Division 21: WA Health, $6 962 660 000 —

Ms C.M. Collins, Chair.

Ms A. Sanderson, Minister for Health.

Ms A. Kelly, Acting Director General.

Mr R. Anderson, Acting Director General.

Ms J. South, Acting Assistant Director General.

Dr A. Robertson, Chief Health Officer; Assistant Director General.

Ms G. Clifford, Acting Assistant Director General.

Mr P. Forden, Chief Executive, South Metropolitan Health Service.

Dr S. Bowen, Chief Executive, North Metropolitan Health Service.

Mr R. Toms, Chief Executive, Health Support Services.

Mr R. Pulsford, Acting Chief Executive, WA Country Health Service.

Mr S. Tomson, Acting Chief Executive, PathWest.

Ms V. Jovanovic, Chief Executive, Child and Adolescent Health Service.

Dr L. Bennet, Acting Chief Executive, East Metropolitan Health Service.

Mr C. Barnes, Principal Policy Adviser.

[Witnesses introduced.]

The CHAIR: The estimates committees will be reported by Hansard and the daily proof will be available online as soon as possible within two business days. The chair will allow as many questions as possible. Questions and answers should be short and to the point. Consideration is restricted to items for which a vote of money is proposed in the consolidated account. Questions must relate to a page number, item or amount related to the current division, and members should preface their questions with these details. Some divisions are the responsibility of more than one minister. Ministers shall only be examined in relation to their portfolio responsibilities.

A minister may agree to provide supplementary information to the committee. I will ask the minister to clearly indicate what information they agree to provide and will then allocate a reference number. Supplementary information should be provided to the principal clerk by noon on Friday, 2 June 2023. If a minister suggests that a matter be put on notice, members should use the online questions on notice system to submit their questions.

I give the call to the member for Vasse.

Ms L. METTAM: My question relates to page 88 of budget paper No 3 and the health and mental health section. I refer to the $81.1 million to purchase the private facility and beds at St John of God Midland Public Hospital. Is this a one-off payment to transfer these beds into the public sector perpetually or for only a finite period of time?

Ms A. SANDERSON: As the member rightly points out, this budget has allocated $81 million for the purchase of 60 beds. The beds already exist; they are already built. That has some benefit in that it limits the delay in the ability to construct such a large number of beds on the facility. I think it is fair to say that Midland Public Hospital was not built to the scale that it should have been at the time and was not futureproofed. There was a lot of commentary at the time that it lacked the number of beds required to service the community. It services the important east metropolitan catchment, but it also services the wheatbelt—the Northam area. It is, essentially, under strain and needs more beds. This is a way of rapidly increasing the bed stock in the east metro area, at Midland, with limited delay in terms of construction, given our constrained construction market at the moment. I will hand to Mr Rob Anderson, who can outline the financial details.

Mr R. Anderson: I think the question was in relation to whether this is a recurrent or one-off cost.

Ms L. METTAM: Yes; is it a recurrent payment? Are these beds just for this year or is it a recurrent payment?

Mr R. Anderson: The beds are recurrent. Once we purchase them, they become part of the number of public beds in that facility. It is a one-off cost to purchase those beds then we have them infinitely.

Ms L. METTAM: Will there be recurrent costs going forward?

Mr R. Anderson: Yes, there will be as per any other public bed.

Ms L. METTAM: Are these 60 beds, which already exist in the system, included in the 1 147 new beds added since the 2021–22 budget?

Ms A. SANDERSON: They are included in the planned expansion of 600.

Ms L. METTAM: It is on the same page, or it could be a new question. My question relates to a dot point further down, which also refers to the 1 147 new beds added to the system since 2021–22. Can the minister provide a breakdown by hospital and number of new beds? What is the location of the 547 plus the 600 beds that are referred to?

Ms A. SANDERSON: The 547 beds built in the last year and a half consist of 157 new beds at Joondalup Health Campus, with 102 general and 55 mental health; 111 new beds at Peel Health Campus, with 81 general and 30 mental health; 70 new beds at St John of God Midland Public Hospital, with 60 general and 10 mental health; 58 new beds will be at Bunbury—sorry, I am reading the future 600. Was the question about the 547 beds?

Ms L. METTAM: It was about the 547 and the 600 beds.

Ms A. SANDERSON: My apologies. The 547 beds are spread around the system. I am happy to list the main areas and the main hospitals with those beds, but there is a lot of detailed information so the member may want to put that on notice in terms of exactly where the 547 beds are. Overall there are 30 more beds at Bentley Health Service and Osborne Park Hospital received another 30. There was an increase at Sir Charles Gairdner Hospital and Fremantle Hospital. Rockingham General Hospital and Bunbury Hospital at South West Health Campus received another 30 modular beds. There was an increase in ICU-capacity beds at Fiona Stanley Hospital. It is very detailed and broken down; therefore, the member will need to put that one on notice.

[9.10 am]

The CHAIR: Member, would you like to put that on notice?

Ms L. METTAM: Just to confirm, we cannot have that as supplementary information?

Ms A. SANDERSON: No.

Ms L. METTAM: Yes, I would like to put that question on notice. That is the breakdown of the 547. How about the breakdown of the 600 beds?

Ms A. SANDERSON: As I stated previously, the breakdown of the 600 new beds is 147 at Joondalup Health Campus, comprising 102 general and 55 mental health beds; 111 at Peel Health Campus, comprising 81 general and 30 mental health; 70 at St John of God Midland Public Hospital, comprising 60 general and 10 mental health; 58 at Bunbury Hospital at South West Health Campus; 53 mental health beds at Graylands Hospital; 40 mental health beds at Fremantle Hospital; 40 at Geraldton Health Campus; 36 at Bentley Health Service, which includes the surgicentre and mental health beds; 18 at Sir Charles Gairdner Hospital; 10 at Rockingham General Hospital; nine at Armadale Health Service; and three at Laverton Hospital.

Ms L. METTAM: Are all the 547 beds currently open?

Ms A. SANDERSON: Yes.

Ms L. METTAM: I refer to page 88 of budget paper No 3 and the new women's and babies' hospital. When will the minister publicly release the business case?

Ms A. SANDERSON: I do not have a date for that. We are committed to releasing it, but I cannot give the member a date.

Ms L. METTAM: Is it likely to be in the next month or next two months?

Ms A. SANDERSON: It is likely to be within weeks rather than months.

Ms L. METTAM: The plan at the new site includes a multistorey car park. Is that included in the $1.8 billion budget?

Ms A. SANDERSON: Car parking has been provisioned within the $1.8 billion budget.

Ms L. METTAM: The original plan for the hospital at the Queen Elizabeth II Medical Centre site included upgrades, a state-of-the-art theatre, an ICU and an emergency department. Will these upgrades still go ahead in full?

Ms A. SANDERSON: Yes, they will, and they were funded in the last budget. They will go ahead regardless of the decision to relocate the women's and babies' hospital. The funding, which already exists, includes an upgrade of ward C14 valued at $22.25 million; a GMP (RAPID) laboratory and cyclotron, with a project value of $32.4 million; an emergency department upgrade and a toxicology urgent care clinic, which is already in last year's budget, at $30.66 million; the replacement of the biplanar unit for the Neurological Intervention and Imaging Service of Western Australia to the value of $11.4 million; a new image-guided hybrid theatre for $12.1 million; and a new 10-bed intensive care unit to the value of $16.78 million. These are already appropriated, and in the budget.

Ms L. METTAM: I understood that the upgrade, or new emergency department and hybrid theatre, would be at a cost of about $500 million. Are we looking at something quite different now?

Ms A. SANDERSON: I have never seen that costing. I am not sure what the member is referring to, but this is the cost that was developed by the department and North Metropolitan Health Service and funded in last year's budget.

Ms L. METTAM: Can the minister confirm that the upgrades at Sir Charles Gairdner Hospital will in no way be short-changed as a result of shifting the women's and babies' hospital?

Ms A. SANDERSON: We are committed to the upgrades, and they are already in the budget. I can confirm that Sir Charles Gairdner Hospital will receive significant upgrades.

Ms L. METTAM: My understanding from people who were involved in the working group is that these upgrades fall short of what was originally proposed. Can the minister confirm that that is not the case?

Ms A. SANDERSON: The member is essentially using speculation from a third party, and I cannot confirm that speculation. What I can confirm is what is in the budget paper and what the government has confirmed, which is that we are committed to these upgrades and the money is in the budget.

Ms L. METTAM: The new plan includes upgrades to Osborne Park Hospital. Are these upgrades funded out of the $1.8 billion allocated to the new women's and babies' hospital?

Ms A. SANDERSON: One of the great benefits of the decision we made to relocate the women's and babies' hospital is that we are able to fund significant upgrades to Osborne Park Hospital. South of the river, we will have a range of birthing and maternity choices for women that do not exist now. The choices will range from a family birthing centre with support for community-based birthing and hospital inpatient birthing, all the way through to facilities for high-risk neonates and safe high-intervention birthing.

Osborne Park Hospital was long neglected under the former government. This government has committed to its future and ensured it will remain fit for purpose as a strong community hospital in the northern suburbs. It is intended that the Osborne Park Hospital upgrades will be able to be delivered within the envelope of the $1.8 billion, but the government is committed to the upgrade. Whether more or less appropriation is required will be determined by the business case, but we are absolutely committed to the future of Osborne Park Hospital. The significant upgrades that have already occurred under this government are testament to that commitment.

Ms L. METTAM: With respect to the upgrades that happened previously, is this unit now being fully utilised?

Ms A. SANDERSON: I am sorry?

Ms L. METTAM: Is the unit being fully utilised?

Ms A. SANDERSON: What unit?

Ms L. METTAM: The unit at Osborne Park Hospital.

Ms A. SANDERSON: What unit? There are numerous units.

The CHAIR: Member, can you refer to the line item?

Ms A. SANDERSON: There needs to be a line item.

Ms L. METTAM: During last year's estimates, the minister touched on the fact that it was potentially not the vibe to have a family birthing centre at the Queen Elizabeth II Medical Centre site and suggested that perhaps Osborne Park Hospital was a better site for a family birthing centre, as part of the women's and babies' hospital. Does the minister anticipate the family birthing centre will be going there?

Ms A. SANDERSON: Correct. I think I have publicly said that numerous times. I have also requested that consideration be given to a standalone family birthing centre at the Murdoch site. At the moment, the family birthing centre in the south is in the hospital, which is not ideal. The best practice is that they are standalone centres with close links to specialist services if required. I have asked that consideration be given to a standalone family birthing centre at the Murdoch site as well as at Osborne Park Hospital.

Ms L. METTAM: Does the minister accept the criticism from clinicians that the move to the Fiona Stanley Hospital site will result in preventable deaths?

Ms A. SANDERSON: I respect the concerns of clinicians, and I will make a few comments about that. I understand that clinicians who work around the inner western suburbs—the Subiaco site or the Nedlands site—have been given every indication that they will continue to work around that site. For a multitude of reasons, their lives, and their practice and work, are centred around that. People need to be very careful about the language they use and to use evidence to back up claims like that. I also think that those concerns are not universally held amongst this specialty and they run an outstanding and excellent service for very vulnerable patients. They are used to running that in a particular way, as a particular model. I encourage them and will work with North Metropolitan Health Service to expand their thinking about what a new model of care looks like for those vulnerable patients. That is certainly the conversation I have had with them.

Around 40 to 45 babies a year may need surgery within the first hour of life. Those births are almost always planned, and when they are not, they would travel anyway. Those babies are usually diagnosed in utero and it is a planned elective caesarean and arrangements are made. That makes the planning a little easier around this cohort. There is already a specialist neonatal service at Fiona Stanley Hospital and I encourage the member to visit that service as well. I know she visited the Child and Adolescent Health Service neonatal service and talked to the clinicians there. We will provide world-class facilities and clinical excellence for those babies and women.

We also have the incredible newborn emergency transport service, which I have seen in person, and the work they do is quite extraordinary. The babies are not "bounced around in an ambulance". I have heard that phrase used; that is not reasonable language. This is an incredible service with a paediatrician and paediatric nurse. The very delicate and vulnerable little patients are cared for very well. The service has received a significant investment under this government over the past few years. Overall, when we make a decision for such an important and strategic piece of infrastructure, it is important that we take into consideration all the risks and all the benefits to the broader community. Individual cohorts need absolutely important consideration, but in my view the fundamental risk that the business case highlighted is that given the complexity of the site at QEII, construction would not start on the hospital until 2028. That is a huge risk. Construction disruption and a constricted site at an already important tertiary hospital would be a significant risk to the community. As minister for the whole system, and as a government that needs to consider the whole system, and obviously the department as well, we came to the view that we could manage the risk and provide an outstanding service for everyone who needs this service—women, babies and women who need gynaecology and oncology rather than maternity services—and that this would be a far better outcome overall for everyone.

[9.20 am]

Ms L. METTAM: I thank the minister; I took up the opportunity to have a tour of King Edward Memorial Hospital for Women and the neonatal unit. As part of that tour, I heard very real concerns from a consultant. He raised concerns from a clinician's point of view. In fact, he stated that he believed they would be better off at King Edward Memorial Hospital until the new site, the gold standard, was available next to Perth Children's Hospital. Very real concerns were also raised about time spent in the neonate transfer service because, as good as that service is, those vulnerable babies, from a clinical perspective, are far better off being in a stable environment. Real concerns were expressed about the shift from the gold standard of being close to Perth Children's Hospital, which is what it is about. How many clinician movements are there every year between Perth Children's Hospital and King Edward Memorial Hospital? I imagine this would be a consideration as part of the decision to go to the Fiona Stanley Hospital site.

Ms A. SANDERSON: The member would have to put that question on notice.

The CHAIR: Member, you will need to lodge that as a question on notice.

Ms L. METTAM: Can the minister provide that by supplementary information?

Ms A. SANDERSON: No, we are not providing supplementary information.

I will respond to some of the commentary. The point I am trying to make, and have made to clinicians, is that we may not need to transfer them. We are open-minded about what the model of care is and what other facilities may need to be provided at Perth Children's Hospital and Sir Charles Gairdner Hospital to maintain that link for that very small and predictable cohort. I will hand over to Dr Shirley Bowen, who will outline what the consultation process will be going forward with the clinicians and what it is they are looking at. I caution people involved around the language and I would certainly caution—I think this has happened to some extent—against trying to whip up anxieties amongst prospective parents who may be having vulnerable babies. That would be irresponsible. I disagree with the proposition that has been put by one person that they would be better off staying at King Edward as opposed to a brand new, world-class tertiary women's and newborn babies' hospital, which will have a specialised neonatal unit. I fundamentally do not agree with that statement. As I said before, there are varying views amongst clinicians about this move. The thing that has concerned people is that the government did not speak to them before it made the decision around the relocation. Ultimately, we needed to make a decision to keep the project moving and we were not prepared to entertain any other delays, given the importance of getting that project up on the ground. I will ask Dr Bowen to outline some of the processes going forward with neonate specialists around this cohort.

Dr S. Bowen: Over the next six to eight weeks we will convene extensive consultation with the clinician groups. We have already been meeting with them regularly since the announcement—that is, the clinical staff associations of the major hospitals involved. We announced this week that we will meet with the individual heads of department of the relevant areas of each of the hospitals. This includes Fiona Stanley Hospital, King Edward Memorial Hospital for Women and Perth Children's Hospital, and under that the Sir Charles Gairdner Hospital group as well. We will discuss with them as individuals their concerns or strategies and options for the future and then convene multiple

workshops to look at various subgroups that fall out of that, which includes neonatal transfers, gynae-oncology for adult women, birthing services, a family birth centre and a range of issues that now need to be finalised to enable the transfer.

[9.30 am]

Ms A. SANDERSON: If this is it on this issue, I will close by saying that in a perfect world we would maintain that link between birthing and the children's hospital—of course we would. But we are not able to build on that site. That is the fundamental issue. Women need access to an ICU. At the moment, women are transferred from King Edward Memorial Hospital for Women to Sir Charles Gairdner Hospital. There is significant risk in that. The move to the Fiona Stanley Hospital site will provide a link for very unwell women to access ICU and reduce the risk that exists now. I am confident that we will come up with a model of care over the next seven years to ensure that we are also able to maintain that strong link for neonates.

Ms L. METTAM: There was concern about newborns accessing paediatric specialists at Perth Children's Hospital. Will there be any benefits for the medi-hotel at Fiona Stanley Hospital as a result of this move? Does the minister anticipate that there will be a take-up of those beds?

Ms A. SANDERSON: It is actually a very large development. It is a health precinct development. One part of it is a medi-hotel. There will also be short-stay accommodation, a hotel, other medical services, consulting rooms, imaging, primary care and allied health. It is a whole precinct of health care. It will be beneficial to every user of that campus, whether they are at Fiona Stanley Hospital, Sir John of God Hospital or the women's and babies' hospital. There is potential to support it. The decision was made around access to the site and the inability to build at Queen Elizabeth II Medical Centre. The medi-hotel was not a major deciding factor. It will be an incredible use of that land and an incredible development and will be helpful for everyone who will use that campus.

Ms L. METTAM: When were the operators of the medi-hotel advised?

Ms A. SANDERSON: They were advised at the same time as everyone else.

Mr P.J. RUNDLE: I wish to go back to the minister's previous comment. Does she think it is appropriate, as health minister, to caution clinicians who are working in the system about coming out and talking? Obviously, some of them have not been consulted. Is it appropriate for the minister to caution them when they are just expressing their opinions and concerns about the challenges and dangers?

Mr S.A. MILLMAN: It does not sound like an estimates question.

Ms A. SANDERSON: It is not a budget matter.

The CHAIR: Member, can you please refer to a line item?

Mr P.J. RUNDLE: It is the same line item relating to Fiona Stanley Hospital.

Mr S.A. MILLMAN: Is it a question about expenditure?

Mr P.J. RUNDLE: There is an amount of $544 million.

The CHAIR: Is your question about the expenditure?

Mr P.J. RUNDLE: It is just a continuation of my question.

Ms A. SANDERSON: I think the question is completely out of order but I will answer it. I did not caution clinicians. I did not say the word "clinician".

Ms L. METTAM: What transport initiatives are being put in place or costed to ensure the safe and timely transfer of babies to Perth Children's Hospital?

Ms A. SANDERSON: We have seen significant investment in the newborn emergency transport service. Dr Shirley Bowen outlined the process going forward with clinicians who will develop that. We have a number of years to develop that and we will do it diligently. As I said, it may not be necessary to transport some babies. Maybe clinicians will be able to go there from PCH. There is a range of opportunities on the table. I am encouraging people to think outside of the model of care that they deliver now and to think broadly about how care might be delivered in the future.

Mr P.J. RUNDLE: I have a final further question on the Fiona Stanley Hospital car parking situation. The minister said there will be a multistorey car park. Is she taking into account the fact that at the moment people cannot get a car park at Fiona Stanley Hospital and they end up running late for appointments and the like? Will there be any activity in the next few years, before that multistorey car park is built, to alleviate the car parking issues at Fiona Stanley Hospital?

Ms A. SANDERSON: The plans involve two multistorey car parks. We will not only replace the car parking that we were going to build on, but also provide two more multistorey car parks. That work can commence as soon as

practically possible. We expect it to start sooner than the build for the hospital. I will hand over to Paul Forden to give more detail. In terms of access, out of the two campuses, Fiona Stanley Hospital is literally just off the freeway off-ramp and there is a train station as well as multiple car parks. Parking is always an issue in health precincts. I am sympathetic because it is hard wherever we go. At every hospital and every single precinct, parking is the issue. This is the most accessible campus in the metropolitan area. We will be providing two multistorey car parks as part of this development. I will hand over to Paul Forden to give a bit more detail.

Mr P. Forden: Obviously, part of it will be to expand the car parking. In the interim, we are reducing demand for car parking. All we have done is introduce schemes whereby staff can work from home for periods of time as appropriate. That has reduced demand for car parking. We have also had a considerable increase in digital outpatients, which has reduced a lot of demand from patients having to travel to the hospital and park their car. Obviously, we have expanded our use of the bicycle scheme.

Ms L. METTAM: Apparently, the reason for the shift to Fiona Stanley was the parking issues at the QEII site. The minister is talking about a significant investment in two multistorey parking sites at Fiona Stanley in the face of significant concerns raised by clinicians and a shift from a gold-standard approach to delivering and supporting neonatal care. Can the minister understand why there is real concern about how this decision was made?

Ms A. SANDERSON: At no single point have I ever said that car parking was the reason we made that decision. There are a multitude of reasons. Of course we would not make a decision like this based on car parking. The member's comment—it is not a question—is fundamentally wrong.

Mr P.J. RUNDLE: I want to get this clear in my mind. Will any extra car parks be built in that interim seven-year period or are there other arrangements, such as those we just heard about?

Ms A. SANDERSON: Two multistorey car parks will be built within that period.

Mr P.J. RUNDLE: What is the exact date for completion of those multistorey car parks? When will they be available?

Ms A. SANDERSON: That will be determined by the tender.

Ms L. METTAM: One of the issues for the QEII site relates to transport and congestion issues. The minister or perhaps the Premier said that staff would not have anywhere to park and shuttle buses would be used for 10 years. I guess the point I am making is that the government, in supporting this dramatic shift in its approach to the women's and babies' hospital, is going to significant lengths to address the parking issues at Fiona Stanley Hospital. We would like some confidence that every effort has been explored to address the well-understood challenges at the Queen Elizabeth II Medical Centre site, given the concerns raised by clinicians and the step away from the gold standard in delivering care.

[9.40 am]

Ms A. SANDERSON: I can give the community absolute assurance that every consideration was given to every single aspect of this construction and development—absolutely. This decision was not made lightly. The constraint around the Queen Elizabeth II Medical Centre car park is about not only the land but also the contract. In the development of Perth Children's Hospital, the former government agreed to a contract with a private provider that limited the ability of any other operator to build and run a car park facility at that site—not only the state but also any other operator on QEII, such as the Harry Perkins Institute of Medical Research. It is an incredibly constrictive commercial arrangement, so that was one of the considerations around it, but not the whole consideration.

Another part was, absolutely, staff disruption and safety. During the Perth Children's Hospital build, staff parking was relocated to Graylands Hospital and staff were shuttle-bused to the QEII site. They were very cooperative and I appreciated their support in that, but—hand on heart—I did not feel it was appropriate to inflict that on Sir Charles Gairdner Hospital and Perth Children's Hospital staff over a protracted period. There were also risks around ambulances getting through construction works to access the emergency departments at Perth Children's Hospital and Sir Charles Gairdner Hospital. Every day, 14 000 people access that site, including staff, patients and support workers. It is not at all a small consideration.

Sir Charles Gairdner Hospital runs statewide speciality services that need to be maintained without disruption. Maintaining bed availability, outpatient facilities and all the other services without disruption was going to be impossible. As I said, the business case outlined that we could not even start construction for the women's and babies' hospital until 2028 because of all the considerations. I acknowledge and appreciate the concerns of the clinicians around neonates. We are very committed to providing the best possible model of care for those babies and their families. This is a really good decision for women and particularly those who live in the suburbs who want access to a range of maternity choices. They will have access to family birthing centre options, the hospital as well as acute neonatal care and acute care. This is a good decision for women and really puts women at the centre of a women's and newborns' hospital.

Ms L. METTAM: We have heard already many neonate clinicians speak out against this decision. The minister said there are clinicians who support it. Are any of those clinicians willing to speak out publicly?

Ms A. SANDERSON: That is not for me to say.

Ms L. METTAM: It would certainly help.

The CHAIR: The minister is not able to answer on other people's behalf.

Ms L. METTAM: I refer to page 301 of budget paper No 2 and the $6.3 million for the delivery of specialist cancer services across regional Western Australia. I would like to ask about the cancer services in the metropolitan area, specifically the Comprehensive Cancer Centre at QEII. I am just wondering whether the minister can provide an update on that.

Ms A. SANDERSON: That does not relate to this budget line item.

The CHAIR: Member, are you looking at page 301?

Ms A. SANDERSON: The member referred to regional cancer services. Metropolitan cancer services do not relate to that budget line item.

The CHAIR: It is not related to this budget line item.

Ms L. METTAM: I will go to page 88 of budget paper No 3, regarding electronic medical records. There is $99.4 million to complete the first stage of the EMR program. I am specifically interested in Perth Children's Hospital. When will this be implemented?

Ms A. SANDERSON: The first part of the electronic medical record program at Perth Children's Hospital will be at the Perth Children's Hospital ICU. That will be part of stage 1. We do not have a date at this point but we will have one in coming weeks.

Ms L. METTAM: When will the EMR be implemented at PCH?

Ms A. SANDERSON: Stage 1 of the EMR implementation includes Perth Children's Hospital ICU. We do not have a date at this point but we will have one in coming weeks.

Ms L. METTAM: When will all stages of the EMR be implemented at PCH?

Ms A. SANDERSON: The time frame for PCH will be subject to the stage 2 business case. We are at stage 1 and we are still completing that.

Ms L. METTAM: Does the minister anticipate that stage 1 will be implemented this year?

Ms A. SANDERSON: I will hand to Rob Toms from Health Support Services. He can give the member more of a time line.

Mr R. Toms: Stage 1 of the program for Perth Children's Hospital includes two key items. One is the deployment of the digital medical record around the end of July this year. The second item is the implementation of the ICU EMR. Planning work is still underway for when that will be completed, but it will be completed as part of stage 1.

Ms L. METTAM: Is the 24/7 supernumerary resuscitation team at PCH in place now?

[9.50 am]

Ms A. SANDERSON: The supernumerary resus team was part of the Australian Nursing Federation's 10-point plan, which was accepted by the government when it put it forward. It was very sensible and constructive, so it was accepted. I make the point that there have always been four resuscitation paediatric nurses on the roster for the emergency department. Obviously, recruitment for this has been ongoing and over a period. We are in a challenging recruitment environment. Paediatric nursing is very specialised. Paediatric nurses cannot be pulled from the general agency pool and paediatric resuscitation is a higher competency and can take about 18 months to achieve because they need real-life resuscitations to achieve competencies. It is not as though highly trained resuscitation paediatric nurses can be churned out. They need to have hands-on experience with paediatric resuscitations. The emergency department at Perth Children's Hospital has around one or two a day, I understand. It is not a high level, which is a good thing that it is not occurring too regularly. It takes time for nurses to gain that competency. A number of nursing staff are currently in the training pipeline to achieve that competency. As much as humanly possible, Child and Adolescent Health Service is seeking to fast-track that training. Currently, we are achieving around two to four supernumerary resuscitation teams and it improves every day. That is on top of the existing roster. We are making good progress with that implementation. We have also received the ratio audit for Perth Children's Hospital emergency department, which outlines that it is exceptionally well staffed given the recent uplift of resourcing that the government provided for staffing to a point of 1:2 to 1:3 nurses per patients per day. On top of that is the supernumerary team.

Ms L. METTAM: When does the minister anticipate the supernumerary resuscitation team will be in place?

Ms A. SANDERSON: It is progressing well and we expect it to be complete in the coming months.

Ms L. METTAM: I refer to page 300 of budget paper No 2, volume 1 and paragraph 31 under the heading "Building World-Class Infrastructure". Does this include and can the minister provide an update on the comprehensive Cancer Centre at Queen Elizabeth II Medical Centre?

Ms A. SANDERSON: No, it does not.

Ms L. METTAM: Is the minister able to provide any update on that project?

Ms A. SANDERSON: We have provided funding for a business case and that has been agreed with the commonwealth and the proponents. My understanding is that they are very happy with the time frame. I met with the proponents recently and asked whether they would be able to, or had ambition to, bring forward the project and they said no because there is a lot of work to do around the business case. We are working with the proponents and the commonwealth around what that business case will look like.

Ms L. METTAM: Does the minister share the Premier's concern that the cost may be much more significant than was originally proposed?

Ms A. SANDERSON: I think it is obvious that construction costs have gone up by about 60 per cent for health infrastructure. Most of our projects are coming in at about 60 per cent higher than originally costed. Whether it is building a house, a school, a hospital, a road or a train line, costs are higher.

Ms L. METTAM: I refer to page 116 of budget paper No 3 and workforce attraction and retention. A dot point refers to $1 million in 2023–24 being spent on advertising and recruitment campaigns. What is the breakdown for the international and national spend?

Ms A. SANDERSON: I can talk around what that funding is for and some of the other workforce initiatives, but for the breakdown of the spend the member will need to put that question on notice. The $1 million is an extension of the Belong campaign, which was launched a couple of years ago to attract interstate and international healthcare workers. It is largely all interstate and international. It is to attract healthcare workers into our system. As the member knows, there is a global rush, particularly for nursing staff. It also includes medical and allied health staff. The campaign has been very successful and our current recruitment efforts over the last couple of years have been very successful. WA Health's workforce has increased by 29 per cent in FTE since 2017. We obviously need to continue that momentum, which is why we have continued with new initiatives in this budget, including the extension of the Belong campaign. There are also attraction and retention bonuses for graduate nurses and midwives who will receive $12 000 over three years to pay their Higher Education Contribution Scheme debt if they take a position in regional health, which I am sure regional members opposite appreciate. We know that when people have a good and early experience of regional healthcare, they tend to stay there. We have also expanded our hospital places significantly for graduate nurses in the metropolitan area as well as in the regions.

Ms L. METTAM: To date, how many nurses have been employed as a result of this campaign?

Ms A. SANDERSON: The member would have to put that question on notice. I do not have that in front of me.

Ms L. METTAM: Can the answer be provided by supplementary information?

Ms A. SANDERSON: No, we are not providing supplementary information. I will ask Jodie South, who might be able to provide a bit more detail and context.

Ms J. South: Directly as part of the Belong campaign, we have a dedicated recruitment pool for nursing and midwifery. To date, it has facilitated 493 appointments.

Ms L. METTAM: To clarify, it is 493 since what date?

Ms J. South: Belong started in October 2021.

Ms L. METTAM: I refer to page 115 of budget paper No 3 and the COVID response. On the $12.3 million in warehousing costs for rapid antigen tests, how many of the 10 warehouses hired to stockpile RATs are still being leased?

Ms A. SANDERSON: I think everyone who experienced the last few years understands that rapid antigen tests were a really essential part of our COVID response, particularly since Omicron. If we recall December 2022, just as I became Minister for Health, we were watching Omicron rip through the eastern states and around the world. We essentially saw a complete breakdown of community services, policing, schools, workforces and so on. No-one could get hold of RATs. The government procured numerous RATs from a range of suppliers. At that time, rapid antigen tests were essentially commandeered by the commonwealth as soon as they arrived at the airport, and no-one could get supply. It has been a really good and important part of our response to COVID. To

date, none of those RATs have expired, to my knowledge, and they are still widely used by the community. I think the acting Mental Health Commissioner used one this morning to find out that he would not be at estimates because he is COVID positive. They continue to be a really important part of our strategy in managing COVID in the community. I will refer to Rob Toms, who might be able to outline storage.

[10.00 am]

Mr R. Toms: Since the state has possessed the 110 million RATs, we have used about two-thirds already, so two-thirds have been distributed already. We have two warehouses we own ourselves and eight we use from external service providers. All the warehouses are still being used to store rapid antigen tests, personal protective equipment and other goods we have procured over the past few years, but we are working through a process of consolidating down to five over time as the stocks deplete and we utilise a lot of the products we have. We are working through a plan at the moment for what that ramp-down looks like and the time frames.

Ms L. METTAM: When is completion of the lease anticipated, and what is the ongoing cost of it?

Ms A. SANDERSON: We will take that on notice. The member will need to put that on notice.

Ms L. METTAM: I am confirming that the minister stated that no RATs have expired already. How many are due to expire before the end of the year?

Ms A. SANDERSON: I said "to my knowledge". The member would have to put that question on notice.

Ms L. METTAM: I refer to page 114 of budget paper No 3 and non-hospital services expenditure. The first dot point states that $239.5 million has been spent to meet contractual obligations and additional contract management costs. Can the minister provide some detail on what contracts this has affected and how much was required to meet obligations and additional costs?

Ms A. SANDERSON: Those contracts are outlined on the same page. There is a range of contracts, including with St John WA ambulance.

Ms L. METTAM: The second dot point highlights the increased costs for indexation to meet RiskCover premiums. Can the member advise how much the additional costs are and why the premiums have increased?

Ms A. SANDERSON: Could the member repeat the question?

Ms L. METTAM: The second dot point touches on the increased cost of indexation to meet RiskCover premiums. Can the minister advise how much the additional costs are and why the premiums have increased?

Ms G. Clifford: I do not have the specific cost of the RiskCover premiums to hand. They would be part of the broader cost indexation that we apply to all our core services. I do not have the specific RiskCover cost with me.

Ms L. METTAM: Do you not have that information?

Ms G. Clifford: Not specific to RiskCover because RiskCover is one part of the cost increases that we see as part of our non-hospital services. Those will cover cost indexation generally, which relates to cost-of-living and wage increases, so it is broader than just RiskCover.

Ms A. SANDERSON: It would also include the cost-of-living payment, the wage increase and any other cost increase of conditions or entitlements that would have been agreed to in the enterprise bargaining agreement as well as those RiskCover costs.

Ms L. METTAM: I refer to page 116 of budget paper No 3 and the Peel Health Campus transformation transition costs. It states —

> To support the transition of privately run health services at the Peel Health Campus back into public hands, an additional $6.5 million will be spent in 2023–24 reflecting the one year extension to the transition date.

During the transition phase who is responsible for the upkeep or maintenance of the health facility?

Ms A. SANDERSON: The contractor.

Ms L. METTAM: Why has the transition been pushed out by one year?

Ms A. SANDERSON: The transition was extended. I outlined quite extensively when we made the announcement last year that it would be extended essentially because we found a range of IT issues, primarily upgrades. We sought a smooth transition of records, policies, procedures, processes and, particularly, IT infrastructure, which needed some work to be brought up to public health standards in order for us to take ownership of the asset, and more time was required to do that. I might ask Rob Toms from health support services, who is leading that stream of work, to give more detail.

Mr R. Toms: When we undertook our initial assessments of what the IT landscape looked like at Peel, it was very, very different from how the public health system works. There are a lot more systems and IT solutions used in the public health system than were used at Peel, so that meant a lot more work was required to move the campus over to the public health system and implement a lot of new IT systems. We also needed to replace its network and a lot of infrastructure on the site. The complexity and amount of work required to do the IT transition was much greater than originally anticipated.

Ms A. SANDERSON: I add that it has long been the desire of the community that Peel Health Campus be a fully government run hospital. It has long been the desire of the community and the staff who work there. More than 90 per cent of the staff have opted to transition into the public health system, which is a huge endorsement of this policy and this decision by this government. It is a huge endorsement, and we are very committed to this transition and we want to ensure that it occurs as smoothly as possible with the least disruption to patients and staff. That is why we sought to extend the date and make sure we can do that. It is like commissioning a brand new hospital when services are brought online, and we have to make sure that everything is working from day one.

Mr D.J. KELLY: Referring to the question the minister has just been asked about who is responsible for the cost of transitioning, I wonder whether the minister could inform the chamber who was responsible for privatising the Peel Health Campus in the first place.

[10.10 am]

Ms A. SANDERSON: I thank the member for the question. Of course, the member is pointing to the fact that it was a former Liberal government that privatised that health campus in the first place to a company that was based in Singapore and not in any way interested in delivering good healthcare outcomes to the community. It has long been a sore point for the community down there, and I think the numbers of staff who have agreed to transition is a testament to how strongly supported this policy is.

Ms L. METTAM: Is the minister concerned that 10 per cent of staff have not committed to stay and continue working at Peel Health Campus, and how much of the working cohort does 10 per cent represent?

Ms A. SANDERSON: I will hand to Paul Forden to answer that question.

Mr P. Forden: Just to clarify: it is not that 10 per cent of the staff have said "no"; they are just seeking supplementary information et cetera. We have had around two per cent of staff say "no", and they are mostly people who are at the end of their working career who have said they plan to retire.

Ms L. METTAM: Obviously, there is significant concern in the community about what is happening with the planned upgrade of the existing facility, which was announced in 2020. What is happening with the upgrade, and what assurance can the minister provide that this will happen as soon as possible? What is the time frame for the upgrade?

Ms A. SANDERSON: The government is very committed to the upgrade and is going through the business case process. That is a very important process to make sure that we get the upgrade right. We committed to upgrading the services we previously announced, which include a number of new services and expansions and the expansion of bed stock. It is still very much part of the government's capital infrastructure plan. We have to go through the business case and the project definition plan to get a time frame. Once that is complete—I expect that to be complete certainly this year—we will have a time frame, and we will then be able to provide that time frame to the community. I think it is important to acknowledge the very constrained construction market that we are operating in, and we have to smooth the pipeline of work. There are a lot of particularly health infrastructure upgrades occurring—record infrastructure upgrades—and there is not a large number of commercial builders that can build to the standard that Western Australia requires, so we have to make sure that the market is able to deliver, as well. We will be working with various proponents when we get to that stage to make sure that we can deliver as soon as we possibly can.

Ms L. METTAM: Does the minister anticipate works to begin next year, as part of the time frame for the transition?

Ms A. SANDERSON: Yes, I do. It is separate from the transition. I make that point: this is separate from the transition.

Ms L. METTAM: Yes. What efforts are being made or will be made in this transition to ensure that staff are retained at Peel Health Campus?

Ms A. SANDERSON: Every effort is being made, chair. I think, from the fact that 90 per cent have said "yes", two per cent have said "no" because they are retiring, and we are working with the remaining eight per cent, the member can see that every effort has been made, and it has been an outstanding success.

Ms L. METTAM: One could argue that the concerns at Peel Health Campus have raised a lot of public concern and concern amongst staff, as well. Is the minister able to provide a time frame for when the operations of Peel Health Campus will be able to resume as normal?

Ms A. SANDERSON: I will hand over to Paul Forden to say a few words, but I will say that we are still working with the South Metropolitan Health Service and we are still working with the contractor to ensure that we can do that. I am hoping to have an update while we are in estimates; if that comes through, I will make the chamber aware of the exact date and when we can start bringing certain services in line. I am just looking at my notes. The writing is tiny! Disinfecting is still ongoing and there is an environmental clean happening today. As I said, we are hoping to have a clearer time frame while we are in the chamber, and if that is forthcoming, I will make the member aware of it. We are still doing births and a number of services are still continuing, but I will hand to Paul Forden to give a bit more detail.

Mr P. Forden: As the minister has said, a number of services are continuing. A number of areas were identified as high or medium risk. Those areas are not being used for patient care. The obstetrics unit was deemed to be low risk, as was one of the theatres, so we have been able to continue with an obstetric service, which has been very beneficial to our local mothers. The emergency department was deemed to be a medium risk; therefore, for the course of this week, we have moved the ambulance admissions away from Peel to broadly Rockingham and Fiona Stanley Hospital. We have moved the emergency department for walk-in patients into the north part of the campus, which is the outpatient area. The vast majority of patients who attend the emergency department still actually attend the site. Only around 30 per cent of patients are brought in by ambulance, so 70 per cent of patients are still attending.

We are waiting for the type of mould to be identified. It is a long process; it can take several days for that to be analysed in the labs and identified. In the meantime, we have cleaned a number of areas already. The emergency department, the Barker Ward and a second ward have already been cleaned in anticipation. That means that once we have identified the mould, we will be able to assess whether it is a type that will allow us to engage services again following the cleaning process. There are plans in place for that to be enacted as soon as we have that decision.

Ms A. SANDERSON: As Mr Forden has outlined, we are just waiting on sample results, and the time frame for reopening will depend on those results.

Ms L. METTAM: Given that, are we anticipating it will be in the next few days?

Ms A. SANDERSON: We are anticipating it, but it depends on the type of mould. We should get those results today. We will have a time line today.

Ms L. METTAM: Was the mould a result of a maintenance issue? What was the cause of the mould and how did this happen? Given that it is a public hospital facility, what responsibility does the government take for the chaos that has happened over the last few days?

Ms A. SANDERSON: At this point in time, our absolute focus is on remediation and getting patients back in the hospital. I am not looking at this point to apportion blame. The Department of Health—both public health under the Chief Health Officer and environmental health—is working with the South Metropolitan Health Service, which is working with the contractor to remediate the issue as soon as possible. It demonstrates the exceptionally high standards that are required in Western Australia and monitored by the Licensing and Accreditation Regulatory Unit. Our facilities are required to meet very high standards and they are safe. The focus right now is everyone hands on deck, working to remediate the issue.

[10.20 am]

Ms L. METTAM: On page 301 of volume 1 of budget paper No 2, paragraph 37.2 refers to Joondalup Health Campus. Does the $269.4 million for the redevelopment of Peel Health Campus include funding for the Joondalup medi-hotel?

The CHAIR: Member, can you please repeat the question? You said "Peel" instead of "Joondalup".

Ms L. METTAM: Sorry—Joondalup; I have Peel on my mind! Does the $269.4 million for the redevelopment of Joondalup Health Campus include funding for the Joondalup medi-hotel?

Ms A. SANDERSON: That funding is for the stage 2 upgrades of Joondalup Health Campus, which is a significant development—far more significant than a medi-hotel. As I previously said, in discussions with the operator, the view was that more investment was required in some of the other services at the health campus. The upgrades to Joondalup Health Campus—both stages 1 and 2—have been very well accepted and celebrated by the local community. That funding envelope for stage 2 includes a 102-bed mental health unit, which will include 55 beds to meet additional demand, and that is a doubling of the number of existing mental health beds at Joondalup; 12 new emergency department beds, comprising 10 bays and two isolation rooms; a specialised behavioural assessment urgent care clinic located within the expanded emergency department; refurbishment of the emergency assessment unit located within the expanded ED; a new 112-bed public ward block, comprising a 30-bed medical–surgical

ward, a 16-bed cardiac care unit, of which six beds are additional and 10 are relocated, and 66 shelled beds to meet future demand; a theatre; a new cardiac catheterisation lab; a refurbished discharge lounge; increased public and staff parking; and upgraded staff facilities. We have also initiated the stroke clinic, which has been incredibly well supported by the northern suburbs community. Our commitment and investment in our northern suburbs health care is significant and ongoing.

Ms L. METTAM: Is the Joondalup medi-hotel project likely to happen at all or has it been canned completely?

Ms A. SANDERSON: We continue to have discussions with the provider about the implementation of the medi-hotel. It is still absolutely a live possibility, but the priority investment has gone into all those important services that I just outlined.

Ms L. METTAM: I refer to page 314 of volume 1 of budget paper No 2 and the medi-hotel in Murdoch. I note there has been some progress on this medi-hotel. When will this facility be completed and receive patients?

Ms A. SANDERSON: The builder and developer are expecting practical completion later this year. They do not have an exact date. Obviously, they are still really constrained by construction labour shortages. It is very difficult to put a commissioning date on it, but it is our ambition that the medi-hotel will be taking patients before winter next year.

Ms L. METTAM: How many beds will the facility contain? I am sure that has already been announced. How many patients are expected to utilise the medi-hotel each year and how many will this provide for Fiona Stanley Hospital?

Ms A. SANDERSON: Could the member repeat the second part of her question?

Ms L. METTAM: How many patient days will this provide or offset at Fiona Stanley Hospital?

Ms A. SANDERSON: The medi-hotel will have 80 beds that the state will contract for—20 mental health and 60 general medical beds. I will hand to Paul Forden, our chief executive of the South Metropolitan Health Service, for more detail.

Mr P. Forden: As the minister said, the facility will have 80 beds. The contractor is planning to run it at an occupancy level of 80 per cent. Therefore, it is anticipated to have 64 patients on average at any one time. Clearly, that will fluctuate based on patient demand. We anticipate the majority of those patients will come from Fiona Stanley Hospital, but the service will be accessible to all public hospitals.

Ms L. METTAM: Does the minister anticipate that some of those beds will come from the women's and babies' hospital as well?

Ms A. SANDERSON: Construction will not be completed until 2029, so we are not factoring it in at this point. As Paul Forden said, they can come from around the system.

The CHAIR: Before we move on to a new question, I would like to request a short five-minute comfort break. Are members okay with that or would they like to proceed? Yes. We will reconvene at 10.35 am.

Meeting suspended from 10.27 to 10.35 am

The CHAIR: Members, are there any questions?

Ms M.J. DAVIES: I refer to budget paper No 2, volume 1, page 313 and the Tom Price Hospital redevelopment. Can the minister advise what the total cost will be for this project? Is it all in the budget?

Ms A. SANDERSON: There is a significant cost escalation for Tom Price for a couple of reasons. The approved budget for the Tom Price Hospital redevelopment is $32.8 million and includes $20 million from Rio Tinto. That is to provide a resuscitation bay, two treatment bays, a mental health assessment room, a procedure room and four inpatient beds, as well as an outpatients' area, imaging, pathology and dental. This will be insufficient to deliver the project, given construction cost increases and a range of other issues. We are undertaking ongoing planning around the cost escalation to work out how we can deliver that hospital within a reasonable envelope that is value for money for taxpayers, but we are still very committed to it. We are also continuing to work with our partner, Rio Tinto. We will soon have a plan to go back to the Expenditure Review Committee to continue with that development.

At the moment, it is very difficult to get construction companies to build, particularly in regional areas, for a price that is reasonable and acceptable to the taxpayer. We are very constrained currently by the market, but we are still working through those issues. I might refer to Rob Pulsford from WA Country Health Service, who might be able to give the member a bit more detail.

Mr R. Pulsford: We are continuing to work to explore value-for-money opportunities. At the same time, there is a parallel process. The intention is to construct the new facility on a new site in the township of Tom Price, so we are still working to secure that. The land is secured, but we are also doing the early feasibility and the land assembly work so the project can continue. Once we have a funded solution in place, we will be right to progress with it.

Ms M.J. DAVIES: I note the minister's comments about the challenges that are being experienced. It was expected to begin by the end of last year. Could the minister provide an update on when the expected construction time frame is likely to commence and what the new construction time frame might be? When would the minister like to see it completed? Is there an idea? I understand that the minister will say "as soon as possible", but is there a time line within government? That is how departments work.

Ms A. SANDERSON: We have to overcome a range of issues before we can settle on an agreed time line, and that is because we do not have the final scope of funding. We are working through that process, and we are working through ways that we can deliver it for a lower cost and what the final scope of the project may be, noting what we have committed to deliver so far. I would have liked to start exactly on time but, as I said, we are in an incredibly constrained environment.

I expect I will get asked a number of questions about the smaller regional projects. I have said this publicly: we committed to a range of projects before COVID, and then when COVID hit, we committed to a range of additional projects as part of the COVID-recovery program because we were expecting the economy to be decimated, as economies were around the world in a multitude of countries. That has not been the case in Western Australia. In fact, we now have an incredibly stretched construction market, and we are challenged, too. Companies are challenged by the cost and availability of labour and the cost of materials. I have taken the decision to prioritise the big regional developments that have an expansion of services and an overall gain to the community from that expansion of services. I have prioritised getting those big regional hospital developments going and getting the construction companies locked in and building. We continue to work through the challenges of those smaller sites. I expect I will be asked about Laverton, Mullewa and Tom Price, and we continue to work with companies to make it attractive for them to bid and tender for that work.

[10.40 am]

Ms M.J. DAVIES: The minister went through the scope of what has been committed. That is not going to change, is it?

Ms A. SANDERSON: No, we will deliver what we have committed to deliver. We are examining how we deliver it.

Ms M.J. DAVIES: Has the government gone back to Rio Tinto to ask it to increase its contribution to the project?

Ms A. SANDERSON: That is certainly an option and is something I will take up. The government is having discussions with resources companies more broadly around contributions to various projects, so that has to be done in a coordinated and strategic way.

Ms M.J. DAVIES: I refer to page 312 of budget paper No 2, volume 1. When is the request for proposal process for the Geraldton Health Campus expected to be complete?

Ms A. SANDERSON: We expect the request for proposal, the next stage of the tender process, by the end of this month, with an anticipated contract awarded by October this year.

Ms M.J. DAVIES: Is the department still targeting construction to commence mid-October?

Ms A. SANDERSON: The contract.

Ms M.J. DAVIES: So construction will therefore not commence mid-2023?

Ms A. SANDERSON: No; I certainly did not say that. It is not unreasonable that it would start this year, and that is the feedback we have had from the tenderers in this process.

Ms M.J. DAVIES: Okay. Does the minister anticipate that practical completion will be by mid-2026, as outlined in the expression of interest documents?

Ms A. SANDERSON: That is dependent on the tender. That is still realistic, but is determined by the tender in discussions with the final tenderer. I confirm that all the planning and discussion so far indicates that construction will commence in the last quarter of 2023.

Ms L. METTAM: I refer to page 297 of budget paper No 2, significant issues impacting the agency. Paragraph 9 indicates that WA Health continues to address the multifaceted root causes of ambulance ramping and refers to the ministerial task force, led by the Minister for Health. How many FTEs does that task force contain?

Ms A. SANDERSON: The task force itself does not employ people.

Ms L. METTAM: Is the task force made up of people in existing roles? How does it work?

Ms A. SANDERSON: A range of work is occurring across the system. The governance of that work, the emergency access reform, is the ministerial task force chaired by me. The people who attend the task force are the board chairs of the three major metropolitan health service providers, the chief executives of the three major metropolitan HSPs,

Treasury, the Department of the Premier and Cabinet, staff from my office as Minister for Health, and staff from the office of the Premier; Treasurer. We already have people in existing roles, certainly in the development of strategy, budget planning and implementation. That work is led by the department for the emergency access reform, in conjunction with HSPs in each of their areas.

[10.50 am]

Ms L. METTAM: Is there a supporting secretariat that supports the role of the task force; and, if so, where do the people in that secretariat come from?

Ms A. SANDERSON: It is supported by the Department of Health; it is not a cabinet committee.

Ms L. METTAM: What level of ramping would indicate that the task force is achieving its goals?

Ms A. SANDERSON: I will try to give a constructive answer to what was not a very constructive question.

Ms L. METTAM: Is that not the goal of the task force?

Ms A. SANDERSON: The role of the task force is essentially to manage a symptom of various pressure points in the system—that is, ambulance ramping or extended transfer of care. I have said repeatedly that there is no quick fix to this issue and no jurisdiction in the world has successfully managed to get on top of it. I consider success to be a downward trend and a downward trajectory. We cannot turn it off overnight. No-one has done that and no-one will because we see peaks and troughs in demand across the system. Various issues arise from time to time. For example, we have closed Peel Health Campus to admissions, so that will put pressure on the system. It is about building more robustness in the system and working with clinicians on the ground, hearing their ideas and implementing their ideas. Ultimately, it is about that downward trajectory. That is what we have seen so far this year with the downward trajectory—the ramping figures have been lower than the year before. That is a realistic and certainly ongoing ambition.

Ms L. METTAM: Can I just confirm that the goal of the task force is to reduce ambulance ramping?

Ms A. SANDERSON: It is one of the goals because it is called the ramping task force. Its goal is certainly not to increase ramping. The aim is to reduce pressure on our emergency departments. We do that in a range of ways. We do that by working through the entire system, not just in the emergency department. I think it is acknowledged that it is not necessarily just the emergency department that needs to reform or shift in the way it is working, or be resourced differently. It relates to various parts of the system, including how we discharge long-stay patients, for example. I note that the Australasian College for Emergency Medicine is very supportive of the task force. It was invited to present to the task force, which it did. We have worked very closely with the college, as we have with the Royal Australian College of General Practitioners, St John Ambulance, Ramsay Health Care, St John of God and all our partners in health. Although there are permanent members, we invite our healthcare partners in to work with the system so we have system solutions to local issues.

Ms L. METTAM: The previous health minister described 1 000 hours of ramping as a horror story. Will the goal of the task force be to get ramping hours well below that figure? I think last month's figure was over 3 000 hours.

Ms A. SANDERSON: The goal of the task force is to see ramping figures come down. That will not happen overnight. As I said, no jurisdiction has successfully eliminated ramping because demand peaks and troughs. The goal of the task force is to work with the system—work with all our HSPs and also our partners in primary and alternative care—so that the emergency department is not the only option. That is one of the goals of the task force. This is about system-wide reform. We are undertaking significant system-wide reform.

Mr S.A. MILLMAN: I refer to the emergency access reform—the same item number. I note that through her advocacy, the minister was successful in securing a $75 million investment to reduce pressure on emergency departments. In addition to the task force and all the discussions that take place at the task force level, another $75 million will be invested as a result of this budget. Can the minister explain her strategy to reduce ambulance ramping in a bit more detail and how staff in our hospitals—those on the front line who have a genuine understanding of what is going on—have been able to participate in the strategy?

[Mrs L.A. Munday took the chair.]

Ms A. SANDERSON: I thank the member for the question. The ramping task force is essentially pulling together the work that is going on across the system to ease pressure points in our system. This budget provided an additional $75 million to address some of those pressures on emergency departments. This is on top of previous funding in the last budget and the *Government mid-year financial projections statement*. The $75 million includes $8.2 million to expand the work of the teams within hospitals that are focused on eliminating barriers for care and developing that system-wide reform. As anyone who has had a parent in a tertiary hospital would know, often we have to advocate and keep things moving to make sure they are getting tests and so on and so forth.

Another $7 million has been committed to progress phase 1 of the state health operations centre—an incredibly important part of our system—which will bring together all the HSPs, the Royal Flying Doctor Service and St John Ambulance, co-located with the police, to provide that central coordination around our health system. Also, $7.3 million has been committed to provide greater options for patients in aged-care facilities to receive geriatrician-led care and models of care in the community. As we know, older Australians are spending longer in hospital. We have included in this provision $3.4 million to expand health in a virtual environment, HIVE, which is currently run out of Royal Perth Hospital. It supports patients who have been discharged from Royal Perth Hospital with ongoing monitoring and provides support for residential facilities. It will help make decisions locally for those residents and help family, along with local support workers, make decisions. That is genuinely reducing readmissions to hospital.

There is also $3.9 million in the budget to extend and expand the integrated older adult model in the North Metropolitan Health Service. The Mental Health Commission has extended the WA Country Health Service mental health emergency telehealth uplift and community treatment. This is consistent with the strategy that was set by the task force following consultation with clinicians and staff who deliver care across our system. They were also strong advocates for developing the WA virtual emergency department, a new community-based service that provides people with better access to care closer to where they live. The early signs are promising. We are seeing an average reduction of 25 per cent. We know that the ramping figure will rise as the flu season approaches in winter, when we always see natural pressure on our emergency departments and our hospitals. The service certainly has strong endorsement from teams in hospitals and those working on the front line. Even the Australian Medical Association, which held a summit last year, which I attended, was very happy with the increased access to alternative care pathways. Many of its members had some really constructive ideas. The Australasian College for Emergency Medicine, My Aged Care and the Health Consumers' Council of WA also support the work of the task force.

Ms L. METTAM: I referred to the 1 000 hours of ramping that the minister's predecessor described as a horror story. When does the minister anticipate that the task force will be able to at least achieve the goal of going under that monthly ramping figure?

[11.00 am]

Ms A. SANDERSON: The member is simplifying an incredibly complex problem and challenge. Hon Kim Hames, the former Liberal Minister for Health, has been on the record as saying this is an incredibly complex challenge and I cannot set arbitrary dates and targets because people's health care and lives are at stake. We are also contending with, as every jurisdiction around the world is, an average length of stay that is 0.5 days longer. That is hundreds of bed days a year. That is because people are sicker. We are not comparing apples with apples when we make that comparison. We are absolutely not comparing apples with apples and it is insulting to the healthcare staff, quite frankly, to make such simplistic comparisons.

People are sick. People are coming in very unwell; they are staying longer and needing more speciality care; our system is providing that for them and we will continue to do that. We want to provide that speciality care outside a hospital environment so they do not have to be in a hospital to receive it. That is absolutely the right reform. When we talk to healthcare professionals on the ground, we hear that this is the stuff that they are passionate about. The stuff that keeps them going is providing the right care for patients when they need it.

Ms L. METTAM: I refer to page 297 of budget paper No 2, volume 1, and significant issue 5. Given the *Sustainable health review: Final report to the Western Australian government* was released in 2019, how many of the recommendations have been adopted and how many are still to be implemented?

Ms A. SANDERSON: This is a transformation. The sustainable health review is not a project.

The CHAIR: Leader of the Liberal Party, can you be more specific in your question, please.

Ms A. SANDERSON: I am happy to continue responding; thank you, chair. This is a transformational program, not a project. We do not put deadlines on it. If the member were to ask any members of the oversight implementation committee, that would be their view. That includes consumers, people with lived experience, clinicians, primary care workers, so on and so forth. I met with them yesterday and we had a great discussion. This is a transformational program that is around improving prevention, different models of care and digitisation. It is sound and it is absolutely the plan that needs to be implemented, but it is done through a transformational and cultural change. That is what is required. At the end of last year, we refocused on six priorities. I think it is fair to say it is a large piece of work, and progress was not as pointy in some areas as some members of the implementation committee felt it should be, and they wanted to see a greater prioritisation. They went through a prioritisation process and we announced those six priority areas in November 2022.

Those areas are improving timely access to outpatient service; implementing models of care for people with complex conditions who are frequent presenters to hospital; implementing a new funding and commissioning model supporting new models of care and joint commissioning; investing in a phased 10-year digitisation; building

a system-wide culture of courage, innovation and accountability; and building capacity in workplace planning to develop the health and social care workforce for the future. I think we can see that the theme in all those is the pressure on the system. It is around the increasing acuity and complexity of patients in our system and the sustainability of the system. Much of the work that we are delivering through the ramping task force is delivering these outcomes.

Ms L. METTAM: Is the minister able to provide and outline which recommendations of the original ones proposed in 2019 have been implemented? I know the minister has said that progress has not been pointy. Does that mean that we will be waiting for some time for the implementation of those recommendations?

Ms A. SANDERSON: I think the member fundamentally misunderstands what the sustainable health review is. I think the term "review" is probably not applicable anymore because it is not a review; it is a transformational program. I think that I have highlighted those areas of priority, but we are implementing in various ways the intent of the sustainable health review across the system and it is a transformational project that will remain in place forever.

Ms L. METTAM: Does the minister think there might need to be some better communication with clinicians and health staff about the new approach to the sustainable health review given that there is a lot of frustration that the recommendations are not being implemented? The fact that the government is unable to commit to the implementation of the recommendations made in 2019, I suggest, only adds to that concern.

Ms A. SANDERSON: The government has accepted all the recommendations of the sustainable health review. It is fundamentally wrong for the opposition to say that we have not committed to them.

Ms L. METTAM: Has the government implemented them?

Ms A. SANDERSON: It is a transformation of a system. It is a 10-year rebalancing of the system. One of the time frames is a 10-year digitisation plan. I recommend that the member reads the sustainable health review. The sustainable health review is an ongoing culture shift and transformation. We have prioritised six reforms, which I have just outlined, that will help support our system and patients with the post-COVID reality. Essentially, every health jurisdiction—certainly within Australia, but internationally as well—is having the same experience: people are coming in sicker, staying longer and needing more care. There are lots of hypotheses about this but some of it is deferred care, whether it is because of a fear of COVID or no access during COVID, not necessarily in Western Australia, but in other states and territories. These are the priorities and ongoing work that will help support it.

We are always improving timely access to patient services. We are always improving and implementing models of care for people who have complex conditions and are frequent presenters. The digitalisation investment is a 10-year phased plan, and we are always building capability in our workforce. The recommendations are not tick-box exercises.

Ms L. METTAM: Would the minister anticipate that the recommendations will be implemented over 10 years?

Ms A. SANDERSON: They are implemented every day across various areas of our system.

Mr P.J. RUNDLE: I refer to "Workforce Attraction and Retention" on page 116 of budget paper No 3. The first dot point states —

> a targeted payment of up to $12,000 over three years for HECS–HELP debt relief for up to 350 newly qualified nurses and midwives commencing employment in regional Western Australia in 2023–24 …

Given these positions are funded to commence from 1 July, how many applications have been received to date and how many nurses have been offered a position?

Ms A. SANDERSON: The budget has not passed Parliament; I make that point. These will be considered as part of the next intake of graduates and there are timing factors around when that occurs. I might ask Rob Pulsford to answer in more detail, but I will say I am very proud of this really good initiative that this government is delivering for regional healthcare. We do spend a lot of money on agency staff to keep services running. We do run services. We are not funded appropriately by the commonwealth, frankly. I am sure as regional members, opposition members will agree that we are not funded appropriately by the commonwealth to run the kind of regional and remote services that we do in Western Australia. What is considered regional in Victoria is not the same as regional in Western Australia and they are considered the same under the commonwealth funding model. It is fundamentally wrong and significantly disadvantages us. Activity-based funding does not work for small hospitals. It does not work for nurse-led hospitals. We subsidise significantly, as is right, to provide as much regional health care as we can in our local regions. We provide a range of incentives and supports for our regional healthcare workers but it is becoming increasingly difficult. I think people are making decisions to move—big, life decisions, post-COVID all over the country around where they want to locate. This is one of those supports in which we are saying to people, "Hey, come and try regional medicine and we know you'll probably fall in love with it and you will stay." It also locks them into a contract for three years. If they want to receive the full balance of that HECS, they need to stay

in a regional centre. They will be considered as part of the next intake of grants. I hope it is a great success because I would like to expand it significantly.

[11.10 am]

The CHAIR: Will the minister refer to Mr Pulsford?

Ms A. SANDERSON: Do you have anything you want to add?

Mr R. Pulsford: Thanks, minister. Recruitment and retention of key staff and nursing staff in particular across country Western Australia is an ongoing challenge for us. Many pieces make up that puzzle. The regional graduate incentive for HECS is just one of those pieces. This incentive will be available for up to 350 newly qualified nurses and midwives who are appointed in a position in regional Western Australia. Priority will be given to 75 hard-to-staff locations across country WA where they will be given the support and supervision that all newly qualified nurses and midwives need and expect, which we provide across business right now.

Ms L. METTAM: How many current vacancies are there amongst nurses and midwives across regional Western Australia?

Ms A. SANDERSON: I request the member puts that question on notice. I could not give that information now and it varies from day to day.

Ms L. METTAM: Minister, this is obviously a significant issue and we welcome the commitment that has been made. Does the minister have a rough idea of the number of vacancies for nurses and midwives? Does she have a general figure?

Ms A. SANDERSON: I am not going to give the member a rough idea. She needs to put the question on notice.

Ms L. METTAM: Can that be provided by supplementary information?

Ms A. SANDERSON: No, we are not providing supplementary information.

The CHAIR: I think the minister has made her view clear.

Mr P.J. RUNDLE: The minister spoke about the Victorian model, which is paying $16 500 compared with the $12 000 that the minister is proposing. How did the department come to the figure of $12 000?

Ms A. SANDERSON: We consider $12 000 a significant investment in someone. Victoria is throwing a lot of cash around and it is entitled to do that. Every state is incentivising in its own way. We consider $12 000 to be a very significant investment in someone moving to regional Western Australia and it is absolutely right. We also provide housing and other regional incentives. In fact, Victoria's incentives are relatively late to the game. Western Australia has had them since the early 2000s so we have been incentivising people to work in regional areas for many years longer than Victoria.

Mr P.J. RUNDLE: Can the minister let me know how the payment will be delivered? Will it be a cash payment every 12 months or will it go directly to paying off the HECS debt?

Ms A. SANDERSON: It will be broken up into three payments. I do not have the exact numbers but it will be essentially spread over the three years of their employment, with the bulk of it towards the end of the three years.

Mr P.J. RUNDLE: If someone graduated the year before the minister announced this project and they do not have a HECS debt, are there any other incentive payments for those people to go to the regions?

Ms A. SANDERSON: Yes, there are regional incentive payments. It is weighted on the region and based on the MMM—Modified Monash Model—which is the rating that the commonwealth makes. They vary from place to place depending on where they are. There are regional payments. There is the critical retention payment, which is a payment for staff working in hard-to-staff places. That has been very successful, certainly in keeping services open over the Christmas holidays when a lot of people want to take leave. Some services were going to be really challenged to be provided. Around $15 million overall is allocated for these regional incentives. We are growing our FTE in regional Western Australia but there are still shortages.

Ms L. METTAM: Can the minister confirm whether the Peel or Mandurah regions will be included in this incentive payment?

Ms A. SANDERSON: No, Peel is not included at this stage but we can look at it.

Ms L. METTAM: Can I confirm that the minister will reconsider Peel's exclusion from the HECS program?

Ms A. SANDERSON: Peel is not included in any of the regional incentives because the incentives are for the WA Country Health Service. We will look at it. Certainly, if the program is successful in regional areas, we will look at how we might implement it in the metropolitan area. Peel is not included in any of the regional incentives because it is for the WACHS staffing areas like Balgo, Halls Creek, Fitzgerald, Warburton—regional and remote areas.

Ms L. METTAM: When does the minister anticipate providing further clarity about Peel and whether it will be able to benefit from that workforce?

Ms A. SANDERSON: It is not included in this tranche. We will consider it in future tranches.

Mr P.J. RUNDLE: The minister referred in one of her press releases, a bit like she did a minute ago, to priority locations. How do priority locations work for this program?

Ms A. SANDERSON: As I just outlined, it is based on the commonwealth's MMM model.

Mr P.J. RUNDLE: Is that about the larger regional centres? Are they centres further away from the metropolitan area? Could the minister explain priority locations in a bit more detail?

Ms A. SANDERSON: First of all, the HECS payment will go to every WA Country Health Service site but we will prioritise harder-to-staff sites. The MMM is a commonwealth rating that takes into consideration the delivery of health care, the remoteness, the demographics, the need and so on. We base much of our planning provisions on that rating.

Mr P.J. RUNDLE: Which categories of the MMM will be eligible?

Ms A. SANDERSON: All of them.

Mr P.J. RUNDLE: Is the minister able to provide as supplementary information a list of the locations determined to be eligible?

Ms A. SANDERSON: Every WACHS location is eligible.

Ms L. METTAM: I refer to page 307 of budget paper No 2. It is under mental health services. I appreciate that we are going to the Mental Health Commission next but I assume this is within Health. I note that the service includes eating disorder programs. How many episodes of care were provided for eating disorders in 2022–23?

[11.20 am]

Ms A. SANDERSON: That is a question the member needs to put on notice.

Ms L. METTAM: Can the minister at least provide that as supplementary information—that is, episodes of care for eating disorders for 2022–23?

Ms A. SANDERSON: I suggest the member put the question on notice. That particular episode of care cannot necessarily be unpacked because eating disorders are complex and often occur with a multitude of either medical or psychiatric disorders. I will find out, but I am not sure whether they are designated in the system as that episode of care like a cardiac episode, for example. I ask the member put the question on notice, and craft it carefully so that she gets an answer.

Ms L. METTAM: How many dedicated beds for eating disorder treatment does WA currently have?

Ms A. SANDERSON: Western Australia has a range of inpatient beds, and patients both under and over 16 years of age are treated in inpatient beds across the system when required.

Ms L. METTAM: How many dedicated beds are there for patients aged under 16 and over 16?

Ms A. SANDERSON: There is no limit as such because patients under 16 years of age are treated at Perth Children's Hospital. If they require inpatient treatment, they are treated at Perth Children's Hospital. There is not a limit.

Ms L. METTAM: Surely the minister, as Minister for Health; Mental Health, must have an idea of how many beds are set aside for eating disorders at Perth Children's Hospital.

Ms A. SANDERSON: That is not necessarily how demand is managed in the hospital. If someone critically requires an inpatient bed at Perth Children's Hospital for an eating disorder or any other condition, they will find one.

Ms L. METTAM: Is the minister able to provide an idea of how many eating disorder beds are utilised over a 12-month period? It is extraordinary that the minister cannot answer what should be a pretty simple question.

Ms A. SANDERSON: That is a detailed data question that needs to be put on notice.

Ms L. METTAM: I assume that the number of beds dedicated to eating disorders would in many respects shape how treatment of eating disorders is funded in the budget. Surely, this information is readily available as part of the estimates process.

Ms A. SANDERSON: There is no question that the demand for eating disorder services has significantly increased over the last two years, and it has increased over the supply, both private and public. There is no question that that demand has increased. Generally, the provision of inpatient eating disorder support for patients under the age of 16 is done across the system, but it is done through wards 4A and 5A at Perth Children's Hospital, where there are appropriate medical and psychiatric supports for those children. We have also made a commitment to expand

the inpatient paediatric eating disorder service. The best supports that people can get are in the community through intensive treatment and support. That is why we have services across the metropolitan area with our intensive outpatient treatments. Services in the North Metropolitan Health Service and South Metropolitan Health Service are up and running, and East Metropolitan Health Service recently received $8.9 million from the commonwealth and is in the process of getting its services and treatments up and running as well, so there will be a complete service there. There is demand from inpatients, and they are accommodated as much as possible in Perth Children's Hospital, and we will continue to do that. It is not appropriate to expect specific bed numbers and episodes of care from the estimates process; that is a question on notice.

Ms L. METTAM: How many beds are in wards 4A and 5A at Perth Children's Hospital?

Ms A. SANDERSON: There are a number of beds, but we do not have dedicated beds as such; it is based on need. If there is a high need for inpatient beds, they will be taken by eating disorder patients. If there is a low need, they will be taken by other patients. There is flexibility with those beds. We do not close beds because they might be needed. If someone needs a bed, they get a bed, and we configure around that.

Ms L. METTAM: The minister stated that there would be an expansion of the inpatient eating disorder facility. Can the minister say how many beds it will be expanded from and to?

Ms A. SANDERSON: I correct my former comments. Although there is not a dedicated paediatric eating disorder unit, we understand that there is a service gap and we are looking at options to create that unit. Children who need a bed for an eating disorder support at Perth Children's Hospital are largely accommodated within the bed stock of wards 4A and 5A.

Ms L. METTAM: Is the minister able to describe what the size of that gap is—how many beds we are talking about?

Ms A. SANDERSON: No, I cannot off the top of my head, but I acknowledge that there is significant demand around eating disorders in the community.

Ms L. METTAM: Will the minister be able to provide that by supplementary information?

Ms A. SANDERSON: I suggest the member put the question on notice.

Ms L. METTAM: The minister talked about significant demand in addressing the problem. It is essential that the minister can define it, so how significant has demand been over the last 12 months?

Ms A. SANDERSON: In the last 12 months, demand has dropped slightly, although it is still high. The eating disorder service outpatient program, which is the publicly run youth program through the child and adolescent mental health service received 179 referrals in 2022 compared with 189 in 2021. The age range of those referrals was from nine years and nine months to 17 years and nine months.

Ms L. METTAM: So demand has dropped but there is still a significant gap in meeting demand.

Ms A. SANDERSON: I do not have in front of me the average wait time for that unit, but it is working to meet demand as much as possible. It is also significant demand in the private system as well. Eating disorder specialists are very hard to come by, they are in very high demand across every jurisdiction, and we continue to recruit as we can.

Ms L. METTAM: Is the minister able to provide by way of supplementary information what the wait time may be to see a specialist in the public health system?

Ms A. SANDERSON: I suggest the member puts the question on notice.

Ms M.J. DAVIES: I refer to page 312 of budget paper No 2 and the line item "Meekatharra Hospital". Can the minister advise what work, if any, has been completed on this project?

[11.30 am]

Ms A. SANDERSON: The business case is complete, and, like every other development, particularly regional, we are constrained by current construction market conditions. However, we appointed a lead consultant team in April this year and a business case endorsed a program that needed to be revised as part of the project definition planning. That commenced in May. The Department of Finance has engaged a consultant. It is determined that the building site could fall within a registered Aboriginal heritage place. Therefore, the consultant is in consultation with traditional owners and their representatives. The functional brief is complete.

Ms M.J. DAVIES: The minister just mentioned a revised project definition plan. Could she advise what was changed from the initial project?

Ms A. SANDERSON: It is not about the scope of services; that will not change. It is about whether it falls in the scope of a registered Aboriginal heritage site.

Ms M.J. DAVIES: Thank you, minister. Can the minister tell me the time frame for project completion?

Ms A. SANDERSON: That will be determined on the tender, and we are not at that stage yet.

Ms M.J. DAVIES: Can I confirm that it is not at tender?

Ms A. SANDERSON: No; we are not at tender. We anticipate the tender will be awarded potentially early next year.

Ms M.J. DAVIES: Will the minister provide the project definition plan for the hospital?

Ms A. SANDERSON: It is not something that is generally provided because there is a range of commercial information in it. No; I will not provide that.

Ms L. METTAM: I refer to page 316 of budget paper No 2, volume 1, which shows that the number of FTEs has increased from 43 846 in 2021–22 to 45 867 in 2023–24, which is a total increase of over 2 000 FTEs. On page 310, we see about 230 of these additional staff were for policy and corporate services. Page 311 indicates 144 of these were for support services. Can the minister confirm that 18 per cent of the new employees for the Department of Health are for bureaucratic positions that have no clinical role?

Ms A. SANDERSON: I will hand over to Mr Rob Anderson to outline in more detail, but support staff are incredibly important for clinical staff. We do not want clinical staff making appointments, chasing outpatients, moving people between wards and arranging radiology. Clinical staff cannot operate to their full extent without administrative staff. Quite frankly, I think this is a red herring that is thrown around —

Mr D.J. KELLY: Insulting.

Ms A. SANDERSON: It is insulting —

Ms L. METTAM: It is one in five staff.

Ms A. SANDERSON: There are ward clerks who manage patient records. They largely take administrative duties off clinical staff; that is their purpose. There is an uplift for COVID staff as well. I will hand to Rob Anderson to give more detail.

Mr R. Anderson: Thank you, minister, and through the chair, it is not as simple as suggesting these staff are bureaucratic backroom staff. A lot of these staff are on major projects such as those we have discussed—the emergency access response program, which supports clinical staff across the system. There were numerous staff, as the minister said, supporting the COVID response during that period. There is also a significant uplift in things such as agency staff usage and leave, which all contribute to FTE. Once we take out overtime, leave and so forth, the actual growth in FTE in administrative services across the entire system over a three-year period is less than six per cent.

But just to recap, there are things included such as the emergency access response program, capital projects that we have discussed at length today, and then there is the enormous digital program across the system as well. All these programs of work require significant administrative staff to operate.

Ms L. METTAM: Can the minister advise how many nurses short each area of health service is from its approved number of nurse FTE?

Ms A. SANDERSON: That is a very detailed data question and it depends on any one day. I suggest the member put that on notice.

Ms L. METTAM: Is the minister able to provide that by supplementary information?

Ms A. SANDERSON: No; I am not.

Ms L. METTAM: Can the minister advise how many doctors short each area of health is from the approved number of FTE?

Ms A. SANDERSON: Again, that is a very detailed data question for a very large health system spread across a large area, and it is different on any one day. I would suggest the member put that on notice.

Ms L. METTAM: To clarify again, is the minister able to provide it by supplementary information?

Ms A. SANDERSON: It is more appropriate on notice.

Ms L. METTAM: What is being done to address the shocking shortage of paediatric staff that is contributing to wait time blowouts of over 18 months?

Ms A. SANDERSON: I missed the second part of the question. What was the last sentence?

Ms L. METTAM: It was about the wait time blowouts we are seeing for paediatric services.

Ms A. SANDERSON: The member said something right at the end.

Ms L. METTAM: It was wait times of over 18 months.

Ms A. SANDERSON: Paediatric workforce development is not within the power or scope of the state government. That is with the federal government and the colleges. Yes, I would like a lot more paediatricians, psychologists and mental health nurses. Much of that workforce development is outside the influence of the state government. That is why we supported the Select Committee into Child Development Services with a specific focus on workforce development and what role universities and medical colleges have played and can play in improving access to those specialties. When it comes to the public system, the Child and Adolescent Health Service has doubled the number of developmental paediatric registrars, so we have doubled the number of paediatric registrars in the CDS service specifically. Of course, there are paediatricians across the hospital because it is a paediatric hospital.

The Child Development Service undertakes a range of mechanisms and blitzes to get people through and seen and assessed as quickly as possible, but it is overwhelmed with referrals. Essentially, for every person that is seen, there is another referral through the door. In some part, that is driven by the National Disability Insurance Scheme and the insatiable demand for funded plans and paediatric assessments for those plans. That has put enormous strain on both public and private health. We hear from both private and public paediatricians that complexity is growing and the waitlists are long, but they are essentially having to manage and monitor people for a long time.

We are employing more people to make sure that people can get more access through the public service, but the shocking shortage, if you like, is an issue across a number of specialties, including psychiatric. Nationally, there is a lot of discussion at national health ministers' meetings about meeting with the various medical colleges and talking to them about how they manage their intake and training programs, and what the federal and state governments need to do to support them to do that—that is, provide the placements in the state systems. It is complex and it is largely outside our influence, but it is something we are very invested in.

[11.40 am]

Ms L. METTAM: The minister referred to having doubled the number of paediatric registrars. Does that refer to the number of registrars in the system or the number of positions? Over what period has the number been doubled?

Ms A. SANDERSON: That is for the Child and Adolescent Health Service; that does not include the WA Country Health Service.

Ms L. METTAM: With respect to getting more psychiatrists and other specialists into the system, I would imagine that health service providers have a role in supporting their placements as registrars in training.

Ms A. SANDERSON: Yes, they do, and they play a really important role. It is not just registrars; it is doctors in training. But there also needs to be transparency from the colleges about the number of placements they require. This is not the case for all, but some colleges do not provide those figures. I would ask the question about how many people want to be child psychiatrists, and we would work to meet that as much as we can. It should not be limited to the placements, but there needs to be transparency from the colleges.

Ms L. METTAM: Is the minister confident that state health is meeting the demand for placements when it comes to the pool of graduating psychiatrists?

Ms A. SANDERSON: It is different for every specialty, so I could not give the member a blanket answer. It is very different for every specialty. I will ask Dr Shirley Bowen to make a few comments.

Dr S. Bowen: I thank the minister. The North Metropolitan Health Service hosts the psychiatric training service for the state, now in concert with WACHS, to come in the following year, and we have a process under which registrars are recruited and their posts are allocated ahead every year. There are plenty of posts available for the registrars that we have looking for work. Of course, our issue is recruiting from interstate—pulling new people into our state—but we have plenty of posts available for them to train in.

Ms A. SANDERSON: For psychiatry, there are more posts than people.

Ms L. METTAM: Can the minister advise how many hospitals have nurse-to-patient ratios in place?

Ms A. SANDERSON: The first cab off the rank will be Perth Children's Hospital emergency department. As I outlined previously, we have received the draft audit. That is progressing well and we anticipate that to be in place for winter this year. There is a working group with union members and staff representatives on the floor who are helping to drive that. The current independent analysis completed by Deloitte is that we are largely meeting those ratios now.

Under the current agreement, we have to give six weeks' notice of rosters. Certainly, in the Australian Nursing Federation agreement, there has to be six weeks' notice, which is very reasonable—people want to know what their roster is—so we actually cannot implement it until the end of that six-week period. We are getting into winter, but we are working towards it.

Ms L. METTAM: What was the cost of the independent inquiry by Deloitte into current staffing levels at WA hospitals, and when will that report be released publicly?

Ms A. SANDERSON: I suggest that the member put the question about costing on notice.

With respect to releasing the report, at this stage, it is a draft report. The department has been trying to organise a meeting with the ANF to run through the results of that draft report. That has not been able to occur. We continue to try to do that.

Ms L. METTAM: Just to clarify: is the hold-up due to the department trying to liaise with the ANF over the report?

Ms A. SANDERSON: The government is committed to rolling out ratios, full stop. Despite this being part of an industrial agreement and the ANF not signing the industrial agreement, the government is very committed to this reform. It is a very important reform in our system. It will make us a very attractive employment prospect and will really help manage the workload for nurses, and this government wants to do that. We want to support nurses in their workload. We will roll out ratios and we will not be delayed in doing it. We would like the ANF to be part of that implementation. I know that we are continuing to meet with the ANF through the commission to seek an outcome to that agreement, but we will push ahead and roll out ratios, because it is important for the system and the reform that we are committed to.

Ms L. METTAM: Can the minister confirm when she believes the Deloitte report will be released publicly?

Ms A. SANDERSON: I do not think I have ever made a commitment to release the report publicly. Currently, it is only in draft form, so I am not prepared to make a commitment at this point.

Ms L. METTAM: I have one further question on the Deloitte report. Is there a reason the minister will not make the report public?

Ms A. SANDERSON: I have never refused nor committed to make the report public. I have not seen it. I am not going to make a commitment on a report that I have not yet seen. It is still a draft report.

Ms L. METTAM: I refer to page 295 of budget paper No 2, volume 1, and the critical response payment.

The CHAIR: Is that three lines from the bottom?

Ms L. METTAM: Yes. Can the minister provide some detail on the critical response payment? What is it and who is it paid to?

Ms A. SANDERSON: Yes, I can. Essentially, this is to provide a financial incentive to staff to maintain service operation in hard-to-staff regions. It is in two parts: there is the critical response payment and the acute response payment. It has been a key factor in stabilising a number of the vulnerable services that we have across Western Australia. There is an allocation of around $15 million for those hard-to-staff regions. We are certainly working to develop a more permanent solution for some of the hardest-to-staff areas. I will ask Rob Pulsford to outline a bit more.

[11.50 am]

Mr R. Pulsford: Just to add to that, the temporary regional incentive program has been a really important strategy to help WA Country Health Service maintain the staffing workforce it needs. There are two key planks to that strategy: one is to incentivise redeployments of nursing staff across regional WA, and the other is to incentivise existing staff, which we have found has been really beneficial and really assisted over December and January when we were under a lot of staffing pressures across the business. There has been a lot of anecdotal feedback and commentary from existing staff about the value that they have placed in the incentive. It has certainly assisted us to stabilise our nursing workforce and to maintain the nursing skills that we need across the zone. Key evidence around that is the fact that we have been able to maintain our nursing rosters across our business during what was a really challenging time.

Ms L. METTAM: I refer to page 304 of volume 1 of budget paper No 2. The rate of re-admissions to acute specialised mental health services within 28 days of discharge continues to remain high at 20 per cent, or one in five people. Given that the target rate is less than 12 per cent—I also asked this last year—what is being done to address this issue?

Ms A. SANDERSON: We can probably canvass this in a little more detail with the Mental Health Commission, but a range of things are in place. We have opened the 40-bed St James transition unit in the metropolitan area, which is essentially a step-down service. People can stay for as long as they need to stay while they get housing, employment and so forth. Everyone knows that housing is a challenge, particularly for discharged inpatients. If people have a stable house and a job, they are much less likely to be re-admitted or to have a significant relapse. There has also been a significant uplift in funding for the active recovery teams, which support people post-discharge, and for the community treatment teams. In fact, our increase in funding for community treatment is far bigger than the increase in funding for inpatient treatment. That is an important part of the re-calibration of those mental health services to support people in the community. Adult community treatment services received $22 million; the active

recovery team pilot received $10.7 million; the Perth sobering-up and low–medical withdrawal services received $7.2 million; and the infant, child and adolescent task force was funded last year to provide virtual support for at-risk children who are waiting. Of course, there was an uplift in funding for the child and adolescent mental health service's Crisis Connect program, which also supports families and children. The WA Country Health Service emergency telehealth service helps to support regional patients and is very effective in preventing re-admissions. That is particularly challenging for regional patients, who do not have an inpatient unit, as we know, so that means that they have to travel to Perth or another region for support.

Overall, the high-level response shows that our investment in community-based treatment is 70 per cent more than our investment in inpatient treatment. That is an important re-calibration of that sector to help prevent people from being readmitted as inpatients.

Ms L. METTAM: I refer to page 316 of volume 1 of budget paper No 2—I also referred to it earlier—and the total number of FTEs, which has increased. There is also reference on page 311. My question specifically relates to the chief executive at PathWest, Adrian Bautista. I am just wondering whether he is still employed by PathWest within WA Health.

Ms A. SANDERSON: This is not an appropriate forum in which to ask that question. I will confirm that he is no longer in the employ of WA Health, but I reiterate that that is not an appropriate question.

Ms M.J. DAVIES: I refer to page 308 of volume 1 of budget paper No 2. Service 6 is public and community health services. I refer to a media statement that was issued on 13 February this year titled "Funding boost for Western Australians living with epilepsy". Can the minister confirm where in the state budget this funding would show up and is there any other funding for Epilepsy WA?

Ms A. SANDERSON: I know what the member is referring to. It is not in the budget papers. Essentially, Epilepsy WA has not been funded by government previously. It does fantastic work. I met with representatives after I became health minister and I requested that funding be provided to Epilepsy WA for the work it does. My understanding—I may be incorrect and I am happy to give the member some follow-up information on this—is that there is a pool of funding for neurological conditions and that goes to a panel and so forth. Epilepsy WA has never been successful in that. I have requested that it be accommodated in some way for future funding. I will need to get a bit more information and come back to the member on that one.

Ms M.J. DAVIES: I am happy to follow up. Has the internal review of community-based neurological services been completed or is it still underway?

Ms A. SANDERSON: On the first question about Epilepsy WA, it was internally funded. That is why it does not appear in this budget. I am not aware of the review.

Ms M.J. DAVIES: I will follow up. This is further to a question that Hon Martin Aldridge asked. There was an internal review of the community-based services receiving funding from the state government specifically for neurological services.

Ms A. SANDERSON: That might be what the member is referring to with the epilepsy funding. Let me get some information and I will come back to the member.

Ms M.J. DAVIES: Thank you, minister.

Ms L. METTAM: Before I ask this question, do we have to move specifically to the Mental Health Commission?

Ms A. SANDERSON: No; it is up to members. If the member wants to ask a question that is based on its budget, ask me the question and I will tell her whether it comes under the health budget or the Mental Health Commission's budget.

Ms L. METTAM: We have questions about the Mental Health Commission.

Ms A. SANDERSON: What I am saying is that I know it is not clear because there is crossover. If the member asks the question, I can tell her whether it comes under this budget and we can deal with it now, or we may need to deal with it during the Mental Health Commission division.

[12 noon]

Ms L. METTAM: That question is coming, but this is a health question. I refer to page 304 of budget paper No 2, volume 1. I refer to the percentage of elective surgery waitlist patients waiting over boundary. Category 1 patients have increased by six per cent. How many elective surgery cases waiting longer than clinically recommended does this equate to?

Ms A. SANDERSON: No patients are waiting outside the clinically recommended time frames, which for category 1 is 30 days. Based on the information I have, no patients are waiting outside that time frame. Sorry—that is median wait time. Overall, as an average, patients are not waiting, but there has been significant effort, and I will ask Rob Anderson to give a bit more detail on those numbers.

Significant efforts have been made across health service providers to manage the deferred care of elective surgery, and some of those are particularly the category 1 or priority cases. It varies from health service provider to health service provider and hospital to hospital, based on their specialty and the availability of staff. For example, there is a shortage of theatre nurses; they are highly sought after. We have put in place the enhanced novice theatre nurse, cardiac surgery perfusionist and anaesthetic technician recruitment and training. We are focused on medical nursing, cardiac surgery perfusionists and anaesthetic technician workforce recruitment, both nationally and internationally. We are also increasing the utilisation of operating theatres to increase the number of patient operations. We are moving suitable patients from tertiary to more general specialist sites that have capacity; an example of the step-down to a secondary site that has capacity would be from Fiona Stanley Hospital to Fremantle Hospital.

We are looking at a range of strategies for endoscopies, which take up a significant portion of the over-boundary cases. Diverting endoscopy cases by postcode to alternative sites to balance demand across the system and converting suitable targeted procedures to same-day procedures, when it is safe to do so, free up beds. Optimising rosters, using locums and investigating staffing arrangements beyond what would normally be considered are targeted measures to avoid cancellations on the extreme or longest waitlists. We are looking at pre-rehab initiatives to support more patients to be ready for surgery to reduce cancellations. Surgery often gets cancelled because the patient is not medically fit for surgery. That happens remarkably commonly, so we help support those patients to be more ready for surgery. We are delivering additional clinics for high-demand specialties and piloting twilight sedation, which is used in the private system, for appropriate patients.

Each health service provider is conducting audits of referrals, and that has resulted in the closure and discharge of a significant number of category 3 referrals. There is ongoing, site-based auditing of category 1 referrals and over-boundary cases. There are trials of alternative models of care to improve wait times and service delivery, including the utilisation of advanced practice roles—for example, ear, nose and throat; audiology; speech pathology; and a multidisciplinary physiotherapy role for orthopaedics.

One of the sustainable health recommendations, number 11, was about outpatient reform, which will address some of the upstream pressures that we get from outpatient referrals. The $8.2 million funded in the midyear review is for a smart referrals digital platform that helps to reduce a lot of the inefficiencies and improve our ability to focus resources on the highest priority areas.

The overall total waitlist is down from financial year to date. In April 2022, it was 29 239; this year, it is 26 819. That is down overall for all reportable procedures.

Ms L. METTAM: For clarification, I thought the minister stated that these were not over-boundary cases. I think the table illustrates an increase in over-boundary cases of six per cent. Further to that, issues regarding surgery for cardiothoracic patients have been raised with me, especially a couple of particularly tragic recent cases. What is being done? I note the minister's recent comments about the employment of an additional cardiothoracic surgeon, but I understand theatre staff are also an issue. What assurance can the minister provide that the cardiothoracic waitlist issues and challenges will be addressed?

Ms A. SANDERSON: The six per cent increase the member refers to was for non-reportable procedures. Cardiac procedures would not be in that category; they are in the reportable procedures, which have decreased. That is the first point. I will go to Paul Forden to outline some of the details, but I want to clarify the reports about some of these terrible events.

Cardiac patients, by their nature, are some of the sickest patients in the health system, and the Fiona Stanley Hospital sees the sickest of the sick. Even the private sector refers patients to Fiona Stanley Hospital because of the expertise there. It was reported that two patients were waiting. My understanding is that one of the patients was not medically fit for surgery, and they passed away from causes not related to that surgery.

The other patient was very tragic. There was a confluence of circumstances. It was a very, very rare procedure that requires two very specialised surgeons to be available at the same time. I think arrangements to go over east were offered, but quite understandably that was not taken up. We have also had high levels of COVID, which had an impact on that surgery at that time. These two cases had a lot of complexity. It is not a black-and-white case of someone dying whilst waiting for surgery. Both cases had a number of elements. Having said that, they are very high risk and vulnerable patients, and Paul Forden will outline what is being implemented by Fiona Stanley Hospital.

Mr P. Forden: Through the minister, the Fiona Stanley cardiothoracic team has increased the number of theatre cases by over 20 per cent since December. The limiting factor in doing that earlier was the availability of cardiothoracic surgeons, and that resource has now been secured. As a result of that, since December, the number of over-boundary cases has reduced by over one-third, and it continues to reduce every single week. We have appointed and agreed contracts with a new cardiothoracic surgeon from the United Kingdom, who should be arriving in August, subject to visa approvals. That will allow us to increase the number even further.

Ms L. METTAM: Is the minister able to provide the number of category 1 patients that line item refers to?

Ms A. SANDERSON: Again, that is another data question that the member needs to put on notice.

Ms L. METTAM: Will the minister not be able to provide it by supplementary information?

Ms A. SANDERSON: We can provide it if the member puts it on notice.

The appropriation was recommended.

Meeting suspended from 12.10 to 12.15 pm