EDUCATION AND HEALTH STANDING COMMITTEE

REVIEW OF WA'S CURRENT AND FUTURE HOSPITAL AND COMMUNITY HEALTH CARE SERVICES

INQUIRY INTO THE ADEQUACY AND APPROPRIATENESS OF PREVENTION AND TREATMENT SERVICES FOR ALCOHOL AND ILLICIT DRUG PROBLEMS IN WESTERN AUSTRALIA

TRANSCRIPT OF EVIDENCE TAKEN
AT ALBANY
FRIDAY, 11 SEPTEMBER 2009

SESSION ONE

Members

Dr J.M. Woollard (Chairman)
Ms L.L. Baker (Deputy Chairman)
Mr P.B. Watson
Mr I.C. Blayney
Mr P. Abetz

Hearing commenced at 10.25 am

ADAMS, MR GARRY ROSS
Acting Regional Director,
WA Country Health Service, Great Southern,
examined:

SEELEY, MS SUZANNE JOYCE
Nurse Director,
WA Country Health Service, Great Southern,
examined:

MULLIGAN, DR JONATHON BRUCE
Medical Director,
WA Country Health Service, Great Southern,
examined:

ROBINSON, MR MARK RICHARD
Acting Operations Manager, Albany Hospital,
WA Country Health Service, Great Southern,
examined:

The CHAIRMAN: On behalf of the Education and Health Standing Committee I would like to thank you for your interest and your appearance before us today. The purpose of this hearing is to assist the committee in gathering evidence for its inquiry into the review of WA's current and future hospital and community health care services, and its inquiry into the adequacy and appropriateness of prevention and treatment services of alcohol and illicit drug problems in Western Australia. You have been provided with a copy of the committee's specific terms of reference.

The Education and Health Standing Committee is a committee of the Assembly. This hearing is a formal procedure of the Parliament and, therefore, commands the same respect given to proceedings in the house. Even though the committee is not asking you to provide evidence on oath or affirmation, it is important that you understand that any deliberate misleading of the committee may be regarded as contempt of Parliament. This is a public hearing and Hansard is making a transcript of the proceedings for the public record. If you refer to any document or documents during your evidence, it would assist Hansard if you could provide the full title for the record.

Have you completed the "Details of Witnesses" form?

The Witnesses: Yes.

The CHAIRMAN: Do you understand the notes at the bottom of the form about giving evidence to a parliamentary committee?

The Witnesses: Yes.

The CHAIRMAN: Have you received and read the information for witnesses briefing sheet provided with the details of witness form today?

The Witnesses: Yes.

The CHAIRMAN: Do you have any questions about being a witness at today's hearing?

The Witnesses: No.

The CHAIRMAN: Thank you. Garry, you are aware that as part of this review we hope to look at needs and gaps in health care services within this region, both hospital acute care and community services and the link between the two. We are also looking for, I guess, needs and gaps in terms of both youth and adults who have alcohol and illicit drug problems. In your presentation we are hoping that you will not only give us a picture of down here but also, because you wear that regional WACHS hat, help set the picture for the wider health problems within the regions. We might have five minutes for each person. If you are happy, we will interject as you make your presentation just to help clarify any points you make to us.
[10.30 am]

Mr Adams: I thought I might start by giving a quick overview of the profile of the region. Within the Great Southern health region we have a population of 53 000 people. The population forecasts suggest the region is expected to experience population growth of about 17.7 per cent between 2004-31, with the population expected to reach about 63 800 in 2031. Much of the growth is in the elderly population, which is 65 plus. Obviously that presents some specific health challenges for us in terms of chronic disease profiles and the disease profile that goes with that age group. Albany has the largest population within the Great Southern with about 32 000 people, which is expected to increase to 35 000 in 2016. As I said, we attract a large number of retirees and by 2016, 20 per cent of the population will be aged over 65.

The CHAIRMAN: Because you are aware that you have an increasing elderly population, what arrangements are you making to deal with that increase?

Mr Adams: Obviously clinical services is informed by those statistics. Our clinical service planning is currently underway, or close to finalisation. Within that plan we are looking at the different disease profiles that we will be expected to provide services for. Obviously, our services that will be provided in the future will need to change according to those plans.

The CHAIRMAN: When will that clinical services plan be available?

Mr Adams: I am not sure of the exact date. It is just undergoing a review process at the moment by WACHS. I can provide a date at a later time.

The CHAIRMAN: It will be useful if you could provide a date. We will be writing a report later this year. We still have hearings in other regional centres so we would appreciate a copy of that review as soon as it is prepared so that we can use that review when preparing this report.

Mr P.B. WATSON: What were the years to 2031? What was the starting point?

Mr Adams: Those figures are from 2004 to 2016 and then out to 2031.

Mr P.B. WATSON: In the past few years Albany has changed a bit with a few younger people coming to town. The ratio has probably changed a bit from the retirement place because industry is picking up here. When you do the long-term forecasts, is that taken into account?

Mr Adams: I have some statistics. In 2007, young people under 15 represented about 20 per cent of the population. Obviously we have to factor in services that will meet their needs as well.

Mr P.B. WATSON: Okay, thanks.

Mr Adams: On top of that, we have a large tourist influx, which again adds to the burden on the facilities here. Our tourist numbers are around 100 000 a year. There are actually a large number of people within the region with private health insurance, so that also affects the choices that people have for health service delivery within the region. We may experience more people going outside the region because they have options of private coverage.

The CHAIRMAN: What are the private versus public services you have within the region?

Mr Adams: We do not have a private hospital here; it is a public hospital but we do admit private patients.

The CHAIRMAN: Is that because there are no private hospital beds in the region?

Mr Adams: No, there are none. We do have private visiting specialists and we have some resident specialists in town who see private patients.

Mr P.B. WATSON: What percentage of people use private cover?

Mr Adams: I have the percentage of private patients in a table here. In 2008-09, the total bed days was 21 611 public bed days and 5 090 private bed days.

Mr P.B. WATSON: Does the hospital do anything to encourage people? We found in other areas that the main issue was the gap. People do not want to pay the gap. Some of the hospitals we have spoken to will encourage people by picking up the gap. Has that ever been looked at in Albany?

Mr Adams: What we say to patients is that if they have private hospital insurance, they can use it and we then basically write off the gap. We get the private patient bed day amount. They have to negotiate the particular arrangement with their doctor. Some doctors have arrangements with the various health insurance companies that allow them to —

Mr P.B. WATSON: Is it well known that that happens?

Mr Adams: Yes; we advertise it. Albany hospital generates the most private inpatient revenue of all the regional hospitals. We do encourage them. We do other things too. If a private room is available because we have some single rooms, patients are generally able to access that. That goes according to clinical need, and we offer some other incentives.

Mr P.B. WATSON: It is hard to get them to use it when they have their own doctor and their own hospitals.

Mr Adams: They do have other incentives such as free TV and private —

Mr P.B. WATSON: I must remember that.

Mr Adams: They get a toiletries pack, free papers and things like that.

The CHAIRMAN: We did not get a written submission from you, but I can see that you have prepared some notes for this meeting. As you obviously have statistics there and as the time is so short this morning, would you be able to provide a copy of the full notes you have prepared by way of supplementary information? I am going to cut you short very soon. We might jump next to Mark, in fact, to look at bed occupancy at the hospital. You would be the right person for that Mark, would you?

Mr Robinson: I would have to take that on notice. We have not had a chance to gather that information this morning, unfortunately.

The CHAIRMAN: I can see you have several pages there. I will ask to you try to condense them into kind of priority areas and maybe provide that to us so we can go through that in detail after the hearing.

Mr Adams: I am reading from a range of documents prepared for different purposes so I am happy to formulate a submission based on these documents.

The CHAIRMAN: Thank you.

Mr Adams: The major issues that we are faced with here are not too different from across the rest of the state. Obviously, our mental health presentations have grown and our ED presentations are growing.

The CHAIRMAN: Can you tell us how many mental health beds you have? Also, previously, you mentioned aged care. How many high-dependency and low-dependency aged-care beds do you

have in the region and, if have you a dementia unit, how many beds do you have for dementia patients?

[10.40 am]

Mr Adams: Do you want the total aged care beds?

The CHAIRMAN: What we would really like to see —

Mr P.B. WATSON: Because we have aged care homes here.

The CHAIRMAN: How many places are there for high dependency and for low dependency in your aged care homes? Attached to those aged care places, do you have beds for patients with dementia or are they separate units? What do you have now and, from the growth that you see in the statistics, how many additional beds will you require in those areas within the next five and 10 years? Those statistics are in terms of aged care. Also, because the number of people suffering from mental illness is, as we know, increasing in the general population, what are the beds and facilities that you have for people who have a mental illness now? Again, based on the growth in population and the statistics as to how many additional mental health patients you are likely to have, what facilities do you currently have that you are providing for both in terms of acute care beds and community placements?

Mr P.B. WATSON: Can you let us know how many beds there are in G ward and roughly the occupancy?

The CHAIRMAN: Tell us what G ward is first, Peter.

Mr P.B. WATSON: Sorry, that is a mental health ward.

Mr Adams: We are currently operating nine beds in G ward. The occupancy is —

Ms Seeley: Around about I think in the high eighties, early 90 per cent range, but I would have to get you the exact detail.

Mr P.B. WATSON: Is that mainly at weekends?

Ms Seeley: No, it is consistent.

The CHAIRMAN: In relation to that, Suzanne, we are obviously very interested in problems that you might have in staffing for both general hospital patients and mental health patients. Are there problems in attracting and retaining staff? Can you maybe describe the situation to us and what some solutions might be in the future?

Ms Seeley: I am sure you are aware that there has been an international shortage of nurses and midwives, and great southern has been affected by that just like every other facility. We have workforce issues; we have swings and roundabouts. Predominantly, we are most affected in the midwifery, mental health and to some extent our ED areas.

The midwifery area is affected because a number of years ago they changed midwifery education from hospital-based to a tertiary qualification. When they did that, the decision was not made to support graduate programs post-completion and when they were funded, we had an increase in the number of registered nurses undertaking midwifery programs. Since that time, a range of other programs have been developed at universities where there are now midwifery-specific programs. It is still an issue trying to get people out into the country. Often in the smaller sites like Katanning where we have a midwifery problem in getting midwives there, it is because in those smaller sites the number of deliveries is small and staff have to work across general and midwifery areas; most midwives want to practice only midwifery. At Albany hospital they practice only midwifery; we made a conscious decision a couple of years ago to have a dedicated midwifery team. We have a very stable workforce there but it is always a challenge to fill all the places.

Mental health is an issue because of the changes to the education program and we do not have any dedicated graduate mental health programs. I think if we are going to develop a sustainable and robust mental health workforce, we need to have funded graduate mental health programs. They are an absolute essential for the future.

The CHAIRMAN: In fact we have been told by other members of the health department that they are comfortable with mental health moving to that postgraduate level. I think from what you are saying that there is a problem possibly with those people who may do the postgraduate mental health program, them being able to come back and really work within a mental health setting. When you talked about that support, what kind of support post that qualification do you think would be useful both for the registered mental health nurse and the hospital in employing those nurses?

Ms Seeley: We need nurses who have good qualifications because with the complexity of the diseases that the patients have there is often more than one disease presenting—it can be drug and alcohol, a mental health issue or a chronic disease such as diabetes. The complexity of the diseases that the staff need to provide care to patients is increasing, so we need well educated nurses and we need well structured, well supported, clinical placement programs to enable them to get the appropriate skills and abilities to put that theory into practice. I would be suggesting something along the lines of some supernumerary time that is funded to allow new mental health graduates to work alongside a more experienced colleague to get that support and develop professionally. In some of the smaller sites in country health, and G ward at Albany is no different, we run a 2, 2 and 2 roster, so we have only two nurses on any shift. If one is a new graduate and there is one other nurse working with them, that puts a lot of responsibility on that one person to not only support the new graduate but also provide care for the patients in the new unit. I have to say that those mental health nurses are supported by others such as psychologists, OTs and other people in the department.

The CHAIRMAN: They are not there around the clock.

Ms Seeley: They need to be supported so we need a structured program. Certainly, in country health in the past 12 months we have initiated a relationship with Notre Dame and country health has been the first area health service in WA to do this. We have a partnership with Notre Dame in Fremantle where we now offer our graduates a graduate certificate for their graduate program. That gives them some incentive to do a structured program and it then articulates if they want to do any more study. It means that the program that they do has clear objectives and clear deliverables at the end of it so that they get recognition for that 12-month program. It is not just coming around and trying to learn on the job; it is about having some structure. I think that would be really good for mental health nurses as well.

The CHAIRMAN: Can we have some more information about that structured program by way of supplementary information?

Mr P.B. WATSON: Is there a stigma working in mental health—you cannot get nurses to do it or is it a security issue?

Ms Seeley: I do not think it is a stigma. It attracts a particular type of person. Predominantly, it is the lack of support when people go in for clinical placements. Because the care is so complex, we cannot send a graduate out to a home to case manage somebody because they just do not have the experience. It is intensive resourcing initially to build up their skills. I do not think there is a stigma. I think there is a group of nurses who really enjoy mental health nursing. It is more about a resourcing issue and a facilities issue.

Mr P.B. WATSON: What about the security side of it?

Ms Seeley: I think security is really important for mental health but it is also important for all nurses these days. Albany hospital does not have robust security systems because it is an old facility

but that has been factored in to the new development. I think there is technology that can improve security but alongside that technology we need adequate training for nurses. You have to have both.

Mr P.B. WATSON: Some people say that you should have security guards here. That is about $1 million a year into a hospital system where surely there are better ways we can look at it.
[10.50 am]

Ms Seeley: I do not necessarily believe that security guards are the answer. I have worked in other facilities where we have had security guards and sometimes they can escalate the situation and make it worse because their training is very basic. They do not understand how to de-escalate situations particularly well. When you engage outside security agents, even internally, the level of education the security guards have is often minimal. They are trained to be bouncers in clubs.

Mr P.B. WATSON: What is the answer then?

Ms Seeley: I think having good electronic systems, good CCTV, proximity cards, the hospital zoned to minimise security and well-designed hospitals so there are single-entry and exit points from wards and having staff who are trained to respond to aggressive situations.

Mr P.B. WATSON: The little buzzer things.

Ms Seeley: Yes; buzzers, duress alarms, "staff down"—all those things—and having a good duress team in the hospital where staff are appropriately trained. When the duress button is hit, a team arrives who is skilled and able to support the staff. If you have a skilled team, they know when to hold back or when one person should go forward. I have worked with a very skilled duress team in the Kimberley. We would have a minimum of five people attend, but only one person would necessarily go forward. The others would hide behind doorways and things because sometimes five people can confront a patient and make the situation worse. To me it is a complex solution to the problem.

Mr P.B. WATSON: Thank you.

Ms L.L. BAKER: I wanted to pick up on your mental health links back into the community. I think other evidence has been presented about some of the gaps in service provision for mental health patients. It does not need to be Suzanne, but any of you can answer. What are your observations around the level of community health services that are available for mental health patients? When you have somebody in and you want to release them back into the community, where are the places that people can be referred to?

Ms Seeley: That is a challenging question. We do have a good community-based mental health team that comes under the banner of WACHS, but there are many non-government agencies in the community dealing with a variety of things, from accommodation to training, to support, to drug and alcohol issues. There is a huge list of them.

Ms L.L. BAKER: Is there enough?

Ms Seeley: Is there ever enough?

The CHAIRMAN: I think the answer is no. Suzanne is being very diplomatic.

Ms Seeley: Mental health is a growing problem. I do not have the accurate statistics, but I understand that they are predicting one in four people in the community will have a mental health issue. That may not be severe enough to —

The CHAIRMAN: No; it is one in four now. It is at least two or three of us, if not four or five of us, at this table, and one of you up the back as well.

Ms Seeley: I think mental health is an area that always needs to be strengthened, but I think it needs to be done in a very focused way. There are particular vulnerable groups in the community such as Aboriginal people. The other vulnerable group is what I call the long-term unemployed but over-generational group. I have worked in some communities where there are three, four and five

generations unemployed. Those particular groups in our community are extremely vulnerable to mental health issues. I think our mental health needs a clear focus.

The CHAIRMAN: Is that a big problem?

Ms Seeley: I think there are pockets of Aboriginals and of those with very low socioeconomic status over a series of generations. They need support and help. Mental health is a challenge for all health professionals because it is so diverse. It affects not only people who come into the G ward and the mental health wards, but also the patients who come into the general wards. People who come in to have their gall bladder out could have a mental health issue also.

Ms L.L. BAKER: You have not mentioned drug and alcohol comorbidity issues in mental health. Would you like to comment?

Ms Seeley: They are significant across the entire organisation. People presenting to our emergency department have drug and alcohol issues that often lead to levels of aggression increasing. That can make it more volatile across the ward.

Ms L.L. BAKER: Are there enough services in place in the community to pick up when someone leaves our care?

Ms Seeley: Drug and alcohol is probably not my area of expertise. But, once again, it is about working with people to make sure that they are ready for help.

Ms L.L. BAKER: No, you do not need to solve the problem. I was wondering whether you are aware of services.

Ms Seeley: The services need to be at different levels, I guess, is what I am saying.

Ms L.L. BAKER: Are there services at the moment?

Ms Seeley: There are services out there. I could not comment on their capacity.

Mr P.B. WATSON: We will be speaking to them later today.

Ms Seeley: I suspect they will tell you they need more.

Ms L.L. BAKER: You do not have experience with referring people to a place and then being told, "I'm sorry; we don't have the provision"?

Ms Seeley: No.

The CHAIRMAN: I refer to the post-graduate courses for —

Ms Seeley: General nurses, yes.

The CHAIRMAN: — first, say, mental health. Once they have done, I think, one-year post-graduate for mental health at, say, Curtin and come back down here to work at Albany, in terms of that supernumerary position or that position where they have a mentor, would that be 12 months or 24 months?

Ms Seeley: I think it needs to be at least 12 months. That is still not the end of their education. Everyone's education in the health system needs to continue. I do not think I can stress enough the importance of the technology, the evidence base and the community expectations of healthcare professionals to deliver a quality service behind those health professionals for them to feel safe. This is what they tell me: they want to have the support of clinical educators to help them make sure their skills are at the cutting edge because, in country health services more so than in the metro area, nurses and midwives have to deal with patients across very broad cross-sections of the health spectrum. They do not have the same luxury of specialisation that our metropolitan counterparts have. They have to deal with a very broad cross-section and that adds to their stress level, because in a group of patients you could be looking after a couple of children, somebody who has had a heart attack and someone with respiratory COAD, all on the one shift and you need that level of knowledge to be able to care for those appropriately.

The CHAIRMAN: In terms of midwifery, I appreciate that in Albany, unlike some of the other regional hospitals, you are able to employ registered midwives. What is the catchment for, firstly, I guess, the pregnant mums coming to Albany hospital, and, secondly, for the other smaller hospitals within the region, where they are not able to fund someone who is a registered midwife and who is not able to be multiskilled across the hospital. Do you think that, just as we have mental health nursing as post-graduate, there should be a one-year generalist degree that should perhaps be funded by the health department, so that midwives in the other areas can help on the general wards?

Ms Seeley: There is a comprehensive program. I cannot tell you the exact name of it at the moment, but it is a program in which nurses graduate as midwives and registered nurses. That has just commenced. It is also not so much about practising in midwifery only—midwives like to do that—it is also the number of deliveries to keep up their skills, so that becomes an issue in the smaller sites.

The CHAIRMAN: What is your catchment area coming into Albany?

Ms Seeley: At the moment we cover Denmark and Albany and any complex cases from elsewhere in the region. We deliver at Mt Barker and Katanning. Katanning is our next largest site. It is having extreme difficulties attracting and retaining midwives at the moment.

Mr P.B. WATSON: I have been told that in some of the other hospitals it is an insurance issue.

Ms Seeley: That is only for people working in the private sector; it is not an issue for people employed by the government. Midwives are in short supply and they choose to work in units. There are ways we can manage it and that is to have different models of care, but often they come with a cost associated with them. Certainly, the Women's and Newborn Network is working on different models of care. But if we want to retain birthing services outside our larger towns, that will come with a cost penalty.
[11.00 am]

The CHAIRMAN: Could we move on to John. I would like to thank you all for that visit around the hospital today. We can see why you have all been lobbying very hard to get new facilities down here, just from looking at the overcrowding, the age of the equipment and some of the services, walking into some of your bathrooms and seeing the lack of fans, and appreciating how difficult it must be for both your nursing and allied health workers and the patients down here. We can see why you have been lobbying so hard. John, could you explain to us the problems with equipment and funding of equipment, and maybe you could do that for Albany hospital and also give us the broader picture in relation to those problems?

Dr Mulligan: I would like to be able to, but I am not sure I am the right person to answer the question.

The CHAIRMAN: Who is the person?

Dr Mulligan: Suzanne knows much more about the equipment issues, or at least the system for replacing equipment, than I do.

The CHAIRMAN: In that case we might come back to you again, Suzanne. Maybe we will give Suzanne a couple of minutes to think about that. We have to finish fairly soon. John and Mark, are there areas that have not been covered by Suzanne and Gary that you would like to flag for us now so that we are aware of them at our other hearings, and you can then give us further information by way of supplementary submissions?

Dr Mulligan: I suppose I would just echo comments that have already been made about workforce issues—attraction, retention and the maintenance of skills of the medical workforce. It is a national issue and it is certainly an issue in country Western Australia. As the population and the clinical needs of the population expand, the medical workforce to support that is under great pressure. I have not been here very long, but it is long enough to know that Albany is very well served, and,

indeed, the great southern is very well served, with a large number of very competent GPs, but their availability to service the hospital work is under constant pressure as it grows.

The CHAIRMAN: What are your suggestions to address that? Have you put your suggestions in terms of a report that you put to WACHS? Where have you made your suggestions for addressing those difficulties?

Dr Mulligan: I think I would need to answer that by saying that it is a changing picture and we are in, if not daily communication with WACHS, certainly very frequent communication with WACHS about the way forward. So there are two issues about that; one is —

The CHAIRMAN: Have you prepared a report in terms of the way forward? I am trying to get from you whether you have prepared a report. The committee would like a copy of that report. Time is limited now and we would like to have the opportunity to see what suggestions are being made at a regional level to address the difficulties that you are experiencing here.

Dr Mulligan: No; I have not in the time I have been here. Have my predecessors? There are a range of submissions about various aspects of the medical workforce but —

The CHAIRMAN: Are you able to provide us with a copy of those by way of supplementary information?

Dr Mulligan: I will try. I cannot tell you what they are. I am just confident that they exist.

The CHAIRMAN: I appreciate the fact that you will look into that and try to find those reports to forward to us.

Dr Mulligan: I will.

The CHAIRMAN: We will move to Mark.

Mr Robinson: To pick up John's theme around the workforce, one of the suggestions I would like to make, speaking very broadly, is that there is a lot of focus on clinical staff and direct clinical support staff. Often the administration and the non-clinical support staff are overlooked in the equation and we find ourselves in situations where highly trained, highly skilled clinical staff are being expected to perform a range of functions that could be easily and better served by administrative and other support staff. That is just a fact of life—the system often focuses on nurses' and doctors' clinical functions, and I can well understand that, but there is another side to delivering an appropriate level of health care that frees up the clinicians to enable them to do that work.

The CHAIRMAN: Again, Mark, you have obviously been aware of this problem for a while, so where have these problems been identified and are you able to provide us with more detailed information in relation to this?

Mr Robinson: Personally, no, I cannot; but I will say that in the planning for the new facility in looking at systems and design issues, the focus is to free up clinicians to enable the administrative and non-clinical support staff we have to better fulfil those roles to support clinicians.

The CHAIRMAN: Suzanne, I am going to ask you one last question and then give the committee an opportunity to ask one last question. We have to finish this session because we have our next people sitting up the back, probably tapping their toes! You are going to discuss equipment. One of the things that were discussed with some of the nursing staff at the hospital this morning was—I cannot remember the term. In the old days we would have called it the "nurse to patient ratio" and I know it is different terminology that you use now. Could you discuss problems in relation to equipment and could you also describe what is currently the old nurse to patient ratio?

Ms Seeley: For clinical equipment, there is a statewide medical equipment working party. WACHS has a representative on that working party. We are given an allocation for clinical equipment. We have a clinical equipment coordinator based in our area office. That money then is allocated out

around the seven regions based on need and priority, but it is never enough. We have approximately 70 hospitals in country health. Our regional resource centres in particular work extremely hard and they have a lot of very aged equipment. That really does impact on the nurses, particularly on their ability to provide good services. We also have an increasing weight problem in our community and we are under pressure to provide bariatric equipment now from operating theatres to wards to emergency departments to physios.

The CHAIRMAN: Suzanne, you said there is a working party looking at equipment.

Ms Seeley: Yes.

The CHAIRMAN: Again, I hate to cut you short but —

Ms Seeley: Pauline Crommelin is the coordinator for clinical equipment for the WA Country Health Service. She has done a review of the equipment in country health and is across the amount of money that is required to address the issues. It is a moving feast, though, could I say.

The CHAIRMAN: As you obviously have a relationship with Pauline, could I ask you to follow up with Pauline and provide us with a copy of that review?

Ms Seeley: Certainly.

The CHAIRMAN: Just so that I get the terminology right, and so that at other places I can follow up on the staff to patient ratio —

Ms Seeley: WA does not have a nursing staff to patient ratio. Victoria does. It is like one nurse to five or six patients. In 2002, I think, the ANF and the Department of Health agreed on a system which is called the "nursing workload". Various wards in the hospitals are categorised at a certain level. Depending on that level, they get so many hours per patient per day to look after those patients. That is based on turnover and a number of other criteria.

The CHAIRMAN: How do you use that in terms of the hospitals within this region in requesting full-time equivalent staff?

Ms Seeley: We would look at, say, last year's activity for, say, bed occupancy in a particular ward. If the average occupancy of a ward was, say, 25 beds, and we would say 25 beds a day multiplied by five hours per patient per bed day, that would give us the total number of hours per bed day and the nurse manager would work out how she is going to split that up across the day.

The CHAIRMAN: Wonderful. In that case we will come back to Mark. You have agreed, I believe, to provide to this committee the information in relation to bed occupancy.

Mr Robinson: Certainly.

The CHAIRMAN: Could we have that for both Albany hospital and the other hospitals that come within this region? You will be aware that the AMA, when they gave a presentation to this committee several weeks ago, were saying that in order for a hospital to be able to perform at an acceptable standard, the bed occupancy should be no greater than 85 per cent. We are interested in the bed occupancy for Albany hospital and for your other hospitals. I am very sorry that we are cutting you short. Dave or Tim will give you the form for any supplementary information.

I thank you for your evidence before the committee today. A transcript of this hearing will be forwarded to you for correction of minor errors. Any such corrections must be made and the transcript returned within 10 days from the date of the letter attached to the transcript. If the transcript is not returned within this period, it will be deemed to be correct. New material cannot be added by these corrections and the sense of your evidence cannot be altered. Should you wish to provide additional information or elaborate on particular points, please include a supplementary submission—this is in addition to all the other information you are giving us—for the committee's consideration when you return your corrected transcript.

Hearing concluded at 11.11 am