was passed over to the department of justice and then on to CQV—the current COVID quarantine in Victoria operation run by CQV. The Auditor-General instigated an audit of this very point in response to an allegation that our contract had been awarded to a medical provider and had been awarded inappropriately. The final report of the Auditor-General found no evidence of conflicts of interest in the procurement of those medical services. The ongoing increasing value of that medical service after 27 July did not lie with the Department of Health of course.

Mrs McARTHUR: Okay. I understand that Onsite Doctor was not registered when it was awarded the contract and it was chosen over existing registered entities. Under your department's procurement policy all contracts exceeding $10 million must be disclosed within 60 days. Why did it take 144 days after the Onsite Doctor contract was awarded for it to be publicly disclosed?

Prof. WALLACE: Again, VAGO have done an audit on this particular contract and procurement. They did make some recommendations around improved reporting, and we have taken those on board and acknowledged those and accepted those findings. But can I just reiterate: the audit was done in specific response to an allegation of conflict of interest, and the Auditor-General found no such conflict of interest. That is really important.

Mrs McARTHUR: Well, the Auditor-General has queried this contract in a report tabled in September, and he raised concerns that the proper review process for this contract was not undertaken. So, Secretary, can you tell us how much of the total funds spent on contracts for hotel quarantine went to entities owned by Dr Henry Pinskier and Mr Nathan Pinskier?

Prof. WALLACE: Well, I will—

Mrs McARTHUR: Take it on notice?

Prof. WALLACE: I will take it on notice, but again remember that the Department of Health was responsible for hotel quarantine only until 27 July. So in the financial year 2020–21 we were responsible for, what, 27 days of the contract.

Mrs McARTHUR: Okay. Thank you. Shall we go to some breast cancer screenings. Secretary, I refer to page 37 of the general questionnaire and to the department's 'Women screened for breast cancer by BreastScreen Victoria' performance measures, where the department's stated objective was screening

267 000 women for breast cancer. The actual outcome in 2020–21 was 236 224. Why did 30 776 women miss out on this vital screening?

Prof. WALLACE: Thank you. Look, as you recall, last year, like many of the services we have already talked about, breast cancer screening was stopped for about seven weeks—I think from March through to May—and clearly that impacted on the availability of the number of breast screens that were possible to be done at that time. Again it is a topic we have discussed at this committee before. There is no question that we and our clinical expert group led by Safer Care and indeed cancer specialists more broadly have been trying to calculate the potential impact of deferred care not just on breast cancer screening but on bowel screening and other cancers. I think time will tell what that will show, but front of mind is the deferred breast screening that happened in the financial year 2019–20. In 2020–21 the government gave specific funding to try and catch up on that deferred care.

Now, have we caught up completely on that deferred care? Not yet. And I think again that alludes to some of the complexities about why we have not caught up yet on the number of breast screens, despite the significant investment in 2020–21 for catch-up. Some of it goes to continued anxiety of individuals coming forward for care. So again, it is not unique to breast screening but it is very visible for breast screening, which is good, because it means we can better target. So it is very much on our radar. The department and breast screen providers are working very hard to try and encourage women to come back who are due a breast screen. But again, I think the most important thing is the response the government has made: it listened to the fact that there were clearly those women who were impacted by closure of breast screening for seven weeks back at the beginning of last year and investment to catch that up. So I think it will be time yet before women—not just women, but women in this particular context—have got confidence to come back and get normal health screening like breast screening. So it is a dual effect: partly deferred care and partly concerns, anxieties for the population itself.

Mrs McARTHUR: Okay. So that would be 29 000 missed out in 2019–20, 30 000 in 2020–21. What medically would you say will be the impact on that for delayed assessment of potential breast cancer?

Prof. WALLACE: We do not know is the honest answer. The Victorian Cancer Registry has estimated overall—so not unique to breast cancer—that about 2500 cancer diagnoses may have been delayed or missed during the calendar year 2020 in Victoria. Again, it is firmly on the radar. We are aware of it, the department is aware of it, cancer providers and screening providers are aware of it, Safer Care through the clinician expert group are aware of it, and it is now about: how do we respond to that? Again, government provided significant additional funding last year for breast screening catch-up. But it is not simply about making the appointments available, it is also about continued encouragement for women to come forward to have their care. So we will not know the full impact of that seven weeks of deferred care back at the beginning of 2020 for some time.

The CHAIR: Thank you very much. Mr Richardson.

Mr RICHARDSON: Thank you, Chair. Thank you, Secretary and department officials, for joining us this afternoon. Just before, Secretary, you were going through capital infrastructure with Ms Taylor. I want to take you to pandemic proofing new hospital builds. We have learned a lot over the journey of the coronavirus pandemic, and since the start of the pandemic the importance of ventilation in reducing aerosol transmission has been highlighted. What steps have been taken to ensure that new hospital projects, such as the new Footscray Hospital, as outlined on page 48 of the questionnaire, have been built to respond to future pandemic challenges?

Prof. WALLACE: Thank you. I might ask Mr Hotham to comment. You are quite right. Clearly one of the really important lessons we learned last year, as did the rest of the world, was the readiness of aerosol transmission of this particular virus and then changes to both existing health infrastructures but obviously new infrastructures. I would say before asking Mr Hotham to comment that one of our streaming hospitals was the new Box Hill Hospital, because it was one of our newest health infrastructures and had fit-for-purpose new wards built obviously well ahead of the pandemic. But the modern infrastructure afforded at Eastern Health at the Box Hill site allowed us to use that as a key streaming site for that very reason. I wonder if you want to go to the other things that we have done?

Mr HOTHAM: Yes, very happy to. And thanks for the question. Look, this is very much something that we have learned a lot about over the pandemic period, and it goes a little bit to the innovation question earlier. There are some things that we have seen in terms of the way that COVID moves through hospital environments that now help us to plan for the next phase of our build, and with that more than $9 billion worth of investment we can now capture those designs in what is coming through. To give you a specific example of that, and perhaps a little bit to the innovation point, one of the studies that we did do was a hotspot aerosol transmission study, which models and simulates the movement of a cough through a hospital environment. You can see the particles, you can see where they land, where they coagulate, and it informs a lot of infrastructure and design choices about the way that beds are set; the way that ventilation works, as you inferred; the way that operationally some of these settings are managed. So that is something that we have shared widely with health services and worked through various expert groups to champion as a learning.

I guess more broadly there are a number of design features that are being looked at. I started to go there earlier in and around EDs. We are looking at designs that are able to segregate COVID-positive patients and regular patients, providing that reduction of risk for both patients and staff. We are looking at more of those ancillary spaces for the flexibility that I mentioned. So there is a real key piece there, including some of those really practical lessons about the spaces that may have been a bit compromised, allowing staff to don and doff PPE, for instance. Some of those things are now encompassed in our designs, so there is certainly something there.

The ventilation piece, more widely than the aerosol hotspot study, is a key learning, and we are designing ways to improve ventilation and airflows in these COVID-19 zones, or pandemic zones, in healthcare settings to optimise ventilation and air circulation strategies, and there are a few elements to that. There are some smaller design features as well. Things like touchpoints, lift access and even having vision panels coming in and out of rooms for staff to understand where there might be some potential contact—all of those things are now features of our thinking. Then perhaps at the macro level there are lessons for us more broadly in the way that we think about precinct design and in the way that we think about where we want to go for the tower builds as opposed to more of a campus design. Obviously towers—and we saw this in public housing of course last year—create particular pinch points and particular risk.

So there are things for us to think about there in our design and master planning that are about some of those broader risks. We heard from Jodie and Euan about the way that the system has worked as one system. One of the other things we are thinking about in master planning terms is: what is the potential for co-location of public and private settings to allow more ultimate flex capacity in our response to a pandemic or a pandemic-type situation? So there are lessons big and small, macro and micro, but these things will now be picked up and played through in that really large investment that is happening in many of those really major infrastructure builds.

Mr RICHARDSON: Thank you very much for that answer. It might be related and cover off on some of those points, but just a page on in the questionnaire, on page 49, it details the Northern Hospital inpatient expansion. It notes the additional space was approved to fit out the level 6 shell space to deliver a pandemic inpatient unit. I am wondering if you could explain for the committee's benefit what this entails and provide an overview of what other capital investments have been delivered in the last 12 months to provide immediate support to the pandemic effort.

Mr HOTHAM: Sure. I am happy to. Look, it probably is the sort of iconic investment that captures some of those design principles that I talked about. I touched on it a little bit earlier in the sense that there was an underspend on that Northern Hospital expansion, and with that underspend we were able to do more with that project and increase the scope. In doing so, yes, as you are asking, we created a dedicated pandemic ward. Now, that is 28 beds. It is purpose built. It is a full negative pressure environment. It has the capacity for 100 per cent outside air and increased air changes, and I think perhaps in lay terms that means that there is no recirculated air in the ward—so really, the highest standard of infection control in that sense. Then it had some of those architectural modifications and smaller features: it incorporated two full isolation rooms, each with a dedicated anteroom; there were different ways to protect the spread of contaminants into the broader ward; and some of those things I touched on about spaces for donning and doffing, they were captured in that particular facility. Importantly, whilst that is a vital part of the surge strategy in the pandemic, when it is not being used for that it will equally be vital capacity for Northern with additional multi-day beds in a fast-growing area. So that particular investment is probably our iconic one.

We have touched on some of the other investments, both the acceleration of projects and the commissioning of new capacity—that was Mr O'Brien's question about Peter Mac. Equally we used some of that $80 million it was to recommission Peter Mac. It was also used for new capacity at Bendigo, new capacity at Baxter House in Barwon, not all of that ICU as you have heard, but very, very much-needed—particularly when the projections were as stark as they were—and really important additional capacity. Then at a much smaller level, and this is funding that was captured in the $1.3 billion, $55 million of that was at a lot of these kind of smaller upgrades around ventilation, scrubbers, structural separation, the flipping of wards, if you like, to be able to be COVID-compliant. We would have undertaken hundreds of smaller works, not all of them big, iconic and eye-catching but really important for the health services. I think it is really important to perhaps underline that many of our works in that vein were very much informed by the health services as what they saw as the risk. We have our own in-house capability but are working with the structural engineers out on site and the clinicians there to manage those bespoke environments. So there are a lot of universal lessons, but each infrastructure solution looks a little bit different depending on the patients, the risk and what else is already in place.

Mr RICHARDSON: Can I take you to another critical health service in the south-east, the City of Casey's Casey Hospital—I know the Member for Cranbourne and the Member for Narre Warren South will be very interested in this—and note the Casey Hospital expansion project, which is referenced on page 60 of the questionnaire, was delivered four months ahead of schedule, which is an impressive effort. Could you please outline for the committee's benefit the benefits the project is delivering for the south-eastern suburbs in terms of the additional hospital capacity in that growth corridor and take us through any other projects that have been delivered early in support of the pandemic response?

Mr HOTHAM: Yes, sure. Happy to. With Casey, that was the first time in some ways that we tested this point about our ability to accelerate a project, and really pleasingly—that had initially been slated to come online mid-2020—we brought that forward by four months in the end to February and it gave us some much-needed capacity in that first wave. That much-needed capacity was on scale, so 128 new multi-day beds, 12 intensive care unit beds, 12 day-surgery beds, six new operating theatres and two upgraded theatres. It was a $135 million investment, and you get the sense about the scale there. Obviously to your question, that is helpful for COVID and helpful in those waves, but it is equally a real boon for that community. In that longer term kind of frame, the expansion there at Casey will help with roughly 25 000 extra patients a year, 8000 more procedures and support an extra 1300 births a year. We are really hopeful that will help to reduce wait times in the catchment area, treat patients with higher acuity needs and cater for increasing demand there.

As I say, that was probably the first time this kind of acceleration piece was tested, and then we were able to accelerate some of those we have touched on, but the Northern is an accelerated project. Goulburn Valley was an accelerated project, so that was the construction of a new five-storey inpatient unit, with 64 inpatient beds, 10 intensive care beds and the first stage of an emergency department with 36 extra spaces. That was accelerated well ahead of time. And then those other examples of both the St George's aged-care facility and the Monash Medical Centre emergency department expansion were probably those really critical ones of acceleration.

But on the point of acceleration, if I could channel my colleagues back in the infrastructure division, we have been very focused on trying to keep our eye on the ball throughout this period, doing whatever we can to find quicker ways to deliver. We have had, as I inferred, appropriate licence, as state-significant projects, to get on with 100 per cent of our workforce on site, albeit with COVID-safe plans in place, and we have seen some really great best practice amongst our projects there. But having accelerated on these projects and got some good results, I guess we are trying to capture those learnings as best we can and continue to look for ways to speed up and get it done, given the demand that you are hearing about today.

Mr RICHARDSON: I might take you just quickly, if that is all right, to the COVID-19 compliance and the health compliance on health construction sites. We know how critical that has been through the pandemic to maintaining safe workplaces and ensuring that critical infrastructure can continue to take place and be delivered on time. Are you able to outline for the committee's benefit the measures put in place at state-run health infrastructure projects to ensure they are operating in a COVID-safe manner?

Mr HOTHAM: Yes, really happy to, and I think it does come back to that critical point. We had the 'state critical' definition, which helped us to operate with those COVID-safe plans in place. Obviously these were COVID directions that were for all civil construction sites under the directions of the Chief Health Officer, and

under that category these construction projects were able to operate at scale with those plans in place. Look, much like the operational kind of bespoke environments, a little bit of this goes to that the COVID strategies are site specific; they look very different depending on the project and are unique to those workforce conditions. But perhaps to give you an idea, there are COVID-safe requirements around physical distancing, as you would imagine, QR code check-ins, face masks, ventilation, avoiding interactions in closed workspaces—this is some of the crib space—and more recently I guess that particularly important compliance around the vaccination mandate as well. So that is all part of the COVID compliance. There is also regular enhanced cleaning across our sites, particularly in the high-touch areas that you would imagine—bathrooms, tearooms—there are COVID-safe marshals on site designated to oversee the compliance, really importantly.

And perhaps on a compliance point, there is compliance and then there is moving into best practice, and I think that is what we are starting to see through some of our construction partners. They want to be ahead of this. Many of them are now starting to use some of the bluetooth tracking technology—lanyards for staff—so if there is an outbreak and there have been isolated small cases on particular sites, that information is vital to Jeroen and his team, the tracking and tracing team, given that it is a really sophisticated dataset. So I think you are seeing a sector that is really keen to do the right thing, and we are seeing some of that best practice on our sites. And thankfully, I guess, the sum total of that is that through a really challenging time where there have been risks that we have all been watching, around supply chains, around shutdowns—watching and waiting and seeing how that will manifest in this project and our project pipeline—thankfully very largely we have managed to weather the storm and the vast majority of our projects are on time and on budget as a result.

Mr RICHARDSON: Fantastic. I might just go to the topic of dental services that were covered a bit before. In the questionnaire, on page 28, it is reported that $16.2 million was funded from the commonwealth dental partnership agreement and was required to be rolled over from 2019–20 into the 2020–21 period to continue activity for public dental services. Are you able to explain for the committee's benefit how the department has continued to ensure all eligible people have been able to continue to receive that urgent and emergency public dental care in a COVID-safe operating environment?

Prof. WALLACE: Yes. Thank you. And it does touch upon some of the answers we gave earlier to a previous question. Again I just reiterate that, a bit like our acute hospital system, our dental health services are co-funded between the commonwealth and the state, and the funding rollover was really a reflection of sort of unmet activity, so we can then move that funding into the next year. Again, there is no question that COVID has impacted our dental health services. We looked at some of the numbers—and it was on one of my slides—so 50 000 less treatments in 2020–21 compared to the previous year.

I would reiterate that there is no waiting time for urgent care, so patients requiring the most urgent care in 2020–21, 92 per cent of them, had treatment within 24 hours, which is ahead of our benchmark target of 85 per cent. So the vast majority of people, more than nine out of 10, requiring urgent dental care get it within 24 hours. And then in terms of the other nearly 228 000 clients—the same for elective surgery—it is really about our dental health services prioritising those by clinical need. So the Dental Health Services Victoria and their partners in the community have really worked very hard to make sure that there is as little deferred care as possible and those who need care urgently get it in a very timely manner.

Mr RICHARDSON: Thank you. Thanks very much.

The CHAIR: Thank you. That concludes the time we have set aside for consideration with you today. We thank you all for appearing before the committee. The committee will follow up on any questions which were taken on notice in writing, and responses will be required within five working days of the committee's request. The committee will take a very short break before moving to consideration with the departments of Parliament. Thank you for your time this afternoon.

Witnesses withdrew.