Division 21: WA Health, $6 403 163 000 —

Mrs L.A. Munday, Chair.

Ms A. Sanderson, Minister for Health.

Dr D. Russell-Weisz, Director General.

Ms A. Kelly, Deputy Director General.

Dr A. Robertson, Chief Health Officer.

Mr R. Anderson, Assistant Director General, Purchasing and System Performance.

Dr J. Williamson, Assistant Director General, Clinical Excellence.

Ms L. MacLeod, Chief Executive, East Metropolitan Health Service.

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

Ms M. Vernon, Executive Services Director, WA Country Health Service.

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

Dr A. Anwar, Chief Executive, Child and Adolescent Health Service.

Mr C. Barnes, Adviser.

[Witnesses introduced.]

The CHAIR: Good morning everyone. The estimates committees will be reported by Hansard. The daily proof *Hansard* 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 close of business Friday, 3 June 2022. If a minister suggests that a matter be put on notice, members should use the online questions on notice system.

Ms A. SANDERSON: I will note that we have had to do some last minute swap-ins due to COVID infections, so we will do our best to answer questions.

The CHAIR: Thank you very much. I give the call to the member for Vasse.

Ms L. METTAM: I will start by referring to budget paper No 2, volume 1, and the fourth point on page 311, which relates to a skilled workforce being a critical priority, recognising the sustained demand and its role and commitment in keeping the community safe. How many FTE staff is the department currently short?

Ms A. SANDERSON: It is incredibly difficult to give a global figure of how many staff vacancies there are at any one time because the department has 800 facilities across the state and employs 55 000 staff. There are clinical staff, non-clinical staff and support staff. That is an incredibly difficult question to answer in a single line. It is fair to say that certainly over the last two years since we closed the border to essentially to keep COVID out of the community, it has been challenging for recruitment, particularly internationally and when there were quarantine requirements. There have been a number of staff vacancies. Over the last two years, there has been a significant uplift in staff and recruitment. Certainly, the health service providers have recruited to 125 per cent of their allocation to ensure that we are filling those vacancies. In the two years to March 2022, the number of full-time equivalents increased by 15.6 per cent, which also includes an additional 512 FTE medical staff. They are full-time equivalents, so there are more bodies on the ground. There are 512 FTEs and 1 456 nursing staff. For 2022, WA Health is employing 1 411 nursing and midwifery graduates. I think that is the first time in a number of years that every single graduate has been offered a job.

There are ongoing efforts to recruit staff. It is certain that positions still need to be filled. Some of those positions are for junior doctors. Certainly, the WA Country Health Service faces a number of challenges with filling positions. It is not possible to say definitively how many staff vacancies there are at any one time, partly because locums and agency staff are filling those positions regularly to ensure continuity of service for those communities. Overall, since 2017, the number of health FTEs has grown by 18.7 per cent. The number of staff employed by the Department

of Health has grown by nearly 20 per cent under this government. I will hand to the director general if he wants to give an overview of anything else that I have missed.

Dr D. Russell-Weisz: I think the minister summarised that very well. The only thing I will add is that we are obviously focusing on specific areas of shortage, especially in midwives and theatre nurses, and on regional and rural areas. There are a number of recruiting strategies. As the minister said, we gave health service providers permission to recruit up to 25 per cent above their normal FTE levels—this is going back quite a few months now—specifically in those areas of shortage. Recruiting in all those areas will be a focus for the next two years. It is not just us. I have talked to my colleagues in every other jurisdiction and they are feeling the same pressures. It is national and it is international. There are the same pressures everywhere. We are also trying to make it more attractive by recruiting as many nursing graduates as we can and encouraging training in the nursing and midwifery fields. Also, we are obviously training more junior doctors now at Curtin Medical School. We are trying to grow our own much more than rely on international graduates.

Ms A. SANDERSON: As an overall percentage, the FTE business-as-usual growth was 14 per cent over four years. Prior to the COVID pandemic, it was two per cent. There is a significant difference; we have uplifted the number of our staff. There is significant workforce planning going on, and part of the sustainable health review was about planning the workforce over the coming years. Delivering that has been prioritised, and we are working with the Mental Health Commission, as well as health services, on what the future workforce will look like. But there is a part for the federal government to play with international arrivals, because although we need a medium and long-term plan to grow our own, we also need an immediate uplift in staffing. Currently, it can take 18 months to emigrate from the United Kingdom, let alone from other areas in the world. The reality is that the National Health Service is providing a fast-tracked process, with a guarantee of citizenship at the end of it for the staff member and their family, and we need to be in a position to compete with that. That will be a priority discussion with the new government.

Ms L. METTAM: I note that the director general touched on the vacancies for midwives and theatre nurses. The minister has been very specific about the uplift in staff. What sorts of vacancies are we seeing? What level of vacancy is there, acknowledging that the federal government also has a role? Can the minister give us an indication of the level of shortage of actual staff across the health sector? Clearly, attracting and retaining more staff is a goal of WA Health. The minister has given the percentage of the uplift. Can she give us an idea of the percentage of the workforce shortage? If she could provide that by supplementary information, it would be welcome.

[9.10 am]

Ms A. SANDERSON: It is not possible to give the member that level of granular data. If she requires that granular data per hospital or per service, I suggest that she put that question on notice. We can give her the broad figures from the system manager and across health services. I can tell her that one of the areas of shortage is midwives. There is definitely a significant shortage, and every HSP is struggling with midwives. Every single midwife graduate has been offered a job. We are trying to encourage midwives, junior doctors and nursing staff to come back. I hope that over the next six to 12 months, as we potentially wind back some of our vaccination clinics, we can bring some of those staff back into hospitals and frontline services. That kind of question about granular data needs to be put on notice. I ask the member to be more specific about her question. There is any number of occupations across the health system and 800 sites.

Ms L. METTAM: Can the minister provide by way of supplementary information the number of vacancies for midwives across our health service providers?

Ms A. SANDERSON: No, I am not going to provide that by supplementary information. The member can put it on notice.

Mr V.A. CATANIA: As the shortage of midwives is a massive issue, particularly in regional WA, can the minister provide that breakdown? I know that women cannot have babies at Carnarvon hospital at the moment and they obviously have to go to Geraldton or Perth to have their baby, which is putting a huge amount of strain on those who have to go to Geraldton or Perth for two or three weeks. Obviously, the patient assisted travel scheme does not cover all that cost, and if they have other children, it can be quite an expensive and difficult period. Can the minister provide a breakdown of the regional hospitals that cannot provide that service at the moment? For example, women from the Gascoyne, Pilbara or Kimberley have to go to Geraldton or Perth to have their babies? Can the minister provide that breakdown so that people will have some ability to plan ahead if they know that they cannot have their child at the regional hospital in their town?

Ms A. SANDERSON: I will speak generally and then go to the director general, who may want to pass to the director of WACHS. Wherever possible, WACHS is committed to continuity of service. It has been challenging to provide obstetric services in Carnarvon, and I am aware of the strain. Geraldton is in the same region, but it is very far away. I acknowledge the challenges that that brings. Geraldton has been doing an outstanding job of picking up

the slack when St John of God Geraldton Hospital closed its maternity wards. It is doing an outstanding job and St John of God has also just reopened its maternity ward and maternity services, which is excellent.

In terms of specific information, I am happy for the member to put the question on notice. WACHS communicates regularly with the community and with patients and clients about where they will need to have their baby and the arrangements that they will need to make. It would certainly be a rare circumstance in which it was a surprise. That is certainly not my expectation. There is PATS support for women travelling to give birth, and to bring in someone to support them and accompany them. From September 2021, fewer than 30 per cent of women were provided with support, but that number has now increased to 55 per cent. We are helping to provide support for those people. I am happy to hand to the director general.

Dr D. Russell-Weisz: Obviously, there are questions about midwives and we want to re-establish those services in those communities where they have been provided before. In answer to the member's question about Carnarvon and Geraldton, it is safer to provide that service at the moment in Geraldton. We have not gone slack on any of our recruitment initiatives, and I think this is why we are concentrating on graduates. The target of 1 200 graduates for 2022 was exceeded, with a total of 1 411 graduates currently being offered employment, including 1 144 registered nurses and 78 midwives. The Belong campaign was announced by the government. We are trying to recruit midwives from overseas and we have obviously been trying to recruit midwives from over east once the border was opened. We recognise those specific shortages. Through the minister, I could see whether Ms Vernon could provide a comment about specific regional areas, or even Dr Williamson from a workforce perspective.

Ms M. Vernon: I would like to assure members that WACHS is working very hard to maintain all services. The member is correct about Carnarvon; we have not more recently maintained the birthing service, but all other services—antenatal and postnatal care—have been maintained by midwives. The challenge in Carnarvon in particular has been the medical obstetric workforce. I would also like to assure people that PATS is fully provided. In addition, for situations in which we have not been able to maintain an obstetric service, we have also made sure that 100 per cent of the travel and accommodation costs are met. We have also worked extensively with the mothers in advance, preparing them and working on their birth plan. That is the situation. The other sites have maintained their birthing service at this stage, but we constantly work to maintain those.

Ms A. SANDERSON: I am very passionate about birthing options, as most people know, particularly in regional areas. I think there is opportunity to look at how we provide better on-country birthing services and localised safe birthing services, including engaging Aboriginal medical services. There are a lot of trained midwives in our regional medical services who hand their women over to hospitals. I want to look at how we can better integrate those services so that there is more continuity of midwifery care for those women and that they feel culturally and medically safe. I can assure members that everything is done to ensure that women have the best birthing options possible.

Ms M.J. DAVIES: We asked a question in the estimates hearing last year about the proposal that was put forward by the Geraldton Universities Centre to train midwives, and it went nowhere. It could not get support from the Department of Health because it could not find placement positions in tertiary hospitals. Could the minister or one of her advisers provide an update on how that is progressing? I assume that that would be a priority if she is talking about growing our own and there is a university centre in the midwest that is looking to deliver those courses. Is that one of the options that is being pursued?

Dr D. Russell-Weisz: I do not know the detail of that. I will ask Melissa Vernon or James Williamson, who I think might be able to help the minister.

Dr J. Williamson: I think the member might be referring to the proposal from Charles Darwin University; is that right?

Ms M.J. DAVIES: Yes, through the Geraldton Universities Centre auspicing the course.

[9.20 am]

Dr J. Williamson: Yes, that was looked into. One of the issues that we have is accommodating our students from universities based here in Western Australia. There are certain requirements about the number of births that each trainee midwife has to see. The birth rate in places like Geraldton is not sufficiently high to support a big expansion of the training workforce there. However, it is something that we are beginning to review. We are looking at the requirements for birthing experience during training. We do not want to dilute that, but there may be other ways in which we can deliver it. We are happy to look at those sorts of proposals on an ongoing basis.

Ms L. METTAM: I note the director general's comment about the specific shortages in the number of midwives and note that the minister is unable to give us an indication of the size of those shortages. Can she provide by way of supplementary information some sense of the level of vacancies for theatre nurses across our health service providers?

Ms A. SANDERSON: I am happy for the member to put that question on notice.

Ms L. METTAM: So the minister is unable to provide any indication of the vacancy rate for theatre nurses.

Ms A. SANDERSON: I am happy for the director general to perhaps give a global figure.

Dr D. Russell-Weisz: If the minister is happy, one of the chief executives—maybe Dr Bowen from the North Metropolitan Health Service or Ms MacLeod from the East Metropolitan Health Service—might be able to give the member an idea of what we are seeing at the moment with midwives and theatre nurses. They can give the member a picture of what they may be dealing with on a daily basis.

Dr S. Bowen: At the moment, as we have discussed, there is a vacancy rate for theatre nurses and midwives. I cannot give the member the exact vacancy rate, but all efforts have been undertaken for the last two years to recruit to those positions. Because we have reduced elective surgery previously, we certainly have had enough theatre nurses to manage demand. As we go forward, we will need a full establishment of those theatre nurses, but two years ago, we had enough theatre nurses to manage our demand and do our work. I think, going forward, as we recommence elective surgery in full, we should have enough theatre nurses, but we constantly recruit obviously, because the workforce cycles through due to age. Certainly, in Western Australia, and in north metro, there are many older theatre nurses who will look to retire, so we are constantly recruiting.

Ms L. METTAM: Can I confirm, then, that elective surgery is currently on hold because there are not enough theatre nurses?

Ms A. SANDERSON: No, that is not confirmation of that. Elective surgery is being slowly scaled up because of the furlough of staff. That is the big challenge. As of Monday, 3 500 staff across the health system were furloughed. That is the challenge with elective surgery. There is no ban or hold-off on elective surgery. We lifted that a number of weeks ago, unlike the other states and territories that have had months of bans on elective surgery. Hospitals are given the authority to flex up and down with those surgeries that they can do safely with the staff available. But there is a challenge at this point with staff vacancies, and that is why it is very difficult at this point to give granular figures. If the member wants granular figures for each area, she will need to put the question on notice, just like members do in the Legislative Council. We cannot provide that for her today. We can provide budget information for her today. The big challenge for staffing at the moment is the furlough of staff, and that is limiting our ability to fully scale up elective surgery. But there is no ban right now on elective surgery.

Mr V.A. CATANIA: I understand the situation in which all those health staff are continuously out, but if the minister is aware of the global number of staff who are out every day, surely she is aware of the number of staff from each department or area who are out. Can she provide a breakdown of the number of midwives needed in regional areas? Surely she has a breakdown of that information, given that she keeps quoting the global figure. Surely she has the total number of health staff who are unable to go to work each day. I cannot see why that cannot be provided as supplementary information, because we are in budget estimates and our role is to ask those questions; our role is to try to get that information. Surely the minister has that answer without us having to wait another 45 days after putting it on notice. It is our duty as the opposition to ask for, and it is her duty as the minister to provide, that information so that the public of Western Australia is fully aware of where those gaps are. I am not saying that it is her fault, because we all know that there is an issue with COVID, but surely she can provide that detailed information. When I see all the advisers sitting there, they would all have a breakdown of the information for the areas that they are in charge of. Surely she can provide that, at least as supplementary information.

Ms A. SANDERSON: The staffing need in the health service is dynamic and the pandemic is putting enormous strain on it. Each health service provider will have a breakdown of their specific area and if the member wants that information, the best way to get it is to put the question on notice.

Mr V.A. CATANIA: The minister has just said that each area has its own information and statistics on where the gaps are. Surely, in good faith, she can provide that as supplementary information to us as the opposition, with the limited numbers we have. This is our opportunity to question and to get that information so that the public of Western Australia is fully aware of those concerns and where the pressures are. The minister quoted a global figure and I think the people of Western Australia would understand and accept that. I do not think there is any reason why she cannot provide a breakdown through supplementary information rather than us having to wait for 45 days—I think it is 45 days—if we put the question on notice. Is that acceptable given that the government has the numbers in the house and it can do whatever it wants? Surely this is valuable information for the public of Western Australia.

The CHAIR: Member for North West Central, I think the minister has answered the question. Did you want to add anything, minister?

Ms A. SANDERSON: I am happy to give the member some assistance with writing the question.

Ms L. METTAM: In relation to the challenges of furloughing, has WA Health recommended that the seven-day isolation period be reduced to five days? Has there been any consideration of that or suggestion to stay home until symptoms pass?

Ms A. SANDERSON: For COVID-positive staff?

Ms L. METTAM: Yes, or for close contacts.

Ms A. SANDERSON: The critical worker policy for close contacts was changed a number of weeks ago, as the member probably remembers, so there is no requirement to isolate for seven days. People are required to wear a mask and do a rapid antigen test every day, and that is in line with the national rules. Western Australia has come in line with the national rules. In terms of the seven-day requirement for COVID-positive people, we take advice from the Australian Health Protection Principal Committee on that. The advice at the moment is for seven days' quarantine for COVID-positive people, and we will continue to follow that advice. I am happy to throw to the DG, but hospitals are doing everything they can to bring people back. It is not the case that it is a deeply bureaucratic process. It is fair to say that it probably was. I know that a lot of work has been done by the chief executives to fast-track that process and there is now the assumption that people will return to work unless they are authorised not to because they are a close contact. I will let the DG comment.

[9.30 am]

Dr D. Russell-Weisz: We have also seen a shift in the number of people who are furloughed. A few weeks ago there were more close contacts than there were cases, but now there are more cases than there are close contacts. We have seen a really agile response from the health service providers. The chief executives all have their own processes in place to not just bring back people who are close contacts, but also encourage those people who are close contacts but are RAT negative and asymptomatic to come back. All hospitals will have to decide where these people go. There may be areas that will be able to bring people back, but the chief executives in other areas may be more circumspect about that—potentially oncology wards or whatever. They take advice from their infection prevention and control experts at the hospitals, but there has been a huge, concerted effort to say, "We need staff back. If you are a close contact and you are RAT negative and asymptomatic, you should come back." We could ask any of the chief executives sitting here today to say how they actually do that. I think it has become more the norm now that they are bringing people back. We have to remember that some close contacts do not come back either because they are symptomatic, and they should stay at home if they are unwell, or because they are looking after COVID-positive children or caring for COVID-positive people. There is a huge effort to bring people back because we want people at work and we have demand on the system. It is more the norm now. That is all I would say.

Ms A. SANDERSON: The thing that keeps me awake at night at the moment is the furlough. We have a highly feminised workforce and they have significant caring responsibilities. The infection rate is occurring in family members and schoolchildren of parents, a lot of whom are staff in the health system. It is a very fine balance between bringing people back and ensuring not only a health-safe hospital, but also the safety of those patients.

Ms L. METTAM: Just to clarify, is the critical worker exemption utilised on a case-by-case basis across the —

Ms A. SANDERSON: I would not call it an exemption. People are coming back if they are asymptomatic, unless they are caring for children or loved ones who are sick. I think that is probably the best way to put it.

Ms L. METTAM: I refer to page 312 of budget paper No 2. This whole section is relevant to the next line of questioning. When will all the promised 520 additional hospital beds be ready and online?

The CHAIR: Do you have a clause there, member for Vasse?

Ms L. METTAM: A clause?

The CHAIR: Are you pointing to paragraph 11?

Ms L. METTAM: It is on page 312 and it is about addressing the demand and capacity.

The CHAIR: Just generally?

Ms L. METTAM: Yes, across the health system.

Ms A. SANDERSON: Since the budget in September last year, 342 beds have become operational, and we expect to complete the 530 beds by October or November this year. Over the coming months, they will be brought online.

Ms L. METTAM: Is the minister confident that these beds will be delivered by October? I note that the parliamentary inquiry into St John Ambulance highlighted the fact that it believes that staffing challenges may be a barrier to delivering the additional 520 beds by October. How is that faring?

Ms A. SANDERSON: We have delivered 65 per cent of that commitment in six months under exceptionally difficult circumstances. I have to give credit to the infrastructure team at the department for really driving that. That has been an outstanding effort. In six months, we have delivered 65 per cent of those beds and I am as confident as I can be that we will deliver the remaining 35 per cent.

Ms L. METTAM: If possible, can I please get a breakdown of the beds provided under contract with private providers versus the public system? Further to that, from October, once all these beds are online, what will be the ongoing arrangement for the beds in the private health system?

Ms A. SANDERSON: I am happy for the director general to answer that.

Dr D. Russell-Weisz: If I could just clarify the question, is the member referring to the up to 20 contracted beds that we have at, for example, South Perth Hospital?

Ms L. METTAM: Yes.

Dr D. Russell-Weisz: The majority of these are our beds. The majority of the 530 beds are public beds. The chief executives have been recruiting to those beds once they are infrastructure ready, because the funding is behind them. There is a very small number within the private sector —

Ms L. METTAM: Is that the 42 beds?

Dr D. Russell-Weisz: At this stage, they form part of the 530 beds and they will continue. As an example, the North Metropolitan Health Service has used South Perth on and off through the years. We use up to about 20 beds there. It is not a brand new system. We used it about 10 or 15 years ago. They were not used until recently and we imagine that that will continue. The vast majority—I would say 95 per cent—would be in the public sector, such as the 30-bed pods that we are putting in at Osborne Park, Rockingham, Bentley and Bunbury. Once they are established, they will be there and they will be there for good.

Ms A. SANDERSON: I think this is all publicly available information. I think there are 26 beds at Hollywood Private Hospital and 20 beds at South Perth, with ongoing funding.

Ms L. METTAM: Will the arrangement with WA Health for those beds continue?

The CHAIR: Member for Vasse, could you direct your question through the minister to the director general.

Ms L. METTAM: I have seen two different figures of 32 and 42 private beds across the health system. What is the ongoing arrangement for those beds?

Ms A. SANDERSON: Just to be clear, they operate just like state beds. The physical beds are leased, but they are staffed by Department of Health staff. The patients like that very much. It is quite nice for them. I do not think there have been any complaints about people being in Hollywood Private Hospital. But the global figure is 26 and 20.

Ms L. METTAM: Over the past two years, has St John Ambulance asked to implement a business continuity plan that included any thresholds around ramping?

Ms A. SANDERSON: To my knowledge, no. The business continuity plan is not about hospital ramping; it is about its capacity to deliver an ambulance to an individual who needs an ambulance.

Ms L. METTAM: There is an understanding that if 25 per cent of the fleet is ramped, there is some undertaking between St John and the state government on ramping. Is that not the case?

Ms A. SANDERSON: I seek clarification from the member about where she got that understanding from.

The CHAIR: Can you clarify your question a bit further?

Ms L. METTAM: I will ask it in a different way. Why did the director general tell St John Ambulance to retract warnings sent out that it will not be ramping over the weekend and will drop patients at emergency departments if safe to do so?

[9.40 am]

The CHAIR: Member for Vasse, this is not related to the state budget, so I need you to change your question.

Ms L. METTAM: It relates to the capacity issues that we are seeing across the health system.

The CHAIR: Can you word it in a capacity-type format then?

Ms L. METTAM: Okay; I will ask it in a different way. Are there currently any arrangements between St John Ambulance and the state government that relate directly to ramping? I will ask a different question.

The CHAIR: Okay. Thank you, member for Vasse.

Mr S.A. MILLMAN: Before we move on to another person in this capacity, might I ask a question?

Mr V.A. CATANIA: I have a further question on this particular point.

Mr S.A. MILLMAN: I am happy for the member to go first.

Mr V.A. CATANIA: I refer to page 312, under "Addressing Demand and Capacity Pressures on the Health System". I will go back to my electorate, because it seems like the forgotten electorate in the Western Australian Parliament,

particularly its health system. In places like Yalgoo and Kew, there is a constant gap when they do not have a nurse there, even prior to the COVID pandemic. There has always been a capacity problem, which puts lives at risk in those towns. I think there are six or eight single nursing posts left in WA—Coral Bay, Yalgoo, Kew, Sandstone and maybe the Kimberley. There are not many left in the state. Places like Coral Bay are under a huge amount of pressure from visitors and tourists. I think the number of nurses in Coral Bay has been increased to two during the school holidays, but there is still a huge amount of pressure. There are gaps in Yalgoo and Kew in particular, where it is a struggle to get volunteers for the ambulance service as it has an aging population. As I said, it is putting lives at risk. It has been well reported that people have to go to mine sites to get a COVID test rather than to the Yalgoo nursing post. Is there any funding to provide those towns with cover from at least one nurse, but, ideally, to ensure that that single nurse has the confidence of staying there and will not get burnout? Is the minister looking at putting two nurses in those towns to cover the load and to reduce burnout, and obviously for safety reasons as well?

Ms A. SANDERSON: The member has asked a good question. I make the point that it is not about funding. There is adequate funding to cover the staffing of these posts. It is attracting the staff that is the challenge. I know that WACHS does everything possible, and certainly the government does everything it can to support it in that. There are a number of initiatives. There is a working group with other HSPs that helps to provide staff to fill the gaps in those regional and country areas.

Mr V.A. CATANIA: That is the issue. They are not getting that relief. Sometimes they do not have anyone for two to three weeks, and the community does not even know that.

Ms A. SANDERSON: We cannot force people. People have to voluntarily put their hand up to go. Everything is done to encourage people, including financial incentives. There are nursing incentive payments that range from $120 to $250 a day. We are working through retention payments and incentives for staff. We cannot forcibly deploy people into communities, as much as that would be appealing sometimes. We do not operate like the Australian Defence Force. These individuals need to want to go, essentially. Staff who are there get sick and they are entitled to leave. We put enormous resources into providing nursing locums and agency staff to ensure clinical safety and the safety of those communities. In the instance of the gentleman who needed to have a PCR test, the clinical staff and WACHS worked very, very hard and closely with him to ensure that he could get a test at a local mine site by using all of their local availability. I give huge credit to the staff on the ground who did that to ensure that that gentleman could get a test. The point is that it is not about funding; it is about staff. The funding is there; it is about how we actually get staff on the ground. I am happy for the director general to comment.

Mr V.A. CATANIA: In Shark Bay, for example —

Ms A. SANDERSON: I have not finished.

Mr V.A. CATANIA: — it is now a five-week wait to see a doctor.

The CHAIR: Member for North West Central, the minister is still speaking.

Ms A. SANDERSON: Through the director general, if the member wants an answer?

Mr V.A. CATANIA: Yes, please.

Ms M. Vernon: Thank you, through the minister.

The CHAIR: Yes, go ahead.

Ms M. Vernon: Thank you. I totally understand the position of small communities, and in particular Yalgoo. As the Minister has indicated, it is not about funding, it is about access to nursing and the workforce generally. One of the important things that we are starting to work on is to try to work with a local workforce, because sometimes the clinical demand does not require two nurses to be there. We have a got a shortage, but we do not necessarily —

Mr V.A. CATANIA: That is because everyone has to go to Geraldton.

The CHAIR: Member for North West Central.

Ms A. SANDERSON: Do not be rude.

Mr V.A. CATANIA: I am not being rude. I am just stating a fact.

Ms M. Vernon: Sometimes the demand does not require that. A range of services go to Yalgoo as well. What WACHS is doing is going to work with a number of the local organisations—the development commission, for example—to start to look at what blended models we can use and what will attract people to stay out there. It is not just about the money. We have really looked at that. Day in and day, out we are trying to maintain those services, as the minister has indicated, through the agency and others while we seek to look at and employ these other models.

Mr V.A. CATANIA: Further to that question, so it is not about money —

The CHAIR: Sorry, Member for Northwest Central—further question; go ahead.

Mr V.A. CATANIA: So it is not about money to attract nurses to these areas. The police department went through not having single police based at stations for mental health reasons, burnout—the whole works—yet in the Department of Health we still have single nurses at nursing posts, which has the same problems. If it is not a money problem has the minister looked at, or will the minister look at putting at least paying for two nurses to provide that ability for two professionals in the community to wax and wane off each other so they are not working 24/7? They could then actually have some respite and be involved in the community, rather than be on call 24/7. That leads to the minister's response that it is very hard to staff because of those reasons. Will the department change its model and put two staff into these hard-to-staff areas for the reasons that I have just outlined if it is not about money?

The CHAIR: Minister.

Ms A. SANDERSON: I make the point that certainly under the new work health and safety legislation we will have to review those nursing posts. That will have to be part of that review, but I do not think the member listened to the answer. Melissa Vernon answered the question very well. It is not about money; it is about actually finding the people to go there.

Mr V.A. CATANIA: Did the minister listen to my further question?

The CHAIR: Member for Mount Lawley, do you have any further questions on this one?

Mr S.A. MILLMAN: I do have a further question, chair, on addressing the issue of demand and capacity. Just on the $11.4 million, minister, $74.1 million is needed to expand the options for discharging patients who remain in hospital for longer than is clinically required. Can the minister tell me about the $74 million required to address long-stay patients and how it will help, primarily, NDIS patients and aged-care patients?

The CHAIR: Minister.

[9.50 am]

Ms A. SANDERSON: Yes. I thank the member for the question. One of the challenges around freeing access to beds in hospitals is long-stay patients. Typically, they are and should be—not always, but typically—NDIS and residential aged-care patients. Aged-care patients who have fallen probably make up a large proportion of that. We have some of the lowest number of residential aged-care beds per capita. Because of that, the state government has purchased a number of transition-care beds. I have to credit the sector for working exceptionally well with us in purchasing those beds. At any given time, there are 100 to 130 patients in our hospitals, either in psychiatric wards or in general medical wards, who need to be elsewhere, and they do not want to be there either. At every hospital that I visit, I meet staff who have a patient on their wards, particularly in mental health wards, who the staff are generally arguing with the NDIS about how the hospital can essentially release those people from hospital and give them a better life. Psychosocial packages have been immensely challenging for the NDIS, I think, and a lot more work needs to be done on that. There are patients in high-acuity psychiatric units for eight, 10 or 12 months. That is not providing quality of life for those patients. A team is established within the department that can case manage each and every individual patient. The team supports them and brings in other agencies, when required, to help relieve some of that pressure. The team works with the family on the best circumstances for that patient to move them out. I meet people regularly who say their mum was in Sir Charles Gairdner Hospital for four months, which is not good for anyone. We really need to do a lot better here. With the change of federal government, we certainly will be seeking to potentially embed an NDIS representative in hospital service providers to help work through those NDIS packages and issues. We will be working with the new Minister for Health and Ageing around aged care and ensuring that we are upping our number of beds in Western Australia and providing better aged-care transition placements for those patients.

Ms L. METTAM: Right. I will have another go. Capacity issues in hospitals are impacting St John Ambulance and causing ramping, which prompted St John to publicly warn that it would not be ramping but dropping and leaving patients over the weekend. Is this actually permitted under the contract between WA Health and St John?

Ms A. SANDERSON: I will make a couple of points about St John. Is the member referring to the email that was sent on Friday that was then retracted by St John?

Ms L. METTAM: I am just referring to the practice and the notion that there might be thresholds attached to ramping, and the suggestion of the practice of St John leaving patients once there was a ramping threshold, and issues raised through the media in relation to this.

Ms A. SANDERSON: There are a number of contractual arrangements with St John that support St John and compensate St John for ramping and for the hours ramped. For fear of being told off by SSO and wading into commercial-in-confidence matters, I am going to defer to the DG, and he can answer.

Dr D. Russell-Weisz: Thanks, minister. Obviously, there is a contract in place and there are payments. There are contracts and demand payments in place, and there have been for a while, on the increasing demand for St John.

I think St John has said quite publicly that this is not a funding issue. In relation to what the member referred to last week, St John has a business continuity plan itself. There is no doubt about that. What was sent out that day, I think, certainly confused some of the sites—we saw that it confused some of the sites—and it conflated a number of issues that were not actually related to ramping. What has been done in relation to that is we have made sure St John has a very, very clear business continuity plan. I cannot go through it today, but St John has its own business continuity plan with different levels. As the member would be aware, the state government has placed two senior police and two senior health staff to assist St John Ambulance. One of the things that we are looking at with St John is its business continuity plan. I do not want to precis the member wrongly, but there is no ability for St John to drop patients off without any approval from the hospital. It actually says in its business continuity plan that approval is required from the hospital to do such a thing. Naturally, St John has to have a business continuity plan that looks at the percentage of ambulances that are ramped and are busy in the community. St John has that in place, but it works very closely with the Department of Health and very closely on the ground with the health service providers. One of the things that we have done is put St John liaison managers in hospitals so that that work can consistently go on whether the demand is high or low.

Ms A. SANDERSON: I make the point that there are three levels of the business continuity plan.

Ms L. METTAM: Yes.

Ms A. SANDERSON: Business continuity plan 1 is to activate critical workers, then there is using outside agencies to support on the ground—Department of Fire and Emergency Services—and then there is level 3. I think the email was referring to level 3. The issue with that is that levels 1 and 2 had not been activated to their full extent, and they require approval from the State Health Incident Coordination Centre to activate each of those levels. That is why we have put people in place—some of our best logistics experts, both health and police—to support SHICC to activate each of those levels prior to having to do anything that would be as extreme as leaving patients, frankly.

Ms L. METTAM: Did the DG or the minister overrule a decision by St John to leave patients or to trigger the third stage of that continuity plan over the weekend?

Ms A. SANDERSON: The email was not approved by the CEO. It was not a decision of St John to do that.

Ms L. METTAM: Right.

Ms A. SANDERSON: And it was later retracted.

The CHAIR: Any further questions?

Ms L. METTAM: Further question. The minister referred to the efforts of DFES to fill in the gap this week and provide some support to St John and ambulance services. What sort of training and what sort of investment has WA Health had to undertake in that effort?

Ms A. SANDERSON: St John has received significant investment from the Western Australian government over the last two years to prepare for COVID, more than probably the health service providers in terms of an increase in funding. St John has had around a 16 per cent increase in funding for the last two years, which would include the demand payment and also the Electronic Transfer of Care payments, which is essentially compensation for hours ramped. There has been significant investment from the state government. Over four years, in fact, it has increased by 32 per cent. St John is a private organisation and is required to reinvest that into employing more paramedics, buying more ambulances and providing better services to the community for the contract that it has entered into with the state. How it does that is a matter for it. St John Ambulance is doing the DFES training, so exactly what the training involves is a question for St John. I understand that it is donning and doffing PPE and driving an ambulance as opposed to a fire truck, which is probably a little bit different, and ensuring that it has basic first-aid skills in supporting its paid paramedics on the ground. All the paramedics have advanced first-aid training and they all have emergency driving capability. It is familiarity with the vehicles.

Ms L. METTAM: Further question. Actually, this is a different question.

The CHAIR: Thank you. Member for Riverton, do you have a new question or a further question?

Dr J. KRISHNAN: I have a further question on this, chair.

The CHAIR: Go ahead.

Dr J. KRISHNAN: Thank you. Minister, this question is regarding the emergency access package. I refer to the $251.7 million package for reducing pressure on emergency departments set out on page 312 of budget paper No 2. What are the 17 initiatives included in this package and how will these address the immediate and long-term causes of ambulance ramping?

A member interjected: Put it on notice.

[10.00 am]

Dr J. KRISHNAN: What for?

Ms A. SANDERSON: I thank the member for the question. Being a long-time clinician, I know that he has a keen interest in and passion for the health of our community. The emergency access package was developed in consultation with clinicians, hospitals, health service providers and people on the ground. It is a coherent package and a range of policies that will help manage some of the drivers of that demand. Ultimately, demand is increasing significantly. Category 2 presentations to emergency departments are up by around 22 per cent. Not only are more people coming in, but also people are sicker and their episodes of care are longer and more complex and require more specialities. Managing that episode of care is becoming harder within those hospitals and the patients are staying for longer. The emergency department waiting room nurses were an important recommendation of the inquiry into the circumstances around Aishwarya's death. That has been in place in a number of emergency departments already. They waited for this budget. It certainly has been in place in Perth Children's Hospital, which has entirely reconfigured its internal waiting room.

The emergency access response is around working through what capacities are available and how it aligns with the sustainable health review and the work that we need to do there. There is a business case for the state health operations centre, and I think there is an enormous opportunity to better coordinate all those services and responses that we need to implement around emergency access.

There is an $18 million investment in real-time data, to understand exactly what the system is doing at any one time and to be able to coordinate that centrally, and $59 million for 120 aged-care beds. We are also expanding the complex needs coordination team, which I talked about in answer to a previous question, and we have the long-stay patient fund. We are also providing transitional accommodation funding and disability transitional care funding. How we manage paediatric eating disorders is also in development. We have a lot of kids who are staying in hospital for a long time and they need better support in their communities. Virtual emergency medicine has been operating at Fiona Stanley Hospital for quite some time, certainly for the last year. There have been various iterations of it across other hospitals that have been very successful, so we are working through expanding those initiatives. That enables patients to be triaged as they are come in. Often, they are able to be admitted directly to a ward or to another form of care; therefore, avoiding the emergency department altogether. There are a number of other initiatives, but a range of complexities is driving these demands, including mental health. A significant number of mental health beds are coming online.

Ms L. METTAM: I have a further question on the ED nurses for the 15 hospitals. Which hospitals have they been placed in? When were they placed there? Where are the gaps in this commitment of $55.8 million?

Ms A. SANDERSON: I will let the director general talk to that.

Dr D. Russell-Weisz: Through the minister, I can say that the emergency department nurses have been rolled out in the majority of our hospitals. There may be one or two hospitals where they are not present the whole time, but we started with Perth Children's Hospital, obviously. Emergency department nurses as well as the core Residential Care Line nurses have been rolled out in all metro and regional hospitals. They are in the majority of hospitals. There may be times when we have acute staff shortages when they are not there, but they are present in the majority of hospitals right around the metro and outer metropolitan areas.

Ms L. METTAM: Is the minister able to state which hospitals are yet to fulfil this commitment?

Ms A. SANDERSON: It depends on any day-to-day basis. I think the major metropolitan hospitals have them. I cannot tell the member exactly, but we can provide that information.

Ms L. METTAM: Further question.

The CHAIR: Did you want that information, member for Vasse?

Ms L. METTAM: Yes, please.

The CHAIR: To be right. Could you confirm exactly what you are after, member for Vasse?

Ms L. METTAM: We would like to know which hospitals do not currently have the 24/7 presence of ED waiting room nurses, as committed to as part of the $55.8 million commitment.

Ms A. SANDERSON: I make the point that the $55 million commitment is in this budget, which has not been passed yet by Parliament. The nurses that are in place now are being absorbed by the current health budget. The commitment will start when the budget is in place.

Mr V.A. CATANIA: I Is it a financial thing?

Ms A. SANDERSON: No. That is not what I said. Those nurses are being absorbed by the current budget.

Mr V.A. CATANIA: So the minister is waiting on finances for this budget to be able to fulfil her commitment.

Ms A. SANDERSON: Do not verbal me, member.

The CHAIR: Sorry, but I think member for Vasse was asking the question to the minister.

Ms A. SANDERSON: Yes. We are happy to provide that information, understanding that that information is based on the current budget. The commitment will start when this budget is released to the HSPs and they employ and recruit fully into those positions.

Ms L. METTAM: Of those ED waiting room nurses that have been committed—appreciating that the funding is yet to be delivered because of the budget process—can the minister confirm whether those nurses are 24/7 waiting room nurses, and that they will not be called away to undertake other roles but are committed to those emergency departments 24/7?

Ms A. SANDERSON: That is the commitment.

The CHAIR: Can I just confirm before we go any further that B1 is to state which hospitals do not have 24/7 emergency department nurses. Is that correct?

Ms L. METTAM: Correct.

Ms A. SANDERSON: I am going to assist the member. That is as of today's date.

The CHAIR: As of today's date.

Ms A. SANDERSON: It changes from day to day, depending on operational needs.

The CHAIR: As of whatever the date is today—24 May. Any further questions to that?

[*Supplementary Information No B1.*]

The CHAIR: Any further questions to that?

Mr V.A. CATANIA: I have a further question. It is not on that topic, but it is on the same page. I refer to "Addressing Demand and Capacity Pressures on the Health System" on page 312. We spoke before about Carnarvon hospital, as an example of not having and adequate amount of midwives to carry out the function of the hospital and having to send people away to give birth in Geraldton or Perth. Is it hard to staff a lot of regional towns, particularly Carnarvon or, say, Kununurra, because of the crime associated with the town and nurses not feeling safe? Has the department lost quite a few nurses because of the crime situation, particularly in Carnarvon, and is it finding it hard to attract and retain staff because of the crime situation? Also, has that meant the department has had to up the security to give some comfort to the remaining nurses who are in town?

Ms A. SANDERSON: The security and safety of our staff is an absolute priority. There are any number of reasons that those posts and those positions are hard to staff, including people's individual circumstances. We have in this budget put $5 million towards immediate upgrades, including security upgrades, for staff accommodation, which is an important factor in their security and safety.

Mr V.A. CATANIA: Does that apply particularly to Carnarvon? I will hone in on Carnarvon, but there are other regional areas, like the Kimberley, where crime is out of control in a lot of these regional communities. Is crime a factor in losing nurses in towns like Carnarvon and in attracting nurses to towns like Carnarvon because nurses do not feel safe?

Ms A. SANDERSON: Challenging social issues are a factor in attracting and retaining any number of public service staff.

Mr V.A. CATANIA: Minister, the issue of crime is plaguing the state's ability to staff our health systems in regional WA. I see that the minister's advisers are all nodding at me. Can the minister confirm that one of the major issues of not being able to attract and retain staff in a town like Carnarvon is the escalating crime situation, and has the minister increased the amount of money towards making sure that those remaining staff feel safe through increased security?

[10.10 am]

Ms A. SANDERSON: Chair, this budget provides $5 million for immediate upgrades to accommodation, including security upgrades. There are any number of factors involved in attracting —

Mr V.A. CATANIA: Is one of those factors crime?

The CHAIR: The minister is answering the question.

Ms A. SANDERSON: — and retaining staff, including challenging social circumstances.

Mr V.A. CATANIA: Is that a yes?

If crime is a major problem —

Ms A. SANDERSON: I will not be verballed by the member.

Mr V.A. CATANIA: — in attracting and retaining staff in regional Western Australia?

The CHAIR: I think the minister has answered. Moving on. Member for Vasse, do you have a further question to this or a new question?

Ms L. METTAM: I have a new question.

I refer to the $64 million commitment for the line item "Joondalup Health Campus Development Stage 2" on page 326 of volume 1 of budget paper No 2. What works will be completed as part of stage 2 of the Joondalup Health Campus? Is a medi-hotel part of this stage?

Ms A. SANDERSON: Joondalup Health Campus stage 2 is a commitment from the commonwealth and state governments. It includes a 102-bed mental health unit; 30 additional beds, 25 beds to meet future demand, and 47 replacement beds; 12 new emergency department beds comprising 10 bays and two isolation rooms; one specialised behavioural assessment urgent care clinic located within the expanded ED; refurbishments to the emergency assessment unit located within the expanded ED; a new 112-bed public ward block; a 30-bed medical surgery; a 16-bed cardiac care unit, with 16 additional and 10 relocated beds, of which 16 shelled beds will also meet future demand; a new theatre; a new cardiac catheterisation lab and relocation of existing cath lab; refurbished discharge lounge; increased parking bays for staff and public; and upgraded staff facilities and upgraded associated services.

The member asked specifically about the medi-hotel. When looking at the drivers of demand at Joondalup Health Campus, we could see there were a range of drivers and it was determined that alternative models needed to be explored for Joondalup to manage those drivers, including more mental health beds. The addition of 102 mental health beds is a far greater contribution to the drivers and the community in the northern suburbs. They are more expensive to staff and more expensive to run, but they will be better overall for the community. We need to be agile in our response to the drivers of demand there. This will be a game changer in the northern suburbs; 102 beds is an extraordinary number.

Ms L. METTAM: When will the mental health beds be operational? I know that the former Minister for Health in last year's estimates said 110 mental health beds were part of the investment. When will the mental health unit—and the minister is stating 102 mental health beds—be operational?

Ms A. SANDERSON: We expect them to be fully operational by February 2026.

The CHAIR: Member for Churchlands, is that a further question or a new question?

Ms C.M. TONKIN: It is a further question.

The CHAIR: Go ahead.

Ms C.M. TONKIN: Thanks. I refer to the asset investment program on page 326. Can the minister advise how the record investment in Geraldton Health Campus and the redevelopment of the Bunbury hospital will ensure regional patients have access to quality care?

The CHAIR: Sorry, member for Churchlands, but that is a new question. I will just park that. The member for Vasse is on Joondalup. Go ahead, member for Vasse.

Ms L. METTAM: Is the operating theatre just one operating theatre? What was the thinking around that? I understand the original commitment was for eight theatres, and now it is just one.

Ms A. SANDERSON: I think the original requested scope from Ramsay Health Care was for eight. I am not sure the original commitment was eight.

Ms L. METTAM: Minister Cook made the announcement for eight.

Ms A. SANDERSON: I will make a comment before I go to the DG. He might want to throw to Shirley—Dr Bowen. The beds will need to come online over a period of time, particularly the mental health beds. Managing a large cohort of mental health patients requires careful management. It is going to be a mix of mental health patients, so there will be older adults and young people's beds. The security and staffing of all of those will need to be managed. Those beds will come online over time; we will not just open them all. There will not be 102 beds open overnight just like that, so we have to make sure that the unit is functioning and staffed appropriately. Director General.

Dr D. Russell-Weisz: Thank you. I might pass to Dr Bowen in a minute, through the minister. There really has been no change to scope of the redevelopment in the last year. The Joondalup Health Campus redevelopment has been planned for some time and has been under construction—I am going to think—over the last 18 months, with the carpark starting first, and then, as the minister has mentioned, the whole suite of new services or expanded services. Obviously, the Joondalup Health Campus also has a private hospital and the theatres lock onto the public hospital. There has not been any overt decision to change the scope in the last 12 months.

The CHAIR: Did you want Dr Bowen —

Ms L. METTAM: Sorry. Yes.

Ms A. SANDERSON: Dr Bowen.

Dr S. Bowen: I can confirm that there has been no change in the scope of the work that is being done currently at Joondalup. It is progressing very well. As the minister has said, the very latest time we would expect those beds to come online would be February 2026, although it is thought that the mental health beds in particular would come on before that, because they are in an earlier stage of the development and progressing extremely well. There are beds in the emergency department that are for mental health patients in particular. It is a quieter environment. They are all complete and operational now.

Ms A. SANDERSON: Through the chair, the announcement from the former minister in August 2021 states "a new theatre", so I am not sure where the member has got eight theatres from.

Ms L. METTAM: I am referring to the 2017 commitment.

Dr S. Bowen: And there is only one additional theatre.

Ms L. METTAM: Yes.

Ms C.M. TONKIN: I go back to my question regarding the asset investment program table on page 326. Can the minister advise how the record investment in Geraldton Health Campus and the redevelopment of Bunbury hospital will ensure regional patients have access to quality care?

Mr V.A. CATANIA: Good question.

Ms A. SANDERSON: Thanks for the question, member for Churchlands. The Department of Health is embarking on, I think, possibly the biggest asset investment program in its history in this short time, certainly as part of our COVID recovery program, to ensure a pipeline of work for both the regions and the metropolitan area. But there are around 800 sites across Western Australia and some of them are in need of redevelopment. Geraldton hospital is one of those. The biggest redevelopment since the Gallop government will occur immediately with an uplift of $49.4 million. There was a significant cost increase due to labour and construction cost increases over the last 12 months in particular. But, importantly, it will provide state-of-the-art facilities for the whole midwest community who currently have to travel to Perth if they have acute mental health issues. There will be a 12-bed short-stay mental health unit, which will complement the step-up, step-down unit that is already operating in Geraldton and was opened recently by this government. There is also an expanded emergency department a new intensive care unit and improved amenities. The intensive care unit will be the second intensive care unit in the regions, and will, importantly, provide training pathways and opportunities for staff locally to stay in place to work in intensive care. A number of them have expressed a desire to do that.

This is part of our election commitment, as is the Bunbury redevelopment, which is a $200 million investment that will contemporise Bunbury regional hospital, which has had quite a shift from a local country hospital to what is now a regional health campus, expanding the general medical, surgical, maternity inpatient units and the acute psychiatric intensive care and high-dependency unit. We are also just about to open around 200 parking bays. When you become the Minister for Health, you become the minister for parking, I have discovered! I think that if we fixed all the hospital and health service parking issues, we could fix what people perceive as many of the issues in the health service. We are expanding the birthing unit, ambulatory services and community mental health services. This is really significant for those local communities and we are excited to be part of that.

[10.20 am]

Mr R.S. LOVE: I note the expenditures that the minister just pointed out in answer to the question from the member for Churchlands. I wonder whether the minister has any further progress to report on the development of oncology services in Geraldton. The minister was asked about this in the last session of Parliament. I am wondering whether any reconsideration has been given to where that funding has not been provided as part of this project.

Ms A. SANDERSON: The federal election has passed, so I think we know that there has been a change of government federally. I make the point, as I did when I previously answered this question, that the commitment made by the federal member was half a commitment to that community. The cost of providing the oncology services is around $18 million to $20 million. The commitment from the member was for $10 million and she has summarily failed to provide the remainder of that commitment, despite requests from my predecessor in this role, who had written to her and requested that she provide the remainder.

Mr V.A. CATANIA: We have had a change of federal government, so the state government should be able to get the rest of the money.

The CHAIR: The minister is answering, member for North West Central.

Ms A. SANDERSON: This government is not making half a commitment to Geraldton. This government is providing the entirety of the funding for the redevelopment for Geraldton to the tune of $122—$122 million; I wish it cost $120 and so does the Treasurer! As I have said previously, we are not ruling it out as part of stage 2, because the government and I understand the need for localised oncology services. There is no question about that. It is just a shame that Melissa Price does not.

Mr R.S. LOVE: Given the result of last Saturday, will the minister undertake to go to her federal colleagues and seek further funding to ensure the oncology unit is developed? It is not the member for Durack who provided that funding; it was the federal government. Will the minister go to the federal government now and ask the new Minister of Health whether there will be further funding for oncology services at Geraldton included in this development?

Ms A. SANDERSON: I am more than happy to do that because I understand the value of oncology services locally, which is why we have provided them in Albany. We will be providing one of the most outstanding oncology regional centres. I note that in the eight and a half years that members opposite were in government, they did not provide it; nor did they provide a penny towards the Geraldton Health Campus redevelopment. The member's pleas to assist his federal colleagues come too late, because we have seen the result of the election. I know that we now have a federal government that, despite an appalling budget situation, actually understands the value of public health care and regional public health care. I feel enormous relief for the entire country, but particularly for the Western Australian health system, that we now at least have a federal government that is not going to make half a commitment but will support the states in delivering public health.

Mr R.S. LOVE: Is the minister going to go to the federal government?

The CHAIR: Are there further questions?

Mr R.S. LOVE: I have a new question. Turning to another situation in the midwest in terms of the provision of health assets, I refer to page 327 and the item "Primary Health Centres Demonstration Program". There is funding of $7.789 million this year and $508 000 next year. This is funding for two projects, as I understand it. One is in Dongara, which has already commenced, and the other is in the town of Mullewa. Mullewa was announced back in 2016. The Premier indicated in a letter last year that there had been a change of scope in the Mullewa project—an additional scope had been added—yet the amount of money has not changed; it is still at the same level as it was in last year's budget, despite the fact that the minister has just made the point that in Geraldton, cost escalations have meant that the government had to fund another significant amount of money to get that project up and running. What is the delivery time line for the Mullewa community hospital? Is that amount of money going to be revised because of the acknowledged cost uplifts in the last year or two and the change of scope as outlined by the Premier?

Ms A. SANDERSON: The government is committed to delivering all of its election commitments. There have been cost escalations and we are working through the processes of government to manage those cost escalations. Mullewa will be part of future discussions around providing the funding to manage those cost escalations, and I will continue to work with the Treasurer and the Expenditure Review Committee on how we do that.

Mr R.S. LOVE: Despite the fact that the money for the Mullewa project is in the budget, albeit it is not enough, there is no clear indication that that project will get underway this year.

Ms A. SANDERSON: That is not necessarily the case. The project can commence in a range of forms, but, as I have said, we have the biggest asset investment program in the history of the state for the Department of Health. We are committed to delivering our election promises. But this government goes through a proper budgeting process, unlike the previous government. We have a proper budgeting process—all requests for funding have to go through the ERC process and cabinet. We have already done that successfully with a range of health projects that are subject to the asset investment program, and Geraldton is a great example of that. I will continue to advocate for what we need to deliver that project.

Mr R.S. LOVE: I point out to the minister that this project has been funded and in the budget since 2016. In the entire time of this government, there has been no progress on the redevelopment of Mullewa Hospital, except for a lot of different plans. A lot of professional planners have made a lot of money out of developing plans, but nobody has put one brick on the ground in Mullewa. When is the government going to start the program?

Ms A. SANDERSON: The fact that it is in the budget shows our commitment to delivering the project, and the fact that we are prepared to broaden the scope —

Mr R.S. LOVE: It has been in the budget for five years.

Ms A. SANDERSON: — shows our commitment to delivering the project. I will work through the proper processes of government to ensure that we are able to do that.

Ms L. METTAM: I refer to page 326 of budget paper No 2, volume 1. Under the asset investment program, I refer to the new women's and babies' hospital and an $8.3 million commitment towards the business case. I note that there is nothing in the forward estimates. When is construction expected to begin on this important project?

[10.30 am]

Ms S. SANDERSON: This is an incredibly important project and one for which I am very excited to be the minister. We are in the process of developing this project. There is $10.2 million approved in this budget for the business case, drawn down from the $1.8 billion that was approved in the previous budget towards that project. We are in the process of doing the project definition plan, which will determine the funding and time frames required to achieve the model. We need that PDP to be completed before we can provide the exact time frame. This is a priority. We understand that King Edward Memorial Hospital for Women has significantly ageing infrastructure. This is a very exciting prospect for Western Australia. I want to ensure that women are front and centre of the development of this project. It is important that we work with clinicians and consult with them, but, ultimately, it will be a women's hospital for birthing, and I want to see women and midwives front and centre of how we develop that hospital.

Ms L. METTAM: When does the minister anticipate construction will begin? Is it anticipated that construction will begin this year or will it be 2026, like the Joondalup mental health beds? When is construction anticipated to begin?

Ms S. SANDERSON: The business case will be approved by the end of the year and we expect forward works to be starting towards the end of next year, but we have to go through the business case process—the proper processes of government.

Ms L. METTAM: Is it anticipated that the number of beds for the women's and babies' hospital will be expanded?

Ms S. SANDERSON: Director general.

Dr D. Russell-Weisz: We expect an expansion of beds in the new hospital. We are going through the business case at the same time as the PDP; it is happening at the same time. That basically will fast-track it. The clinical modelling is being done for the number of beds. We think there is going to be an expansion of the number of beds, not only in the main hospital but also in terms of the neonatal beds. The number of beds that will be added to the hospital has not quite been determined. There is also a lot of work going on with planning on the site. The government has made the decision to put the site to the north of G Block. Obviously, we want to make the best use of the site in relation to patients from the new women's hospital using services that are currently at Sir Charles Gairdner Hospital. But the clinical modelling will be part of the business case and it is expected there will be more beds.

Ms S. SANDERSON: The final determination is yet to be made but there will be more beds. The early indication is that it will represent an increase of around 28 neonatal and 60 inpatient beds.

Ms L. METTAM: I have read reports that the family birth centre, or something like the family birth centre, may not be part of the scope of this project in the initial stages. Can the minister provide some clarification around that?

Ms S. SANDERSON: There are a range of services in the King Edward Memorial Hospital campus. Whether there is physically room, whether it is clinically appropriate, and whether that is what women want to move to the QEII site as a family birthing centre are all being worked through. There are potentially alternative sites that would provide the option for obstetric care where needed on site with the family birth centre. No decision has been made around the family birth centre going there. I will give the member a vibe of how I feel. I am not sure that it should be in a tertiary health campus because that is not why people choose a family birth centre; they want a different kind of birth. But it will be close to obstetric services should they need them.

Ms L. METTAM: I have two sets of questions relating to a similar topic. I refer to page 329 and the item "Paediatric Eating Disorders Unit at Perth Children's Hospital", for which $200 000 is committed in this year's budget. An election commitment in 2021 was for $31 million for a statewide eating disorder specialist service. Where are the plans for this currently at and what is this $200 000 committed to?

Ms S. SANDERSON: The line item in this budget is around the paediatric eating disorders unit. The child and adolescent mental health service is undertaking a reform program that was basically initiated after the Chief Psychiatrist's review of the care and treatment of Kate Savage and CAMHS eating disorder service model. That highlighted the need for an expansion of that service. There has been a significant increase. Funding has been approved to support the business case for CAMHS to provide an inpatient mental health–led eating disorder unit, as well as for some minor infrastructure modifications to the service. We are experiencing a significant increase in eating disorder referrals. Work is going on on the model of care provided for paediatric patients. The $31 million was for people aged 16 and over—I am looking at the Mental Health Commissioner. That is not a line item of this budget; that is under the Mental Health Commission, which we will deal with later and I can then go into more detail around how that is being rolled out. We also secured additional funding from the federal government in the last national mental

health agreement to expand that. That commitment is now almost $40 million. We can deal with that under the Mental Health Commission if the member likes. I might ask Dr Anwar to expand on the paediatric services.

Dr A. Anwar: Post-COVID, we have seen a very acute and steep rise in the number of presentations of children with eating disorders. They fall across a spectrum of illness. Those who need acute nutritional supplementation and nutritional replacement fall into two categories. The first cohort can be discharged and often looked after in the day program or through an outpatient service, but there is a cohort of children who require longer inpatient bed care. This money will help provide some minor modifications on the medical ward so that children can have access to both acute mental health intervention and support from the psychiatry team. It will also allow us to develop a business case for a future larger inpatient bed base that is bespoke and meets the change in pattern of disease presentation going forward. The total sum provided by government is in the quantum of $750 000—$500 000 for developing a business case, and $200 000 for modifications to the ward to allow us to better meet the needs of this cohort of children.

Ms A. SANDERSON: I make the point that the $500 000 is being absorbed by the existing budget.

Dr A. Anwar: Yes.

Ms A. SANDERSON: This is just an extra appropriation to make up that amount.

Ms L. METTAM: The minister spoke about the spike in presentations, which I understand is also COVID-related. What was demand like in 2021 for eating disorder referrals or admissions at Perth Children's Hospital?

[10.40 am]

Dr A. Anwar: I apologise; I do not have the absolute numbers here, but I can provide those. The number of impatient beds taken up by children requiring nutritional supplementation prior to COVID ranged somewhere between eight and 10 inpatient beds. Post-COVID, that number rose to well over 20 and close to 30 inpatients. I can provide those numbers as a percentage rise, but I do not have it on me at this point in time.

Ms A. SANDERSON: Chair, I have got that.

The CHAIR: Okay. Minister?

Ms A. SANDERSON: Between 2019 and 2020, there was a 48 per cent increase in referrals to Perth Children's Hospital and it experienced a 42 per cent increase in bed days for patients with an eating disorder. It is significant.

Ms L. METTAM: This may be something that we deal with under the division on the Mental Health Commission, but I note that the federal government had committed to a residential facility for eating disorders in 2019. Have any plans for such a facility progressed?

Ms A. SANDERSON: That was an election commitment of the member for Canning and the federal Liberal government with no consultation with the state government, which actually delivers these services. It was determined that a residential facility is not appropriate in that area. We are working through the state delivery of care and support for people with eating disorders, and we have certainly achieved an increase in funding from the federal government to provide that. When we work through the Mental Health Commission, we can outline the expansion of eating disorder services in south metro, east metro and north metro.

Ms L. METTAM: This question might get bumped along to the Mental Health Commission division as well, but with reference to page 95 of budget paper No 3 and the $750 000 for interim minor works to develop the business case for the paediatric eating disorder unit at Perth Children's Hospital, can the minister confirm when she anticipates that project will be completed and whether this is part of the $31 million commitment?

Ms A. SANDERSON: It is separate from the $31 million commitment. I will hand it to Dr Anwar behind me.

Dr A. Anwar: That is going to be in part subject to working with the infants, children and adolescents task force. We are going to be working with the implementation team in the Mental Health Commission to re-explore the model of care and therefore dovetail its business case into that.

Mr V. CATANIA: I am going to try and package three questions into one. I refer to pages 326 and 327 and the works in progress. We all hear about bricks and mortar. We have ageing hospitals like the Meekatharra Hospital, which I think it was built in 1959, Laverton Hospital and Tom Price Hospital, I have had a look at the budget; like I said, I am just trying to catch all three in the one question. Can the minister provide detail of where the Meekatharra, Laverton, and Tom Price hospitals are at? Can the minister provide information on when these hospitals will be completed and be able to take in patients and be operational? Having new facilities will be critical for attracting and retaining staff. The Meekatharra Hospital has a lean; someone in a wheelchair can roll from one end of the hospital to the other. That is the state of disrepair of that hospital. These three hospitals had commitments from a previous government, but we are now five years on and it will perhaps take another two or three years, so we may be looking

at 10 years before we actually see patients being processed through the Meekatharra Hospital, Laverton Hospital and Tom Price Hospital. Can the minister provide an update?

Ms A. SANDERSON: The government is certainly honouring its election commitment on Meekatharra and has allocated $48.9 million in capital funding. The purpose is to reinvigorate it as a central health service hub for the Murchison district. It will certainly address ageing infrastructure, as the member has outlined, at the existing hospital. It will consolidate acute care, emergency services, the Royal Flying Doctor Service, and residential aged care, with population health, mental health and community aged care and other primary care services in one facility. The approved business case is for a consolidated new built health service with acute care and other primary care services. The architects have been awarded the contract for the provision of architectural services, and the project definition planning will start this month. Once that is done, we will have a time frame for completion of Meekatharra. The member also asked about Laverton and Tom Price. Tom Price is subject to ongoing work with the WA Country Health Service. We are working with our partners on delivering that. There is currently $23.5 million allocated for the new Laverton project, and the commonwealth has also contributed to that. It will provide two flexible overnight beds, one resuscitation bay, acute treatment rooms, two community-supported home dialysis bays, and ambulatory care. It is true that market conditions are challenging at the moment in delivering those, and there is currently a slight shortfall in funding for Laverton.

Mr V. CATANIA: Sorry, a slight shortfall?

Ms A. SANDERSON: There is currently a slight shortfall in funding based on current market conditions, and we will go through the proper processes.

Mr V. CATANIA: Is that for Laverton?

Ms A. SANDERSON: For Laverton. We will go through the proper processes of government to make up that shortfall.

Mr V. CATANIA: Is there no completion date as yet for the Meekatharra, Laverton and Tom Price hospital projects simply because they have to go through that process or further down the line —

Ms A. SANDERSON: Certainly, with Meekatharra, we are required to complete the business case and project definition plan, and that will provide the time frame. That needs to be endorsed by government. The other two are subject to further funding being required to ensure the delivery of the projects, and we will work through the processes of government to do that.

Mr V. CATANIA: How short is the government on the funding for Laverton Hospital? There is $23 million for the total project in the budget.

Ms A. SANDERSON: It is $23.5 million.

Mr V. CATANIA: How short is it?

Ms A. SANDERSON: We are working through that. It is not a huge amount, but we are working through the processes in government.

The CHAIR: We will break for 10 minutes and come back at 11.00 am.

Meeting suspended from 10.47 to 11.00 am

[Ms A.E. Kent took the chair.]

The CHAIR: Good morning. I remind members that we are still on division 21 until 12 noon. I give the call to the member for Vasse.

Ms L. METTAM: I appreciate the time, and we would like to move to the Mental Health Commission shortly. I refer to page 314 of budget paper No 2, volume 1 and the funding attached to the future health research and innovation fund under point 21. It states that the future health research and innovation fund received $36.4 million this financial year, and it will drop to $25.8 million in 2024–25. Will the fund be topped up or will projects just miss out?

Ms A. SANDERSON: As this is not in my portfolio, but it is in the budget paper, I will ask the director general to answer.

Dr D. Russell-Weisz: Just to recap, the future health research and innovation fund, also known as the FHRI fund, is a landmark initiative of the WA state government. The current estimate from 2021 through to 2023 is $80 million in support of health and medical research. More than $55 million has been awarded to approximately 350 recipients since its establishment in mid-2020. The future health research and innovation fund has been getting an appropriation each year. That has been going out with advice and determination from now the Minister for Medical Research, but via the Future Health Research and Innovation Fund Advisory Council.

In relation to the money in the budget, the WA future health research and innovation fund receives a certain percentage, and he forward estimates are based on the percentage of interest. In 2022–23, $32.3 million in forecast interest earnings is expected to be paid into the account, with $36.4 million forecast to be drawn to fund a range of medical health research and innovation programs. The out years currently do show a decline of forecast expenditure due to lower payments from the future health research and innovation fund from $36.4 million to $29.9 million. That is purely based on the current forecast of future investment returns, which are purely a point in time only. It depends on the investment returns; they are likely to be slightly higher now than when that was forecast. There is so much more money going into the future health research and innovation fund that we will work with Treasury on those funds. At this stage, we have not had advice that they will be topped up but we expect the interest to increase.

Ms L. METTAM: I have a further question, but it has been answered in part. When the future health research and innovation fund was originally committed to or announced, there was anticipation across the sector that it would effectively be a $40 million commitment to those funds. To what extent are those funds vulnerable to the level of interest payment? What assurance can the minister provide that, going forward, there will be a commitment of effectively $40 million in that program?

Ms A. SANDERSON: It is only indicative. Outside of the next financial year, it is really very much indicative; it is not set in stone. Treasury is currently reviewing the government's framework around the fund, including investment options and how it could be potentially increased.

Mr R.S. LOVE: I turn to page 331 and the total cost of services. I am asking it here because I have no idea where else to find the money I am looking for, which is for the service contracts for Silver Chain to operate certain health centres, such as Lancelin and Leeman in my electorate and in others. I was wondering whether the minister could provide detail around both the cost of the Silver Chain service and the service expectation from the contracts that Silver Chain has within those medical centres. I am quite happy to take it as supplementary information.

Ms A. SANDERSON: A review is being undertaken between the department, Silver Chain and the relevant health service providers. They are working to support reform around those community-based services. The approved estimated service agreement for last year, 2021–22, was $92 million, including GST. Depending on the reform outcomes, the service agreement may need to be extended past 2023 to ensure operational sustainability. Is the member asking specifically about the country contracts and not the metropolitan contracts, or both?

Mr R.S. LOVE: I was more interested in where the local health centres are actually staffed or run under contract.

Mr V.A. CATANIA: Can the minister provide a breakdown of both?

Ms A. SANDERSON: The information I just provided the member is for metropolitan services. Through the director general, I will hand over to Ms Vernon.

Ms M. Vernon: I would like to outline what we are doing with the Silver Chain contracts. We are currently working with Silver Chain, particularly around its remote area nursing posts. For country in particular, it has contracts around the delivery of remote nursing services. The member will be well aware of some of those in Shark Bay and Lancelin, and some are in the inner wheatbelt. We are working with Silver Chain around the service model, what is required into the future, and how it would like to work with us collaboratively around maintaining those nursing posts in particular. Again, it has the same challenges as we have around workforce and the delivery of a number of services into those very small communities in the case of some of the wheatbelt ones.

Mr V.A. CATANIA: In terms of Silver Chain, I brought up about the single nursing post and the issues of Shark Bay. We keep hearing about small populations or small towns, but in the case of Denham and Shark Bay, there is often triple or quadruple the resident population there. Traffic from people who go through Shark Bay could be 200 000 or 300 000, which puts a huge amount of pressure on those nursing posts, particularly in Denham, and the Silver Chain. We often hear that these towns are small and that their population is very small, but they are actually not. The level of services that needs to be provided by the Silver Chain to visitors and tourists at the Coral Bay nursing post or in Exmouth—these tourism hotspots—is probably greater than a larger town has to provide.

I just want to make sure that the language is correct. Because it is a small town does not mean that it does not have people presenting to the Silver Chain and not many issues.

[11.10 am]

The CHAIR: Member for North West Central, that is not a question, really. You are making a statement.

Mr V.A. CATANIA: Is the minister able to change the thinking of the health department and say that there is a large population that visits places like Denham, and that the Silver Chain provides a huge amount of services to the travelling public?

Ms A. SANDERSON: I challenge the member's assumption that the department does not think deeply about these communities.

Mr V.A. CATANIA: I did not say that.

Ms A. SANDERSON: I absolutely challenge that.

Mr V.A. CATANIA: I did not say that.

Ms A. SANDERSON: And that it does not think about the needs and requirements of the communities. That is completely wrong and it is rude, frankly. It is rude.

Mr V.A. CATANIA: Minister, I just said that everyone says it is a small town, so therefore there are not enough people to have another nurse there.

Ms A. SANDERSON: Many of the staff who manage these sites also live locally or have come from regional towns, so it is wrong to make the assumption that the department does not think about these towns and the reality that they face as well.

Mr V.A. CATANIA: No-one is saying that.

Ms A. SANDERSON: That is exactly what the member said.

Mr S.A. MILLMAN: My question relates to overall health expenditure on page 309 of budget paper No 2, volume 1. With respect to overall expenditure in the health system, how does this budget compare to when the McGowan government came into office in 2017, and what does it mean for investment over the forward estimates?

Ms A. SANDERSON: I thank the member for the question. This is certainly the best budget that the health portfolio has ever seen.

Mr V.A. CATANIA: In your opinion.

Ms A. SANDERSON: Well, the numbers do not lie.

Mr S.A. MILLMAN: It is a fact.

Mr V.A. CATANIA: It is a fact?

Mr S.A. MILLMAN: The numbers do not lie.

Ms A. SANDERSON: In terms of actual numbers, they do not lie. It is the most significant investment in long–term infrastructure investment as well as an increase in ongoing funding for the budget. This budget commits $2.5 billion to health and mental health; it is a significant uplift in funding. It takes the new investment in WA's health system to $5.7 billion in eight months—in eight months—if we include the midyear review. The annual health budget has grown from $8.8 billion to $11.6 billion. That is a 30 per cent increase since we were elected—30 per cent since we took government. In this year alone, expenditure will grow by 13 per cent, so it is significant. We know that demand is increasing and complexity is increasing. It is not just about money. Although funding and resourcing is absolutely critical, there are more complex issues at play that are driving some of the issues in our system, including staffing and the international challenge around recruiting staffing that every single health service in the world is experiencing. We are in a global competition to staff our health services; there is no question about that. Since the last budget in September, 342 beds have been added to the system, which will bring 530 by the end of this year. That is the equivalent of a new tertiary hospital. The major hospital redevelopments are underway. The women's and babies' hospital is underway. This government has a deep commitment to our public health service and I am very proud of this budget.

Ms L. METTAM: My next question relates to page 310 of budget paper No 2, volume 1, and the WA comprehensive cancer centre. When will the business case planning for the comprehensive cancer centre begin and when will a decision on funding be made?

Ms A. SANDERSON: The business case will begin as soon as the money is appropriated; there is $2.5 million for planning. As the member knows, the former federal government committed $375 million in its last budget towards the comprehensive cancer centre to be developed by the Harry Perkins Institute of Medical Research and built at QEII in Nedlands. The state government has provided $2.5 million for planning and development, so as soon as the money is appropriated, that business case can begin. As soon as the business case is complete, we will then understand the circumstances under which Western Australia will engage with the project.

Ms L. METTAM: Okay. We are happy to go to the Mental Health Commission now.

The CHAIR: Okay.

The appropriation was recommended.