STANDING COMMITTEE ON ESTIMATES AND FINANCIAL OPERATIONS

2020–21 BUDGET ESTIMATES AND 2019–20 ANNUAL REPORTS

TRANSCRIPT OF EVIDENCE
TAKEN AT PERTH
TUESDAY, 17 NOVEMBER 2020

SESSION THREE
DEPARTMENT OF HEALTH

Members
Hon Alanna Clohesy (Chair)
Hon Tjorn Sibma (Deputy Chair)
Hon Diane Evers
Hon Aaron Stonehouse
Hon Colin Tincknell

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Hearing commenced at 1.00 pm

Hon ALANNA CLOHESY
Parliamentary Secretary to the Minister for Health, examined:

Dr DAVID RUSSELL-WEISZ
Director General, examined:

Dr ANDREW ROBERTSON
WA Chief Health Officer, examined:

Dr ROBYN LAWRENCE
Deputy Chief Health Officer, Clinical Services, examined:

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

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

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

Mr JOE BOYLE
Chief Executive, PathWest Laboratory Medicine WA, examined:

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

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

Mr ROBERT TOMS
Chief Executive, Health Support Services, examined:

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

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

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

The DEPUTY CHAIR: Good afternoon, ladies and gentlemen. Welcome to the health hearings, which will take place between now and 4.30 pm. We will have a brief adjournment probably at around 2.30 pm—we will play it by ear—for comfort for around 15 minutes.

On behalf of the Legislative Council Standing Committee on Estimates and Financial Operations, I welcome you to today's hearing. Have the witnesses read, understood and signed the document titled "Information for Witnesses"?

The WITNESSES: Yes.

The DEPUTY CHAIR: It is essential that all your testimony before the committee is complete and truthful to the best of your knowledge. This hearing is being recorded by Hansard and a transcript of your evidence will be provided to you. It is also being broadcast live on the Parliament's website. The hearing is being held in public although there is discretion available to the committee to hear evidence in private. If for some reason you wish to make a confidential statement during today's proceedings, you should request that the evidence be taken in closed session before answering the question.

Members, this applies to you: this is a combination of the annual reports and budget estimates hearings, so before asking your questions, I ask that you identify whether it relates to the budget papers or the annual report and provide the relevant page number.

Parliamentary secretary, would you like to make a brief opening statement of no more than two minutes?

Hon ALANNA CLOHESY: No, that is fine.

Hon NICK GOIRAN: Parliamentary secretary, during, the reporting period 2019–20, what was the typical frequency of communication between the Chief Health Officer and the Premier in the first half of that reporting period?

Hon ALANNA CLOHESY: Honourable member, that information is not contained in any of the documents that I have for either the budget or the annual report. The best we can do is an estimate. I will ask the director general to answer that.

Dr RUSSELL-WEISZ: Through the parliamentary secretary, there have been briefings—obviously, the State Disaster Council ones—but also verbal briefings between the Minister for Health, the Chief Health Officer, myself and the Commissioner of Police on a reasonably regular basis since probably the end of February. If you want the exact details, some of those are verbal, some of those are in person and some of those are, obviously, when the State Disaster Council meets. Maybe Dr Robertson can go further. Obviously, there are written briefings between Dr Robertson, the Minister for Health and the Premier.

Hon NICK GOIRAN: Before any other witnesses answers the question, I think we need to make it clear what the question is. I am asking about the typical frequency of communication between the Premier and the Chief Health Officer in the first half of the reporting period of 2019–20, which is plainly before the COVID-19 pandemic began.

Hon ALANNA CLOHESY: Dr Robertson will make an estimation.

Dr ROBERTSON: Through the parliamentary secretary, during that period, it was probably infrequent. There would have been a couple of occasions when I was involved in a briefing of the Premier as part of other projects in the public health area.

Hon NICK GOIRAN: Thank you. To what degree did that frequency change in the second half of the reporting period?

Hon ALANNA CLOHESY: Again, honourable member, that information is not readily available. We did not come prepared for it. It is not contained in the budget papers or the annual report. The best we can do is an estimation.

Hon NICK GOIRAN: I am very happy with an estimate.

Hon ALANNA CLOHESY: Dr Robertson, do you have an estimation of that?

Dr ROBERTSON: Through the parliamentary secretary, the estimation would be based on the same as what the director general has said. There were a number of involvements through the State Disaster Council through regular weekly and daily meetings. The number of those meetings has changed over time. There was also contact through teleconferences, as required, depending on the circumstances. I have not got an exact number that I can give.

Hon NICK GOIRAN: Is it fair to say that the frequency was substantially increased during the second half of the reporting period?

Hon ALANNA CLOHESY: Yes, it would be fair to say that.

Hon NICK GOIRAN: The question I have then for the parliamentary secretary is: why was no communication tabled between the Premier and the Chief Health Officer for the period 13 October to 20 October?

Hon ALANNA CLOHESY: I cannot answer the question with any amount of confidence because I have not seen any of the documentation that relates to meetings. I would have to look at the question again to see whether the question actually required information about verbal meetings or whether the question actually involved information from teleconferences or other mechanisms.

Hon NICK GOIRAN: Fair enough. Did the Chief Health Officer have any communication with the Premier in the period 13 October to 20 October 2020?

Hon ALANNA CLOHESY: We will ask the Chief Health Officer.

[1.10 pm]

Dr ROBERTSON: Through the parliamentary secretary, over that period, yes, there would have been a number of meetings that I attended with the Premier and provided updates at those meetings. Having seen this question being raised previously, I did not receive any correspondence from the Premier during that period, but there would have been meetings, as I have outlined.

Hon NICK GOIRAN: So no correspondence between the Premier and the Chief Health Officer between the period 13 October and 20 October?

Hon ALANNA CLOHESY: That would actually need to be checked because, as I said, these are estimations. We have not come prepared with that type of information, so to give a definitive answer would not be possible. It is an estimation.

Dr ROBERTSON: Through the parliamentary secretary, we have looked at what emails have been received during that period. I believe that they have come to the Legislative Council, but we have not been asked what correspondence I may have provided to the Premier or the minister during that period.

Hon NICK GOIRAN: So you have only been asked to provide the emails that you received during that period of time; you have not been asked to provide correspondence that you have provided to the Premier during that period?

Hon ALANNA CLOHESY: I cannot actually recall the substance of the motion and therefore the substance of what information was provided, because the information that was provided was a

substantial amount. Let me see whether we have anything about that. We do not have that information with us, so we cannot give an accurate and reliable answer.

Hon NICK GOIRAN: Parliamentary secretary, I think the Chief Health Officer knows what he has been asked and what he has not been asked. I am just clarifying the evidence that he has just provided to the committee. I understood him to indicate that he has provided documentation—being emails—that has been received by his office during the period 13 October to 20 October. That is not in dispute. The question I have is: has he been asked to provide communications—correspondence, emails—that he provided to the Premier's office during that period of time?

Hon ALANNA CLOHESY: Dr Robertson.

Dr ROBERTSON: Through the parliamentary secretary, I am not aware of being asked for that. As far as I am aware, the request was for information that I had received from the Premier and other parties, not for information I may have provided to those parties.

Hon NICK GOIRAN: Okay. That is very significant and I thank you for that. It is not a criticism of you, Chief Health Officer, but obviously the request that has been made to you is very erroneous. That said, can the witness indicate whether there were any verbal communications between him and the Premier in that same period of time?

Hon ALANNA CLOHESY: Again, this is requiring the Chief Health Officer to rely on his memory in a very significant and busy period of time, so the best we can do is an estimation. Dr Robertson.

Hon NICK GOIRAN: That is all right; it was a very high profile week. I have every confidence that the recollection will be accurate.

Hon ALANNA CLOHESY: Thank you, member. Dr Robertson.

Dr ROBERTSON: As highlighted with the meetings during that period, there would have been discussions at those meetings. I would have to check the exact details of what documents or advice I provided.

Hon NICK GOIRAN: Chief Health Officer, is it normally your ordinary custom and practice to keep notes of conversations that you have with the Premier of Western Australia?

Dr ROBERTSON: Through the parliamentary secretary, I generally keep notes of all conversations that I have.

Hon NICK GOIRAN: Are they kept in the form of a diary or some other manifest?

Dr ROBERTSON: They are generally kept in the form of a diary.

Hon NICK GOIRAN: And you have not been asked by the government to provide copies of those diary notes?

Dr ROBERTSON: No, I have not.

Hon NICK GOIRAN: Thank you very much. Deputy Chair, if I still have time in accordance to my allocation, I want to refer to division 23, part 5, paragraph 3 at page 312 of the 2020–21 budget papers and the impact of the COVID-19 pandemic in WA. My question is: was the extension of the emergency period under the Residential Tenancies (COVID-19 Response) Act 2020 and the Commercial Tenancies (COVID-19 Response) Act 2020 based on the advice of the WA Chief Health Officer?

Hon ALANNA CLOHESY: Member, could you give the reference again, please?

Hon NICK GOIRAN: Division 23, part 5, paragraph 3 at page 312.

Hon ALANNA CLOHESY: The reference you have given does not seem to bear much resemblance to your question. Would you like to repeat your question again?

The DEPUTY CHAIR: If I might intercede to assist, I think the member is clearly referencing paragraph 3 at the bottom of page 312.

Hon ALANNA CLOHESY: I have that reference, but there just does not seem to be a correlation between the question and the reference, so I am just asking the member to repeat the question so that we can provide a full answer.

Hon NICK GOIRAN: Was the extension of the emergency period under the Residential Tenancies (COVID-19 Response) Act 2020 and the Commercial Tenancies (COVID-19 Response) Act 2020 based on the advice of the WA Chief Health Officer?

Hon ALANNA CLOHESY: We are not aware of any specific advice, but we would need to go back and check because, as you might imagine, there is a significant volume of advice around both legislation and other public health decisions. Whether the detail of that advice was provided, we would need to check, so we would be happy to take that as supplementary.

[*Supplementary Information No C1*.]

Hon NICK GOIRAN: Thank you. Parliamentary secretary, I refer to division 23, part 5, paragraphs 25 and 26 on page 315 and in particular the statement at paragraph 25 —

> Addressing the inequity of health outcomes and healthcare access for rural populations is a key priority for WA Health, …

And further, at paragraph 26, where it states —

> The Sustainable Health Review places importance on providing services closer to home and recognising the population-based needs of rural communities.

My question is: is the department aware of the impact that the government's hard border closure has had on the Ord Valley Aboriginal Health Service and the inability of Aboriginal patients to access health services, including palliative care services, in neighbouring regional centres in the Northern Territory while the policy was in place?

Hon ALANNA CLOHESY: There are two parts of that question. I will ask the director general to answer some part and provide the context and we might then pass to the chief executive of the WA Country Health Service. We will start with the director general.

Dr RUSSELL-WEISZ: Thank you. Through the parliamentary secretary, certainly this whole pandemic has caused impacts to rural and remote communities and also metropolitan communities. We have seen some outstanding responses from the metropolitan areas to assist our rural and regional colleagues, not just in Aboriginal medical services, but right across rural and remote WA. We also saw that in how we responded to assisting Victoria. Obviously, there has been a slowing of the ability to recruit medical practitioners and other practitioners who normally would come in from the eastern states or internationally. We have seen that in rural and remote areas and we have seen that again in our metropolitan area because of the difficulties of bringing junior doctors in. The actual pandemic has caused this for WA and our whole state health incident control response not only has responded to the pandemic, but also is constantly making sure that our services—not just our services, but other services—are fit for purpose. But there have been some challenges, and Jeff may want to comment further, specifically in relation to the Ord Valley Aboriginal Health Service.

[1.20 pm]

Mr MOFFET: Through the parliamentary secretary, in terms of the specific question, I am not aware of any specific or ongoing issue in relation to access to palliative care for OVAHS in the East Kimberley. During the COVID period—in fact, during 2019–20 generally—we have expanded our palliative care services consistent with the palliative care program investment right across country WA, including in the Kimberley. I am not aware of any specific cross-border issue. I imagine issues may have arisen, but nothing has been brought to my attention specifically. Obviously, there is quite some distance between Timber Creek, for example, which is one of the closest communities, and Kununurra. I guess if there is any specific detail, we would probably have to take that specifically on notice.

Hon NICK GOIRAN: Is it frequently the case that Western Australians are seeking health services from the Northern Territory?

Mr MOFFET: We do have an arrangement in terms of access to health care for urgent conditions with Royal Darwin Hospital and the Northern Territory health system, so for time-critical conditions that Darwin is able to assist with, we do transfer patients to Royal Darwin Hospital, and we have had a purchasing arrangement—in fact, we maintain a purchasing arrangement and agreement with Royal Darwin Hospital. There are times also when patients choose to access chemotherapy or other programs where they may have family or social arrangements that are more connected to Darwin than, for example, to Perth, so Western Australians do access services cross border in the same way that some Territorians will access cross-border services with us in the WA Country Health Service.

Hon NICK GOIRAN: Is that arrangement documented in writing?

Mr MOFFET: The arrangement with Royal Darwin Hospital is subject to an agreement; yes, that is something we review annually and manage. We manage that month in, month out. The cross-border arrangements are generic arrangements through the National Health Reform Agreement and the pricing and purchasing authorities, and that involves activity and financial adjustments each and every year. That is managed between departments' jurisdictions.

Hon NICK GOIRAN: Parliamentary secretary, could you take on notice and have tabled the latest version of the arrangement?

Hon ALANNA CLOHESY: Yes, we can take that, Deputy Chair.

[*Supplementary Information No C2*.]

Hon NICK GOIRAN: I refer to division 23, part 5, "Spending Changes", "New Initiatives", line 5, "End of life choices—Palliative Care Services and Project Implementation" on page 312. What does end-of-life choices palliative care services and project implementation refer to and what services will this funding be used to provide?

Hon ALANNA CLOHESY: I will pass that to Dr James Williamson.

Dr WILLIAMSON: There have been a number of tranches of funding that have been announced for palliative care funding and end-of-life initiatives. Forty-one million dollars was part of the 2019–20 budget and that included $30 million for the establishment and expansion of palliative care service across WA, including country health regions care provided by multidisciplinary palliative care teams, and that includes $3 million towards telehealth services. There was some capital funding for the 38-bed aged-care and palliative care facility in Carnarvon—$5 million was allocated to that—and there was some project funding to progress the implementation of the joint select committee report recommendations, and that is $5.8 million. Would you like further information on that specific $5.8 million?

Hon NICK GOIRAN: I am intrigued, Dr Williamson, that you referred to the 38-bed facility in Carnarvon. Five million dollars for a 38-bed facility —

Dr WILLIAMSON: No, that was the contribution from that budget. The total cost is estimated to be around $16.6 million.

Hon NICK GOIRAN: So the $5 million is being contributed from a palliative care services and project implementation bucket of money—$5 million for a 38-bed facility in Carnarvon. How many palliative care beds are there going to be in that 38-bed facility?

Dr WILLIAMSON: Two.

Hon NICK GOIRAN: So the $5 million is for the two beds or the 38 beds?

Dr WILLIAMSON: Two.

Hon NICK GOIRAN: Five million dollars for two beds?

Dr WILLIAMSON: No, hang on a second. That is just part of the contribution to the total cost of providing the service.

Hon ALANNA CLOHESY: I think the director general has some additional information in relation to that.

Dr RUSSELL-WEISZ: We can to turn to Jeff, parliamentary secretary.

Hon ALANNA CLOHESY: Mr Moffet has some additional information in relation to that.

Mr MOFFET: Dr Williamson is correct. The facility has 38 beds, two of which will be allocated to palliative care. They have been specifically designed with obviously sleepover facilities and amenities to accommodate family and outdoor courtyards and separate access, so they are a high-level amenity, if you like, to cater for families and access requirements in relation to palliative care. Equally, they back on to other upgrades to the facilities around common areas rooms, laundry improvement, digital improvement as well. There are the two rooms, but there are the associated amenities in relation to those rooms as well as the general improvements that will be achieved through the whole of the capital program.

Hon NICK GOIRAN: But it is $5 million for two beds.

Mr MOFFET: Yes, correct.

Hon NICK GOIRAN: Five million dollars?

Mr MOFFET: Yes.

Hon NICK GOIRAN: It seems extraordinary that $5 million could be spent on two beds.

Hon ALANNA CLOHESY: I think you might have missed the part, honourable member, where Mr Moffet explained the full gamut of capital development that extends further than just the two beds.

Hon NICK GOIRAN: Absolutely, parliamentary secretary, but that has got nothing to do with palliative care. My question is about the spending changes that are listed here, which says "End of Life Choices—Palliative Care Services and Project Implementation". The other 36 beds have nothing to do with that, so if $5 million is being allocated for this Carnarvon facility for two beds, then there is a problem. We cannot seriously be suggesting that WA Health has spent $5 million for two beds—$2.5 million a bed?

Hon ALANNA CLOHESY: No, we are not suggesting that it is limited solely to the beds. You heard what Mr Moffet said in terms of the extent of the capital works that support that.

Hon NICK GOIRAN: So the capital works is being spent on non–palliative care infrastructure.

Hon ALANNA CLOHESY: "That support that" were my words—"That support that".

Hon NICK GOIRAN: What proportion of the $5 million —

Hon ALANNA CLOHESY: What you are insinuating is that the $5 million is for two beds and so conjuring a sense that it is for two beds alone. However, there is significant development that is required around that, including providing accommodation for families to stay—that is an integral part of palliative care—and that requires significant capital development. The director general has additional information

Dr RUSSELL-WEISZ: Thank you. Through the parliamentary secretary, not only is it the expansion in Carnarvon and through the WA Country Health Service region, which I think Mr Moffet referred to, there has also been the 10 palliative care inpatient beds within the North Metropolitan Region, the $9 million expansion of community services in the metropolitan area and rural and remote other regions of $6.3 million, and then enhancing the region and palliative care service governance of $2.5 million. There was additional support in the budget in relation to the end-of-life care program and community awareness and a hotline to improve access and understanding of palliative care in the community, as well as money for enhanced palliative care services in residential aged care, which is matched funding between the commonwealth and the state, a total of $11.4 million There have been other announcements in relation to Kalamunda Hospital as well, which we can answer.

[1.30 pm]

The DEPUTY CHAIR: I have to move to the next member.

Hon NICK GOIRAN: This is my last question, Deputy Chair.

The DEPUTY CHAIR: Very quickly.

Hon NICK GOIRAN: How much did you say was for the 10 beds in Joondalup—was that $6 million?

Dr RUSSELL-WEISZ: For the 10 palliative care beds in the northern metropolitan region, it was $9 million.

The DEPUTY CHAIR: Before I move on, I will make an observation. There is no obligation to answer questions through the parliamentary secretary. You are witnesses in your own right. You provide evidence in your own name.

Hon ALANNA CLOHESY: It is just good manners.

Hon MARTIN ALDRIDGE: Could I go to the questions that I lodged pre-hearing, and in particular question 13 relating to the St John Ambulance contract for emergency ambulance services. I thank you for tabling a document in redacted form. I refer to the note below 13)d), which says —

> The Government is tabling a redacted service agreement. In determining the redactions, consideration was given to: —

It refers to a range of things, including —

> Information that is likely to be sensitive and/or commercial-in-confidence …

Can I ask: firstly, did the government consult with St John Ambulance in terms of the release of the contract, and were they redactions that were requested by St John Ambulance?

Hon ALANNA CLOHESY: The director general will respond to part of that.

Dr RUSSELL-WEISZ: Member, in answer to the first question, yes, we did consult. Obviously, as part of a contract with another provider we would always consult with them if we are going to provide a redacted contract, so there was, from my understanding, consultation. The second question I

would probably have to take on notice—if they asked for them. The Department of Health would have gone through it and looked at those specific areas that needed to be redacted. We would have relied on our decision in relation to that, but I would rather check so that I am completely accurate about whether they asked for specific redactions.

[*Supplementary Information No C3*.]

Hon MARTIN ALDRIDGE: I would like you to be able to clarify: if the redactions were not requested by St John Ambulance, I would be interested to know how the government could uphold a claim of confidentiality on commercial grounds, because it is not the state's commercial interest that is being protected.

Can I ask about section 3 of this contract, which was an attachment in redacted form. It is a section called—I will turn to it. Unfortunately, the large document does not have page numbers, so that is not very helpful. But section 3 of the "Services Agreement between the State of Western Australia and St John Ambulance Western Australia Limited" talks about "Removed Services". And 3.1 talks about "Date for removal of Removed Services". Why would a section that talks about the removal of services be redacted?

Hon ALANNA CLOHESY: The director general can answer.

Dr RUSSELL-WEISZ: I cannot answer exactly why that would be redacted, but, as I have already said, we would either be liaising with St John Ambulance and/or we would actually take advice from our Department of Health legal services about why that may be removed. I do not have in front of me the un-redacted version. But I could answer that more fully if I could take that on notice.

[*Supplementary Information No C4*.]

Hon MARTIN ALDRIDGE: Let me ask this a different way. Redactions to one side, this agreement is for two years, so what services existed prior to this agreement that no longer exist as a result of the agreement?

Hon ALANNA CLOHESY: We have to swap folders, honourable member, to get the detail of that.

Dr RUSSELL-WEISZ: Through the parliamentary secretary, I think the most important thing to say is when you look at these services and where the state has been working, and looking at how best all these services may be provided on behalf of the state, there are three groups of these: there is the emergency patient transport service; low and medium acuity bookings, or P4; and country transfers. This is through the service agreement with St John. Then there is non-emergency inter-hospital patient transport services in the metropolitan area, which is through a panel contract with St John, Wilson and National Patient Transport, which is due to expire in June 2021. Then we have a mental health patient transport service for the provision of specialist community and inter-hospital patient transport services. This was expanded over the last couple of years because it was run on not quite business hours, but we needed to run it over some significantly extended hours. We have actually done a lot of work on what sort of services we require from our transport services, and that is not necessarily St John, but, obviously, they provide the bulk of services.

As I said, on 25 September we signed a variation—we signed a new contract to 30 June 2022. There are certain things that were in the original one. So the original service agreement with St John, the mental health patient transport was in, and also the medium to low planned acuity, or P4, was in. Those ones have now been removed or, not necessarily removed, either St John can provide those or along with somebody else. What we have tried to do is look at what is provided service-wise. It is very different for the provision of emergency transport as opposed to, say, transport for outpatients. I would say that St John's has been working with us very well in making sure that we can get the best service provision.

Hon MARTIN ALDRIDGE: Thank you for that explanation.

Can I now take you to section 4 of the agreement which is a section called "Services to Country WA". Whoever is in charge of the black texta at the Department of Health has got a bit carried away here. Interestingly, if you look at the index, which is found just inside the cover of this agreement, you will see it is not redacted. Section 4.1 talks about a "Reduction in exclusivity in Country WA", which is redacted in the body of the agreement. I am wondering whether you could enlighten us with respect to the exclusivity in country WA, which is being reduced?

Dr RUSSELL-WEISZ: Again, member, I cannot talk to why that would have been redacted; we would have taken advice. But we can talk about the exclusivity—that this gives choice for the country health service and it is just making sure that we have the ability to provide services to country WA, whether they be from St John's or not. I may ask Mr Moffet to make some comment about why we have done this. We work very closely with the WA Country Health Service, the Department of Health, and with the holder of the contract. The WA Country Health Service, as we have said here today, has some significant challenges. In reviewing the St John's contract, we wanted to make sure that anything we did provided better services. Actually, St John's has provided a very good service over many years, but sometimes it might not have been St John's that actually was the quickest to respond, or we just wanted an ability to go with somebody else.

[1.40 pm]

Hon ALANNA CLOHESY: Mr Moffet is going to continue.

Mr MOFFET: Just in terms of exclusivity, one of the prominent issues that came up during the consultations through the development of the "Country Ambulance Strategy", from health services but also volunteers in particular alike, was the increasing and challenging demand for inter-hospital transfers, particularly in inner regional Western Australia—the midwest, wheatbelt and south west, and to some extent the great southern as well. I guess through the process of the review it was identified that that was a significant challenge in a service that really needed some increased investment and better measurement and definition, so one of the recommendations was actually to define the services separately—the immediate primary emergency response versus the inter-hospital transfer response, which is generally being purchased by the WA Country Health Service. That was accepted as part of the recommendations.

We have commenced discussions, and in fact have been for some time, with St Johns, around the intent of this provision. There are a number of intents. The primary one is that the clinical requirements of the patient are the predominant factor in determining transport availability and transport logistics coordination—it is not just the availability of assets from St Johns alone; there would be choices. For example, in relation to Northam, Bunbury, many of the surrounding districts and towns in the wheatbelt and south west, and even as far afield as Geraldton and some of the midwest towns, often in the past, and it is still currently the case, accessing a secondary inter-hospital patient transport depends on the availability of volunteers and whether a crew has already been dispatched on a primary call. Often, the clinical condition of the patient is not the determining factor in the timing of that transfer. Sometimes, that obviously impacts clinical outcomes; other times, we need to use RFDS fixed-wing or rotary resources to supplement that, but that is obviously not ideal as that involves further delay as well. I do not have the specific provision in the contract to refer to, but the intention of that provision is really to progressively move away from exclusivity so that in certain circumstances, where the clinical condition of the patient requires more urgent transport than can be provided by St Johns, an alternate provider can be sourced. This is very similar to the way in which our air and medical transport contract with RFDS operates as well.

The second element that is probably worth mentioning is that a number of the subcentres also were very concerned about the after-hours workload around inter-hospital transfers and much preferred an alternate option, whether that was state provided or an alternate provider. Some subcentres are very happy with the revenue that gets generated through inter-hospital transfers; others are very unhappy because it draws volunteers away from their small towns for hours and in fact sometimes a day at a time for the long-haul transfers. I suspect some subcentres would far rather see alternate options in place as well. That was the feedback during the consultation process.

Hon MARTIN ALDRIDGE: Mr Deputy Chair, how long have I got left?

The DEPUTY CHAIR: Approximately 12 minutes.

Hon MARTIN ALDRIDGE: Can I just finish on this topic with a couple of questions. At 4.2 of the agreement, it talks about $5 million in annual funding to the country WA ambulance service. I assume that is an ongoing arrangement, or is that $5 million more than is ordinarily the case? What services are provided to country WA ambulance services from the $5 million per annum in funding?

Dr RUSSELL-WEISZ: If I can, I will just put this into some context in terms of what we have done with the contract, and I will then ask Mr Moffet to talk about the $5 million. It has been a historical contract, so it has been on a base funding model for many years. Health funding has changed significantly. We fund hospitals through activity-based funding. We are much more robust in the way we fund health services. We work with St Johns ultimately, in the deed of variation, to adjust it for demand growth and to have a much better pricing mechanism, so that both ourselves and St Johns could measure, one, performance, and also they would have a much better avenue, if their demand went up, to be funded for that. So there has been a movement in the deed of variation, which takes us to 30 June 2022, and there is better transparency of, one, their performance, and the way we fund them. We hope that post June 2022, this will get even better as we refine the contract further. We did recognise that there needed to be specific additional funding to the base funding for WA Country Health Service with St Johns. Mr Moffet will talk about this, but this will be worked out with them. It is $5 million, so it is a start. We would see this, one, as ongoing, and potentially even increased if there were specific areas within the country that needed to be funded separately from the base metropolitan contract.

Hon ALANNA CLOHESY: Mr Moffet will round that out.

Mr MOFFET: The $10 million over two years—that is $5 million a year—is currently being negotiated with St John Ambulance. We have been in discussions with them for several months now. Essentially, it will support the recommendations of the "Country Ambulance Strategy". The factors that are being considered are really those volunteer subcentres where response times are challenging and where service continuity data demonstrates that, over time, service continuity is also a challenge. Areas like the Murchison and the eastern wheatbelt, for example, are currently subject to some investment attention, so it is likely we will invest in those areas. Similarly, in some of the paid regional centres, such as Bunbury and Kalgoorlie, we know that the response times are being challenged and their ability to support and service the region has diminished over time as the urban workload in those city centres actually draws on the local team, so it is likely that we will invest in sites such as Kalgoorlie and Bunbury as well. That will be about, I guess, both having more professional crews—"professional" as in paid paramedic crews in places like Bunbury—and potentially having an increase in after-hours and weekend response requirements in both Kalgoorlie and Bunbury. There are other sites that we are talking about with St Johns in terms of investment. I think the key point is that we have gone through a really collaborative modelling, data-analysis approach with St John Ambulance and we are looking very close to getting agreement on where the

right investment of that $5 million over two years will be. It is likely that not all of the $5 million will be this year; some of it will be next year as well.

Hon MARTIN ALDRIDGE: Is it fair to say that this $5 million is new money arising from this agreement, or is it a rolling over of the existing arrangements whereby, the year before this, there was a $5 million allocation and then WACHS and SJA worked out the nuts and bolts thereafter? Is it just a continuation of that arrangement or is this actually new money to enhance St John Ambulance?

Mr MOFFET: It is absolutely new money. We are really pleased to see new money arriving to really commence the implementation of the strategy. That complements the announcement of the $9.2 million for the Kimberley ambulance service and WA Country Health Service in investing in the Kimberley as well. There is a combination of funding avenues that are brand new that have not previously been funded.

Hon MARTIN ALDRIDGE: Thank you. I think it is fair to say that just about every agency in the state, if not in Australia, that is involved in a frontline response to COVID-19 has had some sort of budgetary pressures, which have been alleviated by additional appropriations. Given that we are the only state that does not run a state-run ambulance service, what additional budgetary allocation has been allocated to St John Ambulance to deal with the COVID-19 response?

Dr RUSSELL-WEISZ: I would have to get you the actual amount on notice. We work with a lot of partners in relation to the COVID response. Obviously, the commonwealth and the state have funded us for additional expenditure in relation to COVID, primarily PPE. But I believe, going back a few months, there was an allocation made to St Johns when they had those pressures, like everybody did with COVID. I would be very happy to provide the actual amount on notice.

[*Supplementary Information No C5.*]

[1.50 pm]

Hon MARTIN ALDRIDGE: Parliamentary secretary, before I move on to another issue, can I seek an assurance from you, particularly given the standing committee's interest in section 82 notifications to the Auditor General, that on the redactions contained in the services agreement provided to the standing committee, the government will provide a section 82 notification to both houses of Parliament?

Hon ALANNA CLOHESY: Thanks, honourable member. I am glad you noticed my strong and ongoing concern for the provision of information to Parliament over many years. I, as a representative, am unable to provide a specific commitment on behalf of the minister. However, you can rest assured that information that is to be provided to Parliament will be provided and, if not, a relevant explanation will be provided. Also, taking into account the director general, through me, has provided an undertaking to provide some background information on why some sections from the agreement may have been deleted.

Hon NICK GOIRAN: It is the diary notes of the Chief Health Officer with the Premier. They would like to keep those secret.

The DEPUTY CHAIR: Member, you have another four minutes.

Hon MARTIN ALDRIDGE: Thanks, Mr Deputy Chair. I now return to a different line of questioning; this time it is Mark McGowan's fresh idea 120—otherwise known as urgent care clinics. When will the government establish an urgent care clinic in Albany, Bunbury, Kalgoorlie, Geraldton, the Kimberley, the Pilbara and Collie–Preston as committed to at the last election?

Hon ALANNA CLOHESY: Do you have a reference to the budget or to the annual report, honourable member?

Hon MARTIN ALDRIDGE: It is page 315 of budget paper No 2 at paragraph 23.2.

Hon ALANNA CLOHESY: Thanks, honourable member. Planning has resumed and is continuing around the development of UCCs in regional areas. I know that you have asked a number of questions in Parliament about this. The responses that you have received are about the issues around local fit-for-purpose models of care that need to be considered before implementation. The priority regional areas for further consideration for UCCs in an appropriate fit-for-purpose model are those that you have listed. Some of the issues in relation to the delay have included, of course, COVID-19 and the need to reconfigure a range of services, as well as working in collaboration with the WA Primary Health Alliance and the time it has taken to do that necessarily, as well as border closures and resourcing limitations. They are all some of the factors that have contributed to that. I will ask Mr Moffet if there is anything else he would like to contribute.

Mr MOFFET: Could we perhaps refer it to Dr Williamson.

Hon ALANNA CLOHESY: We will go to Dr Williamson.

Dr WILLIAMSON: Thank you. Yes, I can provide a bit of an update. We have obviously been delayed for the reasons the parliamentary secretary identified; nevertheless, we have reinstituted discussions with those various areas that you mentioned. I think what has become clear is that the model that we have in the metropolitan area for urgent care clinics is not necessarily a good fit in some of these regional areas, although of course we have some practices in the Bunbury region already onboard. We have about 130 practices onboard, including a number in the Bunbury region.

I understand recently we are in the process of onboarding two practices in the Collie–Preston region. With respect to Kalgoorlie, we have had fairly extensive discussions there and have identified that the main need, the main waiting list in primary care and the main problems in primary care that we could potentially help with, relate dermatology and skin infections. We are in the process of establishing a teledermatology service to begin to address some of those urgent needs. I think everything gets back to that point of trying to co-design what the service might look like in some of these regional areas and really begin to address the urgent needs that they have there.

Hon MARTIN ALDRIDGE: Dr Williamson, given we are approaching the end of this four-year parliamentary term and this was an election commitment, what time frame is the department working to in terms of implementing an urgent care clinic of some form at the committed sites?

Hon ALANNA CLOHESY: Just before that, Dr Williamson is unable to talk to election commitments, and I think that that is a bit unfair. The department has a range of priorities and he has already highlighted some of the reasons for the rolling out of this service model. Is there anything else, Dr Williamson, that you want to contribute?

Dr WILLIAMSON: Not really.

Hon ALISON XAMON: Parliamentary secretary, I wanted to ask some specific questions about the status of the health networks, but I cannot find a specific line item, so I am going to refer to part 5 of division 23 and general appropriations. Which health networks are still in existence and which health networks, if any, have folded in the last financial year or the previous year? Can I have a list of those health networks that are still in existence, please?

Hon ALANNA CLOHESY: I will ask Dr Williamson to answer that.

Dr WILLIAMSON: You may be aware that we have recently been reviewing the health networks, really to align their work with the recommendations of the sustainable health review. We have

established a number of themes to do with, say, families, ageing, complex care, mental health obviously, and end of life. Those are the themes. Within those, we have a number of networks. For instance, women and children is going to continue, youth is going to continue and cancer is going to continue. We are going to establish an aged-care network, or care of the elderly network. The mental health network and its subnetworks will continue, but they are under the Mental Health Commission.

Hon ALISON XAMON: Can I just get clarification on that? I understand the Mental Health Commission auspices those. Is the health department still partially funding the mental health network; and, if so, how much, please?

Dr WILLIAMSON: Yes. We pay for, I think, two sessions per fortnight of one of the co-leads, but to be absolutely accurate, I would have to check.

Hon ALANNA CLOHESY: Honourable member, we will take that on notice to get an accurate figure on that.

Hon ALISON XAMON: The exact amount, thank you.

[*Supplementary Information No C6*.]

Hon ALISON XAMON: You are continuing with what other networks will be continuing.

Dr WILLIAMSON: At the moment, we are bringing some of the networks together under a given theme. For instance, we are proposing to maintain the diabetes network, we are proposing to maintain the respiratory network and we are proposing to maintain the neurological network. I have mentioned the women and newborns, youth and cancer. I have mentioned mental health and its subnetworks. If I have forgotten one, I would have to go and check and let you know. There have been one or two that have not really been functioning for the past couple of years. The infection and immunity one would be an example, but we believe that a lot of their activities are picked up elsewhere. We have work that is ongoing elsewhere and that is probably a better mechanism for that. With the cardiovascular network, they have been doing some very interesting work at a national level to develop a registry, and that work is continuing under the safety and clinical quality directorate. So, again, their efforts will move towards those sorts of initiatives.

Hon ALISON XAMON: I am happy to take this on notice if need be. Can I have the full list of the health networks that are still continuing? The other part of the question I asked is whether any are no longer continuing. It has been identified that there may be a couple that have become defunct. Can I please have information as to which ones are no longer continuing?

[2.00 pm]

Hon ALANNA CLOHESY: We will provide that as supplementary information.

[*Supplementary Information No C7*.]

Hon ALISON XAMON: As part of that answer, can I please have the actuals that were expended, as well as the projected income for the health networks for both this year and the forward estimates?

Hon ALANNA CLOHESY: We will take all of that in the same question.

Hon ALISON XAMON: Thank you very much.

I turn now to the heading “Spending Changes” on page 311 and the line “Electronic Medical Record System — Planning” under “COVID-19 WA Recovery Plan”. Can the parliamentary secretary please explain whether the concerns identified by the Auditor General back in 2018 regarding electronic records management—for example, business analysis—have already been completed, or if they will be completed as part of this program of work?

Hon ALANNA CLOHESY: The director general will address that question.

Dr RUSSELL-WEISZ: I may have to take the first part about the Auditor General on notice with regard to exactly what we have done; I would rather provide you with a detailed response about what we have done in relation to the Auditor General's —

Hon ALISON XAMON: In that case, if you do not mind, I am actually interested in all the concerns raised by the Auditor General in "Information Systems Audit Report 2018", so if you are going to provide additional information on notice, I would like to have a fulsome answer in relation to the progress of those concerns.

[*Supplementary Information No C8*.]

Dr RUSSELL-WEISZ: The actual electronic medical record was a very welcome decision by government—to start funding in relation to an electronic medical record for the system. It is a journey that many other jurisdictions have been on, and we will learn from those jurisdictions because some have found it very challenging. We have hospitals at different levels of maturity right across the sector, and we have already started work on the electronic medical record and the more global business case that will plot a path over many years for us to actually get an electronic medical record up and running for the system. One of the things we have seen around the world, while these are challenging, is that we do provide better safety and better quality of care with a standard electronic medical record in the system. As I have just said, we do have some hospitals at greater maturity, such as Fiona Stanley Hospital, and some hospitals at lesser maturity, such as Royal Perth Hospital or Sir Charles Gairdner Hospital.

There is a governance committee that has all the chief executives and the department onboard to make sure that no-one is left behind. It would not be the right thing for one or two hospitals to go ahead and get one electronic medical record, and leave the rest behind. One of the things we have learnt is that this is a journey. The big bang approach is not necessarily going to work. We are doing a lot of work at the moment on how we can do this in phases—how we can get it to some of our hospitals that need an upgrade to their infrastructure so that they can take an electronic medical record, as well as rolling out what we already have at some of our hospitals to our other hospitals until we go for a brand-new one. I can assure you, we are looking very much at what has happened in other jurisdictions to make sure we do not make the same mistakes; we learn from them. We have actually had a significant amount of help from Queensland Health because it has been through this. What we have seen from other jurisdictions is that they do have some area health services that have a higher maturity level than others.

What has driven us and driven the team around us is to make sure that we aim for one electronic medical record for the system. That does not mean throwing out what we have done to date. We now have a new radiology system or imaging system being implemented. We have a brand-new pathology information system that has gone live in the last few weeks, and we already have a patient administration system that is reasonably modern and that we would, more than likely, just bolt on because we do not want to replace systems that have done so much work and are actually contemporary.

Hon ALISON XAMON: There are a couple of things. I have noticed that about $8 million has been allocated for this year and for the next year as well. You mentioned a business case. What is that $8 million meant to cover? Is it effectively that investigative activity?

Dr RUSSELL-WEISZ: It does cover the business case, but it actually covers clinical engagement and engagement at the sites. I am probably sounding nervous, because with electronic medical records and anything to do with health and ICT, you have to do it properly. We want to do it really diligently,

and we want to do it with clinicians, so we have asked the health service providers for two clinical reps from each one. These are clinicians on the ground who actually will lead this. We found this in the same way when we commissioned Fiona Stanley Hospital—that we actually needed, in the latter days of commissioning, clinical leads who would drive some of this. It is the preparatory work, and it is actually getting the scoping right. What does it look like? What does the electronic medical record look like in phase 1, phase 2 and phase 3? We have to make sure that we do not over-scope phase 1, or over-promise and under-deliver. The most important thing is we actually get the scope right and we deliver it properly, because the business in the background has to work. We do not want any failures in the business in the background, because an electronic medical record system, whatever we have now, should support good, sound clinical care. That $8 million is for the business case, but there is a lot of work in relation to clinical engagement and research into how we can make this work.

Hon ALISON XAMON: I just have a further question in relation to the scope. Is it anticipated that the scope will go a little further to include, for example, the Mental Health Tribunal and the Chief Mental Health Advocate? You understand the scope of the other agencies that also need to access a lot of this information. At this point, is it simply looking at the way that the hospitals will be talking to each other?

Dr RUSSELL-WEISZ: It is actually looking at them all, but it is going to have to be realistic in what we start with first. One of the things that has come through is that it is not only an electronic medical record that gives the impression of a hospital-based medical record; in very contemporary systems around the world, we want something that goes beyond the hospital. We want it to go into the community, into general practice and primary health care and, as you say, into some of the other critical agencies that oversee health. We will always have that vision that it needs to be as broad as it can be, but not so broad in the initial phases that we lose scope. In health, in the past—I say "health" generally, around the world—if we over-scope, we tend to lose the critical things we need to deliver first. I can assure you we will take it into account, but obviously we also need to take into account what funding we may get in subsequent budgets.

Hon ALISON XAMON: I refer to the line item "Mental Health Patient Transport", again on page 311 under "Spending Changes", "COVID-19 WA Recovery Plan" and "WA Health Initiatives". Why is there no funding for this activity in the 2022–23 forward estimate or will that be funded under a different line item? We have funding allocated for this year and for next year, but nothing after that.

Dr RUSSELL-WEISZ: The mental health patient transport service agreement expires in June 2021. I think I said in an earlier answer that we saw that mental health was specific and we went out for a specific contract with a provider. That is likely to continue. It has been enhanced over the last couple of years. We have enhanced the actual hours this works, so we are doing our best not to retain those patients who have beds in mental health facilities and EDs, and try to move them as quickly as possible, whether it is at seven in the morning or 10 at night.

[2.10 pm]

Yes, there is funding allocated in the budget. I imagine that will continue, but I imagine it will be informed by the contract that we have for our broader emergency services, and I would not want to see this actually then subsumed back into the normal emergency services contract. Mental health patient transport is specific; that is why it has been funded specifically for these two years. Because the service agreement is 2022, with the broader contract we want to look at that, and this is a pilot or was a short-term contract to see how it worked. It is working better than what we had before.

Hon ALISON XAMON: I am not surprised that it is better than what we had before; that is precisely why I was concerned to see that it continues on in the budget. Can I confirm, then, it is the intention

that that specific service will be in maybe next year's forward estimates or something? Because, at the moment, it is not there.

Hon ALANNA CLOHESY: Of course, the director general is unable to answer that because the budget is developed by the executive. But what he has said is that it is a short-term contract with a view to looking at future arrangements. Suffice to say that mental health patient transport is critically important; you understand how important it is and you understand the relationship to patient flow. In order to get it right, we need to take this closer look at it.

Hon ALISON XAMON: I now move to page 315, "Delivering Services to the Community", item 22. There is $80 million allocated for non–hospital health services. I would like to ask, please: how much of that $80 million is earmarked for prevention and promotion programs? That is my first question on that.

Hon ALANNA CLOHESY: Sorry, honourable member; I just did not hear what you said.

Hon ALISON XAMON: Page 315, at the top, point 22, I was asking specifically about the $80 million that has been allocated. What I want to know is how much has been earmarked for prevention and promotion programs specifically. I have other questions about the $80 million as well; I want to know specifically about prevention and promotion at this point.

Hon ALANNA CLOHESY: I will turn to Mr Anderson for an overview or a breakdown of that $80 million.

Mr ANDERSON: Thank you, parliamentary secretary. The breakdown of the $80 million—I am not sure I can answer your question in terms of the preventive health number, but I can give you the breakdown of how that funding has been allocated.

Hon ALISON XAMON: With that $80 million, how much of it is for prevention and promotion and how much is specifically going to community-managed services? I then want to seek a breakdown of which services were receiving that money. I am happy to take that on notice. I also wanted to know whether any of that funding was going to be allocated to community-managed services that are working to reduce the impacts of chronic conditions, specifically for people who have not acquired their condition as a result of lifestyle—for example, things like coeliac disease, type 1 diabetes, neurological conditions and those sorts of things. I am really keen to get a breakdown of that $80 million.

Mr ANDERSON: I can give you the breakdown, if you like.

Hon ALISON XAMON: Yes, please.

Mr ANDERSON: Within the $80 million over the forward estimates, there is $7.5 million for NGHSS contracts. We can give you more detail on that if you would like.

Hon ALISON XAMON: Yes, please. Can I ask that we receive that information?

The DEPUTY CHAIR: I think it is probably easier, member, if we allow Mr Anderson to complete the answer that he had just started to give. That might be a pragmatic way forward.

Hon ALISON XAMON: Thank you.

Mr ANDERSON: Yes. There is approximately $9.3 million for Karlarra House, which is a nursing home up in Port Hedland; there is another $5.5 million for HACC transition in regional areas; there is $6.4 million for renal dialysis services contract increase; and there is another $12.5 million for HACC transition to NDIS—that is the Department of Health's component. There is $4.8 million for Silver Chain high-class consumables; there is $2.7 million for extension of the breast screening services; $6.8 million for seven dental therapy centres—dental operating costs, sorry; and then, lastly, there

is $12 million for ventilator-dependant quadriplegic services. This is a transfer from hospital services into the non-hospital space. That one is not new funding; it is a transition. That comes to, in total, $79.98 million. But we can break down the initial number of the NGHSS contracts that I mentioned. There is also a rebase of about $12.5 million, and we can show you how that works as well.

Hon ALISON XAMON: Yes, please.

[*Supplementary Information No C9.*]

Hon ALISON XAMON: Yes, I am very keen to get that detail, and also, as I said, to specifically know which community-managed health services have received money as well, and how much that is.

The DEPUTY CHAIR: Five minutes, member.

Hon ALISON XAMON: I move to the next part, 22.1. It says that $6.8 million has been allocated for expanding school dental services, and I would like to know what that is going to entail. Does that mean there are going to be more service locations available, or are we talking about expanded delivery at existing locations? That is 22.1 on page 315.

Hon ALANNA CLOHESY: Yes, we are just looking for it. Honourable member, can I just get a clarification: the question is how the school dental services are being expanded?

Hon ALISON XAMON: Paragraph 22.1 talks about $6.8 million going towards expanding the school dental service. What I wanted to ask is: is that simply expanding the level of service at existing locations, or are there going to be additional locations where this expansion is going to occur?

Hon ALANNA CLOHESY: Okay, thank you. The director general will answer that.

Dr RUSSELL-WEISZ: The SDS, or the school dental service, is operated by dental health services within north metro for schoolchildren five to 16 years through a network of dental therapy centres. Obviously, there is population growth, and the $6.8 million was approved to support the expansion of these dental therapy centres across the state. To operate the dental therapy centres, there are usually two full-time equivalents at a current cost of about $95 000 for the 2020–21 financial year. I think north metro is going to work with the department in relation to where these will go.

Hon ALISON XAMON: Sorry; you are saying that we are looking at additional locations for the delivery of the service?

Dr RUSSELL-WEISZ: They are additional locations and also working in relation to the service availability as well. I cannot tell you exactly where the locations are but could potentially provide that on notice.

Hon ALISON XAMON: Can I have that on notice, please?

[*Supplementary Information No C10.*]

Hon ALANNA CLOHESY: Such as they have been working.

The DEPUTY CHAIR: Three minutes.

Hon ALISON XAMON: I have so many questions!

It says at paragraph 22.5 that $7.5 million has been allocated for priority community services contracts. Can I ask what those are and how they are identified?

Hon ALANNA CLOHESY: One more time on the reference, member?

Hon ALISON XAMON: It is 22.5 on page 315. It talks about $7.5 million of increased funding to meet increase in demand for priority community services contracts.

Hon ALANNA CLOHESY: What are they and where are they; is that your question?

Hon ALISON XAMON: I want to know what they are. Actually, specifically, I want to know how they are identified as a priority community service contract. What is the criteria by which that is determined?

Hon ALANNA CLOHESY: Honourable member, it is part of what we were talking about before, the NGHSS, so part of that will be in the answer already from the previous question.

The DEPUTY CHAIR: That will probably be C9, for the record.

Hon ALANNA CLOHESY: It includes Silver Chain and services like that, but you are already getting that list anyway.

Hon ALISON XAMON: Okay, thank you.

Hon ALANNA CLOHESY: In terms of how they are identified in terms of priority, we will take that as a separate supplementary.

Hon ALISON XAMON: How they are determined.

Hon ALANNA CLOHESY: How the priority needs were determined.

Hon ALISON XAMON: Yes; that was my question.

[*Supplementary Information No C11*.]

The DEPUTY CHAIR: One more question, member.

[2.20 pm]

Hon ALISON XAMON: Page 315, item 23.2, $19 million has been allocated for the redevelopment of the ED at Charlies and the behavioural assessment urgent care clinic. What I wanted to ask was: how much of this funding will go toward the behavioural assessment urgent care clinic? I also wanted to know what the maximum capacity of the behavioural assessment urgent care clinic is. Then I just had a couple of other related questions to that particular clinic. It is all part of the one thing.

The DEPUTY CHAIR: You might be out of luck. I know you have come fully stocked with questions.

Hon ALISON XAMON: I am a curious person, Deputy Chair.

Hon ALANNA CLOHESY: I am pretty sure I do not have any information in terms of capacity.

Hon ALISON XAMON: The maximum capacity.

Hon ALANNA CLOHESY: I do not have information here on the capacity. That would be part of the scope of works, which we do not have with us. Let us see if the chief executive of north metro has any further information about the scope of it.

Mr DOLAN: Thank you. We are in the design phase at the moment. We are looking at around seven beds for the behavioural assessment unit. That will require some redesigning of the current emergency department with the observation wards. They will be co-located between the observation wards and the behavioural assessment unit.

Hon ALISON XAMON: That was part of my question. I wanted to know whether the ED and the behavioural assessment urgent care clinic were going to be sharing a waiting space at all. Will they be sharing a waiting space?

Mr DOLAN: No. The behavioural assessment unit will have a separate entrance and process to the general.

Hon ALISON XAMON: Okay.

The DEPUTY CHAIR: We might, ladies and gentlemen, take a brief adjournment for 15 minutes at this point and reconvene at around 2.35 pm.

Hon ALISON XAMON: Deputy Chair, could I just ask —

The DEPUTY CHAIR: No, that is it; we are adjourned.

Hon ALISON XAMON: I just wanted ask whether that was on notice.

The DEPUTY CHAIR: Member, we are adjourned. We can raise that after.

Hearing suspended from 2.22 to 2.36 pm

The DEPUTY CHAIR: I will use this opportunity, at the chair's discretion, to give myself the call for around 20 minutes. My questions pertain to information presented on page 313 of budget paper No 2, volume 1, and specifically paragraphs 5 through 10 concerning "COVID-19 — From Response to Recovery". I note that this is obviously a live issue in every respect, and that in particular at paragraph 9.1 we have an $80 million provision set aside to the end of this year for COVID-19 readiness activities, and I would like to ask some questions about readiness generally. I might just ask a question of clarification. At paragraphs 5.1 and 5.2 we have reference to the establishment of a State Health Incident Coordination Centre and the establishment of a Public Health Emergency Operations Centre. Can I ask, in relation to the last few days in South Australia, when that community outbreak was detected, and through which of those organisations was the information conveyed?

Dr RUSSELL-WEISZ: If I may, I might pass directly to Dr Robin Lawrence, and I might come back and add anything at the end.

Dr LAWRENCE: The information was originally picked up actually via the mainstream media channels at approximately 2.15 on Saturday[1] afternoon, at which point I immediately contacted Dr Robertson and ensured that he was aware of the information. From there, it then worked through the usual processes, which included both PHEOC and SHICC and, I assume, up through the State Emergency Coordinator and through that mechanism as well.

The DEPUTY CHAIR: Thank you, Dr Lawrence. Post that very assiduous monitoring of mainstream media, was there anything confirmed officially from the South Australian government or the commonwealth government to either yourself, Dr Robertson or Dr Russel-Weisz to confirm those reports?

Dr LAWRENCE: I am not aware of anything formally coming into SHICC on Sunday afternoon, but I think Dr Robertson will have more to add.

Dr ROBERTSON: On Sunday afternoon, after receiving that, I talked to the Chief Health Officer from South Australia who confirmed the details of the outbreak, and subsequently there have been discussions at a national level on a daily basis through the Australian Health Protection Principal Committee.

[2.40 pm]

The DEPUTY CHAIR: Following up this process, Dr Robertson, if you do not mind—it is just for the record—I presume at some point after these conversations with your counterpart in South Australia and your consultation with other colleagues nationally, you drafted some formal advice to the government as to the most appropriate response or set of responses?

Dr ROBERTSON: Yes, I did. I provided advice, initially verbally, to the police commissioner, who is the State Emergency Coordinator, and to the Minister for Health, as to my recommendations for

[1] A letter of clarification about this part of the transcript can be accessed on the committee webpage.

the next steps, to which the SEC agreed, and as of three o'clock that afternoon, he issued verbal directions requiring quarantining and testing for those people arriving on the three o'clock flight.

The DEPUTY CHAIR: Dr Robertson, just to confirm, you provided verbal advice to both the police commissioner and the Minister for Health on the Sunday afternoon. I want to be assiduous with presenting the advice that you provided in absolutely accurate terms. Did you provide advice to the police commissioner and the Minister for Health to re-establish a hard border with South Australia or was that a determination made by the police commissioner, the Minister for Health or the Premier?

Dr ROBERTSON: I recommended to the police commissioner that we re-establish further controls on South Australia for the border. The directions are issued by the police commissioner under the Emergency Management Act.

The DEPUTY CHAIR: Dr Robertson, did you subsequently confirm those verbal discussions via a written note of any sort?

Dr ROBERTSON: I believe I did. I would have to check that. It was fairly busy at that stage but I believe I did provide some further advice to the police commissioner that afternoon.[2]

Hon TJORN SIBMA: Could I confirm, sir, that you cannot recall specifically the contents of that written note but, to the best of your recollection, that is what you did, and did you provide it to the police commissioner solely or to the police commissioner and the Minister for Health?

Dr ROBERTSON: I think initially it was to the police commissioner and obviously it would also have been copied to the Minister for Health and his staff.

The DEPUTY CHAIR: Dr Robertson, did you have any direct dialogue on this specific matter, written or verbal, with either the Premier or the Premier's office or was this done through the police commissioner and the Minister for Health's office?

Dr ROBERTSON: We had a meeting that was held that afternoon that was called at short notice, which involved the minister, the Premier, myself and the SEC.

The DEPUTY CHAIR: Were the contents of your briefing note the subject matter of that meeting?

Dr ROBERTSON: Yes.

Hon ALANNA CLOHESY: I do not think the Chief Health Officer indicated he provided a briefing note. He indicated that he may have provided some written information in the form of an email.

The DEPUTY CHAIR: In the form of an email?

Dr ROBERTSON: Yes.

The DEPUTY CHAIR: That was not advice provided by Dr Robertson.

Hon ALANNA CLOHESY: Yes, it was.

Dr ROBERTSON: To clarify that, it was not written advice in the form of a letter. It would have been —

The DEPUTY CHAIR: A quick email note?

Dr ROBERTSON: Yes.

Hon ALANNA CLOHESY: Honourable member, if you want a copy of that.

The DEPUTY CHAIR: Yes, that is just where I am about to lead. Would you be able to provide a copy of that email correspondence, Dr Robertson?

[2] A letter of clarification about this part of the transcript can be accessed on the committee webpage.

Hon ALANNA CLOHESY: Keeping in mind that Dr Robertson is not 100 per cent sure what mechanism he used to provide the information in the afternoon, identifying that it was a significantly busy afternoon, we will undertake to provide what information is available.

The DEPUTY CHAIR: Parliamentary secretary, would you be able to undertake that commitment before the close of business today, considering that this is a contemporary matter and this correspondence has occurred within the last 48 hours?

Hon ALANNA CLOHESY: I am unsure of the mechanisms that are available to me to provide that information before the close of business, which you might know is about two hours away. As I said, the Chief Health Officer has not been able to confirm the form of the information that was provided. So if he is not able to confirm the form of the information that was provided, we will ask somebody to look for it now but I cannot guarantee that it will be provided to you before this session is over and in time for you to make the news cycle.

The DEPUTY CHAIR: I am not intending to do so. The reason for my interest is that it is a significant—I am not connoting policy decisions to witnesses here, but obviously it is a contemporary issue, it has obviously elicited significant public commentary and feedback, notwithstanding we just opened the border in the 36-hour period before it was closed again to a particular state. I am just trying to understand the process by which significant decisions are made by government and the evidence upon which it relies, which has been a feature of discussion in this chamber for the last seven months, as the parliamentary secretary would be well aware.

On to issues concerning readiness, however, I just want to concentrate on two dimensions if I might. Earlier today we had the Water Corporation in, who were unfortunately not in a position to provide much in the way of any useful advice about wastewater testing for COVID-19. I would just like to establish, please, which agency is directing the traffic with respect to COVID-19 wastewater treating and when that process actually commenced. I understand that it began last week. Can I confirm that my understanding of these facts is accurate?

Hon ALANNA CLOHESY: I will ask Dr Robertson to answer that.

Dr ROBERTSON: The testing is a collaboration between the Department of Health, PathWest, our pathology service, and the Water Corporation. This was initially part of a research project called ColoSSoS. The Water Corporation has been working with us to store samples since April but on Friday, 30 October, we commenced testing. Basically, we have been validating the testing methods in readiness for broader testing to commence.

The DEPUTY CHAIR: Dr Robertson, were those tests that commenced on Friday, 30 October, conducted by PathWest?

Dr ROBERTSON: That is correct.

The DEPUTY CHAIR: That was testing of samples taken in April?

Dr ROBERTSON: Over a period of time since April. Sorry, I am not sure if they were weekly. They are samples that were taken between April and October.

The DEPUTY CHAIR: I am referring here to a statement put out last Wednesday by the Minister for Health. Just to understand whether or not there has been an acceleration in the wastewater testing protocol, can I understand—the title of this document is "Wastewater testing underway to boost COVID-19 surveillance". The first dot point is —

> Fresh sampling and testing from State-run hotel quarantine and five metropolitan wastewater treatment plants to commence this week

I understand from that there are two testing schema or protocols that are happening in parallel; is that correct?

Hon ALANNA CLOHESY: Just explain as a whole how it works.

Dr ROBERTSON: There are a couple of steps here. One of them is the validation step. We had to validate the testing to make sure that we could actually pick it up in the samples. Part of that was from the frozen samples but part of it was from fresh samples.

[2.50 pm]

Obviously, part of that validation is to look at the hotels, because we are still getting a number of cases of overseas travellers who are coming in who have the disease, and they are shedding into the toilets, and if we are going to pick up positives, we will pick it up from that sample. That is being largely done through the Shenton Park wastewater facility. That is part of it.

The Water Corporation has a number of auto samplers. There are five auto samplers across the city, which sample all the major drainage areas, and we are starting to look at the samples coming from those areas. A lot of work is required in doing that, largely because what we are dealing with is shedded RNA particles. Some people shed a lot for a long time after they have actually had the disease. The particles are not virus per se, so they are not infective, but some people are chronic shedders. Even people who have completed their time in a quarantine hotel, for example, may be still shedding weeks later, so we have to work out what that actually means. A lot of the thing is around validating that process, being able to test, understanding what it actually means and how it can be utilised effectively in either diagnosing outbreaks or continuing to understand the whole current testing regime.

The DEPUTY CHAIR: Does the testing, particularly around the hotel quarantine sites, occur now on a weekly basis or a daily basis? Is there any sort of intelligence imperative that drives the sampling and the testing site?

Dr ROBERTSON: As we have had no community spread, there is no particular intelligence that we are targeting the testing for at the moment, but we are obviously looking to do regular tests of at least the five main sites. There is some benefit in our testing the hotels, because that allows us to identify what kind of strength of signal we get from the wastewater, based on how many patients we have in the hotels who may be shedding the virus, so it gives us an idea to validate. But it is of limited use other than that, from a validation point of view. We already know that the hotels have the disease, because we have actually tested them. It is more for us to make sure that our processes and identification are accurate. Once we are comfortable that our processes are robust, it is allowing that to be then utilised to look at the larger water drainage areas. That is more useful.

The DEPUTY CHAIR: Thank you. This is the final question before I give the call to somebody else.

Paragraph 10 on the same page I referred to earlier, page 313, refers to adequate levels of personal protective equipment. Is there any way to quantify what would constitute an adequate level of supply—I am presuming here for frontline health workers?

Hon ALANNA CLOHESY: I think the director general will address that.

Dr RUSSELL-WEISZ: This has been an ongoing priority for us from the very, very early days. The most important thing, not knowing—we were going into a pandemic that was basically unknown what we were going to face and how long we were going to face it for. The highest priority was the safety of our staff. Our supply lines in February and early March just dried up. Our supply lines, we were told—for example, for pathology reagents—one day they were coming, and the next day they were not. So we made a decision to go and get as much PPE as possible and as much certified PPE as

possible, and we set up new supply lines. Your question is right in relation to: do we have enough based on what demand? But, initially, it was just go and get the right PPE, get regular supply lines—safety of staff is paramount. We wanted our nurses, our doctors, those people—and allied health as well—in hospitals to look and to see that they were going to be safe; they were not going to run out. We have done that. We have gone from around about one and a half warehouses to between four and five. I make no excuse. We have got a lot of PPE and a lot of good PPE. There has been some commentary in the media about not having PPE. It is just, frankly, rubbish. We have got good PPE. One of our clinical leads—our clinicians have actually led a lot of this work—is a clinician on the ground. We have PPE that is distributed to our hospitals.

We have done a bit of work in relation to this. We now have a dashboard, which is put on the WA Health website. It actually tells you in relation to face shields, gloves, hand sanitiser and masks what we have stock on hand, what we have issued in the last seven days, what is our average weekly usage in the last 21 days, and if there has been any increase or decrease. That tells us, one, we know when people are using it more. They were certainly using it more when we had COVID here, when we had the *Artania*. It is natural that people are going to use it more. We have updated guidelines that we are continually updating about how to use it and when to use it, led by clinicians, I would say, not led by bureaucrats. This is led by clinicians, with clinicians' expertise. Now we have weeks on supply. For example, our face shields have 204 weeks on supply. For our N95 regular masks, we have 179 weeks on supply. That might be said to be overkill, but, again, we make no excuse because our supply lines might run out again.

We also have—it is more of a colloquialism—a COVID cupboard to say if we did get outbreaks here, we know we would increase our usage. We know that our usage would go up, and that is why we have so much stock on hand. We also know where our placed orders are. We were tracking maybe quite well on one component back in May and June, but we knew our orders were very risky. So what we did was make sure that we could actually secure those orders. My traffic lights as of 15 November—today—are all green. If you had been here six months ago, some of them would have been red. We do have a really robust method of having our PPE. There cannot be any doubt that we have got enough. We have good supply lines now that we could increase. We can supply that. We actually put this on our WA Health website every week just so people can see it.

The DEPUTY CHAIR: Just a quick follow-up to that. Could you elaborate, please, on the importance of fit testing of PPE and whether that process has been undertaken, and who gets prioritised for that—I will not call it a service, but I will call it a service colloquially?

Dr RUSSELL-WEISZ: If I may, I will start, and I will ask my colleagues behind me to come in on the details. I think the first thing to say is that when we did have COVID here, we had no healthcare workers infected. We had a lot of COVID at one point at one our hospitals, in Joondalup, through the *Artania*. We did a lot of work. I will say it again: there is no larger priority than the safety of our staff. There is a lot of work in relation to what we call donning and doffing of masks, how to do it so you do not contaminate yourself, and also getting the right masks, so it was getting the right N95s, small and medium, because we all have different sized faces.

In relation to fit testing, we put just under $1 million aside for fit testing. This has not been a financial issue. Fit testing is making sure that especially in your high-priority areas—so when you are in high-risk areas, emergency departments, intensive care units when you are dealing potentially with respiratory patients who are basically shedding a lot of virus, you want to make sure you have everything done well. That means good PPE stocks, making sure you have got good practices and making sure that whatever mask you put on is actually fit tested really well. We put aside $1 million

for fit testing. All the clinical interaction has been led by our clinical lead, by an expert in infectious diseases who has worked with his colleague clinicians across the sector.

We have actually appointed fit testing leads at the health service providers. This week we will get the actual equipment, and we will be training the trainers and also training the high-risk areas very soon. But fit testing is a component to the overall PPE; it is very important. We put money aside for that and we will be training specific areas within all our hospitals, but obviously we will be concentrating on the high-priority areas. The basic rule is you get the right PPE first and you get a heap of it, which we have done. I might pass on to Mrs MacLeod and Dr Lawrence, if they want to add anything.

[3.00 pm]

Mrs MacLEOD: Thank you very much for that. As Russ said, the fit testing is a part of what we are calling the respiratory protection program, which is an important program for our staff safety across all of WA Health and a number of components to it in relation to PPE are good education, hand hygiene, stay at home if you are unwell—and fit testing is one part of that. We have a program in place. We have ordered the number of equipment that will be coming through. The PortaCounts is the piece of equipment, so it is quantitative testing. There will be staff located within each of the HSPs who will be a lead for doing that testing and will be responsible for doing the precision around which staff within each HSP need to be done. We think across all of WA Health is it approximately a third of our staff, around 12 500 staff—a significant number of people that we are looking at actually undertaking the fit testing. Most of the HSPs will have a couple of team members who will be able to actually do that. We are anticipating with the machines arriving and the consumables arriving, we will start a training program—the train the trainer program—in December/January and then be able to get those individuals actually undertaking the fit testing at a local level. It is quite a complex program, as you can anticipate, with the sheer volume of people and a bit of policy that needs to sit behind it as well. It is something that we need to do in a very careful manner.

The DEPUTY CHAIR: If I may, just to clarify, because I do not want to hold up the rest of the hearing, but the fit testing protocol that effectively has been outlined to us in the two recent answers has been spoken about almost in the future tense. Is that a mis-appreciation on my behalf, or is there a gradation of the role out of this that will start next week?

Dr RUSSELL-WEISZ: There will be a gradation. We will not wait until we have all the equipment and all the trainers trained. It will be done in parallel and we will make sure that any hold-up is removed. But also, making sure, at all times, that we have enough PPE behind it as well as doing the fit testing.

Hon DIANE EVERS: I will be quite brief to allow others a bit more time. First, I have one question on budget paper No 3, page 174, with regard to royalties for regions. The particular item that I am looking at is the "Small Hospital and Nursing Post Refurbishment Program". With regard to that program, I notice that the funding has been completed in 2019–20. My question is: does that mean that as these funds have stopped and this program appears to have ended, that all those small hospitals and nursing posts are up to the standard that we require?

Hon ALANNA CLOHESY: I ask Mr Moffet to address that.

Mr MOFFET: Yes, the small hospitals program was part of the broader SIHI program of capital works, which was over $300 million. There were two tranches, really, in the small hospitals program. First, approximately $100 million was spent to tend to standards upgrades, whether it was electrical, roofing or fire. That was the first part of the program. The second program focused on emergency department ambulatory care access and security, and for some facilities in relation to key service requirements, depending on the age of the facility, such as a kitchen, for example, in Goomalling.

Prioritisation occurred at various sites, depending on the age and amenity of the facility. In terms of, I guess, the broader meeting of standards, as capital has gone in, it does trigger a compliance requirement with "Australasian Health Facility Guidelines" standards. Those facilities have been brought up to standard generally with the Australian health facility guidelines. Some of these facilities are obviously still very old; it has not fully replaced these facilities. Some are new builds—Pingelly and Cunderdin for example. Some are significant expansions, such as in Jurien Bay, but the majority of that program really prioritised ED, ambulatory care and then compliance upgrades. In general terms, we meet the Australian health facility guidelines, but not all the facilities are, I guess, a contemporary design, if you would like.

Hon DIANE EVERS: It sounds like you look at them more from one of the aspects of all of them at the same time—it makes sense—in the way of upgrading that. Would that mean then that there will be other processes coming along? Are there any other issues that will be looked at in the near future? I recognise they are not in the budget under that line item, but maybe it is under something else to continue the upgrade of our small hospitals.

Hon ALANNA CLOHESY: Honourable member, it is kind of a bit beyond the scope of these hearings, but we will just see if there is anything else.

Mr MOFFET: I guess just to say that we have a large capital program. This is just one part of that. The primary focus is on projects committed by government. We have not finished the larger district sites, and we have new capital projects committed in this year's capital budget as well. There are significant upgrades and redevelopments still on the agenda, but that particular program has been completed at this point.

Hon DIANE EVERS: My next question in the annual report, at page 85 in the first instance.

Hon ALANNA CLOHESY: Whose annual report?

Hon DIANE EVERS: The Department of Health. It may be a very simple question, at least that is what I am hoping for, but I notice that the majority of expenses are shown as grants and subsidies, with very little detail of the rest of them, whereas if you look at the budget for these items, it is shown itemised across them, and not showing those grants and subsidies—making it very difficult to actually compare the budgeted amounts to the annual reports. I am just wondering what the rationale is for that, and then, when I tried looking at each of the annual reports to match it up, it did not match up either. I am just wondering whether I am missing something.

Hon ALANNA CLOHESY: Agencies are provided with a guideline/instruction from the Treasurer about reporting frameworks. The way that the accounts are provided are within a specified set of instructions I guess. But I will ask Mr Anderson to see if there is anything else he can add.

Mr ANDERSON: That is correct. We have to report through a very strict set of guidelines provided to us by Treasury. If you would like more detail on the income statement, we can provide that to split those numbers out. It is just the financial reporting treatment of how those things are shown.

Hon DIANE EVERS: I think it is more in the budget that I do not have that sort of detail. I mean, you can look at the annual reports and see it in the past, but is there any place that in the budget would break that down more fully as to each of the items in terms of which health service they go to?

Mr ANDERSON: No. The budget is a representation of the appropriation for the whole of Health. We do internally then break that down into separate outcome-based management views for each of the health service providers, but it is not published in the budget, because it is a single appropriation from Treasury. Service agreements are available online, I think, so you can go and find those for all the health service providers.

Hon DIANE EVERS: By the budgeted amounts for those service providers?

Mr ANDERSON: By the OBM—the outcome-based management.

Hon DIANE EVERS: I have just one other question. I refer to budget paper No 2, volume 1, page 312. About halfway down it shows "Lotteries Revenue Reduction". I noticed there was a significant fall-off in the amount on that line item. Is this in relation to COVID somehow, because lotteries funding is being distributed in other ways? This is on page 312 of the budget papers. Where you see the spending changes table, near the bottom of the list is "Lotteries Revenue Reduction".

[3.10 pm]

Hon ALANNA CLOHESY: We do not have that information with us, honourable member, so we are happy to take it as supplementary.

[*Supplementary Information No C12*.]

Hon AARON STONEHOUSE: I would like to go back for a moment to the discussion on PPE. It was revealed that we have stockpiled quite a large amount of PPE; that is great to hear and a relief. I am wondering, however, if there is a shelf life on any of the PPE that we have stockpiled, and what the implications of that shelf life might be for the budget allocation appropriation for the acquisition of new PPE to replace that stock as it expires.

Hon ALANNA CLOHESY: The director general will have info on that.

Dr RUSSELL-WEISZ: Yes, we obviously thought of this at the time, if we had a lot. As WA, the community and health staff have been successful to date in having no community transmission since April, we may end up with a lot of PPE. But we have new suppliers and we do not know what is going to happen over the next three, six or nine months. We have heard some reasonably good news in relation to the vaccination program, but we still have to be ready for the worst-case scenario. We still have to be ready for outbreaks, and we have to be ready where there will be a significant increase in PPE. Hopefully, as and when we come out of this pandemic, we will then more than likely start reducing our orders from the suppliers to make sure we use the PPE. We have a magnificent team in health support services, and I will ask Mr Toms to comment about how we are doing this, but that team is already looking at this to make sure that none goes to waste. We are also supplying some of the PPE to other organisations, should they require it. That means we have not taken as much PPE from the commonwealth as maybe other states potentially have, because we have enough here. But I am always cautious; it is better to have more than we need, subject to an outbreak. I ask Mr Toms to make a comment.

Mr TOMS: Now that we are several months into the pandemic, this is a piece of work that we are currently undertaking—to look at the strategy around how we can minimise any product that goes unused. We are looking at things like how we can cycle it through BAU channels and then supplement any COVID stock with new stock we are getting through for BAU. We are looking at alternative distribution channels around how we can distribute it to other organisations whilst replenishing our own stock, so it is actually a strategy that we are working on as we speak. We expect to have something by the end of the year that will help us to have an organised way of dealing with this in the long run.

Hon AARON STONEHOUSE: Is Health responsible for providing PPE to hotel staff for hotels currently housing travellers in quarantine; and, if so, what is the current progress of fit testing and training and education in the use of that PPE?

Hon ALANNA CLOHESY: We will go to Dr Lawrence for that answer.

Dr LAWRENCE: Yes, Health provides PPE to hotel staff in accordance with the requirements of the WA Health PPE guidelines. That does not prevent some of the big hotel companies, as an example, providing additional PPE and providing their staff with their own international guidelines around when they require their staff to wear it. Hotel staff, in general, do not require fit testing because the respirator masks are only required for close clinical interactions. As an example, there would be no expectation that a security guard would undertake any of those interactions in the hotel environment.

Hon AARON STONEHOUSE: So currently there is no fit testing being provided to those staff, on the basis that they do not require that level of PPE?

Dr LAWRENCE: Correct. They do not require fit testing; they require training in PPE donning and doffing. So, we provide them with surgical masks, visors, goggles, gloves and that sort of thing, and we provide that training for them.

Hon AARON STONEHOUSE: Forgive me; I may be a little ignorant on the difference between fit testing and what might be a quick training course on how to don and doff a mask and goggles. You are saying that training on how to don and doff masks, goggles and basic PPE has been provided to hotel security and hotel staff?

Dr LAWRENCE: Yes, it has, and we continue to audit their use of PPE regularly. The infection prevention control experts from public health undertake that training and do regular audits of all our hotels, and will provide refresher training as well. All staff are trained before they are allowed to commence employment.

Hon AARON STONEHOUSE: Moving on, I turn to paragraph 6 on page 313, which talks about capacity in the health system. I am wondering how we measure that capacity. As a layperson, I would think it might be measured in the number of beds in an emergency department or an intensive care unit. Perhaps you can confirm if that is the case. My real question, however, is: what was Western Australia's public health capacity in January, before this pandemic affected Western Australia, and what is it today?

Hon ALANNA CLOHESY: It kind of depends on what you mean by "capacity". I will hand over to the director general to provide a response.

Dr RUSSELL-WEISZ: I may have to come back to you. If you are looking at the public WA health system, I might come back to you with the exact number of beds we had in January and how many we have now, because that moves around a bit. I will ask Mrs MacLeod to make some comments after this, but when the pandemic started, the WA health system came together, so it was not just public; it was public and private. We had to look at our total capacity. When we were in the midst of our, albeit small, first wave in Western Australia, we actually stopped elective surgery for a number of weeks and freed up capacity right across the sector—not just in the public sector, but also in the private sector. There were commonwealth government grants given to the private hospital operators right across the nation to make sure that capacity was ready for us.

One of the issues the member raised was PPE; another one is having enough ventilators. When we saw what was going on around the world—in Italy, France and the devastating vision we are seeing happening now in the United States and other parts of Europe—we needed to be ready, so we doubled the number of ventilators and looked at the specific capacity for critical-care beds. We have about 120 critical-care beds across the sector, but we increased that up to about 665. That does not mean that we suddenly found intensive care unit beds; it meant that we found beds that could be turned into critical care for patients who needed intensive care, needed to be on a ventilator or needed significant respiratory support.

We also did a considerable amount of work on increasing negative pressure rooms in our hospitals. These are rooms where we treated a lot of COVID patients, and it also protected both patients and staff. Capacity is about beds, but it is also about equipment, consumables and PPE. It was a holistic response where private and public came together and said, "How can we maximise capacity?" If you get a large outbreak, as we saw in Victoria, elective surgery was taken down. They actually maximised their bed capacity for COVID patients. We also found during the COVID outbreak that a lot of our emergency department attendances reduced. A heap of work was done on capacity, and I might, if I can, ask Mrs MacLeod to make further comments.

[3.20 pm]

Mrs MacLEOD: Yes. As Dr Russell-Weisz has said, we did look at capacity across the entire sector in a number of different ways. We looked at general health beds, we looked at intensive care unit beds, we also looked specifically at mental health beds given the nature and the speciality of those beds, and we looked at ICU demand as well. We worked very closely with all the hospitals through the health service providers to make sure we had sufficient oversight and consistency with how we were looking at that. We also worked through the phasing of that capacity so we were very clear at what phases each one of those groups of beds would come through. It was different for each hospital, based on the location of the beds and the proximity to some of the other critical care services. We did that for intensive care. As I said, we made sure when we did the general bed that we did not double count intensive care and general bed capacity because some of what we were going to be using for our ventilated beds, in normal business, could be considered general beds. They were just in a high acuity area where we could actually put ventilators. We were very concerned about not having enough ventilated spaces. We worked very closely with the private sector as well, given we had at that point reduced elective surgery. Obviously, there was a large volume of beds in the private sector, so really working through how we could utilise those beds in the private sector, both for our business as usual and also for any surge in COVID cases. We did the supporting work around making sure we had sufficient workforce, making sure we had sufficient pathology and radiology to support that as well.

Hon AARON STONEHOUSE: Thank you.

I have some questions for Dr Robertson that relate to correspondence. There was a question earlier around correspondence between yourself, sir, and the Premier. What I was interested in was an email, which was tabled in Parliament, from Ms Emily Roper on 14 October 2020 where she provided you with a transcript of an interview that you had given saying something along the lines of, "I don't know if you get these in Health, but if not thought it might be useful." She was providing you with a transcript of an interview that you provided. My question is: was there a subsequent conversation with Ms Roper or with anyone from the Premier's office, between yourself and anyone from the Premier's office, as a result of that email and that transcript that was provided to you on 14 October?

Dr ROBERTSON: There was a range of discussions over those days. We are still meeting regularly on a range of discussions on a range of areas, including with Ms Roper. On being provided with a transcript, there had been some media interest. I am assuming the transcript you are referring to is the one from the Education and Health Standing Committee. There had been some media interest in that and some media speculation in that. I was just provided with a copy of the transcript to review, which was useful, but I subsequently received it from the Education and Health Standing Committee as is usual practice. I had already been reviewing that. I am not quite sure specifically what you are asking.

Hon AARON STONEHOUSE: The email I have is of a transcript of an interview that you gave to a reporter, although the media monitoring transcript does not mention the name of the reporter.

Dr ROBERTSON: Sorry, I misunderstood. There was that, and that was just a transcript. But again, quite often, both our own communications people and other individuals within Premier and Cabinet and within Health provide me with transcripts of various interviews, just so that I am aware of them.

Hon AARON STONEHOUSE: Sure. Noting, as you said, the "media speculation" around that time, was there ever a point between 13 October and 20 October where the Premier or someone within the Premier's office asked you to provide a clarification to the media on your health advice to the government?

Dr ROBERTSON: It was discussed. I am not sure at what stage it was discussed but there was some discussion around the speculation that had occurred and there was some discussion, primarily with my communications people, as to whether it would be useful to put out something that would clarify. There were a lot of claims of things I had said and things that were claimed I had said in both the Education and Health Standing Committee and at the media interview afterwards. There were also claims of secret advice and a number of other claims. It was largely a discussion with our communications people as to whether it would be beneficial to try to clear the air and to actually put out a clarifying statement.

Hon AARON STONEHOUSE: Is that a conversation between you and your communications people, or is this a conversation between your communications people and the Premier or the Department of the Premier and Cabinet? What I am trying to establish is whether at any point that conversation was had between anyone from the Department of the Premier and Cabinet and yourself.

Dr ROBERTSON: The decision on this was mine and mine alone. I was not specifically directed or told to provide any form of statement. It was just suggested that it may be useful to clarify, given the speculation that had occurred on, I think, 15 and 16 October.

Hon AARON STONEHOUSE: Suggested by whom?

Dr ROBERTSON: It was largely through my communications people as to whether that might be useful, but that is a usual process if there is speculation or if we think some of the information out there is incorrect, which we believed it was, to put up a clarifying statement. And we have done that in other circumstances where, for various reasons, the media has not quite got the whole story.

Hon AARON STONEHOUSE: Just so I am absolutely clear: at no stage has the Premier or anyone from DPC asked you to provide a clarifying statement?

Dr ROBERTSON: No; not to my memory. I am thinking of the discussions we had at the time. There may have been some discussions about clarifying statements and whether they were beneficial, but I cannot remember specifically that that was raised but I certainly was not directed or asked to necessarily.[3]

Hon AARON STONEHOUSE: Thank you for trying to clarify that for me. In a previous answer earlier this afternoon, you said that you keep a diary of various verbal conversations and meetings that you attend. Would you be willing to, and will you now, provide that diary to this committee? Before you give me an answer, I might clarify. It would not be provided to Parliament and made a public document as a matter of fact. You can provide it to the committee where it would remain private and the committee would have an opportunity to redact any identifying information of individuals or any contact numbers, contact email addresses and such, so it can be handled sensitively if need be. Are you willing to table that diary or at least the relevant excerpts for this period in question?

[3] A letter of clarification about this part of the transcript can be accessed on the committee webpage.

Hon ALANNA CLOHESY: Honourable member, we might just, with respect, take that as supplementary information. Noting your offer of keeping the information private, we will take that as supplementary and get back to the committee as soon as available.

Dr ROBERTSON: Just a clarifying comment: the diary is not a verbatim diary. This is a diary I keep of meetings; comments that are—information I need to provide at meetings. It also includes summaries of AHPPC meetings, which are national cabinet, so some of those are probably covered by national cabinet restrictions. I have no issues with providing it; I am not sure how useful it will be.

Hon ALANNA CLOHESY: Which is why we need to take it as supplementary.

Dr ROBERTSON: I do not have it here.

Hon AARON STONEHOUSE: That is okay. If it is helpful to you, doctor, a standing committee of the Legislative Council is able to take evidence and documents and keep them as private until they can be properly redacted before anything is released as public; things like cabinet-in-confidence, commercial confidence can be handled with appropriate sensitivity, shall I say.

I do note that you say you have no issue with providing that information, but you do not have it with you right now.

[3.30 pm]

Dr ROBERTSON: I have got one day—20 October, I think, which is probably not going to help you. My previous diary would cover the period. I assume the period you are interested in remains 13 to 20 October.

The DEPUTY CHAIR: This might go on a little. I think what we have is an undertaking to provide a copy of the document of the sort that you are requesting, honourable member. I note that there is a need, in all likelihood, to redact content. I think the procedure would be for the witness providing the information to request that it be treated privately, understanding the rules of the house.

[*Supplementary Information No C13.*]

Hon ALANNA CLOHESY: Thank you, Deputy Chair. That would need to be considered by the minister in providing the information to the committee. Noting those caveats, we will take that as supplementary information.

Hon AARON STONEHOUSE: Dr Robertson, during earlier questioning you mentioned that you were asked to provide certain documents to Parliament in relation to an order of the Legislative Council directed towards the Leader of the House to produce various correspondence. I note that the documents that were tabled—you, of course, have no control over what was tabled and that was the Leader of the House who did that—were correspondence directed to you. You said in an answer to a previous question that those were the documents you were asked to provide. Who asked you to provide those documents?

Hon ALANNA CLOHESY: Honourable member, it was a request from the Legislative Council. If you are asking the method or process that is used once the motion is moved, I cannot be 100 per cent sure on that. Director general, do you know the process?

Dr RUSSELL-WEISZ: I would have to check that. It would probably go through the minister to the department, but I will check whether we need to check the process.

Hon ALANNA CLOHESY: We need to check the process.

Hon AARON STONEHOUSE: I do not want to trip anybody up on procedure of the house, but what I am trying to find out is that it sounds like that order of the house may have triggered a process

within the department, which then notifies people to produce documents that are asked for, or was it that the Leader of the House, who was the subject of the order, or the Premier or someone within DPC who called Dr Robertson and says, "These are the documents that we would like you to go back and get for us and then we will provide these to the Leader of the House today"?

Hon ALANNA CLOHESY: Honourable member, we have to check the process. There is a usual process when the Parliament asks for information. That goes through the minister's office to the department, but we will just have to check if that is the standard procedure, and none of us here know that procedure off by heart. We will come back to you about what that procedure was and the way in which it was used in relation to requests for the Chief Health Officer.

[*Supplementary Information No C14.*]

The DEPUTY CHAIR: By way of helpful guidance, I just remind members that the Leader of the House, in her representative capacity, will be fronting the DPC hearings, so there might be an opportunity for you, member, to prosecute that line of questioning on that occasion.

Hon ALANNA CLOHESY: It is as simple as we absolutely do not know whether it came from the Leader of the House and those sorts of things, but I note that the department has a very rigorous process.

Hon AARON STONEHOUSE: We will take a break from COVID. I have an interest in the Stop the Violence campaign. That is on page 330 under "Other New Works"—the Stop the Violence campaign—with an estimated total cost just shy of $5 million. It is aimed at reducing violent outbursts against medical staff. I was wondering if you can give me an update of what has been the reduction in reported incidents of this type of behaviour to date since the campaign began.

Hon ALANNA CLOHESY: We will start with the director general.

Dr RUSSELL-WEISZ: Thank you, and I will ask Liz MacLeod to add to this because between the chief executive of east metro health service and myself as the director general, we have overseen the rollout of the Stop the Violence campaign. All the other chief executives have been involved. This was following the summit that the Minister for Health held in, I think, June 2019. The government then committed $11.2 million for a Stop the Violence package to urgently address issues of violence and aggression against frontline staff.

It basically had $6.1 million in recurrent internal funding and $5.1 million in additional capital appropriation. Basically, it covered additional security staff, new alcohol and other drug staff, clinical staff, and capital investments, concentrating on the CCTV network. As of 30 June—this might have changed recently, so I am happy to provide an update—nearly 15 additional on-site security staff and nearly an additional 16 extra AOD staff, Aboriginal liaison and remote area staff have been recruited. In 2020–21, $10.6 million has been allocated to meet the full operating cost of staff and contracted services to make sure this continues.

As you know, the background behind it is that our staff were being assaulted and we needed a specific program that could be funded year on year and that could adapt to provide better safety for our staff. It will continue. I do not have on me the actual number of incidents, but we believe they have dropped, purely because activity has dropped in COVID, but also we have much better intervention now. One of the key messages from our staff through the hospitals was that we need extra security staff 24 hours around the clock because when patients or customers do become violent, they become violent very rapidly. We also needed to go to the cause and that is why there was an investment in relation to AOD staff. I can say the funding has been distributed widely between all the five main operational health service providers and the program is going well. One of the points that was put to us was: how do you alert staff to a patient who has become violent

before, or somebody who fronts the ED and may not be a patient, and how do you then have a rapid response? We have done a lot of work in relation to that. Staff are alerted that there may be a risk with this patient. It might be because of their clinical condition, they may have been under the influence of drugs, or they just might be aggressive. I might ask Ms MacLeod to comment further.

Mrs MacLEOD: Thank you very much. In addition to the funding that has been provided and the initiatives funded through that, we have done a range of other things to support our staff in terms of safety. We are undertaking some consistent training across the system. One of the things we are working on in relation to your specific question is getting some better clarity around a code black and consistency with that. One of the issues we have had is the slight variation in terms of when people call it and how it is actually recorded. We have also been really promoting it across the system, so the numbers are difficult to actually tell whether or not we are getting an increase or decrease because we are, quite beneficially, seeing an increase in reporting as well, because that is what we have been promoting our staff to do.

As Dr Russell-Weisz has said, we have been working closely with WA police and have a handover form now that WA police and ED clinical staff sign so that we get very good information in relation to any of the individuals coming through, and we are working on an alert mechanism that can go through then so that other areas in the hospital are advised. We have also been working closely with WA police on models of care for the watch house to see whether we can minimise perhaps some of the transport of people from the watch house to our emergency department. So there are a number of other initiatives in place as well.

[3.40 pm]

Hon AARON STONEHOUSE: I am pleased to hear that. Anything with the word "campaign" conjures thoughts of a PR and advertising campaign. I am glad to hear it is going to practical reduction measures.

Hon ALANNA CLOHESY: There is a lot of substance to it, absolutely.

Hon COLIN TINCKNELL: I refer to annual reports, Department of Health, on page 83, also North Metropolitan Health Service on page 92 and South Metropolitan Health Service on page 74. I note that the Auditor General provided her audit opinion for each of these bodies on 15 September. What accounts for the differing tabling dates for the North Metropolitan Health Service, which tabled on 23 September, compared with the other two annual reports tabled on 13 October?

Dr RUSSELL-WEISZ: We may take it on notice. They do report on different dates. It is likely that one was not ready at that time, and also the Auditor General—sorry, I would rather take this on notice—may not have completed their work at a specific date. They all reported around the same date. I do not think there is any problem that they are not reported on exactly the same dates. Health is obviously a large beast. The Department of Health is probably the smallest of all the entities. We are a $10 billion budget, and these take significant time. I think it is just that these were reported and completed at different times.

Hon ALANNA CLOHESY: It is important to note that, as the director general says, each health service provider has its own governance mechanisms—so their own way of reporting through that. Mr Forden from South Metropolitan Health Service will speak to this as well.

Hon COLIN TINCKNELL: The south and the north.

Hon ALANNA CLOHESY: Mr Forden is from the south.

Mr FORDEN: Speaking for South Metropolitan Health Service, we do have our own governance. That actually is that timing that the Auditor General completes their work, so it is not all completed at the same time. We cannot table until we have had that clearance, so that was the delay.

Hon COLIN TINCKNELL: Keeping on the same sort of plane, I refer to Health Support Services annual report, page 43, which indicates that the Auditor General provided her audit opinion on 10 September, on page 2 of her letter, which indicates that the board did not submit the annual report to the minister until 1 October. What counts for the time taken between receiving the Auditor General's opinion and submitting the annual report to the minister?

Hon ALANNA CLOHESY: Director general.

Dr RUSSELL-WEISZ: When it is completed, it would go to the minister. I do not think there is any particular reason for that. I have never looked at whether it is two or three weeks or whether that is a longer delay than normal. Mr Toms may have a view, but I cannot see any issue with that. What I can say is that the Auditor General, who we have a very good working relationship with, has not raised with me any issue with the reports from either the health service providers, as the Department of Health being system manager, or the Department of Health's reporting mechanism through to the minister. It has never been raised as an issue. I am happy to look into it if there is one.

Mr TOMS: Just to add to that, I am not aware of any particular reason why there have been any issues with those dates. It is a similar sort of process in that once the Auditor General finishes their work, they issue their, I guess, outcome from that work, and then we complete that work and then submit it to the minister's office. It is a similar process to what Paul Forden has described with south metro as well.

Hon COLIN TINCKNELL: I am going to move on to budget paper No 2, page 152, item 113.

Hon ALANNA CLOHESY: Page 152 of budget paper No 2 is not the division for WA Health, so we do not have that. Just continue with your question, and we will see whether we can work it out.

Hon COLIN TINCKNELL: Why are these projects funded by the Department of Treasury, administered item, rather than an increased capital appropriation?

Hon ALANNA CLOHESY: Have you got a list of what projects they are?

Hon COLIN TINCKNELL: No, I do not have a list of the projects. There was a list in the breakdown. I ask for a breakdown of the projects covered by this item.

The DEPUTY CHAIR: Member, I might be able to assist you and assist everybody. Listed under the Treasury section, the footnote to item 113, "WA Health", at the bottom of page 152 has some clarifying remarks, and I will read these in —

> Reflects funding applied to major health initiatives as part of WA Health's Asset Investment Program. WA Health is required to submit business cases or project definition plans for Government approval to access these funds.

Potentially that provides the avenue by which a constructive interchange might now occur.

Hon ALANNA CLOHESY: Just to be clear, this is in the Treasury budget, not the Health budget and its related to item 113 "WA Health" and the note (w).

The DEPUTY CHAIR: I am sorry to do this, but just so you know, there is a cross-reference to that on page 331 in the Health section in the "Funded By" table, so they are interlinked.

Dr RUSSELL-WEISZ: For any major spending, be it spending of capital or appropriation, we would have to do a business case and a PDP. It is possible that there might be funds held by Treasury for

health for specific projects, but they do not appear in the health budget. It might be that they hold them in the Treasury-administered fund, and I think this is what it is referring to. Unfortunately, I cannot see what those projects are, but over time we have had Treasury-administered funds that have been held for health, and we seek money through either the Treasurer's delegation or we seek it through provision of a business case or a PDP. I would probably have to take on notice what those are, just because I do not know.

Hon COLIN TINCKNELL: I would be interested in what those projects are.

[*Supplementary Information No C15.*]

[3.50 pm]

Hon COLIN TINCKNELL: If you look at WA Health's planning on the reconfiguration of mental health services to best support the Western Australian health system—once again staying on budget paper No 2, page 318, paragraph 44—I am asking for an update on the reconfiguration of the mental health services. You are planning on a reconfiguration.

Hon ALANNA CLOHESY: This is the work around Graylands. I will ask the director general to talk to that, as well as the state forensic care more broadly.

Dr RUSSELL-WEISZ: Honourable member, there has been ongoing work in relation to the Graylands site, but it does not just relate to Graylands, because anything we do ultimately in the future to divest the site completely, there would need to be a replacement for the forensic mental health facility and enhancement but also you would need to make sure that the community sector had enough capacity to take those patients into either more appropriate hospital acute or ongoing treatment or community care. Over the last two to three months, there has been a steering committee established, which I chair—it is probably longer than that—in relation to that work, looking at short, medium and longer term options. We know that there is pressure in mental health at the moment. The mental health demand has significantly increased over the last four to five months.

Hon COLIN TINCKNELL: I heard there was a national report out yesterday.

Hon ALANNA CLOHESY: That is a Productivity Commission report.

Dr RUSSELL-WEISZ: That will, I think, potentially inform the basis for any commonwealth reform in the mental health sector. We recognised, even going back to the sustainable health review released by the government in 2019, the second major enduring strategy was mental health. Mental health was called out because there is an increasing burden of disease, not just for acute and forensic hospital care but throughout the whole spectrum of care, from community right the way through to forensic and acute.

The work we have been doing on Graylands is really not about Graylands on its own; it has to take into account what services would you plan for and would you build or invest in community organisations to support patients who either are currently at Graylands or are also going to come to Graylands. We are also doing a review of our current demand modelling at this time. It is not quite out yet, but that will also project into the future mental health demand. We are doing that obviously with the commission. The Mental Health Commission, I am sure, will probably answer this better than I am doing. I can assure the honourable member that we are doing a significant piece of work in relation to whatever services need to be provided in the future should a staged divestment of Graylands occur. It has to occur in a way that we do not divest parts of Graylands before we have the services in the areas for patients closer to home and that we also have the correct reconfiguration of forensic mental health facilities, both in the acute sector and in the community sector.

Hon PIERRE YANG: The thing I have heard overwhelmingly today is on COVID. My question is not on COVID. My question actually relates to a hospital in the northern suburbs, where I have developed a strong interest. In fact, it is an area where I lived and studied when I first came to Western Australia some 21 years ago. Parliamentary secretary, may I please ask in relation to budget paper No 2, volume 1, page 328, are you able to provide an update on the redevelopment works at Osborne Park Hospital and how is it progressing?

Hon ALANNA CLOHESY: Mr Dolan is the chief executive of the North Metropolitan Health Service.

Mr DOLAN: The work is going well. We hope that we will be able to finish some of the capital work around the obstetric unit prior to Christmas and then moving into next year, we will be looking at the additional 16 rehabilitation beds as the next tranche, and then following that looking at expansion of the therapy hub, which is the outpatient therapy centre that we can use, which is predominantly allied health.

Hon PIERRE YANG: I wish to ask another question to the parliamentary secretary. It is in relation to Joondalup Health Campus. Obviously, I have an interest in the northern suburbs. Would the parliamentary secretary be able to provide a progress update on this commitment?

Hon ALANNA CLOHESY: Mr Dolan, would you care to provide an update.

Mr DOLAN: The tender has now closed for the redevelopment of Joondalup Health Campus. I am led to believe that an announcement of the successful candidate will be made within the next four weeks.

Hon NICK GOIRAN: Parliamentary secretary, the Department of Health recently published its annual report. At page 11, it refers, in regard to its COVID-19 response, to the issue of testing. Is there more than one type or brand of test for COVID-19 available for use in Western Australia?

Hon ALANNA CLOHESY: We will go to the Chief Health Officer first and then Mr Boyle from PathWest.

Dr ROBERTSON: The main type of testing obviously for COVID-19 remains our PCR—the polymerase chain reaction test. That is the standard testing that we are using. However, we are doing serology testing. This gives us a better idea of people who may have been infected in the past. That is being undertaken as well. We are also doing some initial work on rapid antigen testing and their utilisation in the future. They have some benefits in the speed of their testing, but there are some serious issues with their accuracy and their sensitivity. We are still validating those tests, and then obviously, as we have discussed before, we are doing the wastewater testing as well.

Hon ALANNA CLOHESY: Just for clarification, PCR is the nasal swab test and serology is the blood test.

Hon NICK GOIRAN: With regard to the PCR, is there one type or brand that is in use or is there more than one type or brand available?

Hon ALANNA CLOHESY: We will go to Mr Boyle for an answer to that.

Mr BOYLE: No. There are multiple platforms of testing, all built around the PCR test methodology. At PathWest, we have four platforms, so we can carry out the tests in four different ways. There are more platforms than that, but in the state we have four.

Hon NICK GOIRAN: So in Western Australia, there are four types?

Mr BOYLE: The private pathology providers also carry out COVID PCR testing. They use a couple of other methodologies. I am not sure exactly, but there are probably at least two.

[4.00 pm]

Hon NICK GOIRAN: Okay. Publicly available, there are four types, and privately there would be approximately two?

Mr BOYLE: Additional types—yes.

Hon NICK GOIRAN: With respect to the four types that are publicly available, are you able to advise what those types are?

Mr BOYLE: There are two what we call chemical in-house tests—two different chemical formulas, if you like—and there are two commercially available test methodologies. One is based around a Roche test methodology and the other is around a cartridge test methodology.

Hon NICK GOIRAN: What determines which of these four platforms is used?

Mr BOYLE: There is a combination of reasons. Initially, we started doing all of the testing before the commercial tests were available, and some of the commercial tests were then in short supply, so predominantly we used the in-house chemical methodologies using the reagent supply that we were able to identify fairly early on in the process, but as supplies became more available, the commercial tests were able to fill some of the volume gap. Our testing volumes are not particularly high compared with the likes of Victoria and New South Wales, so basically we have used different reasons for running different testing types—be it the speed of turnaround of the test, be it the equipment availability at the time, so there has been no particular pressure on any of the test methodologies.

Hon NICK GOIRAN: Is there a difference to the taxpayer in the cost of either one of those four platforms?

Mr BOYLE: The faster turnaround platforms have a cartridge test tape that is more expensive; therefore, we tend to reserve that for a variety reasons. The cartridges have been in short supply in the past, not so much now, but they are the most expensive in terms of methodology.

Hon NICK GOIRAN: What would be the difference between the most expensive type of platform and the least expensive?

Mr BOYLE: I can give you the specifics on notice, but roughly speaking an in-house test could be around $10 to $20 per test, up to probably $70 to $80 for a fast turnaround test result. That is just the actual testing process. The actual end-to-end, be it courier supply or clinical involvement, obviously can add cost to the total test cost.

Hon NICK GOIRAN: Is there a difference by the manufacturers in terms of a particular cycle threshold that they recommend for the tests?

Mr BOYLE: Sorry. I did not understand that.

Hon NICK GOIRAN: Sorry. If somebody is symptomatic, on what days would they be tested? Is that something that is recommended by the manufacturer of these particulate platforms?

Mr BOYLE: Not specifically. I mean, we are talking now specifically about the PCR test, which is the gold standard. That is the most sensitive test that we can use, and that is the most appropriate test to try and find the acute stage of the virus. In terms of the PCR test, the accuracies are all very similar and all very sensitive.

Hon NICK GOIRAN: Parliamentary secretary, with respect to the annual report, on pages 166 and 167 it lists the members of the Perinatal and Infant Mortality Committee. Does the committee continue to produce a report every two years?

Hon ALANNA CLOHESY: I will ask the Chief Health Officer to respond to that.

Dr ROBERTSON: From my memory, they are a three-year report, and they try and produce them once all of that data is available, and that is approximately every two years, but it may be two to three years.

Hon NICK GOIRAN: Is there any reason why the investigation reports and the reports on the data collection analysis ceased to be available on the Department of Health website after 2013?

Hon ALANNA CLOHESY: Member, we do not have that information available so we will take that as a supplementary, and we will check the website as well.

[*Supplementary Information No C16.*]

Hon NICK GOIRAN: Parliamentary secretary, does the Perinatal and Infant Mortality Committee monitor and discuss babies who are born alive and left to die after a failed apportion procedure?

Hon ALANNA CLOHESY: We will go to the Chief Health Officer.

Dr ROBERTSON: I do not know the answer to that question, because the meetings of that committee are confidential and I have no access to the meeting notes.

Hon NICK GOIRAN: Who in Health would have that information available to them so that they can advise the committee?

Dr ROBERTSON: Only the members of the committee have access to that.

Hon ALANNA CLOHESY: And the reason for that?

Dr ROBERTSON: The reason for that is that that is how it is established under the legislation, under the Health (Miscellaneous Provisions) Act. It has very tight confidentiality requirements around both the meeting, the members of that committee, and any of their undertakings.

Hon NICK GOIRAN: Sure, but everything is not confidential, because every two or three years, as you have indicated, a report is prepared. The names of the particular people involved would naturally be confidential, and that is not what I am interested in knowing. What I would like to know at a systemic level is whether the committee monitors and discusses babies who are born alive but left to die after an abortion procedure. Is that something that the committee would be monitoring and discussing?

Dr ROBERTSON: I would need to check that. I do not know the answer to that.

Hon NICK GOIRAN: Does the Perinatal and Infant Mortality Committee report to somebody within WA Health?

Dr ROBERTSON: Under the act, it reports to the Chief Health Officer, but it is not required to provide information to me beyond de-identified information, and a regular report.

Hon NICK GOIRAN: Would you agree, Chief Health Officer, that finding out at a systemic level whether it is monitoring and discussing babies who are born alive but left to die after a failed abortion procedure is a de-identified piece of information?

Dr ROBERTSON: I would have to look at that further.

Hon ALANNA CLOHESY: We will take that as a supplementary.

[*Supplementary Information No C17*.]

Hon NICK GOIRAN: Parliamentary secretary, answers were provided to questions prior to today's hearing. One of the answers indicated that the number of children and adolescents receiving treatment at Perth Children's Hospital's gender diversity service during the reporting period was 329. By way of comparison, in the calendar year of 2018, when I asked that same question, I was advised that the number was 59. In the calendar year of 2018, the number of children accessing the

service was on average one a week. We now have a situation in which it is on average one a day. What is the explanation for this exponential increase?

Hon ALANNA CLOHESY: We will go to Dr Anwar in relation to that, assuming the numbers are correct.

Hon NICK GOIRAN: They are correct if the information provided to Parliament is correct.

Dr ANWAR: You are right. There has been an exponential rise in the call for this service, but I am not aware of what the drivers for that are and I would like to take that on notice, please.

[*Supplementary Information No C18*.]

[4.10 pm]

Hon NICK GOIRAN: For the record, the question on notice was answered on 9 April 2019. It was a question asked by me on 12 March 2019. It was answered by the parliamentary secretary representing the Minister for Health.

With respect to pages 312 and 317 of the budget paper, specifically division 23, part 5, my question to the parliamentary secretary is: is voluntary assisted dying the only existing reform project that has been unaffected or not disrupted by the COVID-19 pandemic?

Hon ALANNA CLOHESY: Can you just give me the reference? Was it page 312?

Hon NICK GOIRAN: Yes, paragraph 3. Or, if you like, page 317, paragraph 35.

Hon ALANNA CLOHESY: I will ask the director general to talk about that.

Dr RUSSELL-WEISZ: Thank you, honourable member. I think all programs were potentially affected by the pandemic in the very, very early days. Things did slow up. You mentioned the voluntary assisted dying program or reform. I think everything was affected in March and April to an extent, and we were so busy dealing with the pandemic that it is hard to actually envisage what really stopped or slowed at that time. What I can say is that certain reform programs have actually sped up. Certain reform programs in the sustainable health review actually sped up. There might be a positive to the pandemic in that we saw telehealth, we saw some huge expansions and we saw some innovations that I think the health system was probably frightened of doing that it just got on and did. I think it is incumbent on us now to make sure that that reform journey does not go backwards. Certain things did speed up. There were certain things with the sustainable health review program that certainly were put on hold. I cannot specifically talk to the voluntary assisted dying reform, the initiative, but certainly in March and April everything would have slowed down. We have been very clear that things have to speed up, right across the board. We have not chosen one over the other. We have focused on things like elective surgery. We have had a huge focus on that, and we now are performing better than we were at 29 February 2020. We have less patients over boundary as a system than we did before the pandemic started, because we put huge efforts into it. I would not characterise it that that was the only program, because it was not; I think everything went on hold for a while. I think everybody in this room would probably nod that things changed so radically, but we do need to get back to business as usual.

Hon MARTIN ALDRIDGE: I want to ask some questions about the country ambulance initiatives that are at page 312 of budget paper No 2. I am sure the parliamentary secretary would be aware of "The Country Ambulance Strategy: Driving Equity for Country WA", which was endorsed and released by the WA Country Health Service board on 29 March 2019, and recommendation 17, which says —

> Expand the Community Paramedic model as a priority in order to relieve pressures for Community Paramedics and those locations currently having the most difficulty in recruiting, supporting and retaining volunteers.

My question is: how many community paramedics do we need in regional Western Australia to give effect to recommend 17 of the strategy?

Hon ALANNA CLOHESY: I do not have information here about recommendation 17, but I will go to Mr Moffet to talk about the implementation of the strategy.

Mr MOFFET: We do not have a specific number. I guess there has been modelling at various times over the years around priority expansion sites for community paramedics. The community paramedic model, as it stands, has been more focused on volunteer training and volunteer number support rather than direct service provision, but I think we have seen increasingly, as volunteer numbers active in a service have diminished, community paramedics have necessarily become more involved in clinical transfers and clinical work. We are currently looking at how we make sure that we validate and legitimise that role. The use of the community paramedic, by whatever title in the future, will involve direct service provision as well, we anticipate. It is important to support volunteers as well as actually provide appropriate responses during rostered shifts. Part of what we are doing at the moment is really getting a good understanding around the data for each of the sub-centres. There are over 160 sub-centres around the state, so it is quite complex to look at the modelling, which is a combination of the existing workloads, but importantly really understanding when volunteer rosters are not available in real time at each sub-centre. We are going through a sort of demand and capacity modelling process, probably over the next six to 12 months, with St John Ambulance, to really determine where the next sites for ensuring that we have continuity of service are, whether that is community paramedic investment or ordinary paramedic investment.

Just referring back to the investment that is available at the moment, the $5 million this year and next year, there are some districts, if you like—the lower inland south west, I think I said eastern wheatbelt, Murchison—that are quite prominent in relation to their low volunteer numbers, and our and St John's operational knowledge of when ambulance responses have been difficult, so it is likely that we will invest early with those available funds in those sorts of areas. But modelling for the whole state is yet to occur. We do not have a definitive number, but we are working through that with St John's based on data, based on proper analysis.

Hon MARTIN ALDRIDGE: Mr Moffet, I did not realise until recently that the Kimberley ambulance service, which is Derby, Halls Creek and Fitzroy Crossing, is actually run by the WA Country Health Service. That is quite a unique arrangement in the Kimberley and that seems to be the target of this investment that I just referred to; I think it is the $9.2 million in the country ambulance initiative. Would it be an unfair assessment that this is the state fixing its own problem as opposed to taking a more holistic approach to the need for community paramedics statewide? What you are saying is that the $5 million a year could well be the conduit to providing more community paramedics in other areas of the state, but that would be subject to negotiation.

Hon ALANNA CLOHESY: Deputy Chair, I think that question is asking for both a political statement and a policy statement, and I think it is an unfair question to direct to Mr Moffet. It is fair to say that the $9.2 million in the 2020–21 budget is about bringing the Kimberley ambulance service in line with industry standards and support through the implementation of the centralised patient transport coordination service within the WACHS command centre. I think it is unfair to ask for a political comment in relation to that.

Hon MARTIN ALDRIDGE: That is your interpretation, parliamentary secretary, but the fact remains, how was the Kimberley ambulance service identified as the priority area for investment? Is there

not an issue in the midwest, the great southern, the wheatbelt and the Goldfields–Esperance region? It just seems to me rather interesting that this investment is going to three locations, being Derby, Halls Creek and Fitzroy Crossing, where, by coincidence perhaps, the WA Country Health Service runs the ambulance service.

Hon ALANNA CLOHESY: I will ask Mr Moffet to respond to how the strategy was developed and the priorities identified.

Mr MOFFET: Again, if we move back to the country ambulance strategy process, including the consultation, one of the priorities identified in that strategy was the fact that the central Kimberley and West Kimberley, including Derby, did not have a professionalised, paid paramedic workforce.

[4.20 pm]

That is, in fact, the only part of the state that does not have dedicated community paramedic coverage. It was seen to be very important, given that the thrust of the whole strategy was moving to appropriate standards to actually incorporate that. The total volumes across Fitzroy, Halls Creek and Derby are over 4 000 calls a year, and the nature of the National Highway means that many of those calls are very significant, clinically, in nature. You are correct to observe that WA Country Health Service has run that service and will continue to run that service, but with paramedical support moving to a standard where, for example, we would move to proper pre-hospital training for nursing staff and orderly staff that currently provide the service to ensure that they have access to the same skills training and, in fact, trauma support and counselling as a professional paid ambulance service. For the central and West Kimberley part of the state to have 4 000 calls and not to have had paramedic services in the past is really quite significant. It means that we can rebalance the workforce a little, so hopefully it will be less of a draw on the nursing workforce, bearing in mind that there are only three paid paramedics in the first instance for the trial, to see how that goes.

Hon ALANNA CLOHESY: Just before we go to the next set of questions, I have available, as requested by member, and seek leave to table, a letter from the Chief Health Officer dated 16 November 2020, to the Commissioner of Police, regarding the South Australian outbreak response directions. There is one reduction, and that is the commissioner's email. I seek leave to table that, as requested.

The DEPUTY CHAIR: Leave is granted. The committee will have to make a determination post this meeting about the status of that document, but for all intents and purposes, please table that document.

Hon ALISON XAMON: I refer to the top of page 321, "Public Hospital Non-admitted Services". I specifically refer to funding for the Perth Children's Hospital's gender diversity service. Is there any additional funding allocated for that service, either this year or in the forward estimates? I understand there is a waiting list, so I seek more information about that.

Hon ALANNA CLOHESY: We will go to Dr Anwar for that.

Dr ANWAR: You are right, there is a waiting list for the gender diversity services, currently manned by 5.4 FTE at a cost of $970 000. A business case is being submitted to the Mental Health Commission for consideration, which asks for an uplift in the FTE to try to meet the demand that is there. There is no additional money at present over and above that mentioned.

Hon ALANNA CLOHESY: All of that would be part of the usual government budget development processes.

Hon ALISON XAMON: At the moment there is nothing. Can I ask what the waiting list was at the end of the last financial year, and the approximate time frames people were waiting to access that service?

Dr ANWAR: Yes, sure. The service is obviously a complex one, with a multidisciplinary team and there are different wait times for different stages of treatment. As of 30 June, 404 clients were engaged in the service, and it currently receives about 18 new referrals per month.

Hon ALISON XAMON: How many people are on the waiting list at the moment?

Dr ANWAR: That I would have to take on notice.

Hon ALANNA CLOHESY: Can we just repeat what the supplementary information being sought is?

Hon ALISON XAMON: I asked how many people were currently on the waiting list for that service.

[*Supplementary Information No C19.*]

Hon ALISON XAMON: The other part of the question is: approximately how long are people waiting to be able to access that service? I understand that it is multidisciplinary, but I am particularly interested in from when they are initially referred to when they first get to see someone.

Dr ANWAR: Can I take that on notice and get back after the session?

[*Supplementary Information No C20*.]

Hon ALISON XAMON: I want to also ask a question about the CAHS annual report at page 46. My question is whether additional resources have been allocated to Perth Children's Hospital to address the increase in children who are presenting with developmental disorders and experiencing severe behaviours of concern.

Dr ANWAR: We have internally allocated some additional resources for children with neurodevelopmental disorders who are presenting. We also have a string of work to ensure that we re-examine the current service provision available for those children.

Hon ALISON XAMON: Sorry, you said you had reallocated internally? So there have not been additional dollars provided for you to be able to extend the service?

Dr ANWAR: The budget is normally allocated, as you know, as a bulk budget, and we have the ability internally to reshape and direct funding internally. Since COVID there has definitely been a change in the pattern of children who have been presenting to the hospital, and we have put in some additional resources in order to help support children with neurodevelopmental delay.

Hon ALISON XAMON: How many children presented in 2018–19 and 2019–20? I am happy to take that on notice if you do not readily have that information.

Dr ANWAR: I do not have that, member. There are some numbers quoted in the annual report, but I can provide that out of session.

[*Supplementary Information No C21*.]

Dr ANWAR: Can I ask for some clarification? Obviously the report talks about children who have neurodevelopmental disorders who present with the additional challenge of behavioural crisis, so we obviously have children with neurodevelopmental disorders who present with physical illness, as well as those who have behavioural crises. I take it your question is directed —

Hon ALISON XAMON: I am particularly after the severe behavioural concerns. Because of the overlap, I am particularly interested in where that fits with students who are at educational risk as well. That is my particular interest in what is happening for those children, although I am quite happy to receive the additional as well, if that is what is being offered.

Dr ANWAR: I will obviously comply with anything you ask me.

Hon ALISON XAMON: I will be happy to receive the additional information on notice as well, thank you. I am specifically chasing information on children who are experiencing behavioural issues, but

I am also quite happy to get additional information about children who have physical issues, as you were describing. That would be wonderful, thank you very much.

I return to page 318, paragraph 44. I want a little more information about the issue of Graylands; I listened with interest earlier. I am not sure if you can answer this; I thought it was a question for the Mental Health Commission. Has a decision been made on whether to ring fence any proceeds from the sale of Graylands for mental health purposes only, or is there still a possibility that those proceeds will go into general revenue?

Hon ALANNA CLOHESY: It is too early for any decisions regarding any potential proceeds of any potential sale because that planning is still underway. Until identification of service types and range of services is completed, there is no way of knowing how much that will likely cost the state, much less if there are any proceeds from sale.

Hon ALISON XAMON: I have been asking them for four years, and I will continue to ask for the next four years until a decision is made!

I also want to ask about the planning that is going into Graylands. Is there a suggestion that the forensic unit, specifically the Frankland unit, might be moved to another location from Graylands? I was under the impression that a decision had been made to have the forensic facility remain at Graylands. Can I have confirmation on that? I would hate to see us revisit the public debate that followed the Disability Justice Centre.

Hon ALANNA CLOHESY: We certainly would not want to provide any false information, generally, to the public. The director general will answer that.

Dr RUSSELL-WEISZ: I think it is more time lines. We are looking at short, interim and medium term options in relation to forensic services. Putting Graylands to one side for a minute, we have provided additional in-reach services to prisons, as we should be doing, for mental health services. At the moment, with the Frankland Centre as it is, if there were any augmentation to that, it would be there, but if we had to divest the site completely in the future, then other things would be considered. But at the moment it would be to look at increasing Frankland because we need additional capacity.

Hon ALISON XAMON: Good, thank you. Please do not move it! I refer to page 318, paragraph 44, which actually refers to the introduction of contemporary models of care. What is it anticipated that they will look like and the time frame for their delivery? It is at the very top of the page at paragraph 44. I want to specifically ask if there has been any funding allocated to either the planning or introduction of these models of care.

Hon ALANNA CLOHESY: That is more relevant to the Mental Health Commission, in terms of the process around how that is being done.

Hon ALISON XAMON: Can I ask if any funding has been allocated; and, if so, how much?

Hon ALANNA CLOHESY: In relation to Health's participation in that process, we would have to take that on notice as supplementary information.

[Supplementary Information No C22.]

The DEPUTY CHAIR: On behalf of the committee, I thank you for your attendance today. I remind members that due to time constraints, the electronic lodgement system will not be reopened for additional questions this year. For witnesses, I advise that the committee will forward the transcript of evidence, which includes the questions you have taken on notice highlighted on the transcript, as soon as possible after the hearing. Responses to questions on notice are due by 5.00 pm, 10 working days after receipt. 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 as to why the due date cannot be met. I thank you but also ask that you promptly leave the chamber for COVID-19 cleaning between sessions. Once again, I thank you for your attendance today.

Hearing concluded at 4.33 pm