EDUCATION AND HEALTH STANDING COMMITTEE

INQUIRY INTO THE TRANSITION AND OPERATION OF SERVICES AT FIONA STANLEY HOSPITAL

TRANSCRIPT OF EVIDENCE
TAKEN AT PERTH
MONDAY, 19 OCTOBER 2015

Members

Dr G.G. Jacobs (Chair)
Ms R. Saffioti (Deputy Chair)
Mr R.F. Johnson
Ms J.M. Freeman
Mr M.J. Cowper

Hearing commenced at 10.09 am

Prof BRYANT STOKES
Retired Acting Director General, Department of Health, examined:

Dr DAVID RUSSELL-WEISZ
Director General, Department of Health, examined:

Dr ROBYN ANN LAWRENCE
Acting Chief Executive, South Metropolitan Health Service, examined:

Mr LEON McIVOR
Executive Director, Contract Management, South Metropolitan Health Service, examined:

Dr HANNAH SEYMOUR
Medical Co-director, Fiona Stanley Hospital, examined:

The CHAIR: Other than Professor Stokes, we are perhaps finding we are meeting rather often, but thank you again for your appearance before us today. The purpose of this hearing, as you know, is to examine the transition and operation of the services of Fiona Stanley Hospital. The television camera will take some vision until we start the true part of the inquiry. I have another few comments to make. The hearing is a formal procedure of Parliament and therefore commands the same respect given to the proceedings of the house itself. Even though the committee is not asking witnesses to provide evidence on oath or affirmation, it is important that you understand that any deliberate misleading of the committee may be regarded as a contempt of Parliament.

I will ask you, as a group, a series of questions that I asked you last week. Have you completed the "Details of Witness" form?

The Witnesses: Yes.

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

The Witnesses: Yes.

The CHAIR: I wonder about that question all the time, because why would you complete the form if you did not understand what it meant? Did you receive and read the information for witnesses briefing sheet provided with the "Details of Witness" form today?

The Witnesses: Yes.

The CHAIR: Thank you all. Maybe I could ask the camera to now vacate before we ask Dr Russell-Weisz to make a brief statement before we start the questions. Thanks, David.

Dr Russell-Weisz: Thank you, Chair. I will try to be very brief just in reflecting, as you said, the times we have been here before the Education and Health Standing Committee and on the commissioning and operations of Fiona Stanley Hospital. The commissioning of the hospital has been an integral part of an unparalleled program of reform, transformation and change for the WA health system. It required substantial reconfiguration of clinical services and a fundamental change in the location and delivery of public hospital services not only at Fiona Stanley, but also at Royal Perth and Fremantle. This was already an environment of unprecedented physical redevelopment across the WA health system, with redevelopments at Joondalup, Rockingham, Midland, the QEII Medical Centre, Busselton, Port Hedland, Geraldton and other smaller sites over the last few years. Expert program management was essential across Fiona Stanley Hospital and

south metro projects to ensure the success of commissioning and reconfiguration. Commissioning of the state's largest building project is not an insignificant task when considered in the context of the physical scale of Fiona Stanley with a complex and broad facilities management contract. Patient safety was always the primary principle when making decisions about commissioning and operations; hence the decision to phase commissioning. These were centred around seven work streams: workforce, ICT, facilities management, clinical commissioning, corporate support, infrastructure and transition. There was detailed preparation, fit-out and go, no-go testing—in excess of 2 100 tests and scenario testing occurred within each space and was carried out for all hospital processes and services, whether they were managed by the hospital or facilities management staff. Rigorous governance and oversight was effected through the task force, which ensured the close and ongoing management of multiple complex and independent work streams, issues and risks. For added scrutiny, gateway reviews were completed in May, August and November 2014, providing independent analysis of the progress of commissioning and transition activities across both Fiona Stanley Hospital and the south metropolitan health system. Initial accreditation by the Australian Commission on Safety and Quality in Health Care, like with any new facility, was granted, with FSH meeting all of the 150 core standards for interim accreditation, with no recommendations.

Whilst the opening of the hospital went reasonably smoothly, once operational, issues did arise that did centre around certain examples of patient care, volumes and flow of work, especially in the emergency department and oncology, and specific issues in ICT. In response, the acting director general instigated an independent review to be undertaken by the Australian Commission on Safety and Quality in Health Care and MMK Consulting. Recommendations were made and are being implemented. Notably, the review did not find there was an increased number of clinical incidents occurring at FSH compared to other similar tertiary sites. ICT has been a significant focus. However, whilst not a paperless hospital, we did deliver the state's first digital medical record, ICU CIS—the clinical information system—and pharmacy automation, plus some of the smaller but newer systems that you saw on your visit. I believe, and the team believes, that this will ultimately be seen as a sound platform to take to other hospitals in WA. In relation to the FM contract, there have been issues such as sterilisation, which did need strong, state, deliberative action, which I believe occurred. Serco's response at critical times, in those critical moments, has been sound, and the majority of those FM services and the interface with health are working well and improving. Whilst there have clearly been operational challenges with opening the state's first 800-bed tertiary quaternary hospital, these are seen in other new hospital builds and commissioning projects all over the world. There is always bedding down time and the time to review systems and processes, which has been required at FSH.

To finalise, the hospital is now fully commissioned, is busy—busier than expected—and is providing a broad range of care to adults, children, maternity patients, neonates and mental health patients, including youth mental health, and rehabilitation. The staff, both commissioning and operational, and whether they are health, Serco or any other staff in the hospital, are hardworking, dedicated and really proud of what they do. However, as with all healthcare services, there are always areas to improve, and we have committed to do this. The commissioning of Fiona Stanley and reconfiguration of the South Metropolitan Health Service, whilst enormously challenging, has been achieved. With your indulgence, Chair, I would like to pass to Professor Stokes to make any comments from his perspective as the director general over the last two and a half years.

Prof. Stokes: I think it was, from my perspective, two and a half years of outstandingly difficult and complex work. I think it is terribly important that we understand, as we do now, the complexity of trying to bring to the working an 800-bed hospital from a greenfields site. It has been a very, very hard task. I sat through and chaired over 100 meetings of the task force, which involved people from Treasury, Premier and Cabinet and the State Solicitor's Office as well as experts in other areas to try and make certain that the first important thing was patient safety and care. When there were

issues associated with a failure of care, I said to the minister that I felt it was important that we get an independent review of patient care. This was carried out, as has been said. I think it is important to note that many of the issues that were found and which I detected in discussion with staff were areas in which there had been, to some extent, some reduction in tenderness of patient care.

[10.20 am]

You can imagine the situation where we had a large number of staff, in the thousands, coming from Royal Perth and Fremantle—two different cultures meeting—a new system with technological advances, some of which were working well, some of which were not, and the difficulty then of trying to work each day through those processes. I think it is a credit to the staff that they did, but some of the issues where there was evidence in which some of that tenderness of patient care which we require was lost. As the director general has said, the group that investigated this found that the incidence of adverse events were no greater than in any other tertiary hospital of the same size. I draw your attention to the recent reports that have occurred from Lady Cilento Children's Hospital in Brisbane, which is going through major issues similar to what we went through in this hospital here. But I am happy to answer any other questions.

The CHAIR: Thanks, Prof. On the matter of task force management, particularly once the hospital was opened in October 2014, can you give us how the task force did manage the transition once the hospital initially opened? As you well know, this committee did a report called "More than Bricks and Mortar", and the task force was created and commissioned by cabinet to give the commissioning and reconfiguration and phasing of the hospital some traction. I wonder whether you could tell us, as a committee, what was the role of that task force once the hospital was initially opened?

Prof. Stokes: The task force continued its activities up until, I think, 30 June this year or it may have been a little later—I just do not have that time under me. That was involved in receiving reports, asking questions on a very significant basis about operational issues. One of the most important things was the decision made for the go, no-go decisions which had to be made for each phase of opening the hospital. That was really a very, very deep piece of work that had to be done, and the task force was very involved in examining those issues, relying, of course, on information given to them, as you would appreciate, but also being able to talk to other members of the hospital staff from time to time. It was heavily involved. Now, at that task force, of course, was the minister's representative who was there, and the minutes of that meeting go to the minister's representative, and I had frequent discussions with the minister about the progress of the issues.

The CHAIR: Prof, those issues, did they go to involving Serco's operation of services?

Prof. Stokes: To some extent they did, particularly in sterilisation and in porterage and in supply.

The CHAIR: How quickly were those problems escalated to the task force for a decision or information?

Prof. Stokes: I beg your pardon; I am sorry, I missed that.

The CHAIR: How quickly was that process in taking those matters and escalating them to the task force for their decision or information?

Prof. Stokes: As you can appreciate, there has to be a lot of investigation into exactly what is happening. I was told, on virtually a daily basis, by Russell-Weisz, who was the commissioning chief executive, of issues, and each week it would come to the task force. It was on a regular basis, so it was not something that was unexpected; we were inquiring into it all the time.

The CHAIR: Did any of those decisions or problems—or how often did those problems and decisions escalate to the Minister for Health?

Prof. Stokes: All on a weekly basis, I kept him totally informed, particularly the sterilisation and then particularly with issues associated with other activities in the hospital and, in particular, with the more recent issues of flooding in the hospital.

Mr M.J. COWPER: Good morning. With the advantage of hindsight and perhaps some retrospectivity, what would you do differently, if you were to do it again?

Prof. Stokes: I think the thing that I would do differently was look at the whole beginning of the hospital right from the start, what was designed and how the facilities management should be undertaken. I must say at this stage that I think that in the majority of managing the facility, the company that is doing that at the moment has done extremely well. But when it comes to what are clinical issues, which I did discuss with the minister and we agreed, particularly things such as sterilisation and those issues, I thought they are clinical issues and should be dealt with by the hospital itself and hence the Department of Health.

The CHAIR: So they should be in-house rather than —

Prof. Stokes: Yes.

Mr M.J. COWPER: In actual fact, what happened was we saw two of those services removed from the contract subsequently.

Prof. Stokes: Correct; yes.

Mr M.J. COWPER: What you are saying is that they should never have been —

Prof. Stokes: My personal view is—I can say this quite clearly; I did say it before—I do not believe they should have been in the contract.

Ms J.M. FREEMAN: And the others like portering? Why is portering not a clinical service or cleaning or —

Prof. Stokes: Portering can be different because there are two sorts of porters in hospitals. There are those that are very important in dealing with patients, both in the operating room and in patients who are in bed for long periods of time, where there has to be posturing. For example, I have been brought up to the paraplegic orderlies we used to have at Royal Perth Hospital, we still have them, who are absolutely fantastic in positioning patients, in making certain that pressure areas were dealt with. So, there are those sorts of porters and there are the others that take patients in wheelchairs and around the hospital.

The CHAIR: Sorry, Prof, the porters that we have at Fiona Stanley cannot do that holding the limb and turning patients.

Prof. Stokes: That is correct, and that is why the decision was made—and I would support that decision—to have assistants in nursing to do that task.

Mr M.J. COWPER: Why do we have so many different categories of assistants? I am not particularly familiar with a contemporary health environment, but why do we have so many different labels on different roles? At the end of the day, I thought the whole essence here would be teamwork in that environment.

Dr Russell-Weisz: Can I take that question, Chair?

The CHAIR: Sure; thanks, David.

Dr Russell-Weisz: I think if you just take nursing as a profession, we obviously have registered nurses and enrolled nurses. It was not a recruitment drive for Fiona Stanley Hospital; assistants in nursing have been around for many years now, because there was a role to play to assist those registered nurses in doing tasks that were of a clinical nature, but required to augment what a registered nurse would do on a ward.

The CHAIR: David, what would they have been known as when we worked in hospitals? We did not have that technology then. What were they called then?

Ms J.M. FREEMAN: PCAs.

Dr Russell-Weisz: PCAs, yes, but it is a different —

Prof. Stokes: Mr Chairman, they were called nursing aides, if you remember.

Dr Russell-Weisz: There were PCAs, but the assistants in nursing—I might pass to my colleague Dr Lawrence—from recollection, and I can come back to the committee, started really 10 years ago now, to actually augment those clinical services or those clinical support services in hospitals. To take porterage as an example, it was very clear that the assistants in nursing then would play a role that the facilities management porters could not do. I think, as the minister said here last time, whether you would actually change that or not, I do not know, but patients are being looked after in the correct way, either through our assistants in nursing or through porters who are still able to move patients but not, say, put them in the right position et cetera. We have had quite a few different roles. The health sector does change; it does not stay simply with doctors, nurses, allied health, which is physios and OTs —

Mr M.J. COWPER: Surely, the whole aspect would be to have the capacity to respond in a changing environment. Of course, in a clinical sense, they change by the minute, so why would you not have a responsive workforce?

Dr Russell-Weisz: I think assistants in nursing has shown that you actually do have a responsive workforce.

Mr M.J. COWPER: Why is there so much demarcation between those areas?

Dr Russell-Weisz: Do you want to comment?

Dr Lawrence: Can I comment on that? There is demarcation between every single profession in a health sense. It does not matter whether you are talking between physio and OT, between doctors and nurses, between assistants in nursing and something else; that is just the way health is. Is it right or wrong? I do not know; it has built up over hundreds and hundreds of years of history. I think there is no evidence at this point in time that the model is any more or any less efficient than the model at Royal Perth or Sir Charles Gairdner, both of which models are not identical either, so each hospital runs slightly differently. The fact that there is a different person doing a different task does not necessarily mean the number of staff within the hospital is any different; it just means that somebody different is doing that task while this person goes off and does something else. If the same person who brought the patient stayed and did that, it means they cannot be off moving the next patient to where they need to be. There is give and take, and I think only in time will we see whether this model is any better or any worse than any of the other models.

[10.30 am]

Ms J.M. FREEMAN: I am completely frustrated with this, because I was around when they negotiated the PCAs at the Liquor, Hospitality and Miscellaneous Union. PCAs were negotiated first at St John of God, Murdoch, which is right next door to Fiona Stanley Hospital, to bring together cleaners, orderlies and food service agencies so that you could have that non-demarked aspect, so you could get that broader aspect of workers, and nursing assistants came into that as well. Clearly, then they pulled out cleaners at one stage because there were issues around handling food and cleaning and stuff like that. When you say that there is this demarcation, you have created this demarcation. This demarcation was not there because, industrially, previously it has been something that you have negotiated as a department with the workforce to have that non-demarked workforce. Is it not the case that because you have gone into a facilities management agreement with Serco, you have created that demarcation?

Dr Russell-Weisz: It is difficult to comment in relation to the facilities, when the facilities management contract was signed, but that was how it was always envisaged to work. As Dr Lawrence has said, it would be a different environment to what is at Charlie's and Royal Perth. I take your point that going back many years there have been many changes, but I do not think it can actually be blamed on the facilities management contract. The facilities management contract for Fiona Stanley was as it was and we needed to react to it, but we were always going to have assistants in nursing at Fiona Stanley Hospital, because they were well established at Sir Charles Gairdner or Royal Perth, so if it is a criticism of the assistants in nursing role, that is for broader Health than it is for Fiona Stanley.

The CHAIR: So, David, what you are saying is that the components of the work that a porter does at Fiona Stanley compared to an orderly Royal Perth Hospital is not, if you like, backfilled with assistants in nursing? The question is: is there an extra cost there? So, for the services that the porters do not do—they do not hold them and they do not turn patients—you have got to get someone else to do that, right? Now, the assistants in nursing help do that. What is the cost of doing that compared to having your porters be orderlies who do all the things they have done traditionally?

Dr Lawrence: The question itself cannot be answered in isolation, but what we can say is that the budget provided to Fiona Stanley is the same as the budget provided per weighted separation to Sir Charles Gairdner. Out of that budget, Sir Charles Gairdner pays all its staff, whether they are orderlies, assistants in nursing or nursing staff. Out of my budget at Fiona Stanley, we pay the contract—the assistants in nursing and all the other staff—so they are factored into the overall cost.

Ms R. SAFFIOTI: But you are not meeting your budget.

The CHAIR: What is the budget?

Dr Lawrence: We went around this the other day.

The CHAIR: And you said you might be able to give us some more information.

Dr Lawrence: Yes, we took it on notice to provide that information, and we will. Correct, we are not on budget currently, but neither are most of my other sites. What I can go back and say is that the workforce build had those built into it, and so the numbers that we were approved to recruit to had those numbers built into them.

Ms R. SAFFIOTI: As you would understand, our committee's role is to have a look at the issue of the contract—the decisions that were made; is it value for money—because a $4.3 billion contract was signed on the justification it was value for money. A key point for us is to determine whether that is the case. One of the key points is that contract had porters in it. Now, Professor Stokes just said that we believe that, I think, the number and the role of assistants in nursing has probably increased because of the defined role of porters in that contract. Can you confirm that as a result of the role that was defined in that contract there are more assistants in nursing than you probably had envisaged initially?

Dr Russell-Weisz: I think that was a question asked the other day and we are going to come back to you on that: whether how much—if—one; and how much there was an increase, because in the workforce build there was always a build for assistants in nursing, which was around 140.

Ms J.M. FREEMAN: It was 125.

Dr Lawrence: It was 125 when the figure was given to you; the workforce build has a build for 140.

Dr Russell-Weisz: You are asking how many—if—of that 140 is additional potentially because of the reduced portering and is that then causing a cost effect and, you are saying, is it not value for money?

Ms R. SAFFIOTI: One the key points of this contract is that it was massive; it has never been done before in the state. There are issues about outcomes in relation to sterilisation, but the other key point is value for money. If the government is going to enter into another one of these contracts, we need the justification, and I am not happy with a media statement saying we are going to have $500 million of savings when every time we try to go through and dissect it, we cannot get an answer. So, this a clear issue, I believe; there was a defined role put in the contract about what a porter would do and that has impacted your ability to deliver your service. I am not saying you have ignored that; you have adjusted to do that. So, the question is: what is the additional cost of delivering the equivalent service that you had envisaged to do? That is all we are asking.

Dr Russell-Weisz: As I said, we will come back to you on notice if we can split those assistants in nursing up—if there were an additional 20. But remember, as Dr Lawrence said, there is a budget given to all hospitals and we expect just for that area—so if you take porterage and assistants in nursing or we look at another model, at another hospital, you would have to compare it with that. Obviously you are talking to a team who was not there at the time of the signing of the contract. It was a global contract, so the savings that you have just quoted, which were around $500 million, were over the suite of services that the facility management provided.

Ms R. SAFFIOTI: But it is comprised of parts.

Dr Russell-Weisz: Absolutely.

Ms R. SAFFIOTI: And we have never been able to get each part, but like I said, I do not accept these numbers being thrown at us continually. Then, when we try to identify a part, we do not get that. I mean, we cannot just keep getting this $500 million, when bit by bit we are proving that $500 million does not exist, so that is my point.

Mr M.J. COWPER: If you could break it down and you might be able to walk me through a real-life scenario. I am a porter at Fiona Stanley Hospital in the intensive care unit and I am requested to do a particular function that is outside my scope. What is the procedure from there?

Dr Russell-Weisz: Can I pass on to Dr Lawrence or Dr Seymour who are at the hospital and who can talk about it a lot more easily.

Dr Lawrence: The staff in general are aware of what the functions of the porters are, particularly now when they were well down that path.

Mr M.J. COWPER: What I am saying is that it is a new hospital and the roles are still being defined. I am a porter, I have it very clear in my mind as to what my role is and I have been requested to do something that is outside the scope of my definition of work. What is the procedure from there? You are standing there in the intensive care unit and you are asked by —

Dr Lawrence: The person would ask their most senior leader, so if I am the nurse looking after the patient, they would asked the nurse manager in charge of the unit what is the next step to get involved, just the same as we would with anything.

Mr M.J. COWPER: And what would that be?

Dr Lawrence: It depends what the task was.

The CHAIR: To roll a patient in ICU because of the pressure effect.

Dr Lawrence: So you get the AIN who is allocated to ICU to come and assist.

Mr M.J. COWPER: You go and find an AIN; would there be one on the ward?

Dr Lawrence: Yes, each ward has AINs allocated to it, and where there is high usage, in areas like intensive care, there is a process to do that, so they have been allocated according to need. It was quite a complex process in staffing the hospital working out where we wanted AINs and in what numbers we wanted them. State rehab has more than the general wards because they need them for positioning. If you go back to the go/no-go, we modelled all of these things and we tested them—

we scenario tested everything—so the staff on the wards were involved in scenario testing every step of the process, from moving patients from wards to theatres, back to ICU and ICU to wards. A lot of work went into it, so people did know how the system was going to work. It did not come as a surprise; it was understood well before the hospital opened how we would have to function.

Dr Seymour: It is just worth commenting that on a day-to-day basis on the wards, teams work no matter who employs the person, so on the ward that I primarily work, everybody works together as part of a team. It does not matter whether you are employed by Serco or Fiona Stanley Hospital or the health department; people understand that they are there to serve patients and to do their best, and they work as a team. I would hate for there to be an opinion go out that that is not how it works; it really does work like that and I would hate people to think that our staff argue about who does what in front of patients. We should not be doing that and we do not, and it is not something that I observe.

[10.40 am]

Mr M.J. COWPER: I am pleased that you said that, because that is what I observed when I visited there last week. What perplexes me is that you have this arrangement that is not conducive to that wonderful work. I think that says more about the staff that you have than perhaps about the contract and how it is written.

Ms J.M. FREEMAN: Dr Russell-Weisz, you have been around long enough to know that at Sir Charles Gairdner Hospital when the portering contract, when the orderly contract—where you around then?

Dr Russell-Weisz: I do not think I was.

Dr Lawrence: I was a junior doctor, I think, at the time, but I recall that.

Ms J.M. FREEMAN: You would have been around at the time when they contracted out and it all went well for a while until the contractor started saying, "We're not making enough money out of that", and orderlies started saying to doctors and to staff, "I'm not doing that job, because I've been told not to do that job." That is why you took them back in-house again, because the contract could no longer deliver. How are you going to make sure that you do not have the same thing happen with your facility manager in that instance?

Dr Russell-Weisz: Could I just answer out from a more practical perspective, please, Chair, because this is something that did come up in the early days? We took a view—a task force was aware of that view—that whenever you get an argument over who is responsible for a patient—this is not to do between a facility manager and a health employee; this could be who looks after the patient—you always should put the patient first, and if there is an issue, you sort it out the next morning between the teams. You never have the patient in the middle. We very much took a view at the time that if there was an issue—be it contractual—that happened in real-time on a ward or in an area, that was not sorted; the patient was looked at first of all. If there is an issue, it comes back to the people who manage the contract later. Does it happen every single time? No, but we really have not—as Hannah has said, on the whole the teams work well together and we have really tried to embed that culture.

Obviously, early on with the interfaces, you are going to have some issues. In relation to portering, for example, it was found that they and Serco need to be reactive about how they hub their porters—where they are actually stationed—and we reacted to that. You can scenario test until the cows come home and you can check everything—and we did try to check everything—but then you wait until the actual day of opening and certain things actually happen that you are not expecting. Again, that is quite normal, so we react to that. But I really want to give the impression that we did say, "You work as a team; the patients should see their care as holistic and as a team."

The CHAIR: David, just on, if you like, the communications strategy with staff, it seems to us that there has been some disconnect between what individual employees tell us and what the department

can tell us about the situation. The portering thing is a case in point. What strategies do you have in place to ensure that the correct information is presented to staff because, otherwise, we probably would not be having this discussion?

Dr Russell-Weisz: I am going to pass to Dr Lawrence for what is happening on the site at the moment in relation to Fiona Stanley. During my time there during the early periods of commissioning and operations, obviously, communication was the key thing—to get as much information out and to try to have people together when you are giving that information, be they Health or be they Serco staff. I can imagine that some of the issues you are hearing about would have happened. But actually addressing them, because in the first 12 months of the operation of a new hospital, whether it happens to be a facility manager or the state itself performing those tasks, there are going to be issues that we would have needed to address if there had never been a facility manager. We were very proactive in doing that. After the commissioning, we had a war-room approach to dealing with the issues—literally, if not on an hourly basis, on a daily basis, things came up, and that was not just about interface; that was a whole suite of things. Then it got more to business as usual, and I will ask Dr Lawrence to comment on what happens now to make sure that communication is as good as possible, albeit that we can always learn.

Dr Lawrence: There are multiple forums. Whether people come to those forums, is up to them. The lead forum for staff is an open forum held with the executive director, which is currently Paul Mark. He has a monthly open forum for any staff member to come and attend and they go through a range of things from budget activity to lessons learnt, to different hot issues. There is also a newsletter which Paul puts out. He is trying to make sure that every newsletter runs a specific article about services. He meets with the clinical staff association and the medical heads of department—again, monthly—so that they are kept informed.

The director of nursing has a senior nurse leaders' forum, in which she meets with all the senior nurses, and has an open-forum discussion around different issues. Similarly, allied health has its own forum. Then we have the devolved management structure, where we have medical and service co-directors, such as Hannah and her companions—we have four service streams—and they meet with their heads of department. All those service directors are co-located in a central office area, which is open plan, and anybody can pop in there at any time. I have been going also to staff forums around all of the south metro area. I have done one since I have taken over at Fiona Stanley. Again, they provide an opportunity to provide information in both directions.

I think we run a fairly open communication channel with the use of email, so anybody who wants to can come to us at any time, and we do our best to respond to that. With respect to theatres, we have set up completely separate forums. Initially, the professor led some of those as the acting director general, but we continue to meet with those. Over the last two to three weeks, we have met again separately with the anaesthetists, all the surgical heads, the nurses within the perioperative area and the anaesthetic technicians. We run a lot of regular forums and we also have reactive forums where we are trying to deal with hot issues as they come through.

Mr R.F. JOHNSON: Can I ask: at what other hospitals does Serco carry out facility management?

Dr Russell-Weisz: Yes, you can.

Mr R.F. JOHNSON: I am asking.

Dr Russell-Weisz: I cannot name all the hospitals, but they provide quite a few hospitals with facilities management in the UK and I understand currently they may be providing one—I will need to check on notice—in the Middle East. It is a wide variety in the UK, because that is where they are based. They have some small contracts, I understand, in the states and elsewhere, and some other contracts in Australia, not just in health but in corrective services.

Prof. Stokes: And in military aspects—in defence stuff.

Mr R.F. JOHNSON: But it is the only one in Western Australia where they are acting as facility managers?

Dr Russell-Weisz: That is correct.

Prof. Stokes: In a hospital.

Mr R.F. JOHNSON: Obviously, in a hospital—that is what I am trying to get at. I think it has been established that obviously they were not up to the job in relation to the sterilisation of surgical instruments and so on and so forth and there has been another where they have fallen short of what was expected and what they were contracted for. That is why you have taken those services back in-house. The minister keeps saying that there is nothing wrong with privatisation, and he keeps referring to Joondalup hospital. I think the difference there is that at Joondalup hospital they are not a facility manager; they are a very professional care and surgical operation that has been established for many, many years. It is a public hospital but it is being run privately. Would you concede that that is very different to what you are using in relation to Serco at Fiona Stanley?

Dr Russell-Weisz: I would agree with you that they are different models. The Joondalup, Midland and Peel model is what I would call a full PPP. It is a full-service PPP, so you contract everything out. They employ the doctors and the nurses. The only staff that we send is junior doctors on rotation, but they actually pay for them. That is a full PPP.

Mr R.F. JOHNSON: And they have been behaving like that. They have been running that health business—if I can call it that—for many, many years now, so they are very professional in their organisation. Would you agree that that is very different to what is happening in Fiona Stanley in relation to Serco?

Dr Russell-Weisz: I do not think it is different in the sense that at Fiona Stanley the contract was never going to be, as I understand it, a full PPP. It was never tendered as a full PPP. I think, there is very few—none in Australia—where you would tender a tertiary or quaternary as a full PPP like Joondalup, Midland or Peel. What I would say is that there are plenty of examples in Australia—we can provide them on notice—where you have a facility manager in a hospital setting providing facility management operations where Health may be employing all the staff. I am talking, for example, about Royal North Shore, where there is a facility manager. There is a facility manager at the new hospital at Gold Coast at the moment. Does it have the suite of services that Serco currently has at Fiona Stanley? No. But does it provide facility management services; is it a privatised service? Yes, it is, so I think the model is there. The model was slightly broader than you see elsewhere.

[10.50 am]

Mr R.F. JOHNSON: Would you say those are more examples, if you like, of cleaning, gardening and —

Ms R. SAFFIOTI: Strict facilities management.

Mr R.F. JOHNSON: — food and beverage and this sort of thing, very strictly limited?

Dr Russell-Weisz: They are more examples of the more traditional facilities management model but we are seeing facilities management contracts become more broader and slightly more innovative.

Mr R.F. JOHNSON: Can I just ask one further question for the moment? We have heard of the problems that have been experienced in moving everybody from Fremantle, from Royal Perth and from Shenton Park into Fiona Stanley almost in a day—overnight as it were; not in a day exactly, but almost overnight—would it not have been more advantageous and better care for the patients if parallel services had been run for, I do not know, a few months, three months, six months, whatever, rather than trying to do everything in one fell swoop?

Dr Russell-Weisz: I think one of the things that we did early on, to answer your question, was phase it. We did actually say that originally it was going to open over a one to two-week period. The then director general, Kim Snowball, asked me when I went in, "What is the best way to do that?" We did phase it. We did run parallel services over that four to five-month period. What we could not do is run, let us say, Royal Perth as it was or Fremantle as it was for much longer. One, you do not have the staff; two, you split the services across three or four sites. Some services need all the backup. You have an emergency department at a tertiary site; you need all the backup. What we did in phasing it was trying to say, "What can we do in discrete blocks where we can leave services at other sites, knowing that we can test the systems well so when we open the emergency department, we can have all the services that back that department?" We could not reduplicate them across three or four sites; there are not the staff and the volumes are not there. It was a patient safety issue. I actually think we got the balance right. Does Prof Stokes want to add anything?

Prof. Stokes: I think that is correct. It was a graduated process of opening, as you would know, particularly the rehabilitation area first on 4 October 2014. So it was a graduated process, but the difficulty is trying to balance, as Dr Russell-Weisz has said, having two services running together when there is not the staff and particularly from the point of view of emergency activities. That is the reason.

The CHAIR: It seems particularly naive that in the original contract was the concept that you would do that in a couple of weeks and it would not be phased. That is the really surprising part; that in the initial contract no-one thought: when we do this, it seems sensible to phase it because that is the commonsense thing that most people would understand that you would have to do, even if they were not involved with hospitals and health. What really surprised us was that in the contract was almost like this stop–start, "In a few weeks we'll be ready to go and not phase it." Of course, then the realisation was that it had to be phased and then obviously all the actual variations that had to come with that. I want to ask a question about Serco's performance self-reporting. What have been the challenges identified in bedding down the self-reporting regime? What has been the quality of it? Is there any dispute still ongoing about the quality of the reporting with Serco, like reporting on itself and how it is performing?

Dr Russell-Weisz: I will make one comment and then pass to both Robyn and Leon. From the onset, in relation to any reporting of the Serco contract—so pre-commissioning; before they got into operations—if we were not happy with the standard or with the detail of reporting, we would not accept it and it would go back. From recollection, there were occasions where that did happen, where we required more detail. But on a regular basis there were pre-ops reports—pre-operational reports or POTS reports as they called them in those days—that came in prior to commissioning. During commissioning, it moved into a new phase over that six months and then in operations it has moved into an even newer phase. I might ask Leon to talk about how that works and, in a hypothetical example, if there were detail he and his team were not happy with, what they would do about it.

Mr McIvor: To answer your question, there has been a steady and sustained improvement in the way the reporting is done, obviously, back from October when the formal monthly reporting commenced. There is still feedback that goes every month but there has been substantial improvement.

The CHAIR: What was wrong with it?

Mr McIvor: It is not that the data was not there, it is the way the data is presented. Sometimes our feedback is as simple as, "Can we have that information presented in a different way?" or "Can we have it in a raw Microsoft Excel format so that we can do something with it ourselves?" and those sorts of things. Those sorts of feedback continue and there has certainly been a substantial improvement in the way it comes through.

Ms R. SAFFIOTI: Can I ask in relation to the reporting—for example, sterilisation—can you establish who initially said this was not up to scratch and then how long did it take and how was the ultimate decision made?

Dr Russell-Weisz: I think there is always a balance between reporting and actually what happens on the ground. One principle we have taken is we are not just depending on reporting. If there is an issue and it goes to clinical care of patients or any operations of the hospital, we need to take any decision now and very much, I think, own sterilisation: myself, Robyn as the then executive director, and Professor Stokes were heavily involved. Whenever we initially found an issue, we would then go back one to Serco, and you have all the information about the different notices given to Serco. From recollection, one prior to the end of last year and then the second one this year. But we did not—we knew there were —

Ms R. SAFFIOTI: Can I just ask, though: Who initially flagged it to you? Was it self-reporting or was it the doctors?

Dr Russell-Weisz: It was certainly the staff who reported it on the ground because when people see that on the ground, they are going to report it. We would not want it to wait for a self-reporting. We acted on it very quickly. I think when it got to the stage post–phase 3, I can remember the meeting we had on 24 February where we said, "This is what we are going to do." There was nowhere in a sense to go. Where Robyn and I were convinced there was an issue, we said, "We're putting our staff in." Does it say, "What do we have to do within the contract?" We actually did not go down to that level of detail because we wanted to do something that gave us surety. Then we went through a process that ultimately led to the sterilisation coming back to the state. Robyn might want to talk about how that actually happened.

Ms R. SAFFIOTI: Sorry to interrupt again, I just wanted the time frame. From the on-the-ground first complaint to 24 February—was it 24 February?

Dr Russell-Weisz: There were issues before that post–phase 1; smaller issues that we then fed back to them. They changed certain practices. Then there were other issues that came up, again from recollection—I only remember that date because of certain things that happened on that date—that we acted on in relation to sterilisation that did not go to KPIs because we wanted to take a view on what was best for the hospital.

Dr Lawrence: If you go back, post–phase 2, when we started to use the theatres, there was a breach notice issued. That was prior to Christmas in 2014. That came to our attention after a couple of incidents were raised with us around contaminated instruments, which has been well documented. At that point, we liaised with the director general and we issued a breach notice, which meant that they had to rectify the problem. We also got in the Department of Health licensing unit to actually go through the sterilisation service and give us any advice, as well as a senior expert from Royal Perth Hospital who went through the service. They actually gave some confidence that they felt that the service was satisfactory and able to rectify the issues that had occurred. It was on that basis that we then proceeded into the following phases, believing that the service could be delivered. They went through the rectification and provided the appropriate documentation. When we moved into the next phase, we got further notification, and they did come from staff. But to be fair, Mr Cotter would phone me as soon as he was aware of them as well, so at times I was made aware from Serco before I was from my staff that there had been an incident. It was those subsequent incidents that then led to the subsequent breach notice and ultimately the take-out. I think we reacted as they came to us; we reacted as quickly we could.

[11.00 am]

Ms R. SAFFIOTI: When was the initial contact made?

Prof. Stokes: If I might add a comment. I had, together with Dr Russell-Weisz, several discussions with the chief executive of Serco from the Australia–Pacific area and indicated the unhappiness that

we were experiencing with their issues. I think it is important to note publicly that at no time did a contaminated instrument ever go to a patient. I think that is terribly important to appreciate. How do I know that? Because my nursing staff, who I met with regularly—both the sterilisation nursing staff owned by Health and those in the theatre—assured me of that. These things were picked up in the processes of sterilisation—checking trays and all of that sort of stuff. I think that is terribly important to note; no patient ever had a contaminated instrument.

The CHAIR: So, Prof, the instruments did not get up into the theatre and someone picked it up and thought, "Hey, I think there's something on this. It's not sterile"?

Prof. Stokes: That happened on two occasions but in the checking process is where they found it. As you well know, one of the most significant things that can occur in bone nibblers are bone chips to get caught in the instrument. They can get sucked up into the stem of the instrument and unless you actually look very carefully, you will not see it. This has occurred to me on several occasions when I have been operating in the past; both at Royal Perth and Charles Gairdner, we found an instrument that has been sterilised and, my goodness, there is a little bit of a bone chip in it. That instrument is cast off and not used. That can happen in the best of circumstances but I think it is important to know that no instrument ever went into a patient, or was used on a patient, that was contaminated.

The CHAIR: We can be sure of that, can we?

Prof. Stokes: Well, I have been told by the nursing staff—our own nursing staff—and nursing staff are professional in this regard. I think it is important also to note that in our discussions with Serco, I asked the question to them: had they conducted sterilisation services in other hospitals? They told me that they had only done it partially in one hospital in England. So, immediately, it was quite clear that they did not have any experience in sterilisation. That is not to say that they could not have developed that if they had applied it appropriately.

Ms R. SAFFIOTI: But maybe not practising on a big tertiary hospital.

Prof. Stokes: Sorry?

Ms R. SAFFIOTI: Probably not using Fiona Stanley as a practice case though. Back to the key point: the contract was probably too big to experiment on a hospital like Fiona Stanley.

Prof. Stokes: I think the contract was an enormous contract and none of us around this table were involved in the writing of that contract, as you can appreciate.

The CHAIR: So, Prof, in your opinion, were these deficiencies in sterilisation—for want of a better term—staff number–related or were they just clinical experience, knowledge, skill, training?

Prof. Stokes: I think it is the latter rather than numbers, probably. It is very difficult to be sure of that.

The CHAIR: Can I just get back to maybe the public perception that there might be a potential that some dirty instrument was not detected by the scrub nurse before she handed it to the surgeon. Have there been any questions from community as patients about, you know, "I've heard all this in the press. I've had an operation at Fiona Stanley; is there any likelihood that I was operated on by a dirty instrument?" How do you handle that and what has the hospital done to handle that?

Dr Russell-Weisz: I might pass to Dr Lawrence here, but in April—I think it was April 2015—there was a claim made at that time that that may have happened and there were certain actions that were taken by the hospital. That does not go against what Prof Stokes said, which is absolutely accurate. I can furnish the committee in detail of what we actually did. I think there was a claim made. I think we set up a number people could phone into and whilst we gave assurances, if any patients rang up—I cannot exactly remember how many did but I can get that on notice for you—there was a process to follow. So, the hospital did set up, in a sense, a hotline for any patients who were worried. It was around about Easter 2015, from recollection.

Prof. Stokes: Can I make a comment. There are was one issue that, I think, has been recorded and that was a heart valve that was to be put into a patient. The heart valve, when it is sterilised, has a cap on it. When it came to the operating room, the cap was off. The surgeon made a decision that—it was still within the sterile pack—it was quite safe and this was inserted in the patient. There have been no untoward effects. The second thing is that, in the sterilisation process, the pH—the acidity—of the water has to be kept very accurately because what it will start to do if it is not accurate is it will start to etch the instruments. When they dry, that etching looks slightly dark coloured as though it could be blood residue. That worried us for a little while until we tested it all and it was not blood residue at all; it was the etching from the pH in the sterilisation fluid. That was corrected. There was an issue at one stage where people said instruments were blood contaminated where they were not.

The CHAIR: David, that case that perhaps the hospital had to deal with in a question about as a patient, was a person potentially operated on by a dirty instrument; is that case resolved?

Dr Russell-Weisz: I have to say, I am not aware of the case you are talking about.

The CHAIR: You were just saying earlier, though, that there might have been a particular concern from someone —

Dr Russell-Weisz: No, there was a concern made by, as I understand it, the ANF at the time.

Prof. Stokes: Yes.

Dr Russell-Weisz: I think it was the ANF who made the claim at the time; it was not the individual person. The ANF made the claim. It was in the press at the time. And because of that—not just because of that, and I will not comment on what we thought of that statement—we made a view that people would be worried when that was out there and we needed to react to it so people could phone in and talk about it. That is why; there was not an individual case.

Ms J.M. FREEMAN: When we were visiting Fiona Stanley Hospital, one of the people that came around with us made a comment about the national efficient price and basically suggested to us that the problem with meeting the national efficient price was, "You're all paid too much." I mean, that was basically the off-the-cuff comment; I do not want to quote him. I understand national efficient price includes a component for non-medical labour as well as medical labour. I want to talk about both of those, if you can, and does Fiona Stanley Hospital record the cost of non-medical labour per national weighted activity unit? If you do, what is included in this calculation and how does it compare to other tertiary hospitals? Then we will come back to the medical labour, but in terms of the non-medical —

Dr Russell-Weisz: I might ask Robyn to make a comment about Fiona Stanley and I will come back then to the national efficient price.

Dr Lawrence: Do you mean non-medical labour meaning nursing, allied health, all of that?

Ms J.M. FREEMAN: No, in that case I would mean the ones that you have contracted out to the facilities manager.

Dr Lawrence: Okay. We do not count labour within the contract; we count a contract price. As we mentioned the other day, it is predominantly a fixed price, so we know pretty much what that is going to be. We can count that on a month-to-month basis; we know what it is.

Ms J.M. FREEMAN: How does that interplay with the national efficient price?

Dr Lawrence: The national efficient price does not give you a breakup per clinical labour, non-clinical labour, gardeners; it is just a price.

Ms J.M. FREEMAN: Your only flexibility, then, to be able to meet your national efficient price if most of your costing, as was given to me the other day, is the cost of labour—because everything

else is a bit fixed. You have a fixed facility management and fixed operating costs of a hospital in many instances. Is your only capacity to meet the national efficient price your labour costs?

Dr Russell-Weisz: Could I just mention something about national efficient price? Our price at the moment, so the price that the Department of Health sets, is not national efficient price at the moment. We know there is a parabola or curve to meet that over a number of years. If you look at the difference at the moment between, say, national efficient price and where Western Australia sits, that is made up of a number of components. Some of it is salaries and wages, which can be above, say, what happens in other states, but it is not the whole reason for it. The price at the moment that is actually given to hospitals or health services is sitting higher than national efficient price. Whilst we are trying to get hospitals down to that over a period, we realise it is not going to happen like that. It is not going to go straight down over one year.

Ms J.M. FREEMAN: I suppose what I am trying to ask, David, is: if you have a fixed-cost contract for your facility manager, then there is no contribution from that fixed cost towards getting you to the national efficient price because you are fixed, that is fixed. There is nothing you can do about the Serco facilities management contract, so the only bit that you have to play with at Fiona Stanley Hospital to meet the national efficient price, which you are above or over hospitals, is the Department of Health contribution at Fiona Stanley Hospital. Dr Lawrence told us last week that Fiona Stanley probably has slightly too much resourcing, so how are you going to handle this? How are you going to do that to meet that, given that you are constrained? Other hospitals—Sir Charles Gairdner Hospital, Royal Perth Hospital, those hospitals—they are going to be able to go into those other areas that you cannot because you have got a facilities management contract.

Dr Russell-Weisz: Which, before Robyn answers, under why it was signed, it was giving savings to the state, which was projecting over the forward estimates and beyond; it was not just over two or three years. I know that may be disputed, but that is what has got to be taken into—that may be disputed!

Ms R. SAFFIOTI: That saving included a tax equivalent payment, which is ridiculous, and also a risk transfer, which had already been established. The transferred risk actually has not happened.

Dr Russell-Weisz: And a cash payment as well.

Ms R. SAFFIOTI: The other key point is you signed that without actually knowing what the national efficient price was, so you signed—not you—the government signed a $4.3 billion contract for 20 years with absolutely no idea how it interrelates with the national efficient price, which you have been asked to achieve, so that is a massive challenge.

Dr Russell-Weisz: It obviously was at the time compared to the likely cost of the state providing the services, and I know this is an issue we could debate for a while, but maybe I will pass to Dr Lawrence to talk about Fiona Stanley Hospital!

Ms J.M. FREEMAN: So she just has to tell us, where are you going to get the resource—slightly too much resourcing?

Dr Lawrence: With respect to resourcing, it does not matter which of my hospitals it is. We will go through a process of benchmarking, essentially, both internally within this state and then benchmarking with eastern states' comparable hospitals with similar safety and quality or better safety and quality outcomes, to look at where our resourcing is variable. When you do that, you can identify where you have too many staff or too few staff, as it might be.

Ms J.M. FREEMAN: You cannot afford any more staff, though, given you are already above —

Dr Lawrence: Sometimes you can swap, so even if you identify you have got too many, it is not a matter of saying, "You must lose X number of nurses or physios", or whatever it might be, whichever professional group. You have to go to the clinical team and say, "This is about how many extra staff we've got; can you redesign your model? I don't care which component of staffing

you use, as long as at the end of the day, we get close to being equivalent to what everybody else is." There then is the issue about our cost gap for our salaries and wages. I need to address that differently, but my first step with any of my hospitals is making sure we are at a relatively safe benchmark level of staffing. I just have to park the contract for the minute; I think that will come out in the wash. I think we said the other day that we need at least a full year of operation to see how that is going to go. The bit I can manage is my clinical staffing and the administrative staffing that I have, and it does not matter if it is FSH or Royal Perth or if I was in the north, any of their hospitals. It is the same methodology.

Ms J.M. FREEMAN: If you park it for a year, the facilities management contract, and you do all of this work around those other areas to do your comparison, what capacity do you have to negotiate with Serco so that you can meet your national efficient price with the facility managers? Is there any?

Dr Lawrence: I think their contract is as it is; it is limited. If I wanted to change the way we delivered services significantly, if someone came up with a much more efficient model because we decided we were going to do something completely different, then we would have to go and renegotiate, and there is an opportunity to do that. Would it be simple and straightforward? It would be complex, just like any other contract negotiation, but certainly they are willing partners to look at different models of doing things, but we are not ready to do that yet.

Ms J.M. FREEMAN: In terms of Royal Perth, you said last week, Dr Lawrence, that Royal Perth Hospital has a challenge in front of it to bring its activity down to what was planned. Can you just expand on that and outline where activity is higher than planned at that hospital?

Dr Lawrence: Across the board it is higher than planned at that hospital. Some of it is within the hospital's control to actually plan to do less work—so, plan to do less outpatient clinics, plan to do less elective surgery—to match that which has been purchased from that site. The emergency department is also over activity, and we can rearrange some of the flows and we will be looking at doing that, now the system is a bit more stable, at how we can rearrange those flows. Of course, with Midland opening next month, some of those flows will change anyway as a result of that, we would anticipate. So, it is an active piece of work with the executive there to match that work volume to that for which it is funded.

The CHAIR: But, Robyn, you do not rearrange that activity, some of that Royal Perth activity in ED, to Fiona, do you? Fiona is already pretty much —

Dr Lawrence: Fiona Stanley is actually —

The CHAIR: That is, anecdotally, what we got the other day —

Dr Lawrence: Fiona Stanley's attendances are higher than what was projected. Its weighted activity continues to run below the purchased activity, so people who are attending are not as sick as what was anticipated, is the bottom line. They have lots of people coming through; they are just not as sick as what we thought. So, from a weighted activity, Fiona Stanley now is tracking just slightly above its total activity. When you look at rearranging, you look at all sorts of things, because it is a complex system. Royal Perth obviously sits in the north of the river; it is hard to get ambulances to come south of the river, so there is a big shuffle that has to happen all the way down.

Dr Russell-Weisz: Just to add, it is not just about those two hospitals; it is also, we mentioned the other day, Fremantle. It is also about the outer metropolitan area; the whole premise of Reid was care closer to home, so we have to take into account what is happening at Armadale, what is happening at Rockingham, what is happening at Peel. We are talking about the southern area.

The CHAIR: On that question about elective surgery and surgery at Fremantle Hospital, you mentioned the other day the activity in Fremantle Hospital is not taking place and therefore we say: if it is not taking place, where is it taking place?

Dr Lawrence: Fremantle Hospital's elective activity is lower than what we would like it to be and lower than what is currently purchased. You could say that has been offset by what is being done at Royal Perth currently. Obviously, that is not ideal because —

The CHAIR: How much lower is that, Robyn?

Dr Lawrence: I knew you were going to ask me that! I cannot tell you off the top of my head; I can look it up, but it depends which specialty it is, so some specialties are only running at about 60 to 70 per cent of what is projected. The medical workload and the rehabilitation and the mental health: mental health is obviously doing very well; medical is doing pretty well with the transfers from FSH, creating capacities as the acute patients move in; and rehab is going well. The challenge has been around re-establishing those elective flows. Part of that is workforce and having the workforce available to be at Fremantle as well as supporting FSH and supporting Royal Perth.

The CHAIR: So what you are saying is some of the Fremantle staff have gone to Fiona, so you have not got enough staff at Fremantle?

Dr Lawrence: No. Some departments run across both sites. General surgery, as an example, is essentially meant to be one department across both sites. It covers the acute workload at Fiona Stanley as well as the elective workload at Fremantle, as does orthopaedics. Some of those models work better than others, and we are still working with the clinicians to resolve how they can make sure that the elective centre—the whole idea of the elective centre was you did not get a list cancelled by emergency patients coming through the ED, so there was stability.

The CHAIR: Absolutely, so if the elective surgery is not being done enough at Fremantle, where is it being done, or is it just not being done?

Dr Lawrence: As I said the other day, across south metro, we are on our targets, so it is being picked up in different sites and different components. Royal Perth is obviously doing a bit, FSH is probably doing a bit, Rockingham and Armadale are doing bits, so we are shuffling the patients around. General surgery is an interesting example because, in fact, the waitlists for general surgery are now relatively small, and particularly the acuity of the cases that can be done at Fremantle are the sorts of cases that you need to use for your list fillers in your tertiary sites, so you cannot move them all out; otherwise, you would have very inefficient lists. But because we now have got numbers of sites doing that lower acuity work, we are actually meeting the demand for it.

[11.20 am]

The CHAIR: Are we doing more planned or elective surgery at Fiona Stanley than you had planned?

Dr Lawrence: No.

Ms J.M. FREEMAN: But you are doing quite a bit of elective surgery at Royal Perth Hospital?

Dr Lawrence: Yes.

Ms J.M. FREEMAN: You said at Royal Perth Hospital, it is overall—every area is running above its targets. Is it a drain on the South Metropolitan Health Service in terms of its operations, when it was never envisaged to operate under the Reid report? Is it effectively a drain to keep it operating?

Dr Lawrence: I do not think I would say any of my hospitals is a drain, because clearly patients require those services. I think it is challenging with the number of hospitals we have got. Just from the staffing perspective, you have got people having to cross more sites than was originally anticipated in Reid. I think the public would probably support the maintenance of them all, however, particularly if that one hospital was your local hospital; you do not want to see it disappear. We have not completed the shuffling of the patients around. There has been, as I explained the other day, a really interesting phenomenon where it does not matter whether it is Royal Perth, Sir Charles Gairdner or Fiona Stanley, when you put those three tertiary sites together,

for some reason there has been this massive flow of emergency patients to the tertiary sector. A 20 per cent increase not this week just gone but the week before that, year on year, 20 per cent more weighted activity to those tertiary sites than the previous year —

The CHAIR: They should be going to see the GP.

Ms J.M. FREEMAN: Are all of those just present and —

Dr Lawrence: The admission numbers are also up, so a number of them are requiring admission but they tend to be the lower acuity. Are they GP patients? I absolutely would not say that. I think we do not know the answer, but what we do know is they have come away from the general hospitals. Across the board, we need a system for patients to go back to their local hospitals where, if they then require tertiary input, they can be moved in. But the current swing of patients attending first time to tertiary hospitals is particularly challenging for us.

The CHAIR: Robyn, on the question of surgery, and not enough at Fremantle and more elective surgery at Royal Perth, what is the relative cost? Is there any cost differential in performing elective surgery at Fremantle versus Royal Perth?

Dr Lawrence: I think the cost predominantly comes in your level of staffing you have in a tertiary hospital site, but the weighted price is the same. Ideally, you want to get your high-volume, low-complexity stuff together. That was the concept of Fremantle, so for a better price, you would get more patients done, essentially. But they are going to get the same weighted price, lower acuity care, but you can churn a lot more patients through and hopefully make a dent on your waiting list across a number of specialties. The sorts of surgeries that we were going to do there were always going to be limited by the acuity that the site could manage, and we also limited the scope of the services so it does not do every sort of elective surgery. It has a really strong focus on orthopaedics and general surgery and it is doing a cold hand trauma and that service is working well from most of the hospitals transferring their cold hand trauma in —

Ms J.M. FREEMAN: What is a cold-hand trauma? It is not your cold hand. I have got cold hands because the air conditioning is not working!

The CHAIR: No. It is not an acute injury.

Dr Lawrence: It means if you get an injury but there are a lot of acute hand injuries that you can say, “Can you go home and come back tomorrow and we’ll operate on it?” It is a lot of fractured fingers and things like that. We call them “cold” because they do not need to be operated on right now, but they do need to be operated on within 24 to 48 hours, ideally. We can send those patients to Fremantle and they can be very effectively managed, but it is dependent on the emergency departments where they present sending them down there. But that model in general is working well. Things like ENT are not done there—ophthalmology eyes. It was always designed to do a large number of all of South Metro’s elective eye surgery, and that is progressing and building up slowly.

The CHAIR: So Fremantle was designed to do that?

Dr Lawrence: That was one of the plans, yes. It is.

The CHAIR: So cataract surgery —

Dr Lawrence: Cataract surgery, all that eye —

The CHAIR: But it is not being done at the moment?

Dr Lawrence: Some is and we are just in the process of migrating the remainder. It has had to be a much—what is the best word? We have had to manage the minutia probably a lot more than we may have anticipated in moving that work around.

Ms J.M. FREEMAN: Doctors would not move?

Dr Lawrence: No. There are doctors there; it is moving the patients that is the challenge, because they sit on waiting lists and you have got to move them. There is a lot of administrative burden in doing that. We do have the central referral service, which refers stuff directly down there, but obviously if people have been waiting on the waitlist for a long time, you would like to move them, and clinicians do have an ownership about their patients. They might have been looking after them for some time and that patient might have been going to Royal Perth, or whichever other hospital, for some time, so there is a process to move each and every one of those, and that takes time. Just sending them new referrals does not give the volumes that we require.

Ms J.M. FREEMAN: In the executive briefings for March and April, it states that the facilities manager has informally advised that it believes it is providing a cleaning service about the specification requirements in some areas and is reviewing the potential to submit a variation claim against the increasing staffing it has provided. Also, in our hearing last week, we were talking about the different green, yellow and red cleaning, and that most cleans are green and yellow. I want to know what your position is on that sort of variation claim. Is that variation because there are more reds, and are the reds beyond what was expected and is that going to be costing more in terms of the contract, because they renegotiate reds, do they not?

Mr McIvor: The cleaning contract has a very large fixed component and one adjustment price, and the adjustment price is called an isolation clean, and a red or an amber depending on how the direction is given can be called an isolation clean. So you get paid per clean for each isolation clean, in addition to the monthly fixed component.

Ms J.M. FREEMAN: Which are greens.

Mr McIvor: No. Remember, cleaning is everything from someone spilling coffee in the food court through to patient areas. When we talk red and green, we are focused on the patient areas. If isolation cleans are requested by clinical staff, the way it works is what we call an adjustment payment. The price is agreed, but the consumption or the units of how many times you do it is what is open ended.

Ms J.M. FREEMAN: Has there been an increase in those reds or that variation—the amber or the red cleans?

Mr McIvor: I would have to go back and see what we budgeted just against the isolation cleaning price; I am not sure. There has been lots of work done around that, because clinicians have to request that level of isolation cleans. We are tracking within budget in the broader sense, if that was really the question.

The CHAIR: The question for me was: you pay this fixed price; are you surprised by the number of isolation cleans? That is a variance so you pay extra for that. Do you go, "We paid this fixed amount but there are a lot of these isolation cleans that we pay extra for that we did not —

Mr McIvor: We have had to start tracking them and they have had a lot of clinical meetings about isolation cleaning. I do not know if "surprised" is the word, but we track it. It is an adjustable —

The CHAIR: Is there a high number of those?

Mr McIvor: I would have to check the details.

Ms R. SAFFIOTI: I suppose what we are asking is: did you budget for a certain amount of isolation cleans and are you coming in over that amount?

The CHAIR: Can we take that on notice?

Mr McIvor: I would have to check. We would have had a contingency budget for adjustment amounts for things above the fixed. Exactly whether we are tracking above or below it, I would have to come back to you on.

Ms J.M. FREEMAN: Given that I raised that last week and you have come here and you have got people here, did you not bring that information with you today?

Mr McIvor: That is not the question I got out of last week's question.

Ms J.M. FREEMAN: All right. What did you get out of last week's question and you can answer that for me? What did you come here thinking —

Mr McIvor: Last week —

Ms J.M. FREEMAN: Yes; go for it.

Mr McIvor: Last week I thought you asked me if there are red cleans, do we pay more for those, and the answer was yes.

Ms J.M. FREEMAN: So you did not think, "She wanted to know that there were more red cleans happening and she might want to know just how many more red cleans there might be"?

Mr McIvor: Correct.

The CHAIR: Thank you, Janine. Leon, can you provide us with some of that information as supplementary?

Dr Russell-Weisz: We will provide it as supplementary, yes.

Ms R. SAFFIOTI: As the final question in that section, have you been informally advised that there is a belief that there needs to be a variation to the contract?

Mr McIvor: We have had a proposal from the FM based on cleaning. It is not just based on things like increased level of services; it is based on changes to square metreage and those sorts of things.

Ms R. SAFFIOTI: So you are negotiating currently with the FM about a variation to the contract?

Mr McIvor: No. We are reviewing it. We have not made a decision one way or another whether to discuss it further with them or reject it outright. We have not formalised that position. We are not negotiating with them at all on it in that sense.

Ms R. SAFFIOTI: But they have advised you that they are looking for a variation.

Mr McIvor: That is right. They have submitted a proposal and we are reviewing it.

Mr R.F. JOHNSON: So when will you make that decision?

Mr McIvor: I imagine in the next couple of weeks. I think that is usually how long it takes.

Dr Russell-Weisz: With all these things, that does not mean that we accept the premise that they put a variation forward. There is a process it goes through and we may reject it outright.

[11.30 am]

Ms R. SAFFIOTI: Sure. Can I just follow up then? Any other variations to the contract they have submitted?

Mr McIvor: It is a long contract, and we are in the fifth year. Is there anything specific you would like me to try to answer?

Ms R. SAFFIOTI: What is the potential exposure to taxpayers' money; shall I ask that question?

Dr Russell-Weisz: I think that is a pretty broad question in relation to the variations, especially as we are into, now, four or five months following, really, full operations—it is probably slightly longer now. But in relation to specific variations we have had —

Ms R. SAFFIOTI: Maybe can I ask, by way of supplementary information, could you provide the current alive variations that they have submitted?

The CHAIR: Yes, how many variation requests have been submitted?

Mr McIvor: "Proposal" is probably a better word. They are not necessarily a variation until we go through a variation process —

The CHAIR: Well, proposal requests.

Mr McIvor: — but a request for change or something is really what you are asking?

Dr Russell-Weisz: Yes, we can provide that.

Ms R. SAFFIOTI: Yes. Is that confirmed, that it will be provided by way of supplementary information?

Dr Russell-Weisz: Yes.

The CHAIR: Thanks, David.

Ms J.M. FREEMAN: Have you accepted any variations to the contract, other than the variation you made by taking out sterilisation and ward clerks? Because that was a variation we put into the contract, was it not?

Dr Russell-Weisz: I would have to actually check how we did this, but the ward clerks, or the scheduling, billing service, as well as the health records management—two services—was by agreement between the two parties. Whether that was by variation or another contract method, I can get back to you. That goes back a while now, over two years; I cannot remember. In relation to sterilisation, that was through the —

Mr McIvor: It was a take-out provision?

Dr Russell-Weisz: That was a take-out provision, rather than a variation, I am pretty sure to say. So, that was not a variation.

Ms J.M. FREEMAN: Have any variations been accepted that you are aware of?

Mr McIvor: There have been administrative variations around very minor, back-of-house-type administration on how to coordinate a certain type of payment or if there has been gap.

Ms J.M. FREEMAN: If there has been a gap?

Mr McIvor: Just an administrative gap in how do we pay for this through this mechanism, where we forgot to add it to this list, and those sorts of things.

The CHAIR: With no financial implications?

Mr McIvor: That is right. There have been very few. If the question is around substantive financial adjustment, then there is none that spring to mind that have had a —

The CHAIR: You can understand that that is very important to us.

Mr McIvor: Right.

Ms J.M. FREEMAN: So the cleaning proposal, would that give substantial financial impact?

Mr McIvor: If it was accepted on what was delivered, then I would think so, yes.

Ms J.M. FREEMAN: You will not know that for a few weeks, and will that be public?

Dr Russell-Weisz: It normally does not —

Mr McIvor: It would be normally commercial.

Dr Russell-Weisz: — become public because it is commercial. But, also, if Serco put forward a variation and we do not accept it, then, no, it does not. Obviously, if they then do not accept our non-acceptance, there is a process in the contract they can go through. But, no, it would not normally become public.

Ms J.M. FREEMAN: So just take me through this, David. If there is a variation, what Leon has just said is that if their proposal variation, which is a variation to the cleaning contract, was

accepted, it would have a substantial financial impact. Are you saying that if you accepted it or if they then took it through the process and it had to be adopted, that a substantial financial impact would not be known to the state taxpayers?

Dr Russell-Weisz: That is not what I said. That would be known—the commercial process, obviously until we get to that stage, we would keep commercial-in-confidence until that stage.

Ms J.M. FREEMAN: Yes. But at the time that it either is accepted or it is enforced upon you, because that is in fact what you are requiring and that is why they need the variation, that will then, what, be reported in the annual report? How will the state taxpayers know if the cleaning part of the contract has a substantial financial additional payment?

Dr Russell-Weisz: It would be certainly reported through the normal process. South metro health service reports through to me in the budget, so it would be known there. But I do not think—could I correct you —

Ms J.M. FREEMAN: So I will just have to ask you in estimates; is that what you are telling me?

Dr Russell-Weisz: Yes, I will look forward to that! But can I just correct you? I do not think it is "enforcing"; there is no ability for them to enforce something that we do not like. But they may take something—there is a dispute resolution process, expert advice —

Ms J.M. FREEMAN: I am used to going through dispute resolution processes, as you would understand. Then you get to the point where you go before an independent arbitrator, and that arbitrator says, "Sorry, Fiona Stanley, or South Metropolitan Health Service, but if you're requiring this level of cleaning, because that's where your patient care is all about, then you're going to have to pay this. That's a part of that", that is sort of enforcing it, do you not reckon?

Dr Russell-Weisz: I do not think it is enforcing; it is actually saying you have used a contract and independent expert advice has said, "We believe it sits here", and then, yes, we would then go through a method of payment. I think also that because there is a suite of services—25 services—in this contract, there are others other ones. That is why we said, after about a year, that there are a number of other ones that we could talk about now that we would have to assess and then you look at the lump sum.

Ms J.M. FREEMAN: So you might take something else out?

Dr Russell-Weisz: We would not take something else out, but we may be getting gains from something else—gains from another part of the contract—that we would actually, obviously, have to make as apparent as anything that we are spending more money on.

Ms J.M. FREEMAN: So this now really interests me. Let us say you make a gain out of the help desk and stuff like that, so you can reduce that amount there, but you have had a substantial increase in the cleaning aspect of it. The state taxpayers will not know that, will they, because you will not itemise that? Can I ask when we get to the stage of estimates, all that sort of stuff? How will we know whether what you contracted for cleaning was what you paid for cleaning, and what you contracted for help desk was what you contracted for help desk? Will it all just be one body of money, and you are just going to say, "It's right and it's tracking"?

Dr Russell-Weisz: I think there are two answers to that question. Number one, yes, it would be global: how is Fiona Stanley tracking with its budget? That takes into account all facilities management services and clinical services. Individually, it is prudent that we would know where we are making gains and where we are paying more money and why.

Ms J.M. FREEMAN: Will that be transparent to the taxpayers?

Dr Russell-Weisz: I would like to think so, but I would have to check within the provisions of the contract about what we can make known or not known. Because the majority of services are fixed-

price services, we are not expecting to get many variations with this contract, and I think that was how it was originally framed.

Ms J.M. FREEMAN: But you are already a year into it and they have put in a variation to cleaning, and that is going to have a substantive impact if you accept it.

Dr Russell-Weisz: Only if we accept it.

Ms R. SAFFIOTI: Can I ask the last question on the cleaning? Have the clinical staff requested more isolation cleans because they are not satisfied with the general level of cleaning?

Dr Lawrence: I do not believe that is the case. I believe they request isolation cleans with clear clinical parameters, usually with a knowledge or a significant concern that the patient is an infection risk.

Ms R. SAFFIOTI: But if the activity is pretty much on track, then obviously either the contract was written poorly or the activity or the requests are higher than anticipated, because to be so early into the contract and to see this as an issue means that something has not been structured right in the contract.

Dr Lawrence: Are you referring to Serco's submission or —

Ms R. SAFFIOTI: No, I am talking about the contract the government signed in relation to the amount of cleaning and the type of cleaning it requires. If there is already a proposal in, and we know cleaning is an area of key issue in the hospital, then obviously that contract was not developed rigorously enough.

Dr Lawrence: I do not know that the proposal that has been submitted is related to the volume of red cleans and isolation cleans. It is a separate issue, because they are paid for those isolation cleans per unit.

Ms R. SAFFIOTI: No, we just heard that the proposal that has been submitted is in relation to the amount of isolation cleans.

Ms J.M. FREEMAN: No, it is a different variation.

Ms R. SAFFIOTI: What is it in relation to?

Mr McIvor: It was a discussion around increased cleaning activity in certain parts of the site, and adjustments to square metreage and those sorts of things.

Ms J.M. FREEMAN: They get paid more for the isolation cleans in any event, so it does not really matter. The facilities management will be happy for it to get asked for as many isolation cleans as it wants, because that is a variable.

The CHAIR: But it still has implications, because that is, sort of, a variant payment outside the fixed cost. So you pay for every extra isolation clean, so it has a financial implication.

Dr Russell-Weisz: It is in —

The CHAIR: Are there, as you say, proposals or requests for variants around portering?

[11.40 am]

Mr McIvor: Not that I am aware of. I would have to take it on notice.

The CHAIR: When we visited Fiona Stanley and we talked to some Serco representatives, they just implied that perhaps there might be a variation request or proposal in and around other duties.

Dr Russell-Weisz: We will check if there has ever been any variation on portering, but what I would say is that Serco representatives would, from my experience going back a few months ago, talk to you about the pressures that they are feeling, or that they are aware of—where there is a heavier workload or where there is a lighter workload. They would talk to us, but until there is a proposal or a proper variation we would not consider it, and we may not even consider it now.

The CHAIR: You are not aware of one?

Dr Russell-Weisz: I am not aware of one, but I will ask the site to double-check whether there ever has been one on portering.

The CHAIR: I wanted to move to helpdesk, but you have a question, Murray Cowper.

Mr M.J. COWPER: When we visited Fiona Stanley, Dr Seymour presented us to a patient, and she inquired as to who we were, and I explained that we were all elected members of Parliament, as part of this committee, and the purpose of being there was to establish whether or not the taxpayers of Western Australia are, one, getting value for money, and, two, the delivery of a world-class health facility. I was pleased to note that the very sprightly 85-year-old woman with a broken hip said that she spoke very highly of the manner in which she was treated, but she did raise the issue of when she first presented at the ED, and at the time it took to process through the ED. I understand that we have heard today that a number of, if you like, lesser injuries are presenting at the ED. I was just wondering what is being done, what adjustments can be made to fine-tune, if you like, the capacity of the process of people coming in unexpectedly. In this case, she slipped whilst carrying her grandson and broke her hip and she came through the process. Everything was almost faultless, with exceptions. I suppose you would encounter ebbs and flows, particularly on a Friday night, but what is available to the ordinary Western Australian people who present in EDs that can make sure that that very critical first few hours of getting the treatment that they need?

Dr Russell-Weisz: As a broad statement, WA has put EDs at the forefront of everything it has done, to reduce overcrowding. It is nothing particularly to do with Fiona Stanley Hospital; this happened many years ago, led by the current Minister for Health, in relation to the four-hour rule. That was based on evidence. If you have increased overcrowding in emergency departments, you have increased morbidity and mortality, and patients do not do as well. All the reform processes we put through Sir Charles Gairdner Hospital, Royal Perth Hospital and the other sites was about getting patients through as quickly as possible—not being too quick, so that we do them any harm, but so that they get the best patient care, and, if they are going to be admitted, get to the ward as quickly as possible, and, if they need to be discharged, they get to be discharged as quickly as possible. That was very much around that four-hour rule, or the NEAT target. I must say that I was concerned, when Fiona Stanley opened as a new hospital—new hospitals have processes that it takes time to bed down—how their four-hour rule performance would go, and really it has been excellent since opening. We have, I think, had some days where we have been in the 80s—I would have to check—and one day where we were in the 90 per cent of people getting through within the four-hour rule, because we embedded processes in commissioning—sure, we have had to amend some—that actually allows the safe carriage of patients. That does not mean every patient has a patient experience that they necessarily enjoy through the emergency department through high-peak times when people are triaged in relation to urgency category 1, 2, 3, 4 or 5. We are always looking at ways to improve the patient flow through the hospital. It is not just about EDs: it is about the ward; it is about community discharge; it is about a whole suite of things. I am comfortable that we have got processes in place that will always continue to be improved. I guess I might ask Robyn or Hannah specifically in relation to Fiona Stanley, and maybe this case and what happened that day, if there is anything that they would like to say that they are doing at the moment with Fiona Stanley ED.

Dr Lawrence: I think the most important thing is that Fiona Stanley is actually leading the three tertiary EDs in its ability to move patients through the emergency department into either discharge, transfer or admission. It is actually doing outstandingly well, given that it only opened in February. It has also probably got, if not the best, then amongst the best, pathways for fractured neck of femur, so this lady was probably actually pretty lucky in turning up at Fiona Stanley. They get to theatre very quickly, they get operated on, and they get into rehab if required. As Russ says, there is always room for improvement, and we are continuously looking at, particularly where

there is blockages and where they are, and there are some, but it is performing really well compared to its comparators in this state.

Mr R.F. JOHNSON: Has there been any ambulance ramping in the last seven days?

Dr Russell-Weisz: I can probably answer that. In the last seven days, there was some last Monday, but from recollection, at the tertiary sites there has been minimal or no ramping since Tuesday last week, and very little over the weekend.

Ms J.M. FREEMAN: Does that include them going into that ambulance holding bay? When you talk about ambulance ramping now, is that just the ambulances outside, or does that include the two paramedics that are sitting with the patients?

Dr Russell-Weisz: No, it does not include—if a patient is being looked after by those two or three or whatever, no it does not, because that was to reduce ramping, but ramping is obviously reported by St John's, so it is the ability for their crews to get back on the road. I was actually with the chief executive of St John's this morning, and he was saying how marked the reduction had been over the last two to three months of ramping in general. Yes, it tends to occur, and we have got more improvements to be made, and that is only one component. Those people are only one component. I go back to the patient flow. The best thing is to get the patient flow through the hospital. Mondays are notoriously the toughest times, but it has been good in the last seven days.

Ms J.M. FREEMAN: How do you measure who sits in that—you must have a measurement of whether they are doing any work, because you would hate to have a situation where you are not having any patient ramping but you are still paying for two ambos sitting —

Mr R.F. JOHNSON: You are paying a million and a half, I think, are you not?

Dr Russell-Weisz: No, not just for that—the whole suite, and I am actually not paying that yet. I have not gone up to that amount of money yet. We are paying quite a small component for those two paramedics at each of the sites. What we are doing is, come November, we will be—we have looked at the data about when we use those people the most, and we will try and fit, then, those people to reflect when those times are. I keep getting corrected by my colleagues, saying that it is Sunday evening; it is not. When I looked at the data today, it is Mondays and Tuesdays, and sometimes on Fridays. We need to be a bit more responsive, but that and other avenues that we have put in place have begun to work. We have seen a huge reduction and St John's have shown it by their own figures. They are not our figures, they are theirs.

Ms J.M. FREEMAN: I think Hannah wants to answer your question.

Dr Seymour: I think it just reflects that we are, as Robyn and Russ said, one of the highest-performing hospitals in Australia in delivering the NEAT target, but it still does not mean that you have individual patients who do not get that absolutely ideal experience and still say that it was a little bit too long for them. That is because hospitals are very complex environments, but we need to keep challenging ourselves and our clinical teams and the teams within the hospital and that is why we need to keep improving and why we need to keep focusing on it, because we want to. People come to work every day to provide that ideal experience to patients.

The CHAIR: David, can I ask you a question about helpdesk? Thank you for the answers you provided to the committee via correspondence on 14 October. In that, you state that the FM is not meeting a number of KPIs relating to helpdesk response times.

Dr Russell-Weisz: Can you refer me to a page?

The CHAIR: Page 10.

Dr Russell-Weisz: Helpdesk, yes, thank you.

The CHAIR: A simple question: what is the underlying cause of this unsatisfactory helpdesk figure? The communication nerve centre that we visited at Fiona Stanley the other day was

fantastic, but apparently they are not meeting their response times. What would you think would be the underlying cause of that?

[11.50 am]

Dr Russell-Weisz: I will make a broad comment and then ask Robyn and Leon just to comment generally at the moment. Help desk, as we have said in the letter, experienced very significant challenges in the early phases because of the volumes of calls coming in. It is one help desk, so it comes in for internal calls and also external calls come into help desk or what I have always known as a switchboard, but, you, know, help desk. They log calls. I know it sounds as bit antiquated, but —

Ms J.M. FREEMAN: No, no; I know "switchboard".

The CHAIR: I know "switchboard" too!

Dr Russell-Weisz: Okay. There were certain things that we learnt through the commissioning, the complexity of the site, that we knew not only challenged them externally, but challenged them internally. There was a higher volume of calls coming through; many were internal calls coming through to help desk asking for help. We understood through that early six months that those KPIs were very challenging. The KPIs were set and they are very challenging. You have to look at what other sites would actually tend to make those KPIs. I did at one point know those KPIs backwards in relation to priority 1, 2 and 3, and maybe Leon can talk to those. Certainly, during commissioning there were challenges. Things did settle down and they were very much more prepared for phase 3, so that knowing that the number of calls they got for phase 1 was well above what they thought, they were very much better prepared for phase 3. I might ask Leon or Robyn to make some comments about current issues with the KPIs.

Mr McIvor: The first point on the help desk function: they still do what we traditionally refer to as a switchboard, which is connections, but the help desk also deals with any number of jobs that are logged and dealt with around a need for a clean or a need to move something or a need to react to some maintenance and those sorts of things.

The CHAIR: "My computer's not working."

Mr McIvor: Yes, and the traditional IT help desk that most people are probably familiar with. From October 2014 to the end of this previous financial year, they took some 700 000-plus phone calls. A lot of those KPIs sit in the 90 per cent–plus, so, of course, that makes it very challenging on a 24-hour-a-day service to staff it. Also trying to get the true help-desk question sets correct around the KPIs. If you ring up to do a clean, like, "We've spilt something in the food court, we'd like someone to come and pick it up please", then you need to go through a couple questions to work out where it is and those sorts of things. So, trying to streamline that process where they can to make sure that the call time and the call dealing time is tight, they are the sorts of challenges they have had.

The CHAIR: In the response also you told us that Serco issued an excusing notice in relation to the help desk. An excusing notice is presumably—correct me if I am wrong —

Ms J.M. FREEMAN: A forgive me notice.

The CHAIR: — "We're failing and it's not our fault." What is the basis of the facilities manager issuing an excusing notice in July 2013? Was it in relation to some of those complexities you have just outlined?

Mr McIvor: Yes, and also around what they call an identity access management system and that there has not been one provided, so a lot of the comment in the excusing causes around whether or not that is impairing their ability to respond and meet the KPIs.

The CHAIR: Someone rings in and says, "I want to speak to Dr X and I think he is conducting a clinic in the orthopaedic clinic", is that the identification problem you are talking about?

Mr McIvor: I think identity access is a Department of Health tool that was designed around, I guess, almost trying to automatically update if someone changes their personal phone number. I am sure it is linked to those sorts of things. Yes, the ability to look at, I guess, a single or reduced number of systems and then link it to the contact details of individuals.

Ms J.M. FREEMAN: Is that identity access for the doctors or is that for the patients?

Mr McIvor: WA Health staff.

The CHAIR: Is that likely to improve as we bed this down?

Mr McIvor: Absolutely; it is. There is work being done behind the scenes around all of that and making sure phone numbers are accurate and those sorts of systems.

The CHAIR: Can you just walk us through: what does an excusing notice look like? Give us a little bit of narrative around it.

Mr McIvor: Fundamentally, it would usually outline a KPI, if they believe they have failed and if they believe, as you pointed out, they have an excusing cause; in other words, that there were causes outside their control that caused them to fail the KPI. They usually break down a narrative into why and it gets sent to the contract management team; it gets reviewed. That is broadly how it works.

The CHAIR: What has been your response to this, "It wasn't our fault; it's not our fault; we're failing but it's not our fault"? What is your response from the Department of Health?

Mr McIvor: We rejected that request.

Ms J.M. FREEMAN: What does that mean?

The CHAIR: Where does that go then?

Ms J.M. FREEMAN: Yes, that is right. Does that mean we get money out of them or are we giving them money? What works; what happens?

The CHAIR: Finally, we get to the nub of it. What happens then?

Mr McIvor: We held meetings to walk through our reasoning; we have walked through their reasoning. Often, we request more information, so often we say that it has not met all the requirements or we do not have enough information to make an assessment. We meet closely with them and work through it; we do not just send each other letters all day. At the moment, they have given us some more information and our team is now, I guess, essentially re-reviewing it. If we cannot agree, then it moves to a formal process up through a senior contract management meeting and goes through that path to, effectively, just sort it through the dispute resolution process you outlined before.

Ms J.M. FREEMAN: Who is the independent arbitrator?

Dr Russell-Weisz: There is not actually one appointed because they could not be across every single facilities management service. You nominate that person at the time.

Mr McIvor: You could have ICT very technical issues versus some other matter, so on an issue basis if you had to, you would work your way to find an independent arbitrator.

Dr Russell-Weisz: I think we were also very clear to Serco—and I think we have answered that in 25(a) and (b)—that we did understand there were some reasons during the commissioning of the hospital. As all staff got used to the new hospital, higher volume calls, we said, "Right, you won't be abated during that time, but you should have had plenty of time to be ready and to meet those KPIs." Those KPIs were signed off by both Serco and the state at the time of the contract signing.

Ms J.M. FREEMAN: In terms of if you get to the independent arbitrator point, and you say it is an ICT issue—or, let us say, it is a cleaning issue, so you have to get to the independent arbitrator. They have submitted this variation; you disagree; you go through the next senior management contract and up to an independent arbitrator. Is the cost of the independent arbitrator factored into the fixed cost of your facility management contract or will that be an additional thing? The reason I ask this is because if you are clever and it is going to cost you more—if you get an independent arbitrator and that independent arbitrator is a commissioner, let us say, of Fair Work Australia who earns twice as much as what I do, just sits in the Fair Work Commission. So, if you are clever and then you have to get lawyers and all that sort of stuff, it may be that the variation is cheaper for you to pay —

Mr McIvor: Even if it is not a variation, if it is one KPI that failed for X dollars, yes, it may be it costs more money and staff management time than it is worth taking that way.

Ms J.M. FREEMAN: My question comes back to that one: is there a proportion in the facilities management contract to pay for independent arbitrators or is that a cost above a facilities management contract?

Dr Russell-Weisz: If we could take that on notice. My understanding is that it is an additional cost but it is shared. That is my understanding. I might be wrong, but I have seen the very clause about the independent arbitration, but I cannot remember it.

Ms J.M. FREEMAN: You do not have costs awarded either way; you just share it at that level? You are going to tech for me, are you not?

Dr Russell-Weisz: I am going to read that bit of the contract again.

The CHAIR: Can I ask a question about the impact of the recent flooding? Some media reports say there is now mould under the floor in the MRI suite from that flooding. Is that true?

Dr Lawrence: It is partly true.

The CHAIR: What part is true and what part is not?

Dr Lawrence: It is from flooding. There is some mould under the floor of the MRI suite, which is being repaired. It is not from the bellows.

The CHAIR: The next question is then: where else is the water or the mould coming from?

Dr Lawrence: I think that is being investigated.

The CHAIR: We have a problem there maybe. We have got a leakage somewhere.

Mr McIvor: My understanding is they found a very small drip in one room —

The CHAIR: That is a leak.

Mr McIvor: That is right, but what I am saying is that over a period of time it went under the floor, so it is not the bellows. They have located and isolated the drip, which is on the floor.

[12 noon]

Dr Russell-Weisz: As you said, it is separate to the bellows.

Mr McIvor: But that is being treated as a construction defect at the moment, which means it goes down a different process to see if it is of if it is not —

Ms R. SAFFIOTI: Was the bellows a construction defect?

Mr McIvor: Again, it is being treated in that manner. It goes down that road and then usually insurers as well as the builder—and we met with the builder and continue to do so.

The CHAIR: So, at this point, the bellows replacement was not carried out under the building warranty process of Brookfield?

Mr R.F. JOHNSON: Probably.

Mr McIvor: Brookfield provided the bellows where Serco did the work, given that they have now effectively taken responsibility for the management of site, and then the building defect process goes along and is still going as to absolute root cause and how it happened.

The CHAIR: So the cost of the bellows is not government, taxpayer, Department of Health, it is —

Prof. Stokes: It is the builder. If I might comment, Mr Chairman, I had extensive meetings with both the builder, strategic projects from Treasury, who were involved in the design, and the people from the bellows company, and Serco. I put to them that there were four things that could have gone wrong: either the design of the hydraulic system; secondly, the stuff that was used in it—the bellows or piping; thirdly, where there was a design fault in the whole process; and, fourthly, as to whether or not there had been adequate maintenance of the system. They were the four technical things that could go wrong.

The CHAIR: It could not be maintenance; it is quite new.

Prof. Stokes: It could be—no, you see, the maintenance of the hot water system pumping the hot water through, the issues where the temperatures are kept correct —

The CHAIR: If the water is too hot, it cracks the bellows.

Prof. Stokes: It could; or if it is too cold, it could do the reverse. It was clear at those meetings that the builder was quite concerned about these issues. As far as I can determine, when I left, they were accepting as builders the responsibility of these issues, and whether they should then go to the bellows company and so forth is another issue.

Mr R.F. JOHNSON: Sure.

Ms J.M. FREEMAN: Is there any question in the analysis of this problem whether the delay in putting patients into the hospital had some impact on the flow through those pipes and therefore the deterioration of the bellows? Has there been anything that would indicate that because you did not have—I could imagine, you had such a long period of time when the hospital was not operating, you probably did not have hot water going through; you just had water sitting in the pipes for that period of time. Has anything been raised by the builder or the facilities manager that says the issue was because there was a delay in patienting the hospital?

Dr Russell-Weisz: I will ask the team here, but from my understanding, no, and we were running—I remember wandering around the hospital—water all over the hospital at the time for that very reason to make sure that the pipes were being used. Can I say that I do not agree it was a long period of time. When we looked at how hospitals should be commissioned, we looked at evidence right around the world, and we said for an 800-bed hospital, how does this normally happen? We think that nine months from getting the keys to actually having the first patient is around about average; it is average, but challenged. Yes, it was not envisaged, as the chair has said before, but it was reasonable and they certainly were running water through all the systems, both the builder before they handed over and when they handed over to Serco.

The CHAIR: Robyn, can I ask you again another related question around the MRI suite? Is the MRI suite operational; and, if not, what is being done to make it operational?

Dr Lawrence: My understanding is that it is operational and there has been no disruption to patient flow-through.

The CHAIR: In relation to the mould, has Serco indicated that any additional cleaning is needed as a result of the flooding, or it is not included in the fixed-cost component of their cleaning obligations?

Dr Lawrence: In relation to the mould, no, not to the best of my knowledge. The floor had to be replaced.

Mr McIvor: It will to be wrapped up as part of the building works to remedy the —

Dr Lawrence: It is not mould on the outside but underneath the floor covering, so in replacing it —

Ms J.M. FREEMAN: David, at the beginning you talked about the hospital working as a team and patient first and holistic care, and communication is the key thing. Further on you talked about every step of the way in terms of process not being just about emergency but about community discharge. I raised previously, and was told when we went on our tour and here last week, that I still cannot understand how it is you can send a discharge form and have no feedback—that it was not received. I note that Mr Olsen is in the room. What I want to know is how we are moving forward. The answer has been that the back-up is to give the patient the discharge form. If it is patient first and treating the whole thing as holistic, and knowing that patients are not reliable or they may have mental health issues or a whole bunch of other things, how is the Department of Health and Fiona Stanley now dealing to make sure that if there are reports that can have an impact on someone's health and a discharge statement that can have an impact on someone's health, how are they ensuring that patient safety is first in this instance? I am trying to stay away from specifics, because I understand that we probably cannot go into specifics, but I want to know what the hospital has thought about and considered in being able to address this.

Dr Russell-Weisz: I will probably hand over to the hospital for the actual hospital, but this is broader than Fiona Stanley; it is how you get information out to GPs, out to the community, and how there is good information coming back. I do not think there is a simple thing, like I think you mentioned a read–receipt, because even if something has been read or been received, you do not know if it has been read by the right person or it has been actioned. In a different life as a general practitioner, I would have regular contact with hospitals and back and forth, but it is an extraordinarily busy system, and there are lots of patients—as you have just seen—coming to emergency departments and being discharged. One of the things years ago was that discharge summaries would come far too late and would not be given to the patient. As one of two GPs in this room, I would get discharge summaries once I had seen the patient, and it did not come with the patient. That always changed. That really is the fail-safe, knowing that it is not really a fail-safe as well. In relation to the specific system that we are running at Fiona Stanley, it would need to be looked at on a complete health basis about how you are going to get that read–receipt. Again, I have not been assured that you actually get the right person who reads it. Again, it is that communication with somebody who has got —

Ms J.M. FREEMAN: But currently we do not have a read–receipt, so you do not even have that as a —

Dr Russell-Weisz: No, we do not. Again I may be wrong, but I cannot think of any system in any state that has that, and that is also going to give me the surety, even if I had it, that the GP—or not necessarily the GP but somebody from the practice—has read it and is going to action it in the correct way. But that does not stop us trying to improve the communication between hospitals, GPs and the community. It is incumbent on both parties to make sure that communication can be as simple as a phone call. On a whole suite of issues, I would not want to rely on email or just on that, because I do not know if the patient or the general practitioner would have got it. I might just ask Robyn or Hannah to comment on anything that we are doing at Fiona Stanley because we have NACS in there and also all Royal Perth—or they want to add anything to what I have said.

Dr Lawrence: I think we covered it pretty much in our response. I think one of the really important things is there are people in the middle of this, and typically it is junior doctors, who fulfil the role of completing the discharge summaries and make the communication with the general practice. Repeatedly, I guess, it gets highlighted to me that, as a junior doctor, you do not necessarily understand the criticality of the task you are doing in doing that. It is almost seen as a task rather than a critical piece of clinical communication. That is the really important piece, I believe; so we work with the junior doctor at orientation to inform them what sorts of things they should be putting

into the summaries, how they should be communicating it; the importance of not only having it completed so you are going to give it to the patient and get it posted if necessary, but also picking up the phone. If there is a really critical timely piece of information, the phone is often the only reliable way. Having said that, the number of times you cannot speak to the general practitioner at the other end is somewhat frustrating to the junior doctors.

Ms J.M. FREEMAN: Or teaching the Y generation to get on the phone is also a challenge.

Dr Lawrence: They are pretty good with texting, but that is actually the most important thing that I see in the whole process; it is that continued education for the junior doctors and making sure they understand that it is not an administrative task, but is actually a really important piece of clinical information transfer.

[12.10 pm]

Dr Seymour: I think we need to keep working with our senior doctors to make sure that they are clear with the junior doctors what information needs to be transferred, so I think it is an ongoing task. I think what we have done is made substantial improvements in completing discharge summaries. It used to be much lower. We are now completing more than 95 per cent of discharge summaries in 48 hours, so information is definitely getting completed. Again, with that volume of work, it is really hard to make sure that it always has exactly the right information in it and we need to keep working on that.

Ms J.M. FREEMAN: The other issue was the aspect of not getting timely blood—the bloods not going through when Mr Olsen's son was in hospital. Again, we cannot talk about specifics, but have those processes been better in terms of getting bloods through and stuff like that, because that was one of the issues: a test was done, the results of which were then retested, but the first test did not go through whilst he was still in hospital, so the medication was wrong?

Dr Lawrence: There are two processes in any investigation. One is having the investigation done and having the results go into the system where they can be read. That is in real time, so at any point in time, once the result is available, it appears in the electronic system. If for some reason there is a delay at the PathWest end, they decide it needs further investigation—if it is a pathology specimen, they might decide it needs to go to a special microscopist—that is a processing issue at the PathWest end, and I probably cannot talk about that.

Ms J.M. FREEMAN: And PathWest is a —

Dr Lawrence: It is a public entity, state government, part of Health, but I guess I am not expert in their field, so I do not want to talk about something I do not know about. If there is an urgent result, typically, they would get phoned through. So if they know it is urgent or it is something grossly abnormal, often we would expect a phone call to come with those, as we would with radiology. But otherwise, once the result is available, it actually is in iSOFT for somebody to be looking at.

Ms J.M. FREEMAN: Is it actually on the computer?

Dr Lawrence: On the computer, yes. That is the same in every site; it is not different to FSH.

The CHAIR: Thank you, I am aware of the hour and we did tell you 12 o'clock and we have gone 10 minutes past.

Thank you for your evidence before the committee today. A transcript of the 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 via these corrections and the sense of your evidence cannot be altered, but we do appreciate any of the supplementary information you have undertaken to provide for us, and, of course, that in

relation to the notes you sent back to us in relation to 24(a), the estimate of the cost of this wastage being calculated. I believe that is a work in progress and you have given some undertaking to provide that information for us when you know.

Dr Russell-Weisz: Yes.

The CHAIR: Thank you very much.

Hearing concluded at 12.12 pm