STANDING COMMITTEE ON ESTIMATES AND FINANCIAL OPERATIONS

2022–23 BUDGET ESTIMATES

TRANSCRIPT OF EVIDENCE
TAKEN AT PERTH
TUESDAY, 21 JUNE 2022

SESSION TWO

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 2.00 pm

Hon SUE ELLERY
Minister for Education and Training representing the Minister for Health, examined:

Dr DAVID RUSSELL-WEISZ
Director General, examined:

Dr ANDREW ROBERTSON
Chief Health Officer, examined:

Ms ANGELA KELLY
Deputy Director General, examined:

Dr DUNCAN WILLIAMSON
Assistant Director General, examined:

Mr ROB ANDERSON
Assistant Director General, examined:

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

Dr SHIRLEY BOWEN
Chief Executive, North Metropolitan Health Service, examined:

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

Ms MELISSA VERNON
Executive Director, Operations Hub, WA Country Health Service, examined:

Mr PAUL FORDEN
Chief Executive, South Metropolitan Health Service, examined:

The CHAIR: Welcome to today's estimates hearing. 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.

Can I just get an indication from everyone that you have read, understood and signed the document titled "Information for Witnesses"?

The WITNESSES: Yes.

The CHAIR: Your testimony before the committee must be complete and truthful to the best of your knowledge. The hearing is being recorded by Hansard and broadcast live on the Parliament's website. The committee will place the uncorrected transcript of your evidence on the internet a few

days after the hearing. When the transcript is finalised, the uncorrected version will be replaced by the finalised version. This is a public hearing, but the committee can elect to hear evidence in private. If for some reason to wish you make a confidential statement, you should request that the evidence be taken in closed session before answering the question. Members, before asking your question, I ask that you provide the relevant page number and paragraph numbers wherever possible.

Minister, would you like to make a brief statement?

Hon SUE ELLERY: I will, thanks, chair. I was made aware this morning by my office that answers to questions which had been lodged prior to today's hearing had not been provided to the committee, so I communicated to the Minister for Health about that. On her behalf, I offer an apology to the committee, and I think you will find that the director general has something to say about that as well.

Dr RUSSELL-WEISZ: Through the minister, yes, chair, we also apologise for this oversight. We pride ourselves on getting in questions on time. These questions were much later than expected and I can only offer an apology on behalf of the Department of Health and that we will make sure that it does not happen again.

The CHAIR: Thanks for that. I will just comment on that because, quite frankly, it is unsatisfactory as far as the committee is concerned. This is the first time it has happened. The officers did contact the department on a number of occasions, and calls and emails were not returned. The issue with regard to questions prior to hearing is that it provides members an opportunity to prepare for the hearing. We are in a situation now where the members opposite will not have had access to those responses, because we only received them at 11.00 am this morning. They then had to go to our staff, who had to go through them and then provide them to the members who are sitting here now. The minister sent me an apology this morning, and I appreciate that, and I appreciate your apology, director general. But, as I said, it does make it very, very difficult for members to scrutinise agencies when we do not get questions really before it is too late. Thank you.

Having said that, members, I will go to the committee first. I assume everyone who is sitting here has questions aside from that.

Hon SAMANTHA ROWE: Minister, I am referring to budget paper No 2, page 312 and it is 11.4. It is in relation to the government's commitment of $74 million to address long-stay patients. My question is in two parts. First, how is this going to help patients waiting on the NDIS services to be discharged into more appropriate community settings; and, secondly, how will this address the inadequate supply of aged-care places in WA and the impact that that then has on our hospital system?

Hon SUE ELLERY: I am advised that at any given time, there are between 100 and 130 WA hospital beds occupied by patients who actually no longer need acute hospital care but are awaiting NDIS services and appropriate accommodation, and the cost of that to the WA Health service is about $110 million a year. At a state level, the WA Departments of Health and Communities and the Mental Health Commission are working together to support the discharge of patients who have been in hospital for those extended periods of time, and that has supported the discharge of some of the longer stay patients. However, it does remain a problem and a pressure point in the system. You might have noticed the meeting of the Premiers and first ministers with the new Prime Minister just last week where health was the number one issue, as all jurisdictions identified that bed blockage and discharge delay are common.

Since 1 July 2021, a long-stay working group has provided complex case input or consultation for more than 200 patients. That includes approval of funding packages of some $700 000-odd as at May this year for 37 patients to provide interim disability support. In respect to aged care, it is also the case that we are under strain in part due to inadequate supply of aged care, so we announced $251-odd million for the emergency department reform package, including nearly $60 million for 120 aged-care beds to help transition older patients out of hospital and nearly $6 million for the long-stay patient fund to help address barriers that are stopping elderly people from leaving hospital. We continue to strongly advocate to the commonwealth for them to address those issues that are affecting the WA aged sector. It is the case that the number of older people waiting in hospital for commonwealth-subsidised aged-care services has risen sharply over the past year. As at the end of April, 69 patients were waiting in metropolitan WA public hospitals for more than 14 days for access to aged-care services, and there are a range of measures that are being put in place to try to address this at a state level, including us putting in money where, frankly, it is not our constitutional responsibility to do. We will continue to advocate to the commonwealth to ensure that aged care is adequately funded to address the issues that are impacting on the hospital sector.

Hon JACKIE JARVIS: I refer to page 310 and spending changes. Under "New Initiatives", there is a line item that says "Albany General Dental Clinic Expansion". It starts with $180 000 in 2023–24 and it goes up to $1.3 million by the year 2025–26. Is this a new program? I am intrigued by WA Health's involvement in dental in Albany.

Hon SUE ELLERY: It was an election commitment. We committed to double the size of the Albany general dental clinic from four public dental chairs to eight. WA Country Health Service has advised north metro that due to existing facility limitations and site congestion, the expansion on the Albany hospital site was not feasible, so a new build and location in Spencer Park, which is a suburb of Albany, as the honourable member would be aware, within 700 metres of the current Albany Health Campus will be purchased to expand the general dental clinic. The final location has got to be confirmed through the Department of Finance. As at 30 June last year, there were some 15 000 eligible patients in Albany and the greater southern region. Consequently, a high proportion of the region is eligible for care. Eligible patients had raised concerns to the Minister for Health about wait times for non-urgent care, so preliminary planning has begun to develop the project definition document. North metro finance will work with Finance on how to manage, procure and deliver that.

[2.10 pm]

Hon JACKIE JARVIS: Page 313, it is dot point 15.6. It says there is $5 million to address urgent staff accommodation in regional and rural areas while a whole-of-government solution is being considered. Can you provide more information about what that program is?

Hon SUE ELLERY: Yes. This is obviously a key issue not just for WA Country Health Service but for many government agencies with staff placed in regional WA so a significant investment is required to address staff accommodation requirements to continue to support Health to deliver into remote and regional areas. There is $20 million to address urgent staff accommodation refurbishment and replacement. The program will provide urgent essential refurb upgrades and new housing assets to address the shortfalls. That includes upgrading WA Country Health Service accommodation that is critical to service and is currently unfit for purpose, replace existing dwellings past their useful life where it is critically needed, provide additional accommodation where it is critically needed and provide fit-for-purpose staff housing across the country health service ensuring compliance to work health and safety provisions. I am also advised that security assessments have been completed on 306 properties to date and priority security upgrades are now underway. I would also make the point it affects me in my other capacity as the Minister for Education and Training. There is a review

being conducted by Communities on GROH and how we can use the money that we have got to spend more efficiently, how we can identify where stock needs to be replaced or where stock can be moved between agencies to address the housing shortages for critical staff in regional WA.

Hon Dr BRAD PETTITT: I refer to budget paper No 2, volume 1, page 320 around mental health services note 1, which states that there will be significant additional investment in non-admitted mental health hospital services for the remainder of this financial year and in 2022–23. What types of non-admitted services are in greatest demand?

Hon SUE ELLERY: I will ask the director general to make some comments bearing in mind it is the Mental Health Commission that would have responsibility.

Dr RUSSELL-WEISZ: There has been, obviously, a focus on the whole spectrum of mental health services from inpatients, non-admitted statewide mental health services and also teaching, training and research. Your question was specifically about community mental health services. There has been overall an increase in expenditure in relation to—I will cover these—hospital services through the 2021–22 and 2022–23 budgets. For mental health beds, there is $35 million for non-admitted mental health services, including an active recovery team trial and for uplifts to adult and youth community treatment services, there is $27 million. There is a focus on both mental health hospital services and also community services. We are obviously focusing not just on what we do as inpatient but obviously what the Mental Health Commission is purchasing in the community as well. There will be continued investments in both country and metropolitan areas over the next forward estimates. Any specific questions I will probably have to send to the Mental Health Commission for exactly what their purchasing decisions were in the 2022–23 budget.

Hon Dr BRAD PETTITT: On a slightly different note, page 322 of budget paper No 2, paper volume 1, public and community health services, shows that in 2022–23, the number of FTEs was expected to fall by 490. Can you explain the reason for this, please?

Hon SUE ELLERY: I will ask the director general to make some comments.

Dr RUSSELL-WEISZ: Again, for the specifics of why it is falling, I would ask that we ask the Mental Health Commission to answer. However, normally when there is a fall in FTEs, it might be for specific services that were time-limited. We have seen that there is a decrease. There also is a decrease in the net cost of service but it is likely to be for specific services that were time-limited. Again, I would have to get some specifics around that.

Hon SUE ELLERY: It is a bit tricky because the Mental Health Commission has not been called. I take responsibility for providing answers that fall within the purview of anybody here; I am not sure I can in respect to an agency that has not been called. It is the same minister but—I do not know.

The CHAIR: Could you give it a go?

Hon SUE ELLERY: I can ask.

The CHAIR: If you could ask, that would be very helpful.
[*Supplementary Information No B1.*]

Hon NICK GOIRAN: Minister, if I can take you to page 311, budget paper No 2, volume 1. There it lists various significant issues impacting the agency and at point 5 it says that the budget is focused on a number of things, and one of those is supporting WA Health's workforce. There has been some publicity around the current staff and skills shortages. What are the specialties in our state who have had their service delivery most affected by these shortages?

Hon SUE ELLERY: The director general can provide you with an answer.

Dr RUSSELL-WEISZ: We have seen workforce challenges throughout the last two and a half years right across the board. Whilst I will answer in a minute about the specific areas, we have seen workforce challenges in rural/remote, both in medical nursing and allied health. Also in the metropolitan area, we have had workforce challenges, but they have been less acute than they have been in the rural regional areas.

Our specific focus at the moment would be on midwives, theatre nurses and junior doctors, more generally. We are seeing more junior doctors come through because we have another medical school now that is producing junior doctors. But the area of specific shortage at the moment, and that we are concentrating on most, would be midwives. We have specific shortages in some of our rural and regional sites, and we also have specific shortages at our metropolitan sites as well. I would say we have a concerted effort to recruit workforce right across the board.

[2.20 pm]

Towards the end of last year, we gave the health service providers the ability to uplift their staff by 25 per cent in specific areas, so getting prepared for when we would be affected by the pandemic. We were obviously targeting areas like intensive care, emergency departments, junior doctors, but every jurisdiction is looking for staff now, and there are challenges not only in Australia and New Zealand, but right around the world. We have the Belong campaign, which we have been pushing not just in Australia but internationally. Since the borders have opened up, there has been some easing of some of our workforce pressures but, as I would say, typically we are seeing those pressures in areas such as midwives, theatre nurses, anaesthetic technicians, and there are some other particular very small specialist areas that we are targeting.

Hon NICK GOIRAN: Dealing with the issue of midwives, which is the highest priority at the moment, how many midwives in Western Australia are on leave as a result of disciplinary action commenced against them for failing to adhere to the COVID-19 vaccination requirements?

Hon SUE ELLERY: I will take that on notice, we do not have that information with us.

[*Supplementary Information No B2*.]

Hon NICK GOIRAN: Sorry; you said that you would take that on notice. Is that an indication that there are some that fall into that category?

Hon SUE ELLERY: There may be. I just asked the director general if we had it here and he said no, so that is why I am saying we will take it on notice.

Hon NICK GOIRAN: Yes, but that was with respect to the quantum. But just in terms of the qualitative response —

Dr RUSSELL-WEISZ: I would imagine that through the course of the year, there have been one or two. There have probably been a few staff members who have chosen not to be vaccinated. We have a very high vaccination rate in relation—I presume you are asking about COVID-19 vaccinations. I would have to take on notice how many are "under disciplinary investigation" amongst midwives. I imagine there would be some, but it would be very, very few.

Hon NICK GOIRAN: Okay; that is helpful. Thank you for taking that on notice. Preliminary access restriction periods—PARPs—would we have information in regard to how many of those notices have been issued?

Hon SUE ELLERY: I am advised we would need to look across the sector, but we would have to take that on notice.

[*Supplementary Information No B3*.]

Hon NICK GOIRAN: I am surprised, because I see some witnesses nodding and seeming to indicate that they have that information available here today. It would assist the committee if it was available, but nevertheless, that has been taken on notice. We will get the total number of PARP notices that have been issued then.

Hon SUE ELLERY: If you identify what you are looking for, honourable member, we will make sure that we can provide that.

Hon NICK GOIRAN: That is what I am asking.

Hon SUE ELLERY: I said that we would take it on notice.

Hon NICK GOIRAN: So we are clear that we are going to get the full number of PARP notices that have been issued.

Hon SUE ELLERY: I can give you a commitment that I can ask that question, and that is what I will do.

The CHAIR: Just to confirm—do you know what you are asking?

Hon NICK GOIRAN: I think so, and I think the director general knows. I do not know whether the minister does, but it does not matter, because she will not sign off on the answer. It will be the Minister for Health who does.

Hon SUE ELLERY: I am advised that we can provide it, but we are unable to provide it today.

Hon NICK GOIRAN: Can we then identify, with regard to these PARP notices, is the data available to indicate which type of specialty or which type of officer this might apply to? For example, if the person is a midwife or might be a palliative care staff member or specialist nurse. I think you mentioned that there are other specific challenges with regard to theatre nurses, junior doctors and the like. Is it possible to categorise these things?

Hon SUE ELLERY: I am advised, honourable member, that, yes, the health service providers would have them by categories. They just need to make sure that they are not doing it in a way that reveals the identity of the person.

Hon NICK GOIRAN: So, if we can have it itemised, then?

Hon SUE ELLERY: By categories, as long as—I do not know; if there is a category that has only one person in it and everyone in Western Australia knows who that person is, then we would have to find another way to give you that information.

Hon NICK GOIRAN: Understood. I am confident that the director general is on the same page as me with respect to this question. Can I ask whether these mandatory directions are still in force? I think they are the Health Worker (Restrictions on Access) Directions (No 4) and the Booster Vaccination (Restrictions on Access) Directions (No 2).

Hon SUE ELLERY: I will ask the Chief Health Officer to respond.

Dr ROBERTSON: Yes, they are.

Hon NICK GOIRAN: Can you indicate to the committee why they are still in force?

Hon SUE ELLERY: I will ask the Chief Health Officer. As a general principle, the Chief Health Officer provides advice to government. The government accepts that advice and the Chief Health Officer has certain powers available to him under his legislation. He can give you the reasoning behind the particular reason that those mandates are still in place.

Dr ROBERTSON: Through the minister, when the decision was made to lift the number of mandatory vaccination requirements, three groups were left. Those were healthcare workers, residential aged-

care workers and workers within disability services accommodation. As a group, they deal with the most vulnerable in our population, and obviously there are also other measures in place, including masks, in a number of those facilities as well, so it is around how we reduce the risk to those particularly vulnerable populations.

Hon NICK GOIRAN: Chief Health Officer, have you given advice to government on whether there is an increased risk to patients of having a doctor or nurse or health worker who is not what we would describe as vaccine compliant? I should not say "we"; it is certainly a term the government has used in those directions.

Dr ROBERTSON: Through the minister, I have provided advice to government on what the risk would be from healthcare workers providing care, obviously in a hospital setting. In other settings, obviously the risk is similar to the social, but in a healthcare setting, where there are particular vulnerable populations, particularly those who, for example, may be immunocompromised, or have a very serious disease that has increased their susceptibility to infection, then obviously the vaccination is another step. We know the vaccine does provide some initial protection against infection and transmission as well as providing protection against serious disease. But there are other measures in place that are designed to reduce that as well, including the use of masks and obviously requiring people to remain at home if they are unwell.

Hon NICK GOIRAN: Just with respect to the issue of transmission, you have given the government specific advice, then—I am asking a question—that a doctor or nurse who has not had the vaccination is at greater risk of transmitting COVID-19 to their patients?

Dr ROBERTSON: They are at greater risk, at least in the initial phases.

Hon NICK GOIRAN: At greater risk of transmission?

Dr ROBERTSON: Yes, at greater risk of both acquiring the disease and of transmitting in the early stages. We know that that does wane over time, that protection against being infected and transmitting to other people, but there is an increased risk for those who are unvaccinated, at least in the initial stages.

Hon NICK GOIRAN: So at what point does that risk then disappear?

Dr ROBERTSON: The risk will wane over time. It is a bit hard to gauge, but there is still some protection out to three months, and potentially beyond that.

Hon NICK GOIRAN: So if a health worker had been vaccinated, let us say, six months ago, with their third dose, would they be at a lesser risk of transmitting COVID-19 to an unvaccinated health worker?

Dr ROBERTSON: Just to make sure I am clear on the question: are you saying there is less risk from somebody who has had three doses of vaccine as opposed to someone who is unvaccinated?

Hon NICK GOIRAN: At the six-month mark.

Dr ROBERTSON: At the six-month mark? Look, it would be difficult to say what it is at the six-month mark. There is research —

Hon NICK GOIRAN: If it is difficult to say, Chief Health Officer, why do we keep excluding these people from the workforce given that the director general says we are in desperate need of having midwives and others?

Hon SUE ELLERY: I will turn to the Chief Health Officer in a moment, but it is about trying to keep the maximum number of people safe for the maximum period of time. That is why the government has accepted the Chief Health Officer's advice.

Hon NICK GOIRAN: Which at the moment says that it is unclear after the six-month mark.

Hon SUE ELLERY: Correct; so let us err on the side of precaution and saving lives for as long as we possibly can.

Dr ROBERTSON: Part of the public health risk assessment is around the precautionary principle and around what is a proportionate response. From a precautionary principle, where we believe there will probably remain greater protection from a vaccinated cohort than an unvaccinated cohort, particularly with a very highly vulnerable population, then as part of the decision-making, remembering, of course, that the majority of our population will not be at six months—some will be, but they will be across that between three and six months generally—so there will be protection from those groups. At this stage, we believe it is proportionate, given the vulnerability of that population, to continue those requirements.

Hon NICK GOIRAN: Is it the intention to continue these mandates for those three groups that you mentioned indefinitely?

Dr ROBERTSON: Those three groups are under review. In my last advice I indicated that I would be reviewing those at four weeks, so basically reviewing them before the end of June and providing advice to government on that. Then, depending on the outcome of that advice, I will continue to review them on a regular basis.

Hon NICK GOIRAN: Will that advice be made publicly available?

Hon SUE ELLERY: It usually is. It is usually published on the website.

Hon NICK GOIRAN: I disagree, minister, because in Parliament both Hon Tjorn Sibma and I think Hon Martin Aldridge have repeatedly asked for information to be publicly available. The most recent advice, which I think was provided to this committee, said that it was not the intention to do so. Some information has been made public. I do not want to mislead anyone here to suggest that nothing has been made available, but a lot has not. That is why about this particular instance, apparently they will be reviewed before the end of the month.

Hon SUE ELLERY: I am happy to take that on notice, chair.
[*Supplementary Information No B4.*]

The CHAIR: I will divert from my normal practice and go straight to Hon Dr Brian Walker who has to go on urgent parliamentary business at 3.00 pm. I will give him the call now and then I will revert back to script.

Hon Dr BRIAN WALKER: Thank you, chair. Basically, you will know I have a special interest as the only medical officer in this building since 1971. I look with great interest, in the limited time we have here, the first question I have is budget paper No 2, volume 1, page 310, "Graylands Reconfiguration and Forensics Taskforce". I bear in mind that you said earlier that mental health is not part of this. There is a new initiative there reflected on page 315 at paragraph 28, the $10 million spend—this may have to go on notice, of course—$5 million for each year.

Hon SUE ELLERY: I cannot keep up.

Hon Dr BRIAN WALKER: On page 315, paragraph 28 refers to mental health as an important priority for the government. The background to this is I used to also work in Corrective Services, which often served —

Hon SUE ELLERY: Is there anywhere the honourable member has not worked?

Hon Dr BRIAN WALKER: Not in your office, honourable minister! It was often seen as a repository for psychiatrically ill patients who had committed crimes. The lament among the psychiatrists there

was that there was no space in Graylands. I appreciate Graylands has been reconfigured, and it is probably wise as well, so, on notice I would imagine, can we have broken down how this money will be spent and what is the plan for Graylands and can we look at taking some of the pressure off Corrective Services where the mentally ill psychotic patients are prisoners and are actually treated medically rather than correctively?

Hon SUE ELLERY: I will get the director general to make some comments, and if there is something specific we need to follow up by providing a supplementary, I am happy to do that.

Dr RUSSELL-WEISZ: The line item you refer to, honourable member, really relates to the Graylands reconfiguration and forensic task force, or GRAFT, so I will refer to GRAFT as the acronym. It is another health acronym, I apologise.

Hon SUE ELLERY: GRAFT, in an estimates budget hearing, is probably not one to use.

Dr RUSSELL-WEISZ: I will try not to use that one! The planning for Graylands has been ongoing for some time, but Graylands, as the sole major tertiary facility really in WA, any planning has to consider where we would put our step-down facilities, be they secure units, community care units and also treatment in the community. Anything I talk about here, the planning has not been done in isolation just looking at the forensic services on their own; it has been done at a whole of system. The task force was established by this government and has been working through a whole suite of planning for Graylands and anything that is related to Graylands. The $10 million is there for a very robust business case to go to the 2023–24 budget, with a focus initially on the forensics part of it. As the honourable member said, the acute forensics part of Graylands is around about 30 beds and has been 30 beds for some time. We have provided over the years more in-reach into prisons and also into the communities from the psychiatrists and the mental health teams that are situated at Graylands and who actually go and visit the community. But there is a need for an expansion of services either at Graylands or another site. There is already forensics at Graylands. There is the space there and intention to actually expand the forensics unit there as part of this broader business case. We have also at the same time looked at the configuration of services at Graylands. When Graylands was built, when I was a clinical doctor, it was very different from where and how we treat patients now—and should treat patients now. They should be treated in the community. They should be treated much closer to home in their local hospital, and that is why we are looking at the investment of the secure units that are not just in one site such as Graylands, but in sites such as Osborne Park, Bentley and Rockingham, and, indeed, we have now an acute psychiatric unit at Broome, for example. So there has been a lot of investment. This is taking it to the next level. We are also looking at the reconfiguration of Graylands. There are a lot of old buildings on the south west corner of Graylands—I hope I have got that right; it is definitely the south of the Graylands site—that could be potentially consolidated in the main Graylands site and we could also build more appropriate and contemporary services at Graylands to serve the local community. The work that has been done this year, which is under the chairmanship of Jim McGinty, who is the chair of the task force, and has been looking at the whole suite of what we require in mental health, but with the focus being very much on justice and on forensic mental health generally.

Hon Dr BRIAN WALKER: The next question is probably more contentious. I have to point out that my approach to what the government has done with COVID has been very supportive, but I am also science based in asking questions. It has been irritating to me that for some time my ability to question the Chief Health Officer has been zero, so the data I am referring to is absolutely without the support of government information, which I greatly desire. It is specifically looking at the vaccines, following on from what Hon Nick Goiran has been saying. Looking at the spending change in volume 1, page 310, under “COVID-19 Spending”. I am looking at getting some measure of

understanding because if we are not being very precise with how we are managing the vaccine continuation, then as I mentioned in my budget speech, what we are seeing is a concern, a risk and financial implications both direct and indirect costs to the community and the exchequer.

My non-specialist approach has been to look at the efficacy between 32 per cent and 48 per cent at preventing infection and between 37 per cent and 73 per cent preventing severe disease, so it certainly has efficacy. That is from February 2022. That is fine, but it is not particularly great, and it concerns me that we are overestimating the power of our vaccines to do the job that we have paid for. The second thing is the waning efficacy over time—which is, I think, a major concern I would share that with you as clinicians, I am sure—over the population, and that is from March 2022. It suggests that we are actually looking at a fairly short term protection over time. So there is waning efficacy, which has not yet, to my opinion, been properly assessed. I have always told my patients and, indeed, my colleagues here in the house that five years later we will look back and say what we should have done. My question actually, through the minister to the Chief Health Officer, is going to be: are we able to have the access to the information you provide to the government so I at least can be reassured that this is the way scientifically we are supposed to be going?

Hon SUE ELLERY: Two things—the Chief Health Officer is a widely read individual. I have known him for a long time. I am just not sure that he actually has read your budget reply speech, but you do not know, he may well have, but I suspect he may not have! In respect to information that is held by government and is held as part of the cabinet process, then the answer to that is a straight up no, you will not get access to that information. I am happy to ask the Chief Health Officer to provide you with any further information he is able to to have a technical discussion about some of the issues raised. I am happy for the Chief Health Officer to make some comments about that.

The CHAIR: On the assumption, of course, that you have not read the honourable member's budget reply speech!

Hon Dr BRIAN WALKER: Which I am sure you have not!

Dr ROBERTSON: Which I admit I have not, no!

Obviously, I provide advice to government that is released. The major formal advice is released in that way. There are other discussions that remain cabinet-in-confidence as a part of that process, but I am happy to discuss any specific questions that that may arise.

Hon Dr BRIAN WALKER: This last one is very short. Again, in my budget reply speech, I did mention that we would be well advised, I think, to consider a pandemic-specific response rather than these emergencies carrying on, because we will expect this to be something of the future, and it would, I suspect, save the bottom line for future budgets. Has there been any consideration, I ask the minister, of implementing discussions on creating a specific pandemic response, much the same as they have in Victoria?

Hon SUE ELLERY: I will get the Chief Health Officer to provide you with some advice on that. My recollection, honourable member, is that there is a discussion that is going on at a national level, perhaps about a pandemic strategy going into the future, but that just might have been someone proposing that. I am sure I heard some media coverage of that in the last couple of weeks. But I will ask the Chief Health Officer to make some comments.

Dr ROBERTSON: As we start to transition from this pandemic, you know, there is obviously work commencing on that transition phase. What that looks like at a national level will obviously include consideration of the lessons we have learnt from this pandemic and how we would translate them and prepare for a future pandemic. A lot of the work we are starting to do now within the department is actually focused on ensuring that we have captured those lessons and that, should

we need to start this process again and move to that, we can learn that as part of our planning going forward.

Hon JAMES HAYWARD: I refer to budget paper No 3, page 179, "Asset Investment in Health and Education". I would like to ask about any plans to expand the capacity of the of the Albany Health Campus. I noted that there does not appear to be any money set aside specifically for any project in the next four or five years.

Ms VERNON: The Albany Health Campus has had expenditure. Practical completion of extensive infrastructure was finished in 2016.

Hon SUE ELLERY: I might get the director general to add something to that.

Dr RUSSELL-WEISZ: There is also planning of the radiation oncology service, which is being planned for at the moment. I cannot tell the honourable member exactly where that is up to and when that is expected to be open, but we can provide that.

Hon SUE ELLERY: Yes, we will take that on notice.

Hon JAMES HAYWARD: Thank you for that. Is there a sense that things are okay at the Albany Health Campus? That is certainly not the understanding the community has in terms of its desperate need for development. It does not appear it is even on the radar.

Hon SUE ELLERY: I will get the director general to make some comments about that.

Dr RUSSELL-WEISZ: We are constantly looking at every hospital. We have a clinical service framework. We have an asset investment program. There has been a significant amount of investment throughout the country in country hospitals, for example, the Geraldton Health Campus, which is being expanded. There is a commitment by the government for the Bunbury redevelopment as well. Albany was actually, in a sense, the first cab off the rank that had that expansion.

I have not been told of any specific issues with the Albany Health Campus. We are aware that all regional centres, just like the metropolitan centres, are under significant pressure—significant pressure from their emergency departments, elective surgery, just general demand. That is certainly what I would say we are hearing from the likes of Albany, Bunbury and Geraldton specifically. But we will always be considering the clinical modelling that will then inform the planning that we would need to advise government on for any further expansion. But obviously the focus that we have at the moment is on the Bunbury redevelopment and Geraldton Health Campus, because Albany had that redevelopment initially and is having radiation oncology redeveloped there at the moment.

Hon JAMES HAYWARD: How long does it take for the planning process that you have just described to be put in place? If we have got no money in the budget now, say, for the next four or five years for Albany, reasonably, given that process you have just explained, what is the sort of time frame, do you think?

Hon SUE ELLERY: I do not know that you can put a precise time frame on that. The budget papers are the budget papers. If government needs to make another decision, government will. It has two opportunities every year, either in the budget or in the midyear review, and if government makes a decision that it needs to do something differently or bring something forward, that is what government does.

Hon JAMES HAYWARD: Also just the same line in relation to Margaret River hospital, again, are there any plans for expansion at that site?

Ms VERNON: Margaret River at this point does not have any budget allocated to upgrade. There is some preliminary review and planning work underway to consider that, and we will be working with the department on that.

The CHAIR: Hon Steve Martin, sorry, just before we do that, there was the issue with regard to Albany Health Campus. Were you going to provide any further information on that?

Hon SUE ELLERY: If we have any. I do not mind if you note it down.

The CHAIR: All right, if there is any available.
[*Supplementary Information No B5.*]

[2.50 pm]

Hon STEVE MARTIN: Minister, I refer to budget paper 2, volume 1, page 313, which talks about a number of issues including the $1.8 billion establishment of the new women's and babies' hospital, and I have a question around that, please, around hospital bypass. With regards to pregnant women, how many maternity bypasses have occurred across the metropolitan area in the last month—and I assume this might have to go on notice—the last 12 months; and have there been any in the WACHS system, please?

Hon SUE ELLERY: That is very big question, and it certainly would need to be taken on notice.
[*Supplementary Information No B6.*]

Hon STEVE MARTIN: Page 317 in the same volume, minister, which talks about the outcomes and key effectiveness indicators, the percentage of elective waitlist patients waiting over boundary for reportable procedures. Again, this is probably something to be put on notice, the percentage of patients waiting longer in each category has increased. I believe the number is more than 33 000 on the waitlist. What measures, can I ask, are being enacted to try to reduce this growing demand? I believe other states have enacted a blitz to deal with this, allowing hospitals to open on weekends and after hours, for example, to operate at 125 per cent capacity. Is this something that the state has considered or is considering?

Hon SUE ELLERY: I will ask the director general to make some comments on that.

Dr RUSSELL-WEISZ: Thank you. Through the minister, yes, we have the number of, as you said, 33 000 on the waitlist. What we concentrate on is making sure we categorise them into categories 1, 2 and 3s: urgent, semi-urgent and less urgent. Those patients need to be operated on in a clinically recommended time. It is a national clinically recommended time: within 30 days for category 1, within 90 days for category 2 and within 365 days for category 3. Those are the figures you have seen that have deteriorated. They have deteriorated around the world. They have deteriorated in every jurisdiction. On the last figures, we sit second or third of a jurisdiction about how we perform with our elective surgery. The government last year put a blitz in place—as you mentioned, the word "blitz". We had a catch-up after the more prolonged shutdown in 2020. We made up a considerable number of elective surgery cases. We also had a time where we took down the non-urgent category 2s and category 3s this year. We actually planned for a period of around 10 weeks. It was less. The private hospitals we took down as well.

Our plans now are to get back to what I am referring to as a new business as usual, to focus on our emergency demand and our elective surgery. So, there are no restrictions at the moment. The health service providers have no restrictions on bookings for elective surgery and they can do whatever they need to do to make up the elective surgery that was delayed during that time. It will take us a while to make up that time. We do not have the pressures such that Victoria and New South Wales were under when they were shut down for a long period of time, but we have seen those people who are waiting longer than the recommended time grow. Since mid-May when really

restrictions came off completely, health services have gone back to what we would call a new business as usual. They have gone back to trying to get as many patients as possible on the elective surgery lists as they possibly can, but they have obviously still got significant staff furlough.

So, the staff furlough was high a month ago. It is reducing week on week, but there are still staff furloughed due to COVID. And our focus will be not only on the reportables—you mentioned the reportables; those are people who sit on an elective surgery waitlist—but also a category we call the non-reportables. I apologise for the name. It is a national term. It means those people who are waiting for gastroscopies, colonoscopies. What we can say is that we are considering, as staff furlough get better, short, sharp—what I would call—blitzes. We are considering having theatre times at weekends or extended hours. All of that is considered by the health service providers, but they obviously are working with a system that has significant emergency demand and still significant staff furlough.

If the minister wishes, we could ask one of the health service providers to talk about what they are actually doing now at the moment in relation to trying to get more elective surgery.

Hon STEVE MARTIN: That is a very detailed answer, director general. Thank you for that. You made reference to where we sit in the ranks with other jurisdictions. Is that document able to be tabled or can we put that on notice please?

Dr RUSSELL-WEISZ: It is available. Basically, if I take the median days waited, what I would call the most normal year we had before the pandemic was 2019–20 and the median days waited, we were, basically, below the average, which was 39 days. We were 36, with New South Wales, 53; Victoria, 27; Queensland, 40; South Australia, 43; Tasmania, 55; and ACT, 48. So, of the mainland states we were the second-best performer. And even in 2020–21 when it was extraordinarily disruptive because of COVID, because of shutdowns, our median days did go up from 36 to 46 days, but New South Wales jumped to 68; Queensland to 42; South Australia to 50; Tasmania to 65; and ACT to 49. We still held our place. But this will be a constant theme for us in the years to come to make sure that we do not let the elective surgery waitlist get worse. I am not saying that number is not important. The number of people on the waitlist is important, but it is not the number that we focus on. What we focus on is how the clinicians triage, how they triage into 1s, 2s and 3s, and we must then focus on getting all the 1s done, as many as we can within 30 days, as many as we can within 90 days for the 2s and as many as we can within 365 days for the 3s. That is what we are measured on nationally and that is what we need to focus on.

So, long as we are aiming for between 90 and 100 per cent of all patients are done in the recommended time—we obviously want to get up towards the 100 per cent, but sometimes that is just very hard—we want to make up those measurements in the next six to 12 months.

Hon DONNA FARAGHER: If I could turn to page 310 under "Spending Changes", there is a reference to child health checks. Can I just get some clarification as to what that funding relates to, please?

Hon SUE ELLERY: This project has ceased. It was funded for part of 2021–22. The evaluation report has been prepared. This does not tell me whether that is before the minister or not, but there is additional money, $2.7 million over two years, so $1.4 million in 2021–22 and $1.3 million in 2022–23 to translate the learnings from that pilot into 2022–23.

Hon DONNA FARAGHER: Can I just ask what is the pilot you are referring to?

Hon SUE ELLERY: It was looking at dedicated engagement strategies to increase the completion rates of the 12-month and two-year-old assessments, including families with identified risk factors. I will ask Dr Anwar to provide you with some more information about the project and what has been learnt going forward.

[3.00 pm]

Dr ANWAR: There was a trial run at two sites—one at Midland and the second at Bunbury—that looked at enhancing screening at 12 months and two years as part of childhood screening. For the one-year check, there was an improvement in screening from 41 per cent to 57 per cent, and for two years, from 28 per cent to 57 per cent. There was a close-out report which tried to assimilate all the information and see the changes in practice that had been applied, either in the way that we engage with families or the way that families have opportunities to engage with us, so that we can disseminate that new practice through our other child health clinics. We are currently discussing how the moneys that have been allocated can be used to incorporate the learnings into BAU.

Hon DONNA FARAGHER: Thank you for that. Perhaps if I could take this on notice; I would like some more detail with respect to the actual pilot. That would be helpful. I suppose this is more my follow-up question from a general sense: I note that with regard to child health checks, when we look at the targets and what actually is occurring, particular with those 12-month and two-year checks, we are seeing quite a significant decline. I am interested in terms of the targets for child health checks for regional-based children. I am interested in why the targets under the WA Country Health Service is only 50 per cent for two-year checks. Why is that, and why are regional children deemed differently from metro-based kids?

Hon SUE ELLERY: I will ask Dr Anwar to comment on that, although I have to say, just on listening to his explanation, that it may well be because we are coming off such a low base for the two-year check.

Hon DONNA FARAGHER: I am keen on the discrepancy between the two areas.

Dr ANWAR: I would like to come back after the session and take part of the question on notice. My understanding is that the targets have been slowly, incrementally driven up to make sure that what we do not do is set targets that are ridiculous. That is my understanding—that we are on an incremental journey to push up the targets. The 50 per cent represents a point in the journey as opposed to the absolute end, because we all agree that the target should be 100 per cent for both 12 months and 24 months, and both WACHS and CAHS are aligned on that.
[*Supplementary Information No B7.*]

Hon DONNA FARAGHER: I now turn to page 316.

The CHAIR: Just before we go on, honourable member, did you have two questions or was it just the one that we were getting the response on?

Hon DONNA FARAGHER: In terms of taking on notice?

The CHAIR: Yes.

Hon DONNA FARAGHER: The first question was to get some more detail with regard to the pilot and its outcomes, and with the second one I think there was some more detail that was going to come back to me with regard to the targets and the differences between —

The CHAIR: The targets, then, will be B8.

Hon DONNA FARAGHER: Thank you.
[*Supplementary Information No B8.*]

Hon DONNA FARAGHER: If we can go to page 316, I think this is the best place for me to ask these questions. It is under service summary 6, "Public and Community Health Services". The minister would be aware that I have been asking a number of questions in the house with regard to the delivery of child health appointments by community health nurses, drop-in sessions, parenting groups and child development service appointments. The advice that I have been consistently

provided with, albeit I understand that child health checks are now being done face to face, is that a number of these services are either being provided online or are still not available because the department is working under the red phase of the COVID-19 framework. I did note the director general in an answer to my colleague, Hon Steve Martin, referred to there being a new business-as-usual approach. My question, though, is with respect to child health services. Appreciating that we are still in the red phase, given that a number of these appointments and services are actually delivered outside the traditional clinical setting and the fact that private providers, playgroups and others are delivering services face to face, I am interested to know if any time frames have been put in place by the department or, indeed, the Chief Health Officer to determine when child health appointments, parenting groups and child development services will actually be able to be provided face to face.

Hon SUE ELLERY: I will start with the director general and then we might go to the Chief Health Officer.

Dr RUSSELL-WEISZ: And I might ask Ms MacLeod to comment as well on SAR. The SAR has been a very good document in relation to how we have transitioned during the pandemic. As the honourable member says, it gives us guidance in relation to what we do—whether we do things face to face or we do not. It also does a heap of other things about, you know, what PPE to use, visitors, and how hospitals basically work during the different phases. I may ask, if I can, through the minister, the Chief Health Officer to comment, and also the chief executive of the East Metropolitan Health Service, who is also the lead chief executive for COVID operations to comment on how the SAR is being used as well.

The CHAIR: Who are we going to?

Hon SUE ELLERY: If we start with the Chief Health Officer and then we will go to Mrs MacLeod.

Dr ROBERTSON: The decisions around where we sit with some of those are very much hospital based.

Hon DONNA FARAGHER: But they are not all.

Dr ROBERTSON: No, sorry. I appreciate you are also talking about some of the community face-to-face services as well, but there are some of the decisions that are based at the hospitals. We are in the process of reviewing where we sit within the SAR, given the fall in the number of cases and the fall, obviously, within our hospitalisations and the level of ICU admissions. It is likely that we will at some stage move away from red to a new phase. That phase will obviously again look at further freeing up some of the current restrictions that are imposed both in the community and at a hospital level.

Mrs MacLEOD: As Andy has said, we have worked our way through the SAR. We started with green, we have then gone to amber and we are now in the red phase of the system alert and response framework. We are working up, as we have done in each of those phases, what the next phase will look like. The SAR really comprises information that is based on the advice from the Chief Health Officer and also the advice that we determine in consultation with some of our lead clinical staff, such as infectious diseases and infection prevention staff, that is around how we perform services in the health setting. We keep it all in the SAR so that we have consistency across our health services. It then provides a single place that our staff can go to to work. That is the rationale for it. We are in that phase at the moment. In term of the next stage, a lot of work is going into that and we will be working with Andy in terms of when that is available to be released.

Hon DONNA FARAGHER: I appreciate the response and I understand where we are with regard to the red phase and I understand the concept with regard to a clinical setting, but I would like to get

some clarification. If a child is receiving a speech pathology assessment, for example, for half an hour, how is it not possible that that could be delivered face to face in a COVID-safe manner as opposed to going to a private setting? Indeed, as the director general has indicated, we are going through a more business-as-usual approach. I do think it is important. We are talking about a lot of these issues in terms of moving on and in a way that we can do things safely. When it comes to child health services and, indeed, parenting programs for new mums and families, it is actually important. I am keen to understand if there is a time frame with respect to those particular services that are not being provided in a clinical setting as such—a tertiary hospital—but in those community-based areas.

Hon SUE ELLERY: I will ask the director general to make some comment. I guess the answer would have to be that I cannot give you a time line as to when those decisions are going to be made. The point you make is taken; I understand it. I am sure the people sitting here understand it as well, but I will ask the director general to make some comments.

Dr RUSSELL-WEISZ: I totally understand the honourable member's point about being face to face. When I refer to—my term—business as usual, things are going to be very different post-pandemic. It is not a return to 2019, be it elective surgery or emergency demand. We are just coming out of one of the highest acute phases in the COVID-19 pandemic. Only three or four weeks ago, we had the highest staff furlough that we had ever seen. In some of our rural and remote locations, that has caused services to be extraordinarily constrained. But we do want to get back to face to face.

[3.10 pm]

Also, what I would say is that we do not want to lose the gains that we have made in telehealth as well—some of the gains that we have made in telehealth where patients have either preferred telehealth or where telehealth has been a very good medium in negotiation between patients and clinicians. They are not actually travelling long distances. We want to get that balance right. What I can say is that the SAR is being reconsidered actively at the moment, and we will not put undue delay on returning to a more face-to-face environment if that is better for the patient.

Hon DONNA FARAGHER: I suppose my final comment is with regard to that, and then I will let go. I accept and understand the value of telehealth. It is not a criticism with regard to telehealth, and many utilise that on a daily basis; however, I would request that there is consideration given sooner rather than later with regard to face-to-face services for child development services.

The CHAIR: Thank you. I am going to now move to the handsome gentleman on your screen, Hon Martin Aldridge.

Hon SUE ELLERY: I can only see Marty.

The CHAIR: Can you hear us, Marty?

Hon MARTIN ALDRIDGE: I can, Mr Chairman. Can you hear me?

The CHAIR: Are you all right there, mate? You look terrible, mate. How are you feeling?

Hon MARTIN ALDRIDGE: I am getting there.

The CHAIR: We have plenty of doctors here if you need any help.

Hon MARTIN ALDRIDGE: A telehealth consult?

The CHAIR: Cheers. Over to you.

Hon MARTIN ALDRIDGE: Thank you, Mr Chairman, and thank you for everybody's tolerance in allowing me to join by videoconference.

I have some questions at budget paper No 2, page 310, with respect to COVID-19 response spending and, in particular, the procurement of rapid antigen tests. As I understand it, the state has procured some 110.7 million tests, and the Department of Health has been responsible for 85.7 million of those tests being procured. I am just wondering: are we now in a position where we have procured all the rapid antigen test that were ordered?

Hon SUE ELLERY: My first comment is that I am incredibly impressed that you are wearing a tie in isolation. That needs to be noted. I am assuming it is trackie daks on the bottom.

In respect to RATs and those RATs that have been purchased by Health, I might get the director general to make some comments and then I will go to Angela Kelly, who can talk about the procurement stuff.

Dr RUSSELL-WEISZ: We did go through a rapid procurement of rapid antigen tests at the time. I think it was pleasing that we both—mainly Health—bought the rapid antigen tests that have now been given out to the community. I think we are now seeing that most of the positive tests that are being reported are RATS—it is up to about two-thirds RATs and one-third PCR, or even less in the PCR space on certain days. The community has got very used to using RATs and actually reporting RATs online.

As far as where we are with the RATs, through the minister, I am going to ask Ms Kelly to talk to this if that is okay.

Ms KELLY: I can confirm to the honourable member that the department did order and has received 85.7 million RATs. The Department of Finance ordered 25 million RATs. We did receive—very much in the early days—1.33 million RATs from the commonwealth. That was a stockpile that the commonwealth purchased to assist states. It was probably in December, and we received those in probably the January period. We are allocating those RATs out to those groups who require them. We have a process where organisations can seek RATs, and we look at the distribution of those. We obviously have some drive-through distribution points where we are distributing those RATs to members of the public. That has been well received. Clearly, we are getting RATs out into areas where they are required and, obviously, we have been supporting our own healthcare workers by providing RATs to them as well.

Hon MARTIN ALDRIDGE: Just on the distribution, are the 110.7 million all managed and held by the Department of Health? I guess the second part of the question is: obviously, it is difficult to know how many have been used because once they leave government hands you lose control of that information, but can you give me some sense of how much of the 110 million is still in government stockpiles versus has been distributed to others?

Hon SUE ELLERY: I will ask Ms Kelly to provide an answer to that.

Ms KELLY: I can confirm that the Department of Health is now the single agency that is distributing RATs. The 25 million RATs that were ordered by the Department of Finance have either been fully distributed to the community or have been provided to Health so you have got one agency now distributing.

With the minister's agreement, we will provide on notice where we are actually at with how many RATs we have got left. I have got a number in my head, but I do not want to guess that. I do know that we provided at least 30 million RATs out in the last several months, but that may have gone up over the last month, but I have not been around for that. I will get that, minister, with your agreement.

[*Supplementary Information No B9.*]

Hon MARTIN ALDRIDGE: In terms of the quantum, how was it determined that 110 million tests for a state like Western Australia was an appropriate number?

Hon SUE ELLERY: I am not sure that we can give you a precise algorithm, but I will ask Ms Kelly if she can make some comments.

Ms KELLY: There was no methodology behind it. As you will remember in the December period, we were seeing some significant increases in COVID-19 around the world, particularly with Omicron and those numbers coming out of South Africa. They were increasing around the country and around the globe. Agencies were ordering RATs. We wanted to make sure we had a significant number to protect the community and to enable us to do that surveillance if required. We sought and put orders in as quickly as we could. We were also aware of what our colleagues were doing in other jurisdictions. We placed orders. We lost some orders because other states paid a higher price, and some of our orders went that way. We believed at the time to get as many as we can to ensure that we had enough for the Western Australia population.

Hon MARTIN ALDRIDGE: Why was the procurement effort split between the Department of Health and the Department of Finance?

Hon SUE ELLERY: That was really a decision of government. At the time, it was deemed that Health needed to focus on its workforce, in particular, and the people using its workforce, and we had the broader community and perhaps other government service delivery agencies who had different needs than Health had. The responsibility was split between Finance and Health.

Hon MARTIN ALDRIDGE: Thanks. Can I ask, of those tests that were ordered—the 110.7 million—would it be known how many of those were saliva tests?

Hon SUE ELLERY: We might take it on notice, honourable member. I am not sure that we have it here.
[*Supplementary Information No B10.*]

Hon MARTIN ALDRIDGE: Can I ask a question now to the Chief Health Officer with respect to rapid antigen tests? I have had a unique experience in the last week and so I am joining you by videoconference. I have been experimenting with my family. Every member of my household is COVID-positive at the moment, and I have been making them take these saliva tests daily. Even though I know they are positive—via PCR or nasal swab RAT—I am unable to return a positive result from any member of my household on these saliva tests. Given all of us are swimming in these things, I cannot give them away to the public anymore and I think after my experience in the last week I am not sure I want to, I am wondering whether the Chief Health Officer has considered the validity of continuing to use these saliva tests as part of the diagnostic measures in place for COVID-19 response?

[3.20 pm]

Hon SUE ELLERY: Before I turn to the Chief Health Officer, the honourable member would be aware that a number of questions have been asked in the house about the lollipop version of the saliva test, which is different from the tests you spit into. You would understand the requirements that are set at a national level about the way those tests work and that the lollipop version was found to be in excess of the national standard. Nevertheless, you are not the first person to raise the question about the lollipop tests, so I will ask the Chief Health Officer to make some comment.

Dr ROBERTSON: We do continue to look at the accuracy and sensitivity of the rapid antigen tests. All the rapid antigen tests that are registered by the TGA have to meet a certain standard. They have to have at least an 80 per cent sensitivity to be sold. Beyond that, they will vary in their sensitivity. Saliva tests do have utility. Particularly with young children and the like it is far easier to get them

to comply with a saliva test than a nasal and oropharyngeal swab, so they do have some benefits. We have seen that obviously if they are not done correctly—there is generally a requirement for swabbing for up to 90 seconds with the oral swabs, the saliva swabs, and often that is not done to that extent, so their sensitivity is probably reduced. We will continue to look at them. Obviously, we purchased a range of different swabs at the time, so we do have different ones available for people to look at.

Hon MARTIN ALDRIDGE: Thanks. I want to ask further on the procurement process. I understand that four suppliers were identified by government, and the first order was placed on or about 14 December. How were those suppliers identified, and who identified them?

Hon SUE ELLERY: I am advised that it was through PathWest and perhaps Finance, and PathWest is not here. I can take that on notice and if I am able to provide an answer, I will do that.
[*Supplementary Information No B11.*]
Hon MARTIN ALDRIDGE: If we could include in B11 who the four suppliers to government were, that would be helpful as well.

Hon STEPHEN PRATT: I refer to the asset investment program on page 326 of budget paper No 2. A few line items refer to investment in beds across the system. I am hoping the minister can provide an update on what the government is doing to expand the number of beds in our hospitals to provide additional capacity.

Hon SUE ELLERY: Since the last state budget, an additional 342 beds have been added to the hospital system, with a total of 530 to be added by the end of this year, which is the equivalent of building a new tertiary hospital. This budget includes an additional $223.4 million investment in health infrastructure, increasing investment in new health infrastructure to $1.6 billion over the next four years. That is on top of the $1.8 billion set aside for the new women's and babies' hospital, which means about a $3.4 billion spend in the health infrastructure pipeline. With respect to beds, the 342 in the metropolitan area is 265 general beds, 39 ICU beds and 38 mental health beds, with 324 of those currently operational. Of the announced beds, 230 are infrastructure-ready and 212 are operational. By the end of October 2022, 498 or about 94 per cent of the 530 beds will be infrastructure-ready.

Hon PIERRE YANG: I refer to the $251.7 million package for reducing pressure on the ED set-up in budget paper No 2, page 312. What are the 17 initiatives included in the package and how will these address immediate and long-term causes of ambulance ramping?

Hon SUE ELLERY: Reducing the pressure on emergency departments is a priority. As you say, $251.7 million is for the ED reform package. Those 17 initiatives are across WA Health and the Mental Health Commission. It is deliberately part of a system-wide approach to reduce demand pressures, in both the short and long-term. Those initiatives include ED waiting room nurses, the establishment of 24/7 registered nurses; emergency access response, an integrated system-wide approach to managing demand and capacity; the State Health Operations Centre, preparation of a business case to provide a centralised point for 24/7 oversight of the system-wide operations; real-time data; a transition care program—I referred to that earlier with respect to aged care; the expansion of a complex needs coordination team to reduce ED presentations and hospital admissions or readmissions when they are not required; a long-stay patient fund, which I referred to earlier as well, to try to remove some of those barriers to discharge; the transitional accommodation program for adults with complex care needs; the disability transition care pilot to address the delayed discharge of medically fit patients who have complex needs; paediatric eating disorders, the establishment of a dedicated children's eating disorder inpatient unit; virtual emergency medicine, an extension of the South Metropolitan Health Service program and

expansion of the North Metropolitan Health Service program, and East Metropolitan Health Service; and the COVID-19 home monitoring program, a telehealth service. There is significant investment in addressing EDs.

Hon PIERRE YANG: Can the minister elaborate on the State Health Operations Centre in paragraph 11.2.2 and what it could achieve?

Hon SUE ELLERY: The State Health Operations Centre will reduce duplication across the system. It is a centralised contact point to enable oversight and troubleshooting of inter-hospital transfers and bed occupancy management with an initial focus on the whole-of-journey for regional to metro transfers, as well as supporting emergency department diversion strategies to reduce ambulance ramping and ED overcrowding. This budget contains $3 million to establish a project team and develop a business case, to scope it, design it and establish the SHOC as a strategic system function.

[3.30 pm]

Hon SUE ELLERY: The department has also commenced implementation of digital solutions to provide capability to collect, synthesise and analyse the information required for situational awareness of the system. The SHOC will provide 24/7 monitoring and oversight of system-wide operations with the aim of maximising capacity and efficiency of available resources to meet increasing demand. It will, crucially, comprise several Department of Health functions and encompass other government agencies as well, including locating together to share operational intelligence and capacity to look, literally, across the whole system at any given point in time.

Hon PIERRE YANG: Minister, I may wait for the next turn for my future questions. Thanks.

The CHAIR: Minister, I guess you want another comfort break.

Hon SUE ELLERY: I am good, if everyone else is.

The CHAIR: I do, actually! We might do it now before we start the second round. Five minutes, guys, so you can stretch your legs. We will be back in five minutes.

Hearing suspended from 3.30 to 3.38 pm

The CHAIR: Okey-doke. Let us rock ‘n’ roll.

Hon SAMANTHA ROWE: Thank you, chair. I have got a question around voluntarily assisted dying, minister. The reference page is 310, with the spending changes table—right down the end you see the additional funding for voluntary assisted dying. Are you able to advise us how that additional funding is going to support patients when it comes to their end of life?

[3.40 pm]

Hon SUE ELLERY: Recurrent and increased funding is required to support the implementation of voluntary assisted dying and support the statewide care navigator service, the statewide pharmacy service and the Voluntary Assisted Dying Board to respond to greater than anticipated levels of demand. There is $1.5 million, plus $95 000 for enhancements to the ICT system. The $1.5 million is salary and other goods and services to support ongoing operations and increased demand, and $95 000 is for ICT. Although the funding is classed as recurrent, there is no funding showing in the out years. Modelling will be undertaken to establish required funding for the out years to provide for ongoing support.

Hon JACKIE JARVIS: I am referring to page 314. It is under the infrastructure spend. Dot points 16.3, 16.4 and 16.5 relate to major upgrades of some regional hospitals. I am particularly interested in the $200 million upgrade of Bunbury regional and the $122 million for Geraldton Health Campus.

Both of them note that some stage 1 works are either progressing or completed. I am just wondering if I can get an update on what works have been completed and the forward plans for those upgrades.

Hon SUE ELLERY: In respect to the Bunbury Hospital redevelopment, critical works are substantially complete. The service planning reform and implementation scope is underway. The project definition plan has been finalised and endorsed. This will enable the delivery of contemporary models of care, with the expected growth in the population in Bunbury and the south west. It comprises a $22.8 million commitment made in 2019–20 and an additional $177.3 million commitment for redevelopment of the hospital site through to 2028–29. It will assist Bunbury to respond to existing pressures on the current infrastructure. The critical works, which have already been done, are the fit-out of the offsite leased facility, some car parking bays, construction of transportable buildings and procurement of critical ICU equipment.

In respect to Geraldton, which I think was the second part of your question, the tenders went out and came back, and as with many, many tenders for infrastructure right now, they came back significantly over the pre-tender estimate. The Department of Finance is consulting with the construction sector in how we progress but minimise the delivery risk and improve value for money. On the Geraldton Health Campus project, consideration was given to, "Do we bundle it with other projects?" It was determined it was already attractive to the market without needing to bundle. The additional funding of $49.4 million increases the overall project to $122.7 million, which will enable the project now to progress to tender.

Hon NICK GOIRAN: Minister, I refer you to page 311 of the budget papers and the seventh significant issue under the heading "COVID-19 Safe Transition". The second line says —

> WA Health remains agile in shaping the approach to public health policy, and continually adapts its response measures as the community transitions to living with COVID-19.

As I understand it, the third of the public health state of emergency declarations was declared at 1625 on 22 September 2021. Is it still in force?

Hon SUE ELLERY: I would need to ask the Chief Health Officer that. Say the title of the —

Hon NICK GOIRAN: Declaration 3.

Dr ROBERTSON: They are still in force, yes.

Hon NICK GOIRAN: When was it last extended?

Dr ROBERTSON: I can find that information out for you. I just need to check that information. It is due to be extended, I think, on Thursday this week, so my understanding is it would have been Thursday—10 days ago.

Hon SUE ELLERY: But for completeness, we will give you the actual date.
[*Supplementary Information No B12.*]

Hon NICK GOIRAN: I appreciate there is a distinction between when you declare the extension and when it becomes in force.

Dr ROBERTSON: It comes into force as soon as the extension has been signed.

Hon NICK GOIRAN: Okay. It is different with the state of emergency declarations.

Dr ROBERTSON: It is an extension to the state of emergency. There is the initial declaration and then there is a recommendation to the minister to extend the public health state of emergency.

The CHAIR: Sorry; just to clarify here, what do you actually need now?

Hon NICK GOIRAN: You will make the declaration, Chief Health Officer, at a particular time. The one that I was referring to was at 1625 on 22 September 2021. As I understand it, that is simply the time that it is declared, but it may then have validity from midnight on such and such a date.

Dr ROBERTSON: No.

Hon NICK GOIRAN: That is certainly the case with the state of emergency declarations. It may be different with the public health state of emergency.

Dr ROBERTSON: It depends on what we are talking about around the state of emergency. The declaration comes into force on signing—from that time that it is signed. It is signed and dated and timed—from whatever time it comes into force. Similarly, if it is extended, when the minister signs it, it comes into force for two weeks from that time and date.

Hon NICK GOIRAN: Right; we will see what comes back on the question on notice.

The CHAIR: Do we have clarity on what you actually want?

Hon NICK GOIRAN: I think that what is going to be told to us is when it was last extended and when it is next going to be extended.

Hon SUE ELLERY: Correct.

The CHAIR: I confirm that is B12.

Hon NICK GOIRAN: Further to that, on 16 August 2021, Kelly Crossley sent a draft briefing note to the Chief Health Officer, and in that briefing note, it talks about a phase C and phase D. It says —

> At Phase D, COVID-19 will be managed consistent with public health management of other infectious diseases. Cases in the community will be minimised where possible, without the implementation of ongoing restrictions or lockdown periods. Planning is underway for the Department of Health and the WA Police to gradually move us out of the State of Emergency to Phase D.

Will phase D commence when the declaration of a public health state of emergency is no longer extended?

Hon SUE ELLERY: Chair, if I can ask if the honourable member will table the document he is referring to and then I am happy to take it on notice so the Chief Health Officer has the opportunity to read the document that is being referred to.

Hon NICK GOIRAN: Let us deal with that one at a time. First of all, I have no problem providing this document, because it is actually you, minister, or your government that provided it to this committee at a previous hearing.

Hon SUE ELLERY: That may well be the case, but we do not have it in front of us right now.

Hon NICK GOIRAN: No problem at all. Perhaps a member of staff can assist to make a photocopy of this document. That said, minister, I am simply asking, for the declaration of a public health state of emergency, whether that is the criteria by which we will then commence phase D.

Hon SUE ELLERY: Again, honourable member, I am not trying to be difficult here. I am happy to take that on notice because I would like the Chief Health Officer to have time to read the document you are referring to and consider his response. I think that is an efficient use of the committee's time, so I am happy to take that on notice.

Hon NICK GOIRAN: Has a number already been allocated to that?

The CHAIR: No.

Hon NICK GOIRAN: I do not find it satisfactory, but I am used to it with this minister.

[*Supplementary Information No B13.*]

Hon NICK GOIRAN: Is it intended that there be a phase where no state of emergency declaration is in force but a public health state of emergency is in force?

[3.50 pm]

Hon SUE ELLERY: That is a hypothetical question. The CHO might have some views on it, but I do not think that you would get a definitive response. It is a hypothetical proposition. The Chief Health Officer might like to make some comments on that.

Dr ROBERTSON: As we progress out of this pandemic, there are a number of considerations as to whether we continue with the state of emergency under the Emergency Management Act, for which we are the hazard management agency, or whether we continue under the Public Health Act state of emergency or one or other of those—or if we do move away from them, at what stage do we do that? That is still under consideration and obviously both myself and the State Emergency Coordinator would provide advice to government if and when we get to that stage.

Hon NICK GOIRAN: What is the criteria being used to make those decisions?

Hon SUE ELLERY: There is no single criteria—I am happy for the Chief Health Officer to make some comment about that. There is no single checklist, as far as I am aware, that says, "When we get to this, this, this and this, we will do that." That has never been the case in a kind of prescriptive way. The way that public health officers have managed in the last two and a half years, in my observation, is that they literally weigh the social with the economic with what I describe as the clinical and they make proportionate decisions. There is not one single formula that you can apply at a single point in time to determine, "This is what we're going to do." I welcome the Chief Health Officer to make some comments.

Hon NICK GOIRAN: To be clear Mr Chairman, before the Chief Health Officer responds, I am not asking for a formula; I am asking what the criteria is that is being used to make these decisions.

Hon SUE ELLERY: I see that as the same thing, but I will ask the Chief Health Officer.

Dr ROBERTSON: The state of emergency under the Emergency Management Act and under the Public Health Act and the directions that sit under those continue to assist us to manage the current outbreak as it is. As of 6.00 pm last night, we still had 29 277 active cases in the community and we still have over 1 071 cases in schoolchildren per day, so we are still managing that. One of the major ways we do that is obviously requiring people who have COVID to be isolated, and that is done by direction under the Emergency Management Act. We have also got requirements to continue to vaccinate people. That is done under some of the directions under the Public Health Act. Those directions still have a very important role in ensuring that we continue to manage as the pandemic comes down. It is falling—there is no doubt about that—but we may plateau and we may still see the rise of other variants, including the BA4 and BA5 variants. We have started to see that play out in Sydney and on the east coast. Those states of emergency and the directions that sit underneath remain very important in helping us manage and further reduce the harm that has arisen from the pandemic.

Hon NICK GOIRAN: Okay. You have indicated that there is a criteria being used—it seems to be the number of active cases and also the number of cases in schoolchildren.

Dr ROBERTSON: That is one consideration, but it is not the only consideration. It is around how we decrease the spread, how we continue to ensure the protection of the population, whether that be through masks on public transport, masks in high-risk settings. It looks at a number of the different factors—how we protect vulnerable populations and what the best way of doing that is.

Hon NICK GOIRAN: Just to interrupt there, Chief Health Officer, what you are talking about there is how you then manage the situation. What I am asking for is the criteria that you are using to determine whether there is an ongoing public health state of emergency. I can understand if you are using threshold levels of active cases, and you say at the moment it is 29 000 active cases and in your expert opinion you say 29 000 is too much. That is not a level that you as Chief Health Officer are comfortable with and so therefore you use that as a rationale for continuing the public health state of emergency. I am not medically qualified so I am in no position to disagree with you about that, but I can understand the need for that threshold. My question is: are you using any other criteria other than active cases, including in schoolchildren, to make that determination?

Hon SUE ELLERY: I will turn to the Chief Health Officer in a moment. Again—I do not say this because I am wanting to be overly simplistic—my observation of the way that the Chief Health Officer has framed his judgements over two and a half years is he is balancing the economic with the social with the clinical and trying to get those in proportion to each other and determining: to what extent is this having an impact on the economy, to what extent is this having an impact on the kind of social measures that put into account? I do not think that the Chief Health Officer will be able to give you a finite, "Here is the set of criteria that I am precisely going to apply." I am happy for him to speak for himself, but my observation is that it is a balancing act, and if one of those things is more impacted than others, his advice reflects that.

Dr ROBERTSON: As the minister has outlined, it is an around managing the risk at the time. Obviously, our caseload is one consideration, but it is not the only consideration. It is also the caseload in various vulnerable populations, whether that be in remote Aboriginal communities, whether it be in our prisons, whether it be within our schools. It is also around the considerations of how we continue to protect the population and what other measures may be in place that we need to continue to assist in protecting the population. It is also looking more broadly at what is happening externally to both WA and Australia and if there is likely to be future threats that we need to be cognisant of, whether that is a new variant, whether it is a new potential issue that we need to be aware of. They are all factored into the advice. I provide advice up to the minister on a fortnightly basis on whether we should extend. It is not based on single criteria; it is based on an assessment of the risk and the benefits of maintaining some of those measures going forward.

Hon NICK GOIRAN: Chief Health Officer, as I understand it, none of the other states have declared a state of the emergency at the moment—they certainly have in the past. What level of active cases did they use that you will then use to also assist you before ceasing to declare their state of emergency?

Hon SUE ELLERY: I certainly will turn to the Chief Health Officer in a moment. I just make the point that different jurisdictions have different instruments. Some of them have only relied on one; we have relied on two, so that may well have impacted the decision around their timing and, of course, the honourable member would be well aware that the pandemic has worked its way through the others states at an earlier and faster rate because we were so successful in controlling our borders. I invite the Chief Health Officer to make some comments.

Dr ROBERTSON: Obviously, as the minister said, there is different legislation. You will be aware that South Australia and, I think, Northern Territory have introduced subsidiary legislation that actually enables their Chief Health Officers to continue to issue some of these directions even if they are not in a state of emergency, so that is one approach that they have taken. Yes, a state of emergency has gone, but those powers have just been moved across to the Chief Health Officer in those circumstances. Our legislation is different. As the minister said, we are operating under two acts. A number of them were only operating under one and some of those were not a public health act. We

have had to adjust, but largely how the various directions have been implemented are reasonably similar across most of the jurisdictions. There are minor changes. If you look at things like vaccination mandates requirements, they are fairly uniform across all states and that is done under either a public health act, an emergency management–type act or some other arrangements with their Chief Health Officer. It is done in different ways to achieve basically the same outcomes.

[4.00 pm]

Hon STEVE MARTIN: Minister, I have a couple of questions on page 326, the asset investment program. One of them as a follow-up from Hon Jackie Jarvis's questioning about Geraldton and Bunbury. I will start with Bunbury, if I may. The original number was $38 million, I believe, announced in October 2020, and now it is $200 million. I have a long list of what the original $38 million was for. Can you perhaps tell me what the extra spend gets the Bunbury health campus? I think I am using a different page to Hon Jackie Jarvis, but 326.

Hon SUE ELLERY: No, I have it. I am trying to find the corresponding note. My corresponding note takes me to Byford, which is of no assistance to Bunbury. Honourable member, was there something in particular that you that you were looking for? It has been re-cashflowed now to the $200.1 million. Can you repeat for me, sorry? Is there something in particular?

Hon STEVE MARTIN: I will give you some detail about what I have in front of me that the original $38 million was for, which was originally: upgrades to the emergency department, additional operating theatre, acute medical assessment unit, mental health observation area, expanded capacity of the ICU, increased parking bays for the site, improved Hospital in the Home and telehealth capabilities at community locations. That was the original spend and now it has gone to $200 million. I am after what are we adding to that list that gets to $200 million?

Hon SUE ELLERY: I will ask the director general to make some comments on why the PDP came with a higher than originally estimated cost. I will ask the director general to do that.

Dr RUSSELL-WEISZ: I cannot find exactly where you are pointing to with the $38 million, but there was an original budget going back maybe a year and a half, two years, which had a much smaller figure. Since then, there was work done in relation to the Bunbury redevelopment. There was clinical modelling done which showed what the requirements would be for 2025–26. As we do with every site, that clinical demand and modelling capacity was done. It was actually projected right the way out to 2030–31, so we were looking to see what we needed both in emergency department, medical, surgical, rehabilitation, maternity, paediatrics. Also there was some work to be done in relation to the sterilisation unit down there. There was other associated work. There were certain things that had to be varied. There was also site engineering services, including a new central energy plant, which, if you were expanding Bunbury regional hospital—and, basically, the $200 million was to take into account any escalation to the tender and regional loading.

I think over the last couple of years, what WA Country Health Service and the department has found is that obviously Bunbury is the major hospital in that area and it is undergoing huge demand—both Bunbury and Busselton. There has been a focus of both government and the Department of Health in looking at exactly what Bunbury requires, not just out to 2025–26 but out to 2030–31. Those are the main areas of focus, but what I can say is the PDP is being worked through. As we speak, we are finalising that at the moment to actually come up with the suite of services that we will require not just for 2025–26 but 2030–31 for Bunbury. But the $200 million was a major shift from the original; I thought the original was $20 million not $38 million.

Hon STEVE MARTIN: Minister, you explained some of the process around the Geraldton hospital tendering and I think you used the words—and I apologise if it is not exact, but "seeking better

value". So, the costs have risen tens of millions of dollars over the original quote, I assume, and it was knocked back because the tender documents that came in were above budget. Are we anticipating that somehow they will go down or are we starting the project on whatever comes in next time? I am a little bit unclear as to the process.

Hon SUE ELLERY: Sure, honourable member. I can understand that. It is about how we manage the tender. So we did look at, given the state of the construction market, should we look at packaging together several projects to make it more attractive? So, for example, is there a school that needs to be built in Geraldton to try to make a package of construction big enough to be attractive to a prospective tenderer. The view was that the Geraldton Health Campus was already attractive to the market without the need to bundle it up with something else, but it might be that we do a two-stage way of managing the contractor model going forward. There is still work being done on that. The additional funding of $49.4 million will enable the project to progress to tender. The Department of Finance will lead that and they will work with the WA Country Health Service and Health in preparing the tender documentation.

Hon STEVE MARTIN: Just one more quick one on the asset investment program. This is one that is not in the list so I apologise; I do not have a line item. I have been approached by a constituent in Beverley who was anticipating a $6 million spend on the Beverley hospital. Is there someone from WACHS who—I do not know where that constituent has plucked that number from, but I assured him I would chase that up and see if there is anything on the list.

Hon SUE ELLERY: We will not have any notes here because these are prepared against the budget papers. I will see if I can find out. I think we are safest to take it on notice, so if you want to spell out precisely what you want.

Hon STEVE MARTIN: Is there a spend imminent on the Beverley Hospital, $6 million or otherwise?

[*Supplementary Information No B14.*]

Hon DONNA FARAGHER: If I can turn to page 317, with regard to waitlists and perhaps this might need to be taken on notice, are you able to advise what the current median and average wait time is for a child accessing ear, nose and throat elective surgery at the Perth Children's Hospital?

Hon SUE ELLERY: I would need to take that on notice, honourable member.

[*Supplementary Information No B15.*]

Hon DONNA FARAGHER: If we could go back to page 316 under "Public and Community Health Services", at the last budget estimates hearing, and I appreciate, minister, you were not sitting where you are today, it was another minister, but we were informed that the Child and Adolescent Health Service had put forward a business case of $2.5 million for additional staff for child development services. At the time I was informed and I was consistently told that it was still subject to budget deliberations, albeit it was after the budget was actually released. I did note, though, that you, minister, in response to a debate that we had in this house with regard to the early years back in April this year indicated that there would be an additional $2.5 million to deliver child development services. I want to clarify, has that $2.5 million now been approved by the government and; if so, is it new funding or a redirection of funds by the department?

Hon SUE ELLERY: Good question. I will see if Dr Anwar can provide you with some information.

Dr ANWAR: Through the minister, $2.5 million has been put in the base budget for the child development service. However, there is a reassessment of CDS happening at the moment. It is under the banner of future directions projects and it is a two-phase program: one, doing some data analytics to understand the flow of children into the child development service and their

management through the service; and the second is to get some feedback from staff and consumers. We anticipate trying to put another submission into government for the midyear review in order to see whether there needs to be a further enhancement to the CD service through budgetary support.

[4.10 pm]

Hon DONNA FARAGHER: It would be good if we got some more funding, so you would get my support. Can I ask, though: is the $2.5 million new funding or was that a redirection of existing funds?

Dr ANWAR: Through the minister, it was redirection of existing funds.

Hon DONNA FARAGHER: Was that through the child and adolescent development service?

Dr ANWAR: Through the Child and Adolescent Health Service.

Hon DONNA FARAGHER: Health service—sorry. So you are intending to put forward another business case before the midyear review?

Dr ANWAR: We are currently doing a reassessment with a view to putting a business case, yes, to the midyear review. We anticipate that.

Hon DONNA FARAGHER: Again if I can remain on this section with regard to school health nurses, I understand that the last former analysis with regard to workforce—I heard the comments made by the director general at the beginning of the session with regard to workforce—that the last analysis was undertaken in 2013. I did get a response last week from the minister that did not indicate that there necessarily was going to be a new formal workforce analysis with respect to school health nurses, but it was up to individual health service providers. I am going to ask again through you, minister: is there intended to be a new formal workforce analysis specifically with regard to current requirements for school health nurses to meet current and future demand?

Hon SUE ELLERY: I will ask the director general in a moment, but I will make this comment that there was, as I recall, a rollover of the agreement between health and education in respect of school health nurses, basically to try to get us through COVID where we were moving people around to meet clinical needs all over the place. I think there has probably been a bit of a hiatus in the status quo on kind of rethinking that, but I will ask Dr Anwar to make some comments about that.

Dr ANWAR: Through the minister, I am not aware of a formal review of the workforce, but we do have a memorandum of understanding that we review regularly with the Department of Education to re-examine the model of support that is provided to schools by the school health nurses. But I am not aware of the current active review of the workforce.

Hon DONNA FARAGHER: Thank you for that. I suppose as part of that ongoing analysis, and I hear what the Minister has said—you would need to take this on notice—how many school health nurses by FTE have been identified as being required to meet current demand for these services, both in the metropolitan from the Child and Adolescent Health Services as well as the WA Country Health Service? I appreciate that that will need to be taken on notice.

Hon SUE ELLERY: Can I just clarify, we can probably give you the data of how many FTE are in place, but in terms of how many to meet future demand —

Hon DONNA FARAGHER: No—current demand. For reference, minister, the department have been able to provide that detail with regard to child health nurses, so I was specifically asking in the context of school health nurses.

Hon SUE ELLERY: Sure.

[*Supplementary Information No B16.*]

Hon DONNA FARAGHER: One more question on this, and this is just a point of clarification. Can I just ask with regard to child health nurses, is there currently any wait time or a standby list for children wishing to access a child health nurse, either through CAHS or the WA Country Health Service? I have been told that there is, but I have not heard of it before. I want to clarify it.

Hon SUE ELLERY: I am not sure if we are able to answer it now. We will need to take it on notice.

Hon DONNA FARAGHER: On that basis, if there is a wait time or a standby list, could you also advise in that answer any particular areas of the state that are more impacted or have higher wait times or standby lists?

Hon SUE ELLERY: Yes.
[*Supplementary Information No B17.*]

Hon DONNA FARAGHER: Can I ask one more? Could I just ask with regard to wait time—

The CHAIR: You have still got a couple more minutes.

Hon DONNA FARAGHER: A couple more minutes—this is my last question.

The CHAIR: Only because you are my favourite!

Hon DONNA FARAGHER: With regard to allied health services and paediatric services offered through the metropolitan child development service, I have previously asked on a few occasions now the median wait times for children accessing these services, but I am wondering whether or not the department—again, on notice—is able to provide both the median and average wait times for accessing paediatricians, speech pathologists, audiology, physiotherapy, clinical psychology and occupational therapy. I seek median and average wait times.

Hon SUE ELLERY: I think we would need to take that on notice.

Hon DONNA FARAGHER: I am happy for that to occur.

Hon SUE ELLERY: I will make the point, though, as a significant workforce issue, for example—I think you mention psychologists in that—for the member's information, one university stopped producing them. I know in my capacity as the Minister for Education, we have had to sit down with the universities and talk about how many psychologists they will keep producing because they are not producing enough to meet demand. It would not matter if the Department of Health had 10 squillion million dollars to spend on psychologists; if they are not being produced, we cannot employ them.

Hon DONNA FARAGHER: I understand that, minister, and that is why I have also indicated in this house on previous occasions that we actually need to think outside the box on other ways we can look at how we might be able to address this issue—not just with respect to funding, but through other ways.
[*Supplementary Information No B18.*]

Hon MARTIN ALDRIDGE: Can I just follow on from an earlier line of questioning with respect to workforce. I think the director general identified a number of occupations, if you like, within the health workforce that were in need. I am just wondering: do the health service providers still have approval to recruit up to 25 per cent above their FTE approved limits or has that now expired?

Hon SUE ELLERY: I will ask the director general to respond to that.

Dr RUSSELL-WEISZ: Through the minister, the 25 per cent was at the time—it goes back to, and I would have to be absolutely clear; I think it was towards the end of last year—was in specific areas. If there were specific areas that they needed to over-recruit to because of significant staff furlough

or shortages, yes, they would. But really, now, we are going into the 2022–23 budget. We would assume that going forward we will be going back to an activity based funding environment. We have always been within that environment. However, what I would say if you picked midwives as an example, if for some reason the health service provider could over recruit midwives, we would certainly encourage them to do so. If there were loads of midwives applying for positions, and they were suitably qualified, we would certainly encourage them. I know health service providers will talk amongst themselves if there were more, say, midwives or intensivists or theatre nurses, because if one area cannot recruit them, then other areas certainly will. Unfortunately, we do not really have that luxury at the moment when we are recruiting midwives. What I would say, is we are offering many more graduate positions for nurses. We have got a number of strategies in place that Dr Williamson can talk about in relation to trying to attract midwives or people to train as midwives once they become nurses, if I am using midwifery as an example again. The other real strategy for us is to grow our own—not just grow our own in junior doctors, but also grow our own in midwives and nurse graduates. We are employing or offering graduate positions greater than at any time in the past, but, obviously, we need to balance that with senior nurses and senior midwives. If there is any more detail of what we are doing, we can ask Dr Williamson.

Hon SUE ELLERY: Through you, chair, I do not know if you want some further information.

Hon MARTIN ALDRIDGE: No, I think that is sufficient for that question. I know that this workforce recruitment has been a focus for the last couple of years, and I know there was, I think, a $2 million interstate and international campaign. Obviously, there were some challenges in getting people to migrate to Western Australia over the course of the last couple of years. How big is the problem? Are you able to quantify, even in a basic form, how many people we need in our health system that we do not currently have? I know that midwifery has come up repeatedly throughout the hearing today—specifically are you able to say how many midwives we need as of 2022?

[4.20 pm]

Hon SUE ELLERY: I will ask the director general to make some comment. I am not sure that we have or would even be able to provide specific numbers, but I will ask him to make some comments.

Dr RUSSELL-WEISZ: We can certainly see that we are recruiting, net, more staff than we lose. Because we have 55 000 staff in the system, obviously it is hard to track that at all times. But if you are requesting specifics in relation to, for example, midwives, as a group, that we would be short of, we could at a point in time tell you how many we are short and how many we are trying to recruit to, but it does change very regularly.

Hon MARTIN ALDRIDGE: Can you give me a sense of it? You said that the most acute shortage that you have is in midwives. I mean, do we need 10, do we need 100, do we need 1 000? What is the target of these campaigns? Surely, we have some idea of how many we actually need.

Dr RUSSELL-WEISZ: I cannot tell you the exact number of, say, midwives at the moment. I might pass to Dr Williamson, who may have more details. But what I can say is that at the moment, for example, at one of our rural sites out of, say, an establishment of 12 full-time equivalents, we might have six. We might be augmenting that with people from the metropolitan area. The metropolitan HSPs have been very good at supporting our country areas. That means we might be six FTEs short, but it does not mean we are always running to six FTEs short because we are augmenting it by Nursewest—we are bringing locums in, when we talk about medical staff. I probably have to take that on notice. We could certainly look at it for midwives across the state for June, but that would mean the health service providers providing us with how short they are. We do not do midwifery everywhere. It is probably harder to do in general nursing because there are so many of them, but I might see if the minister —

Hon SUE ELLERY: I think we will take it on notice, so that for completion we can provide you with a rounder answer.
[*Supplementary Information No B19.*]

Hon MARTIN ALDRIDGE: Can I just clarify, as part of B19, the three categories that were identified were midwives, theatre nurses and junior doctors. Could I get a sense of the number of each of those people that we are short and seeking to recruit as part of B19?

Hon SUE ELLERY: Honourable member, I am happy to do that. I will just put the caveat that the director general made as well that that does not mean that those services are not being delivered. Services are backfilling and temporarily filling those positions as they are able to and as they need to.

Hon MARTIN ALDRIDGE: Obviously, the workforce is facing significant challenges. I do not know, necessarily, in terms of numbers, how many we are trying to recruit. In terms of theatre nurses, what sort of impact is the lack of theatre nurses having on elective surgery, or is the elective surgery waitlist more a symptom of the shutdown in elective surgery?

Hon SUE ELLERY: Are you able to make some comments?

Dr RUSSELL-WEISZ: I will make a comment and then I might pick on a health service provider to answer that. Theatre nurses is an area of focus. To be honest, honourable member, the staff furlough has had more effect on our elective surgery than actually a lack of staff. That has affected us more. Maybe I could ask, through the minister, Mrs MacLeod and Mr Forden to comment.

Mrs MacLEOD: Certainly, while theatre nurses are an ongoing challenge in terms of recruitment, they are not one of the major issues at the moment in terms of getting through our waitlists. In addition to having staff furloughed for COVID and being close contacts for COVID, one of the other contributing factors with waitlists is actually patients being COVID-positive as well and, at times, not well enough to undergo the surgery. There are actually multiple issues that are contributing to some of the waitlist management at the moment. We are trying very hard, obviously, to get some rectification strategies around what that looks like, but it will require our staff to be back at work and then, also, the patients to be through some of the COVID surge as well.

Hon MARTIN ALDRIDGE: Okay.

Mr FORDEN: I just reiterate that operating theatres have multidisciplinary teams. Furloughing is the biggest hurdle to getting through activity. It could be the nurse practitioner, it could be a cleaner, it could be the surgeon, it could be the anaesthetist. It is more complex than just saying it is one particular group of staff. But also, we are looking for role diversification. We obviously have theatre nurses, but we also have ODPs et cetera. We are proactively looking to scale up so that we can get over the elective hurdle in as short a time as possible, as the director general said earlier.

Hon MARTIN ALDRIDGE: In terms of the elective waitlist, particularly the cat 1s and cat 2s, are you able to give me some numbers on how many we have on each of those waitlists as of today or this month or this week?

Hon SUE ELLERY: I will get the director general to make some comment and then we might be able to take that on notice.

Hon MARTIN ALDRIDGE: Okay.

Dr RUSSELL-WEISZ: Thank you. I am just looking at the most recent, up-to-date figures. At 31 May, we had basically 33 206 reportable cases on the elective surgery waitlist. Again, "reportable" is our general elective surgery. Out of those, the numbers on the list in May 2022 were 1 447 for category 1, category 2 was 6 830, and category 3 was 24 929. They all add up to 33 206. As I said,

the focus is on the percentages that are over boundary. What I would say is that if you look at the statewide median waiting time for the categories in May 2021 and May 2022, it has not deteriorated significantly. The median waiting time for reportable procedures—that is the bulk of our procedures in category 1—is 12 days. The median time is 12 days, where patients have to be operated on within 30 days. For May 2022, it has only gone up by a day to 13. Category 2 has to be within 90 days. The median waiting time in May 2021 was 42 and in May 2022 it was 51. It is not a huge increase. It reflects the recent shutdown. Category 3, which has to be within 365 days, has moved from 131 to 155.

On the non-reportable procedures—our colonoscopies, gastroscopies; they are critical procedures because, obviously, they detect cancer—again, the category 1s have not moved; they have only gone up from 13 days to 14 days. Category 2s have only gone from 47 to 60. There is focus on that, but our focus is on the category 1s. Having gone through the most disruptive series of events that any health system has seen over the last couple of years, where there has been major disruption to our health system and major disruption to elective surgery, only to see that movement by one day is actually quite pleasing, but it does mean that we need considerable focus on making sure it does not climb up further. There will be considerable effort on dragging that down.

Hon MARTIN ALDRIDGE: Can I just have one last question on this issue of workforce. I receive a number of emails—I got a bunch this week—and I am sure you do, too, minister and director general, giving me advice about our health system, and that the lifting of the vaccine mandates on health professionals will resolve this issue almost overnight. I know you took some questions on this earlier in the hearing. Are those workers who have left because of the mandate or who perhaps are still excluded because of the mandate having a material impact on the health workforce or not?

Hon SUE ELLERY: I will ask the director general to make some comments, but I can certainly make the point that there are just not enough of them for it to have any material impact. It is certainly not the case that the problem will be fixed overnight if they all come back. That is across the board, whether it is health, education, police or anywhere else. There is just not enough of them, which is actually a good thing for the rest of us. I will let the director general make some comment.

Dr RUSSELL-WEISZ: The minister is absolutely correct. There is not enough of them. The health system and health staff have responded magnificently to the pandemic. We have very good uptakes in relation to COVID-19 vaccinations. The Chief Health Officer has talked about the mandates that are still in place. Obviously, I think the thing that we probably have not talked about today is that our hospitals are dealing with very, very vulnerable patients. There are areas in our hospitals that have patients who are severely unwell. They would be severely unwell whether they had COVID or they did not or whether they were exposed or they were not. We have a responsibility as healthcare workers to be as heavily vaccinated as we possibly can be. I can really honestly say that if we brought back those people who had chosen not to be vaccinated, it would make minuscule difference to the workforce. We need targeted approaches to workforce shortages. Everyone is suffering the same way in Australia and around the world. We just hope to see improvements over the next 12 months.

Hon DARREN WEST: I refer to page 310, "Spending Changes", "Paid Paramedics for the Regions"—$5.4 million in 2022–23, increasing to close to $9 million by 2025–26. How many additional paramedics does this provide and how will paramedics be allocated across the regions?

Hon SUE ELLERY: In 2020–21, we had $9.2 million over four years to support paramedic support in the Kimberley—at Derby, Fitzroy Crossing and Halls Creek—and six replacement ambulances for the region. A further state investment of $10 million is supporting a range of projects linked to the country ambulance strategy recommendations, including an additional 25 paramedics for country WA to address immediate areas of service need and to support local paramedic crews and

volunteers. A total of 27 additional paramedics have commenced throughout the state, including additional in the eastern great southern, south west and lower wheatbelt regions. There was also an election commitment of $30 million for additional paramedics and ambulance services in regional WA over the next four years. That includes an additional 18 paramedics.

Hon STEPHEN PRATT: My question also refers to page 310, under spending changes. There is a line item, "Newborn Emergency Transport Service". The allocation is $2.7 million per annum allocated each year. Can the minister advise whether this is a new program?

Hon SUE ELLERY: If I have not put it on the *Hansard* to date, congratulations on your third newborn, honourable member. I am advised the newborn emergency transport service is the only specialist team of doctors and nurses dedicated to providing mobile neonatal intensive care to retrieve sick or pre-term infants and transport them to tertiary neonatal intensive care in WA. There are significant challenges in service delivery. There is a significant increase in clinical demand. Funding of $14.1 million has been provided in the state budget for 2021–22 through to 2025–26.

Hon JACKIE JARVIS: I refer to page 315, line item 27. It talks about the new children's hospice. Given that that hospice is based in Perth, does that provide support for regional families, either through an outreach service or perhaps a residential service?

Hon SUE ELLERY: It is not built yet. Cabinet has approved $3.8 million to support an immediate uplift in WA paediatric palliative care services. The Perth Children's Hospital Foundation has engaged architects to develop a design for the new centre, and the design team is currently working on the schematics for that. A site has been identified as suitable for use by the relevant regulatory bodies. The federal government has agreed to provide $5.7 million towards the construction of the hospice. I might get Dr Anwar to add some comments to that.

Dr ANWAR: The hospice forms one element of service delivery for the statewide paediatric palliative care service. The paediatric palliative care service already provides collaborative working with the WACHS in supporting children who have a life-limiting condition outside metropolitan Perth. It is anticipated that that will continue to be bolstered when the hospice is built and there is some space to be able to accommodate that staff base. The hospice forms one part and, yes, it is absolutely anticipated that the statewide service will continue to support children and families in regional areas.

Hon STEVE MARTIN: Following up on the workforce questions that have been asked—I apologise if I am going over stuff that has been done—that $2 million advertising campaign I believe started last October to recruit workers. Are there any incentives still available for nurses and midwives under that program?

Hon SUE ELLERY: I will ask Dr Williamson to provide some information about that.

Dr WILLIAMSON: Yes, there are incentives, and we are looking at further incentives to that program—approximately $8 000.

Hon STEVE MARTIN: This may need to go on notice. Can we get a breakdown of how many FTEs we have picked up since October in those two job descriptions and from where they have come, whether local, interstate or overseas, for nurses and midwives?
[*Supplementary Information No B20.*]

Dr WILLIAMSON: Sometimes it is very difficult to track back an offer of employment to a specific campaign but we can tell you how many have been engaged from overseas.

Hon STEVE MARTIN: I refer to the small rural hospital services item on page 324, volume 1. I have a couple of questions around the Wyndham Hospital. It is not mentioned in that scheme by line item

but I am asking about the cessation of 24/7 emergency services last October due to staff shortages. Has that 24/7 service at Wyndham resumed?

Hon SUE ELLERY: I will ask Ms Vernon to make some comments about that.

[4.40 pm]

Ms VERNON: Wyndham has a 24-hour service. It has a 24-hour service from 7.30 to 7.30, with onsite nurses and on-call nurses. Just so you are aware that it has that service, it is on-call overnight. That service will resume when we have adequate supply of nurses. At this stage we do not, and it will be some months before we can resume an onsite nurse presence at Wyndham. But we continue to work with the community and other agencies to maximise the services into Wyndham.

Hon STEVE MARTIN: How many FTEs do you have there at the moment and how many are you short?

Ms VERNON: There are many sites in the country. For a 12-hour service, which we are currently running, an overnight call, just over nine FTE are required. There are currently three resident nurses, three agency nurses and a clinical manager. It would appear that we would need between 12.5 and 13 FTE to run that service 24/7 with leave cover.

The CHAIR: Can I just clarify that? Are you saying it is 12.5 and 13 that it is short?

Ms VERNON: No, I understood that the honourable member asked how many we would need.

Hon STEVE MARTIN: I asked: "How many do you have employed at the hospital now, and how many do you need?"

Hon SUE ELLERY: If I can interrupt, just to be complete and to ensure we can get other questions, if I take it on notice, we can get to the whole answer.
[*Supplementary Information No B21.*]

Hon NICK GOIRAN: I refer to page 309 under total appropriations in the budget paper. How much of the budget is allocated to cardiac services in Western Australia?

Hon SUE ELLERY: I can get the director general to make some comments. I am not sure we could actually pull out a single number for the honourable member.

Hon NICK GOIRAN: Can you take it on notice?

Hon SUE ELLERY: Even then, that is not how it is budgeted, so I am not sure that we could do that. I can get the director general to make some comments.

Hon NICK GOIRAN: Let me ask my next question and we can see whether we can make progress that way. Is data collected about the incidence of myocarditis and pericarditis?

Hon SUE ELLERY: Yes, it is.

Hon NICK GOIRAN: I assume that this, no doubt, will need to be taken on notice: can the committee be provided with the number of instances in the current calendar year and each of the preceding five calendar years?

Hon SUE ELLERY: We can take that on notice. I am not sure whether they are provided by that measure.

Hon NICK GOIRAN: It is either calendar or financial year—I suspect it is calendar, but knowing Health. You can provide it either way.

Dr RUSSELL-WEISZ: Conditions are coded; we go by the national definition of coding. I presume there is obviously a coding for pericarditis and myocarditis. It might be coded in a slightly different

way, but if we could take that on notice and answer it in how they are coded, we could certainly report on that.
[*Supplementary Information No B22.*]

Hon NICK GOIRAN: Has there been an increase in the number of instances of pericarditis and myocarditis since the COVID-19 vaccine rollout?

Hon SUE ELLERY: You will get that in the information you have just asked for. We do not have that at hand.

Hon NICK GOIRAN: I am not asking for the number; I am just asking whether there has been an increase. I appreciate that you do not have the exact numbers here.

Hon SUE ELLERY: I am not sure that I am able to answer it.

Dr RUSSELL-WEISZ: I cannot answer that at the moment. I do not know whether Dr Williamson has anything. In comparison year-on-year, we could probably compare 2017 to 2019.

Hon NICK GOIRAN: I guess I am just trying to get a sense from the experts as to whether it is a current point of concern within WA Health at the moment. If it is not and we are just getting routine numbers, then we can move on, but if it is a point of concern, I would be interested to know.

Hon SUE ELLERY: We will ask Dr Williamson to attempt to answer your question.

Dr WILLIAMSON: We have been monitoring this. We have been monitoring ED presentations with symptoms consistent with myocarditis or pericarditis. We have not seen coded data yet and have not seen admissions data yet. But this is something that we are conscious about and we are monitoring. The issue is separating a vaccine effect from a COVID effect, because it depends when the vaccines were administered, particularly to young males, which tends to be the group that gets that vaccine-related side-effect.

Hon NICK GOIRAN: It is the monitoring going to manifest itself into some form of report or research or something that might eventually be publicly available?

Dr WILLIAMSON: Yes, we are monitoring it through our safety and quality team at the moment and they generally report annually on what they are picking up. We have not been specifically asked to generate a report on that subject, but depending on the quality of the data, we will probably go ahead and do that.

Hon NICK GOIRAN: Do we also have data as to how many people died of COVID-19 and how many people died with COVID-19 but were being treated by WA Health for separate health issues?

Hon SUE ELLERY: I might get the director general to explain some of the complexity about actually being able to pull out "of" and "with", because I am not sure that we would be able to give that to you precisely. I will ask the director general to make some initial comments.

Dr RUSSELL-WEISZ: If the minister allows me, I might ask Mr Anderson and the Chief Health Officer to make some comments.

Hon SUE ELLERY: Yes, the minister will allow.

Dr RUSSELL-WEISZ: We have reported nationally. Consistent with New South Wales and Victoria, we report on deaths, we report on COVID, whether it is "of" or "with" because, again, you may have somebody who comes in with a condition that is unrelated to COVID. They might have concomitant COVID and that condition might be worsened, or they might have a longer recovery because of COVID. People have talked about "of" and "with" as though there is a line in between. It also relies heavily on the coding. It relies on there being a consistent practice. Your question, honourable member, is around deaths. You are going to be able to record whether a patient had COVID-19 and

died of or with COVID. Whether they had any other conditions that were worsened or precipitated by that is going to be quite difficult to tell. We report deaths on COVID in a nationally consistent way. What I probably cannot tell you is if it was a death primarily due to COVID and nothing else if somebody has conditions that go along with that. I might pass on to Andy, first, if he wants to make a comment on this from a national perspective, and maybe Mr Anderson.

Dr ROBERTSON: Just to follow up on the director general's comments, nationally the approach has been just to report on deaths for exactly those reasons. It is very difficult to get exactly whether they have died purely from COVID or whether they died with COVID, or they were somewhere in between. It is a continuum. Obviously, if you have serious heart disease and you are in hospital and you get COVID, that might be the factor that leads to a premature death. It is actually not easy to differentiate between the three. We are following the national guidance in that space.

[4.50 pm]

Hon NICK GOIRAN: Just before the third witness further adds to this, what would assist this conversation is: is it a done thing to actually record on a death certificate the cause of death is COVID-19?

Dr ROBERTSON: Through the minister, if we know it is purely from COVID—for example, if there are no other major health issues that could have been the major contributor—yes, it is. It may be that COVID-19 is the primary cause of death. On other death certificates, it may be a secondary cause or a third cause.

The CHAIR: So what is the total number of deaths in Western Australia where the primary cause is COVID?

Dr ROBERTSON: I do not have that figure.

The CHAIR: But you can get that? As you have just said, if it goes on the death certificate as the primary cause of death, we must be able to establish that.

Dr ROBERTSON: It becomes difficult because if they have heart disease, for example, the heart disease still may be recorded as the primary cause of death, but they could have survived that hospitalisation or they could have survived that incidence of heart disease if they had not had COVID. They are exacerbating the thing. It is not clearly just —

The CHAIR: No. I understand that there is a degree of ambiguity; I really do. I have just listened to the debate and, no disrespect, I have just heard you say that if COVID is the primary cause of death, that will be identified. Is that not the case?

Dr ROBERTSON: It may have more than one primary cause of death. This is the issue.

The CHAIR: No; that is fine. I do not want to make life difficult for you, Chief Health Officer. I thought if it was that easy, whereby you could say someone's primary cause of death was COVID, we must know. If it is not that easy, that is fine; I will not pursue it.

Hon NICK GOIRAN: But the question is: does that data exist? Is that something that is coded? Do we know what the causes of deaths are that are recorded on death certificates?

Hon SUE ELLERY: I will get Mr Anderson to make a comment—way better.

The CHAIR: It normally works!

Mr ANDERSON: The cause of death is encoded in ICD coding, which is what we have discussed previously. The only definitive way that we can determine a principal diagnosis or a range of conditions in the inpatient setting is through inpatient coding, and that can take anything from six weeks to three months to be completed following discharge. On your questions previously about

pericarditis and myocarditis in a calendar year, that is going to be very difficult for anything since COVID actually hit because we are still in that period of trying to complete coding. The cases that take longer to code are those that are more complex. Once you start to get things like COVID in the patient record, along with the fact they may have a range of other complications, which is what Dr Robertson was speaking of, that is going to be a far more complex case to code than somebody who came in with a similar underlying comorbidity who did not have COVID. It is very difficult for us to provide that data to you at this point in time, particularly for the period which you would be most interested in. With regard to cause of death, that is not coded from the hospital record. There will be patient records that will talk about cause of death, but that is something that is recorded and captured in other datasets that we have to then access nationally. It is not a simple thing to provide.

The CHAIR: Okay; I get that, absolutely.

Hon MARTIN ALDRIDGE: I have just a couple of discrete questions. One is with respect to a question asked prior to hearings—question 2. I must admit it is the only question that I have had time to read prior to the hearings commencing. It relates to funding for state-based epilepsy organisations. I note that there was a review being conducted into the community-based neurological services in Western Australia, and the answer that has been provided is that that review has been completed. Are you in a position to table that review?

Hon SUE ELLERY: Honourable member, I will take it on notice. I do not know that the minister has considered it in any detail, so I cannot guarantee that I am going to be able to table something, but I will pass the request to the minister.
[*Supplementary Information No B23.*]

Hon MARTIN ALDRIDGE: I understand that we are now the only jurisdiction in Australia that does not provide financial support to its state-based epilepsy association. Is there a reason why that is the case?

Hon SUE ELLERY: I would imagine that that was canvassed in the review. I cannot give you an answer to that question. I can take it on notice.
[*Supplementary Information No B24.*]

Hon MARTIN ALDRIDGE: Can I ask a question around the contract with St John Ambulance. I understand it is due to expire in about nine days. I am just wondering what the status is of the negotiations with St John's on a new contract.

Hon SUE ELLERY: I will ask the director general to make some comments.

Dr RUSSELL-WEISZ: We are working very closely with St John's in relation to an extension to the contract whilst the negotiations are ongoing for a future contract.

Hon MARTIN ALDRIDGE: So, we are reverting back to an extension like we have seen in the last couple of years to buy some time, if you like, to allow a new and fulsome contract to be negotiated; is that correct?

Hon SUE ELLERY: I am advised it is very short term to enable discussions to continue.

Hon MARTIN ALDRIDGE: This could be something that comes up in the hearings tomorrow as well. On the arrangement in which the state is assisting St John Ambulance by way of resources from the WA Police Force, the Department of Fire and Emergency Services and WA Health, is that at a cost to the state or is there some cost recovery process that is taking place with St John's for those services that are provided?

Hon SUE ELLERY: I am advised from health's point of view, which is the only agency I can answer for here, we are not charging for it. It is being provided out of existing resources in health.

Hon STEVE MARTIN: I refer to page 338 of volume 1. I believe that the state has received $4 million for the development of a residential eating disorder treatment facility.

Hon SUE ELLERY: Honourable member, sorry; we think we have run out of pages. We do not have a 338. Is it the Mental Health Commission?

Hon STEVE MARTIN: It is; I am sorry. Is that appropriate or not?

Hon SUE ELLERY: No; the Mental Health Commissioner is not here.

Hon STEVE MARTIN: I have a couple of quick ones that can go on notice. It will take no time at all. On page 312, we are addressing demand and capacity pressures on the health system at point 11. How many code blacks or bed state blacks were called in WA hospitals last month in the metropolitan area and WACHS, which I assume we will have to get on notice?

Hon SUE ELLERY: On notice.
[*Supplementary Information No B25.*]

Hon STEVE MARTIN: I refer to page 312 and addressing demand and capacity pressures on the health system and point 11. How many code yellows, declared when a hospital has either an infrastructure or other internal emergency which will affect its service delivery, were called in WA hospitals in the last month in the metropolitan area and WACHS?

Hon SUE ELLERY: I did not even understand the question, but I am sure Hansard did!

The CHAIR: We have still got another minute or two. Can you just read that slowly, please, once again?

Hon STEVE MARTIN: It is page 312 and the topic is addressing demand and capacity pressures on the health system and point 11. How many code yellows were called in WA hospitals in the last month in the metropolitan area and in the WA country health system?

Hon SUE ELLERY: Yes, I can take that on notice.
[*Supplementary Information No B26.*]

The CHAIR: That brings us to the conclusion of today's hearing. Before I do my little closing statement, which is always very dramatic, I just emphasise yet again—I have had a bit of feedback from members during the hearing—to the minister, and I know that you will relay this to the minister, and also to the director general just how significant it is that we get our questions well before an hour prior to hearings. It just makes it really, really difficult for members to be prepared. If you just take that on board, thank you.

Hon SUE ELLERY: Agreed.

The CHAIR: Thank you very much for your attendance today. Members, you may wish to submit your remaining questions through the electronic lodgement system, which will close at 5.00 pm on 1 July 2022. Witnesses, the committee will forward the uncorrected transcript of evidence, with questions taken on notice highlighted, as soon as possible after the hearing. Responses to questions on notice are due by 5.00 pm on 20 July 2022. Should you be unable to meet the due date, please advise the committee in writing as soon as possible before the due date. The advice is to include specific reasons why the due date cannot be met. Once again, I thank you very much for your attendance today.

Hearing concluded at 5.01 pm