STANDING COMMITTEE ON ESTIMATES AND FINANCIAL OPERATIONS

MISCELLANEOUS PROCEEDINGS

TRANSCRIPT OF EVIDENCE
TAKEN AT PERTH
WEDNESDAY, 23 JUNE 2021

SESSION ONE
DEPARTMENT OF HEALTH

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

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Hearing commenced at 10.13 am

Dr DAVID RUSSELL-WEISZ
Director General, Department of Health, sworn and examined:

Ms ANGELA KELLY
Acting Deputy Director General, Department of Health, sworn and examined:

Mr ROB ANDERSON
Assistant Director General, Purchasing and System Performance, Department of Health, sworn and examined:

Dr DUNCAN JAMES WILLIAMSON
Assistant Director General, Clinical Excellence Division, Department of Health, sworn and examined:

The CHAIR: On behalf of the committee, I would like to welcome you to today's hearing. It will be broadcast. Before we go live, I would just like to remind everyone that if you have any personal or private documents with you, please keep them flat on the desk to avoid the cameras because it is being broadcast. The committee acknowledges and honours the traditional owners of the ancestral lands upon which we meet today, the Whadjuk Noongar people, and pays its respects to their elders, both past and present. I now require you to take either the oath or an affirmation.

[Witnesses took the oath or affirmation.]

The CHAIR: You will have signed a document entitled "Information for Witnesses". Did you read and understand that document?

The WITNESSES: Yes.

The CHAIR: These proceedings are being recorded by Hansard. A transcript of your evidence will be provided to you after the hearing. You are our first hearing in the new estimates committee, so welcome. Just as a bit of an explanation for you so that you are not being singled out, in the last estimates hearings we had the annual reports and the estimates hearings combined, which were a little constrained. We feel that, as a committee, it is incumbent upon us to have a look at various agencies within government to hear how things are going, and particularly with an area of health, of course, which has had quite a lot of public profile over the last 12 months, for logical reasons. That is why we have asked you to come in and, ideally, give us a bit of an insight into what is really going on into the health sector. Thank you very much for taking the time. We are very conscious of the fact that it is a difficult environment for everyone, particularly those in health.

Hon Jackie Jarvis, Hon Samantha Rowe, Hon Nick Goiran and Hon Dr Brad Pettitt are members of the committee. I am Hon Peter Collier. I am the chair and Hon Samantha Rowe is the deputy chair. Each member of the committee will be given an opportunity to ask any questions.

From my perspective, the one area I am interested in is, if you have a look at your annual report with regard to key issues for the department and for health in general, we are dealing with climate change and preventing chronic disease and injury, which are significant issues et cetera, the one

glaring omission, and I am not sure if it would normally be in your annual report, particularly at the moment, is with regard to ambulance ramping. Is that a significant issue for Health at the moment?

Dr RUSSELL-WEISZ: Chair, yes. Ambulance ramping is a symptom of the demand that we are seeing here in Western Australia, but also right around the country. We have seen a spike in demand over the last six to nine months. It really started to grow from September/October last year, and then has grown ever since. The demand is coming through our emergency departments. As you know, we triage patients into triage 1, 2, 3, 4 and 5, with 5 being the lowest category and 1 being the highest. We are seeing really unprecedented demand in the T2s and the T3s—so, triage 2s and triage 3s—so higher acuity and higher complexity, and also an increase in volume as well. Whilst we are not seeing an increase in admission rates—so the percentage of admissions is basically stable, because there is more volume coming through our emergency departments, and it is in the higher complexity—we are actually seeing this obviously flow back onto the ramp.

In Western Australia, we pride ourselves on our four-hour rule performance. As you know, we led, and we are still leading, the other states with our four-hour rule performance in relation to how many patients you get through an emergency department within four hours. However, because of this demand—we have seen some percentages over the last three to four months in the triage 2s and the triage 3s of increases of between 13 and 16 per cent in demand—we are seeing patients flow back onto the ramp. It is a significant issue, but the significant issue more broadly is patient flow. We are putting significant efforts into patient flow. That is a number of things that we are looking at to make sure we reduce ramping, ultimately; we increase patient flow through our emergency departments; and we get patients out the other end in an appropriate clinical manner.

Whilst we have seen a general increase in demand, and, as I said, this is being seen around the country, we are also seeing an increasing pressure on mental health patients coming into our departments. Also, we have increasing bed blockage at the other end. There are a number of strategies that we are focusing on through this period. I will just go through those so you understand how we are addressing the increase in ramping and increase in pressure. We obviously want to encourage ED avoidance and diversion. Not everybody who comes in an ambulance actually gets admitted. For example, I think it is around about 60 to 65 per cent—I will take Rockingham as an example—of those who actually come in an ambulance to the ED do not actually get admitted. The government have set up the urgent care clinics. We are doing our best to divert the most appropriate patients to general practice, noting there has not been a huge increase in that general practice–type patient; it is more in the higher complexity. Also, general practices are busy. If we talk to our primary care colleagues, they are busy. They are as busy as we are.

The CHAIR: What do you mean by "higher complexity", just as a matter of interest?

[10.20 am]

Dr RUSSELL-WEISZ: Higher complexity—so they are basically sicker patients. As I said, the triage 2s and triage 3s means they either have greater comorbidities or they are sicker because they have a number of things that are going on with them that need acute care. Also, they need longer in the emergency department to be stabilised, but there are also difficulties getting them through. So one thing is diversion; the other thing is increasing capacity. We have opened around about 150 extra beds in the system. We are also working on making sure we have the best patient transport. We obviously rely on St John to do the emergency transport. We have two other providers who assist us with our mental health patient transport. The health service providers themselves—the hospitals—are also looking at all those things that really made a difference within the four-hour rule in the hospitals. What are those key things at the front door and through the hospitals that can actually improve patient flow?

Mental health is a significant issue for us, and it really goes into those long-stay patients. We have a stream of work at the moment that is focused on long-stay patients. We have a number of long-stay patients that are not just in Graylands, but in all our hospitals. They do not need to be in hospitals, but they do need to be in the community where there are wraparound services, both clinically and non-clinically. Some of it is as basic as housing. Some of it could be housing. There are a lot of patients who are waiting for NDIS, so waiting for the National Disability Insurance Scheme to be able to assist them. We have a stream of work now that is really focusing on those individual patients to make sure we can actually get them out of hospital into appropriate accommodation, because it is not just about new beds, it is about freeing up capacity in our current hospitals. There is also a significant amount of work going on in relation to workforce.

Obviously, the committee would be aware of some of the workforce shortages we have within the health sector in specific specialities; for example, in midwives, in intensive care unit nurses, in theatre nurses and in psychiatrists when it comes to medical practitioners. Some of that is because we are not bringing in as many overseas-trained practitioners as we were. But we have a number of strategies. This is a problem most jurisdictions are facing. We are trying to attack this in a number of strategies, noting there is no magic bullet to this because we have got this increasing demand that is coming through our sector.

The CHAIR: Thanks, I appreciate that. Has COVID had anything to do with the increase in ambulance ramping?

Dr RUSSELL-WEISZ: Look, yes. The way I describe it is COVID is always with us. So since March or February 2020, our hospitals have been working extraordinarily hard. I will probably be blunt: there is this belief out there that we have not had COVID, so why are our hospitals busy? Now, our staff have done an extraordinary amount of work in relation to COVID. We have had to be ready. We have had new practices and new policies we have had to put in place. Obviously, there are still patients who come in every day to our hospitals that are suspected of having COVID, and there are certain precautions that hospitals have to do, both in emergency departments and the wards, in relation to COVID procedures. So I would say COVID has had a role in relation to the extra pressures on the health system, but it is not just to do with emergency departments; it is right across the sector.

The CHAIR: That is right, because the ambulance ramping, the increase in numbers, were accelerating well before COVID, weren't they?

Dr RUSSELL-WEISZ: Certainly, we had pressures pre-February 2020. They were going up, but not at the scale that we have seen probably since November 2020.

The CHAIR: Just as a matter of interest, I am not sure whether the government is seriously considering this or not, but they are talking about taking over the ambulance system from St John. Would you be supportive of that?

Dr RUSSELL-WEISZ: I have had no discussions recently on that issue. The first I saw of the terms of reference of the parliamentary inquiry was actually last night. We have had a partnership with St John for many years. St John basically provides our emergency services. We work with them hand in glove. So with the parliamentary inquiry I saw announced last night, we will obviously, as the health department, work extremely positively with the parliamentary inquiry, as I am sure St John will.

The CHAIR: But would you be supportive of taking the ambulance system from St John?

Dr RUSSELL-WEISZ: We always look at how hospitals operate. Whenever we have a private provider providing a service for us, always you have to look at not just value for money, but also a value for

quality assessment of it. I would naturally be supportive of any government looking at whether we are getting the right service out of St John Ambulance, but I would not proffer an opinion now, prior to a parliamentary inquiry, in relation to your question of whether we would take over the St John Ambulance service. I mean, they have a huge amount of paramedics who do an outstanding job in some very challenging situations. They have also had to respond to the COVID situation. We have two or three COVID ambulances that actually respond to our hotel quarantine or respond to patients who may have COVID. They, like all our partners under COVID, have responded magnificently to the COVID pandemic. They have been a partner like everybody else.

The CHAIR: Thanks very much. Just with regard to the ambulance ramping per facility, do you have that information available? Are you able to provide that per facility from 2017, 2018, 2019, 2020 to date?

Dr RUSSELL-WEISZ: Yes, we can provide that. The actual ramping numbers come from St John. They measure ramping and we just take the figures from St John. We do not collect our own, but we also look at transfer of care time and also —

The CHAIR: Is it done monthly?

Dr RUSSELL-WEISZ: It is done monthly. We actually see it. We also see it daily as well.

The CHAIR: Good. I think monthly will be fine, if we can have it monthly from 2017 to the most recent figures.

Dr RUSSELL-WEISZ: Yes, if we could take that on notice.

The CHAIR: That will be taken as question 1. Thank you. Just one quick one, because it is related to exactly what you talked about: what is bed capacity at the moment in Western Australia?

Dr RUSSELL-WEISZ: I would have to look at the exact figures today. It fluctuates day to day. What I can say is at a point in time. This goes back to a question we answered for media. If Rob has the actual numbers on that date, we might go to that. What I can say is we have added, as you know—it was announced a couple of days ago—about 158 beds. The government announced 117 in mid-March, so there would be 117 extra beds which are over and above the ones they have already announced which will come online between 2023, 2024, 2025, with the Joondalup expansion, the Peel expansion, all the emergency department expansion. But around about the numbers on that day, have you got that, Rob?

Mr ANDERSON: No, I do not, but we can provide them.

The CHAIR: I will ask for that in a moment, if you do not mind. With regard to bed capacity, and you did allude to this with regard to the ramping, is that contributing to the increase in ambulance ramping?

Dr RUSSELL-WEISZ: It is the bed capacity, but it is not as simple as just building more beds.

The CHAIR: No, I understand.

Dr RUSSELL-WEISZ: I could free up long-stay patients who are in acute beds, you actually improve patient flow. So a lot of the efforts—it is not just me—from the health service providers is working with the department to concentrate actually on those patients who would be better served, potentially, in the community, if we could provide wraparound services around them, also, if there was specific housing or if we could get them into NDIS packages. It is quite a prolonged process to get patients into those packages. So the focus is, yes, free up capacity, get some more capacity, which we have done, but also free up capacity in our hospitals.

[10.30 am]

The CHAIR: Is it a physical issue, a resource issue or a combination of both?

Dr RUSSELL-WEISZ: Certainly a resource issue at the moment. We have opened up 117 with resources, but if we were to open any of our—and there are some beds in the system that have been decommissioned for a very, very long time, some for many years, and some of that would need capital resources—but they have been decommissioned for a very long time so we have concentrated on the beds you can open straightaway, which we have done. We are also going to concentrate on opening up capacity in the sub-acute sector or looking at providers who can, as I said, provide wraparound services clinically so patients could be in the community. As I said, for example, if I could free 50 per cent of the 80 beds at Graylands, it would give me 40 acute beds to flow through.

The CHAIR: With that said—just to conclude on this—with the information you may have, again, can you provide that information on a month-by-month basis, on capacity or how do you —

Mr ANDERSON: Beds fluctuate. They fluctuate as beds are opened and closed, and there is no daily audit of beds. We undertake that as we need to. So we generally appoint some time. I think the most recent one we did was a month or two ago. We did one in February and we did one last year as well.

The CHAIR: I am trying to help you with regard to getting this information. I would like to see the bed capacity per facility from 2017.

Dr RUSSELL-WEISZ: Yes.

The CHAIR: What would you be able to provide there? Monthly or in —

Mr ANDERSON: We can definitely do 2017, because we did that at a point in time, and we can give you one, I think, it is last month or the month before. We can give you a snapshot for two time periods.

The CHAIR: But can you do anything in between?

Mr ANDERSON: Potentially. We cannot give you monthly, but I could see what is available.

The CHAIR: What I would really like is to get as much as you possibly can over that period of time from January 2017 until today, basically.

Mr ANDERSON: Yes.

The CHAIR: I appreciate what the situation is, it is a point in time, but could you get me whatever you can from that four-year period?

Mr ANDERSON: Yes. The accuracy—the number of beds that are in the system—we can generally give you that. It is the number that are closed for operational purposes, they will not resource beds if they are not required.

The CHAIR: Yes. I appreciate that.

Mr ANDERSON: That is the bit that is never accurate, so that is why we will only give you audit points in time.

Dr RUSSELL-WEISZ: Could I make a point just about beds? Obviously, you will see the beds as one number, because it is all beds. I am not being pedantic, but there are different types of beds. So we have multi-day beds, people who use beds for more than one day; we have day of surgery beds; we have chairs; we have a number of beds that operate in the system. So if people come in for surgery for a day, they may use a bed that you would not use as a multi-day bed. So we probably can give

you that information for 2021, just to show that there is a whole suite of different types of beds in our system.

The CHAIR: Yes. That is what I would like to get, if you would not mind. Thanks. That is question 2.

Hon JACKIE JARVIS: I would just like to follow up on the ramping question. My elderly father lives with dementia and is in aged care in regional WA, and has been since November. Twice in the last few months there have been instances, both on weekends, where the aged-care facility has called an ambulance for medical issues that I would class as urgent but not emergencies. In both instances, I had asked that I would take him for what would be a 10-minute drive to the Busselton hospital, but in both cases I was told no, an ambulance would be called, which surprised me. In both instances, he was released from hospital within a few hours. Once he needed a scan, once he needed an X-ray, and I was able to take him back. Do you have any data, or is there pressure from the aged-care sector? Do they have a policy of discharging care to an ambulance rather than to perhaps a family member?

Dr RUSSELL-WEISZ: I would like to say there is pressure from the aged-care sector. What I will say is the hospitals and health services have worked very hard with them because they tend to do it as a local area. We are trying to let hospitals build their links with the local area and the local aged-care providers. For example, I know it is not regional, but in south metro we know there are some really good links between hospitals and aged care. There is a model now being set up which is really called their virtual emergency medicine model. If somebody is coming in, let us say you have an aged-care resident with a catheter blockage, there is no point putting them in the queue of ambulances, coming into a very busy acute emergency department. So they are now diverting 30 per cent of their ambulances potentially to other areas in the hospital where they can get their care. So there is pressure from the aged-care sector. I might ask James just to comment on the residential care line and other things that we do to actually try and take pressure off the ED and support the aged-care sector.

Dr WILLIAMSON: We have been meeting fairly regularly with the residential aged-care sector throughout COVID. In fact, we are probably closer now than we were before, to be honest with you. There are a number of practices trying to assist them in making decisions about how they manage people who fall ill in residential aged care, particularly in respect to the wishes of the individual themselves. First of all, we have done quite a lot of work around advanced health directives et cetera but also in respecting the wishes of the family. Those conversations are held in conjunction with the patient and the family. That is one piece of work.

We have, as the director general mentioned, the residential care line, which is led by a nurse practitioner and a number of other nurses, which can go out to residential aged care and can provide simple interventions such as changing catheters, blocked PEG tubes and those sorts of things. They also provide education to the residential aged carers as to how to manage things onsite.

We have a lot of initiatives now through palliative care. We have education for residential aged care and in-reach services for residential aged care too, but I am not aware of any, if you like, blanket rule that says if somebody needs medical attention, then they have to be transferred out of the residential aged-care facility by ambulance. I am not aware of that.

Hon JACKIE JARVIS: In the context, this was in Busselton and it was on a weekend. The care my father receives at the facility is fantastic and the care our family has always received at the Busselton hospital has been fantastic. It was just, particularly in a regional area where you quite often have volunteers, I was just mindful that I would have preferred not to have had a volunteer and have an ambulance used up in a regional area. I am also mindful that aged cares have different protocols around COVID at the moment, so there are some issues around visiting times et cetera.

Dr RUSSELL-WEISZ: Just to add to that, we are doing work with St John and they have really taken this on themselves as well to sometimes—they have a secondary triage area, so they will see what cases are coming in or asking if ambulances—and they will sometimes make a call, "Well, are you sure you need an ambulance?" They are better to answer this than me, but they have other strategies where patients can get diverted away from hospital to somewhere else, but obviously if they are in any doubt, then they would call an ambulance. In your case, member, I would be happy to look into why that was —

Hon JACKIE JARVIS: My father needed to be in hospital because he had to have an X-ray. My level of concern was more the pressure it was putting on hospitals and ramping, if an ambulance was being called when a family member had volunteered to take them.

Dr RUSSELL-WEISZ: Yes. We are not seeing a lot of ramping at our country sites. A little bit has crept in at our regional sites, but it is not huge.

Hon JACKIE JARVIS: Thank you.

Hon SAMANTHA ROWE: Lately, we have seen a drop-off in people taking up private health insurance. Does that have an impact, then, on our public health system, say in relation to waiting times for elective surgery?

Dr RUSSELL-WEISZ: Yes, member, it certainly does. I will make some opening remarks and then I might pass on to Angela or Rob to talk about maybe some of the figures we have seen. It makes a huge difference. We have seen a drop-off, for example, in not so much cover for elective surgery, but for obstetric cover. So, for obstetric private cover, people are choosing not to take private health insurance in maternity. You have seen our major maternity hospital and also Fiona Stanley Hospital do more deliveries than we originally planned for because there are more coming from private to public. Obviously, we give a good service as well, so we have seen that shift. We have seen that little shifts in elective surgery can add to the waitlists, so whilst there are numbers on our waitlist, we really concentrate on times. We have category 1s, 2s and 3s. Whilst numbers get quoted on the waitlist—it might be 10 000, 20 000 or 30 000; the numbers are not so important that you—clinicians actually categories them as urgent, semi-urgent or non-urgent.

[10.40 am]

Category 1s have to be done within 30 days, category 2s within 90 days and category 3s within 365 days. We have seen some outstanding performance by the public system. We are seeing now that the number of people who wait over boundary —

Hon SAMANTHA ROWE: What does that mean?

Dr RUSSELL-WEISZ: It means that if you are, say, a category 1 patient, you need to be operated on within 30 days. If you wait longer than 30 days, you become what is called an over-boundary patient. We push our health services to make sure they actually operate within that period of time. We have seen a reduction from 2019–20 of maybe 28 per cent of people in category 2 being over boundary reduced to 18 per cent, and this was through a pandemic. That is a massive reduction because we have really concentrated on our elective surgery performance. That is why more people are coming onto our lists. So more people are coming on. Whilst people do quote a figure of this many people on the waitlist, we do not concentrate on that; we make sure that those people are being seen in the correct time.

We had a blitz, as you know, in the last six months of last year—$36 million—to actually push through elective surgery and to make up for the period where elective surgery was lower during the two and a half months of lockdown last year. At the moment, it is around about nine per cent, so basically 91 per cent of patients get operated on within the correct time.

Hon SAMANTHA ROWE: Within that time period that is —

Dr RUSSELL-WEISZ: Yes, that is set. So it is 91 per cent. We are always trying to make it lower. We have gone as good as 94 per cent. Also, if you look at the 2019–20 year, WA was one of the best-performing states in its elective surgery. It has a median wait time of 36 days. This was published in February. For other states, New South Wales was 53; Queensland, 40; and Tasmania, 55. We were second to all the states. It is a huge focus for us to make sure we get our elective surgery done so that patients do not wait too long.

The CHAIR: In the budget papers, where you were talking about the 2020–21 budget target on those three categories, there is nil target for all three. Why is that?

Dr RUSSELL-WEISZ: Can you point —

The CHAIR: Under WA Health, "Outcomes and Key Effectiveness Indicators", on page 319 of the budget papers.

Dr RUSSELL-WEISZ: Sorry, I have the annual report and not the budget papers here.

Mr ANDERSON: So the target against waiting times?

The CHAIR: Yes.

Dr RUSSELL-WEISZ: I can assure you that we have not changed our target for category 1. The actual performance for 2019–20 was 15.3 per cent. We will report obviously on our current performance in this budget.

The CHAIR: There is no budget; it says "nil" for each of the three categories.

Dr RUSSELL-WEISZ: These are national targets. The actual targets are actually written in the outcome. So for category 1 it is over 30 days. That is what I was explaining for over boundary. In 2019–20 and in 2020–21 the target was nil, because what we basically try and do is get all those to zero. If you take all of those together, we are now sitting at 91 per cent. I will go the other way—nine per cent of patients wait longer than the recommended time. We try and get that down as far as we can. We never really achieve 100 per cent because you will always get maybe category 1 patients who need two or three surgeons, and if they are complex, they may not be able to be done in the 30 days.

Hon SAMANTHA ROWE: I want to ask a question around nursing if I can. Is there a plan to have more nurses come into the system, and how are we going to do that with the international borders closed and so forth? Does that have an impact, or is there another plan to see more nurses come into the system?

Dr RUSSELL-WEISZ: We have a number of strategies. I might ask James to go into a bit of detail about this. We are recruiting more graduates, so more nursing graduates are coming into the system. The government announced more places for nursing graduates, so we are bringing more through. We have recruitment drives, we have recruitment pools specifically targeted at some of our shortages—midwives, intensive care, theatre nurses—and we do have national and international recruitment. We can bring people in and we have brought people in, but, to be honest, there are less people. You would think that WA was an attractive place to come. We are very happy to bring in nurses and doctors internationally, so we do have targeted campaigns, but I might ask James to go through in just a bit more detail than nursing.

Dr WILLIAMSON: The work around this in the nursing and midwifery workforce has been led by our Chief Nurse and Midwifery Officer, Robina Redknap, and it is really in two phases. The first is basically an advertising campaign, both nationally and internationally, in order to bring nurses in who have full qualifications in the area that we are interested in, particularly around mental health,

midwifery and some of the specialist areas that the director general has mentioned. In addition to that, we have to look at our ability to attract and retain nurses, and some of those are flexible working arrangements. There might be provision of child care and various other aspects like that. In the longer term, we are developing a five-year workforce strategy around nursing and midwifery to see if we can be more consistent in the nurses that we are bringing forward, and midwives too.

That is the sort of framework in which we are operating. To talk about the international recruitment—obviously, this is problematic. There are some areas where there are potential ethical concerns about recruiting nurses—you know, from the sub-continent or somewhere where we might have done so in the past. It is not so very long ago we were actually exporting our nursing graduates overseas. We had an excellent arrangement with Grampian in Scotland where probably somewhere between 50 and 100 nurses—I cannot remember the exact number—went over there to do graduate programs. That was extremely successful. They got an outstanding training. Now that they are completing that, many of them are looking to come back. We are looking at that particular cohort in great detail. Some of them have already made their own arrangements to come back and we have tried to facilitate that. We know that some of them are being picked up by the private sector, but, you know, they are adding to our nursing and midwifery workforce, and we will do everything that we can to facilitate that.

Normally we would probably bring in about 150 junior doctors each year, usually from the Republic of Ireland and the United Kingdom. Obviously, we have been unable to do that. Nevertheless, we do have a significant number of doctors who have indicated that they would like to come over here. I have had approaches from some of the health services to see how we might facilitate that, and I have spoken to the Chief Health Officer and others about how we can support these applications and fast-track their transfer back to Australia or into Australia. So we have a range of international recruitment options which are available at the moment.

Hon JACKIE JARVIS: I am interested in regard to the nurses we are training ourselves in WA. Do you have a sense of the number of enrolled nurses versus registered nurses, and is there a mechanism or a system to upskill those people who have completed an enrolled nursing qualification?

Dr WILLIAMSON: Off the top of my head, I am afraid I could not tell you what number of registered nurses we have and enrolled nurses, and the total number of midwives, et cetera. I do know that we have shortages across the board. In terms of what we are doing about it, clearly what we want to do is to offer in situ training and upskilling to bring people perhaps from general nursing into some of the specialist areas, as the director general has mentioned. We are certainly looking at that. Some HSPs have had very well-developed programs for a while and others are now looking at those to see whether we can coordinate that approach. In terms of bringing on new graduates, we are expanding our graduate programs. We are increasing the number of nurses that we are employing directly. We are looking particularly to bring on additional nurses in areas like mental health, and we are certainly looking to bring on additional midwives. There are some changes to midwifery training in the university sector, which may have an impact on the flow of new graduates into the system, and we will be working with the university sectors to address that and smooth that.

The CHAIR: Jackie, did you want the numbers for that?

Hon JACKIE JARVIS: No, that is fine.

Hon NICK GOIRAN: Director general, mandatory contact registers were required to be maintained from 5 December last year. Were you involved in that decision?

[10.50 am]

Dr RUSSELL-WEISZ: Yes, I would have been, I am about to say, peripherally, with the Chief Health Officer when those were done. You are talking about the SafeWA?

Hon NICK GOIRAN: Yes.

Dr RUSSELL-WEISZ: Yes. I was certainly involved, and our team were involved, in the development of the app.

Hon NICK GOIRAN: Was it your understanding that such records could only be accessed for COVID-19 contact tracing purposes?

Dr RUSSELL-WEISZ: It was until I became aware that, legally, the police could call on those.

Hon NICK GOIRAN: When did you first become aware of that?

Dr RUSSELL-WEISZ: I was aware—I have looked at my diary—about 10 March, there was a meeting that I had with the incident controller at that time and one of our public health officers raised the issue formally. It was raised because, I will check, member, whether it was a second or a third request, but the public health team were concerned. The issue a couple of weeks earlier had been raised informally with me and then there was, I think, some dialogue between the police who were requesting specific information, and then when it was raised formally, because I think that was the third request, at that time, I then wrote to the police commissioner on 12 March, I think. I wrote to the police commissioner and I also spoke to him on 11 March because obviously we were concerned that potentially this was being used for very potentially appropriate purposes because of what happened, I think, at the—I am about to say the Kwinana, hopefully that is right, the Kwinana motorplex, but certainly the public health team were concerned and raised it with me formally, that these were being used by the police, not commonly, but were being used. We were given what are called OTPs—Order to Produces—which we did get advice from our own legal team that we had to comply with.

Hon NICK GOIRAN: This regime started on 5 December last year. You say that you were involved peripherally with respect to that decision. It was your understanding that the records would only be able to be accessed for COVID-19 purposes. At the time when the decision was made to mandate these registers, how significant did you consider it that this assurance was being provided to Western Australians, that it would only be accessed for COVID-19 contact-tracing purposes?

Dr RUSSELL-WEISZ: To be honest, I cannot tell you what I was thinking in December, member, but this was one thing that was said at the time, and I made that clear when I officially then briefed the minister, which was late March, but when I actually sent to the commissioner, I said in my letter to the commissioner that we are concerned that this is being used for purposes other than health.

Hon NICK GOIRAN: So would you describe the assurance that was provided as a significant assurance?

Dr RUSSELL-WEISZ: Yes, absolutely. Yes.

Hon NICK GOIRAN: Hence why you had the concerns and raised it with the police commissioner?

Dr RUSSELL-WEISZ: Yes.

Hon NICK GOIRAN: When did you first raise it with the Minister for Health?

Dr RUSSELL-WEISZ: I think I put a briefing note up on about either 30 or 31 March.

Hon NICK GOIRAN: You say that you had some informal discussions prior to 10 March. I think it was first formally raised with you on 10 March, you had some discussions with the police commissioner on the eleventh and you then wrote to him on the twelfth.

Dr RUSSELL-WEISZ: Yes.

Hon NICK GOIRAN: When you say that it was raised with you informally, what does that mean? Who raised it with you informally?

Dr RUSSELL-WEISZ: I think late in February there was an email trail between actually James and myself that just said, look, this is an issue and —

Hon NICK GOIRAN: Sorry, an email trail?

Dr RUSSELL-WEISZ: Well, an email that said—I think James was covering me when I was away, and he said, look, there was an issue in relation to this, but it was being dealt with between public health and I think the police at the time. It was then formally I had a meeting—again, I would have to check—it was either 10 or 11 March, so pretty soon after that when the contract tracing—the senior public health physician in the contract tracing team had raised it with the incident controller and they sought to meet with me to formally raise it. When I heard about—I think we were—to be honest, at the time we were then concerned, could this be a recurring theme? Now, there was one—I think there were only probably two or three requests at that time—before that time—and when that was raised, I wrote to the—well, actually, I picked up the phone and I spoke to the commissioner. That is the first thing I did.

Hon NICK GOIRAN: The following day. Now, this email trail, do you know what the dates were of these emails?

Dr RUSSELL-WEISZ: I cannot tell you that. I think it was about 25 February, something like that.

Hon NICK GOIRAN: Would you be able to provide those emails to the committee?

Dr RUSSELL-WEISZ: I would be able to provide those emails to the committee, yes.

The CHAIR: That is answer 3.

Hon NICK GOIRAN: On 25 February, you received some emails, you called that "informal". Formally, you received this information on 10 March. I would describe you as then dropping everything, contacting the police commissioner the following day. The letter that was tabled in Parliament last week dated 12 March refers to "our recent discussions", plural, so obviously you have discussed the matter with the police commissioner more than once, if that letter is accurate.

Dr RUSSELL-WEISZ: I actually do not think—to be honest, member, I certainly can recall speaking to him on that day, be it the tenth or the eleventh, but I do not recall speaking to him before that. I can check.

Hon NICK GOIRAN: Let us say that there was only one discussion that took place, but certainly you are operating at a pretty fast pace at this point, and yet the Minister for Health only finds out about it on 31 March. Why the huge delay?

Dr RUSSELL-WEISZ: Well, I was waiting to hear back from the commissioner because initially the discussions with the commissioner, I think, would have gone something like this: we are concerned this is being used for probably legitimate, legal purposes, but this is being used outside that assurance. Can you let me know? And the police commissioner was going to get back to me, which he did. So he got back to me on the nineteenth. I then had to check, spoke to probably the team, and a briefing note was written.

Hon NICK GOIRAN: Right, and there was no verbal discussion with the Minister for Health prior to 31 March?

Dr RUSSELL-WEISZ: I do not recall any, no.

Hon NICK GOIRAN: No. This is despite the fact that you described this assurance that was communicated as significant?

Dr RUSSELL-WEISZ: Yes, that is right. But I mean, we actually took legal advice at the time to say: do you have to produce these? And we do. And that is why I picked up, the minute I knew that this was a significant issue, and when I say "significant issue", when I had a briefing from the team, which was actually the incident controller and also one of the public health physicians, I acted straightaway, because I think we were concerned that this was ongoing, and the police commissioner spoke to me straightaway and he said, "I'll get back to you. I can understand your concern."

Hon NICK GOIRAN: Yes, and he wrote to you on 19 March —

Dr RUSSELL-WEISZ: He did.

Hon NICK GOIRAN: —and yet the Minister for Health only finds out about it on 31 March. I cannot understand why the phone would not have been picked up to the Minister for Health as quickly as it was picked up to the police commissioner.

Dr RUSSELL-WEISZ: I would have to check what happened around that time. What we were writing was a briefing note to the minister. We wanted to let the minister know what had actually transpired, and I think you would be aware that we attached both letters to that briefing and we sent it up. Now, there might have been—there was a lot going on in those 10 days, you know, but we were very—and also I am not sure there had been any other OTPs during that time. I would have to check whether they had asked for any.

Hon NICK GOIRAN: When did you first discuss the matter with the Chief Health Officer?

Dr RUSSELL-WEISZ: Certainly on that, I think the Chief Health Officer might even have been at that meeting on the tenth or the eleventh, but I would have to check, member. I would have to check.

Hon NICK GOIRAN: All right. You would be able to come back to the committee with that information?

Dr RUSSELL-WEISZ: Yes, sure.

The CHAIR: That is question 4.

Hon NICK GOIRAN: Director general, in answer to some questions posed to you earlier today by the chair with respect to this inquiry that has now been announced by the Standing Committee on Public Administration, you have indicated that it would not be appropriate for you to give your view at this point while there is a Parliamentary inquiry currently under foot.

Dr RUSSELL-WEISZ: Yes.

Hon NICK GOIRAN: How long have you been director general of Health?

Dr RUSSELL-WEISZ: Since August 2015.

Hon NICK GOIRAN: And in that period of time, have you ever raised concerns with the Minister for Health about the performance of St John Ambulance?

Dr RUSSELL-WEISZ: It would certainly not be on a regular basis. If we have a concern with the performance of St John Ambulance, we do it through our contract team. So we have a contract team that sits under Mr Anderson at the moment, and if there are issues with the performance of St John Ambulance—to be honest, if you talk about the ramping here, to actually put that on St John Ambulance, to actually put the ramping issue on St John Ambulance is not what I am trying to say here. The ramping is a symptom of the system being under pressure. We also measure our own performance, which is transfer of care time, it is also our four-hour rule, or what is colloquially known as "WEAT" time. So all of that, we measure our own performance. It would be pretty remiss of me to blame St John's for ramping.

[11.00 am]

We expect St John to have the right number of paramedics and the right number of ambulances. We expect them to respond and to be able to address their key performance indicators. There is a whole contract management team that sits in the department that liaises with St John Ambulance on a regular basis.

Hon NICK GOIRAN: Has the reporting of ambulance ramping changed?

Dr RUSSELL-WEISZ: Well, no, because it is actually St John's figures. We actually also report our transfer of care time and we also report our four-hour rule time. It is their figures. We do not change them. We basically take their figures.

Hon NICK GOIRAN: Has the reporting always remained the same?

Dr RUSSELL-WEISZ: Always remained the same, yes.

Hon Dr BRAD PETTITT: My questions are quite macro in some ways. Please forgive me as this is not my area of expertise, but it is something that I have been interested in. It is broadly in and around preventative health and how that kind of links in with the health sector more generally. Maybe as a preamble to that—I could not find this, so excuse me if you have provided it—but I am kind of interested in how the health budget has grown in relation to the overall budget. Has it grown as a percentage? The reason I ask that is thinking about preventative health and how we actually start to manage that, assuming that is the case—that is my assumption. I am interested in what percentage of your work fits into that broadly preventative category. I am thinking here both in terms of mental health, activity and obesity, even climate, as key parts of that. I am trying to get a bit of a sense of what you see is the value of that. Has that been something that has been given greater focus going forward?

Dr RUSSELL-WEISZ: It has, and I think, member, it comes from the sustainable health review. The sustainable health review, through all its 30 recommendations and its first enduring strategy, was focusing on prevention. Our sustainable health review is our blueprint for the future. It focuses heavily on prevention. One of its recommendations is to increase the amount of funding out of the health budget, so the proportion of money spent on health should go up by 2029 to five per cent.

Hon Dr BRAD PETTITT: Five per cent of the health budget on preventative?

Dr RUSSELL-WEISZ: On preventative. There has been work done on what that actually means. That does not mean treating chronic disease; it means actual prevention. That prevention is a significant focus in everything we do. The other one is climate change. As you know, there was a climate change inquiry by the government which was handed down, I am trying to think, probably late last year. Obviously one of our focuses will be in setting up the recommendations that came out of that, which is a sustainable development unit, so an SDU, that will be set up by the department. Because we do have responsibility on climate change and it is not just in relation to prevention or prevention initiatives that obviously we do every day, day in, day out. The focus was you have to move, albeit slowly, from a focus on acute hospital care right the way through to preventative care.

Unfortunately, as treatments, acute treatments, get more expensive and get more complex, they become more expensive and therefore it is sometimes quite hard getting more money into the preventative space. But I think through what we have shown with COVID, we have a very, very strong public health record in WA. We led a lot of the anti-smoking back in the 1980s and 1990s. I think we will continue to force as much funding into public health. We do have a glide path now between where we are now, which I think sits around about 2.9 per cent, to try and get this up to five per cent. What I would say, member, on pure preventative activities. I do not know if Angela or Rob want to comment?

Ms KELLY: Perhaps the other point, member, would be that as a percentage of the health budget, it is about 30 per cent. Now, that sits reasonable with other jurisdictions. If we continued at the spend we were at probably five or six years ago, that would get up to 36 or 38 per cent. A large part of the implementation of the sustainable health review is about maintaining roughly about that 30 per cent, but as the director general has indicated, we need to make sure that we have the funding in the right place and that we are focusing on prevention, which is largely why the recommendations were put in.

The CHAIR: Do you have a breakdown of the mental health beds per facility?

Mr ANDERSON: That would be part of the bed reply we will provide to you. It was about mental health expenditure. It will be in the annual report as well, and in the budget papers. We expend approximately eight per cent of our total budget on mental health services, so that is inpatient and community.

Hon Dr BRAD PETTITT: Do you know how much of that is preventative? Does mental health have the same five per cent target for preventative or is that different?

Mr ANDERSON: Preventative is the total budget, which is just short of $10 billion in the current year. So it will be five per cent of the total. That is not mental health-specific. It is based on a set of criteria as to what is considered preventative health and what is not.

Hon Dr BRAD PETTITT: So it would not be a specific requirement?

Mr ANDERSON: Not for each line of funding, no. But there may be elements within each line of funding.

The CHAIR: Have you had any updates on the sustainable health review? Do you do that? Do you do periodic updates?

Dr RUSSELL-WEISZ: We do.

The CHAIR: That is available publicly, is it?

Dr RUSSELL-WEISZ: There is an independent oversight committee, which was chaired by Professor Hugo Mascie-Taylor. That independent oversight committee I think is being re-established by the government. There were regular reports preceding the recent election. I do not think there has been anything since then. But one of the horizons of the sustainable health review is actually now—July 2021—so we expect the report will come out after that.

The CHAIR: And that is publicly available?

Dr RUSSELL-WEISZ: Yes.

Ms KELLY: The plan is for it to be publicly available, chair.

The CHAIR: So July?

Dr RUSSELL-WEISZ: We would have to report to the oversight committee. We would expect it to be publicly available.

Hon JACKIE JARVIS: My question is with regard to, again, staffing, and particularly in regard to specialist doctors. You may not know the answer, but with regard to the respective colleges of specialists and their process of admitting people to those colleges, does that cause staffing issues, and do those colleges have regional allowances or could all those specialists be potentially in the leafy western suburbs of Perth?

Dr WILLIAMSON: I might take that question. It varies from college to college, to be honest with you. Some of the colleges have national recruitment bodies or admission bodies into training. It is

actually quite awkward, because people who have got a commitment to stay in Western Australia—they might have family commitments—might actually get a training post elsewhere and have to move interstate. Similarly, we might end up training people who have got no long-term ambition to remain in Western Australia. So for some of the colleges, that is problematic. In some cases, the recruitment into college training programs does not necessarily marry up too well with where the need is with the health service. In recent years, we have found ourselves with an excess of emergency physicians, for instance. From a period a few years ago where we did not have enough of them, we probably over-trained the number of emergency physicians. There are some areas—the director general mentioned psychiatry, I think, earlier on—where we are under-training. When we look at how that is happening or one of the reasons that that might be happening, we find some pinch points within the training program. Within psychiatry, we have been doing some work with the college of psychiatrists and we have identified that consultation liaison psychiatry, in particular within the larger teaching hospitals, and child and adolescent mental health would be two areas where, if we had more consultants in place, we would be able to train proportionally more doctors. So they are the areas where people get stuck. As I say, if you wish, I could give you details about the individual colleges and how they recruit, but there is a variety, depending on what your speciality is.

The CHAIR: Did you want that information?

Hon JACKIE JARVIS: Yes, I would be interested in that. I would be interested if any have almost regional targets with regard to that.

The CHAIR: That is question 5. I wanted to pursue this a bit more, but we can do that next time. Getting back to the ramping et cetera, just with regard to the average numbers presenting to ED, do you have an average number on a monthly basis per facility?

Mr ANDERSON: Yes.

The CHAIR: You do? Could we get that from 2017 to current?

Mr ANDERSON: Yes. Can I, with your permission, make a clarification to an answer that the director general gave before to the question on definition of ramping hours that Hon Nick Goiran asked? There was a change, I think last year, but that was to put more emphasis on the performance of health by creating particular time points. Anything in excess of that would be considered ramping, whereas previously there was some, not of an arbitrary nature, but it was a decision point by paramedics—essentially, St John Ambulance—as to when ramping began. You could see ramping might have begun at, say, 15 minutes for one patient and 40 minutes for another patient. It was very hard for us to performance manage that with our HSPs, so with St John Ambulance we developed a new indicator—transfer of care—which essentially is not a new indicator, but it created a time point which was black and white, essentially. If it goes over that period of time, it becomes ramping hours. If we were to report to you retrospective ramping hours, that would be under the new definition so that you would have stability and comparability across that period of time.

Hon NICK GOIRAN: So we can compare like for like?

Mr ANDERSON: That is right. Yes.

Hon NICK GOIRAN: Director general, can I ask you a question about health support services?

Dr RUSSELL-WEISZ: Of course.

Hon NICK GOIRAN: In the report tabled by this committee in the previous Parliament in November, report 83, they noted a qualified opinion audit by the Auditor General with regard to health support

services. The reasons were significant weaknesses in information systems. The Minister for Health responded on this issue, according to the report, on 3 November last year, saying —

> HSS has established a program to govern and oversee the activities that will be undertaken to address the GCC Management Letter, with particular focus on the two Significant Findings. The program consists of 81 specific activities, of which 8 have been completed to date. The progress of this program is being tracked by the WA health system ICT Executive Board, the HSS governing Board and HSS Executive team to ensure all activities to address the control weaknesses are completed by March 2021.

My question is: did that happen?

Dr RUSSELL-WEISZ: It has, member. It was tracked. If I could take the question on notice, I will get you an update exactly on those two recommendations from HSS.

Hon NICK GOIRAN: Thanks.

The CHAIR: Did you need a response?

Hon NICK GOIRAN: Yes, if we could take that on notice.

The CHAIR: That is question 7. Thank you. With that, I think we will wrap up this hearing. Thank you so much for attending today; it is very much appreciated. As I say, I am very conscious of how busy you are. It was very enlightening. I am sure we will catch up again. Can you please end the broadcast.

A transcript of this hearing will be sent to you for correction. If you believe there are typographical or transcription errors in your transcript of evidence, please indicate your suggested corrections on the transcript. Errors of fact or substance must be corrected in a letter to the committee. When you receive your transcript of evidence, the document will also indicate the questions that you have taken on notice and when the responses are due back to the committee. If you want to provide additional information or elaborate on particular points, you may provide supplementary evidence for the committee's consideration when you return your corrected transcript of evidence. Please speak to the committee staff if you have any further queries. Thank you very much once again for attending.

Hearing concluded at 11.13 am