STANDING COMMITTEE ON ESTIMATES AND FINANCIAL OPERATIONS

2015–16 ANNUAL REPORT HEARINGS

TRANSCRIPT OF EVIDENCE
TAKEN AT PERTH
THURSDAY, 27 OCTOBER 2016

SESSION FOUR
DEPARTMENT OF HEALTH

Members

Hon Rick Mazza (Chair)
Hon Peter Katsambanis (Deputy Chair)
Hon Alanna Clohesy
Hon Helen Morton
Hon Sally Talbot

Hearing commenced at 1.18 pm

Dr DAVID RUSSELL-WEISZ
Director General, examined:

Ms REBECCA BROWN
Deputy Director General, examined:

Mr ANDREW JOSEPH
Group Director, Resources, examined:

Mr PETER MAY
Group Director, Finance, Chief Finance Officer, examined:

Professor FRANK DALY
Chief Executive, Child and Adolescent Health Service and Perth Children's Hospital Commissioning, examined:

Ms GERALDINE CARLTON
Acting Chief Executive, South Metropolitan Health Service, examined:

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

Mr SHANE MATTHEWS
Acting Chief Executive Officer, WA Country Health Service, examined:

Mr WAYNE SALVAGE
Chief Executive, North Metropolitan Health Service, examined:

Mr ROBERT ANDERSON
Executive Director, System Performance, examined:

The CHAIR: On behalf of the Legislative Council Standing Committee on Estimates and Financial Operations, I welcome you to today's hearing. Can the witnesses confirm that they have read, understood and signed the document headed "Information for Witnesses"?

The Witnesses: Yes.

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

Hon SUE ELLERY: Good afternoon, everybody. I want to ask a question in respect of the Department of Health's annual report, as opposed to others that are within the jurisdiction of your agency. On page 117, in respect of major capital works in progress—Perth Children's Hospital.

Under the column headed "Expected Completion Date", it states "TBA"—to be announced. I wonder if you can update us on that.

Dr Russell-Weisz: Through the chair, can I just ask about the page number? Page 117 of the Department of Health, or the metropolitan —

Hon SUE ELLERY: Yes, the Department of Health.

Dr Russell-Weisz: Yes, and it is page 117.

Hon SUE ELLERY: We have had this problem before, if you have a problem with page numbers, in that sometimes if you print off a copy, the page numbers will be different to the document that is tabled in the Parliament. To help you, it is under "Financial disclosures—other financial disclosures", and it is the fourth page of that section. There is a table 17, headed "Major Capital Works". The one I am looking at, under table 17, in my document it is the second table of that. The initiative is the Perth Children's Hospital development. Have you got that?

Dr Russell-Weisz: Yes, we have.

Hon SUE ELLERY: Okay, so expected completion date is to be announced. Can you update us on that?

[1.20 pm]

Dr Russell-Weisz: I can. I would like to start by saying that in relation to the Perth Children's Hospital development, clearly there have been some construction issues that are still being resolved at present, and at this stage, until we actually receive practical completion from the builder and it is actually handed over to Health, we cannot give an exact date in relation to the opening; it would be speculative. As soon as we actually do get practical completion from the builder, we have a completion plan that will take us to full commissioning. What I can say is that since early July, there have been a number of commissioning activities, along with construction activities, to get the hospital open as quickly as possible, but obviously as safely as possible. We will not be opening the hospital until it is safe to do so. If I may, chair, I will pass over to Frank Daly to make any additional comments on that.

Prof. Daly: I think that is a very good summary. We have been serially disappointed by the managing contractor's inability to define the date of practical completion, and, when that is done, for them to miss that deadline. We did a relatively innovative and new endeavour back in July, as the director general said, with the managing contractor's permission, and access to the building, to begin early commissioning activities by our own clinical staff on the site in anticipation of a practical completion date of sometime in August or September. We have actually been able to achieve an enormous amount in those last three to four months. We have now educated and trained and had induction for over 1 500 members of our clinical staff at Princess Margaret on site; we have managed to commission and clean our operating theatres; our sterilisation unit has achieved its qualifications; we have now achieved a poisons' licence; and over 85 per cent of our ICT equipment and applications has now been deployed across the hospital. Unfortunately, we have now reached a point where we cannot go into the final stages of our commissioning process towards opening clinics, beginning elective surgery and opening the hospital on the final move day without practical completion and the building under our own control. We need that so that we can complete full end-to-end testing of all of our clinical areas, and that full end-to-end testing is dependent on us having not only full access to the building but all of the building's underlying systems fully operational and safe. So we are in a situation at the moment where we are doing what we can. There are several still deliverables that we can continue to complete in the commissioning and ICT deployment space, and we are doing that with our staff, and staff continue to go onto site every day to do their training and familiarisation. As the director general has said, until we know an exact date of practical completion, it will be purely speculative now to identify an opening date.

Hon SUE ELLERY: I find it hard to believe that you and the contractors are not working to an expected practical completion date. I can understand it will shift from time to time. You might have an objective—let us aim for 1 November; that is what we are aiming for. What is the most current objective aim that you are working to, or that you have been advised by the construction team that they are working to, in respect of practical completion?

Dr Russell-Weisz: Clearly, I mean the answer is that is as soon as possible. We would like to take practical completion as soon as possible. In my view, seeing the number of issues that they have to close off, I would imagine it is at least three to four weeks away, but I am speculating as Health is not in charge of the construction. As the committee would be aware, the Department of Treasury is in charge of construction of the asset, which will then hand it over to Health. I would imagine that even if that time can be made up, that would be favourable. But I do not want to hang my hat on it is going to be another four weeks. It may be longer than that. What we do know is once we have that practical completion and the building is handed over, we have a very rigid commissioning program with a go, no go process—similar to what we did at Fiona Stanley—which allows, as Professor Daly has said, us to test and do all our clinical scenario testing that takes us to the phased opening. The phased opening has not changed. The phased opening has been announced, which is outpatients first, then elective surgery, and then a final move day where we move the patients from Princess Margaret to Perth Children's Hospital. That has not changed. But we need a definitive, reliable date from the managing contractor to be able to give you a date; and because a number of dates, as Professor Daly has stated, have been missed, I do not want to put another date out there because I am not sure it would be met at this stage.

Hon SUE ELLERY: I am sure you do not want to put another date out there—that is pretty clear. But the question I am asking you is what is the current expected project completion date, because I find it incredibly hard to believe that a date for the current expected completion has not been the subject of discussion either between your agency and Treasury or you and the construction people directly?

Dr Russell-Weisz: I can say that I understand that clearly Treasury are working very hard with the managing contractor in relation to securing a date. They have sought an up-to-date program from the managing contractor to give a date, as, I think, 10 days ago or a week ago. I have not actually seen that program yet. From my perspective, I know there are about four or five key things that need to be completed in construction. As soon as we get there, we will then lock in a date. We know that we want to do a final move day on a Sunday. So in a sense we are ready to go. I might just ask Frank Daly to see if he can add anything to that. I am actually not avoiding the question. I am saying that I do not want to give a definitive date. I know the managing contractor —

Hon SUE ELLERY: I am not asking for a definitive date. I am asking what is the current expected practical completion date?

[1.30 pm]

Dr Russell-Weisz: We do not have that from the management—I have not been told that from the managing contractor, except what I can say is every effort is being made to get to that date as soon as possible. However, as I said, Treasury has sought an updated program from the managing contractor to get to us a realistic practical completion date. Can I ask Frank to add to that, chair?

Prof. Daly: Thank you. Through the director general and the chair, I understand your dismay at there not being a current indicative date of practical completion.

Hon SUE ELLERY: I don't believe it.

Prof. Daly: The last indicated date was in early October. As the director general has said, the contractor is managed by Strategic Projects and Asset Sales and they obviously work on a daily basis with the managing contractor. I am involved in high-level meetings with the managing contractor twice weekly. The managing contractor has been asked to indicate the next date on which

they are programming to provide practical completion. They have not, as of this morning, provided any indicative date.

Hon SUE ELLERY: Okay; they have not provided the most recent one. What was the last indicative date that they gave you?

Prof. Daly: Midnight, 10 October.

Hon SUE ELLERY: What has been put to us is that project completion date has blown out to May 2017. Has that date been raised with you?

Dr Russell-Weisz: Through the chair, that date has not been raised with myself, at all.

Hon SUE ELLERY: What, then, do you think is the time line for you to be given the next indicative date?

Dr Russell-Weisz: I have been advised by the Department of Treasury at our last meeting that we would expect to see a program from the managing contractor within the next week. However, I would caveat that; that then needs to be interrogated by the Department of Treasury because clearly, we want a realistic date. They need to see if that program is realistic and if it is going to be able to be made. We might get a date, but then I would be seeking that date from the Department of Treasury after they have looked at the managing contractor's plan. In my view—Frank can correct me if I am wrong—I would say in the next week we would expect to see a date from the managing contractor. Is that about right?

Prof. Daly: I do not have anything to add.

Hon SUE ELLERY: One of the processes that arises out of hearings is to put questions on notice.

Dr Russell-Weisz: Yes.

Hon SUE ELLERY: I would like to put a question on notice, if I may, chair: within the deadline for you to provide answers back to this committee, if you are provided with an indicative date—I am not asking for a definitive date; I am asking for an indicative project completion date—I would like you to provide that to the committee.

[*Supplementary Information No D1*.]

Hon SUE ELLERY: Can you advise what the current status is of lead contamination in the water?

Dr Russell-Weisz: I will start, if I may, chair, and then pass to my colleague again. Again, this is a construction issue so the details may be best asked of Strategic Projects and Asset Sales but we are aware, at this stage, that there has been a lot of work in relation to lead in the water. A number of parties are working on it with the managing contractor. The last readings, as far as I understand, in relation to lead in the water is that the lead levels are still higher than the Australian drinking water guidelines. However, they have been falling, and they have been falling in relation to the flushing that has been occurring at the Perth Children's Hospital.

The CHAIR: How much higher are they than the Australian standard?

Dr Russell-Weisz: They take a range of samples from a range of different places in the Perth Children's Hospital. As far as I can understand, they are slightly above—not hugely above—the Australian drinking water guidelines. If you want to know the exact levels of the recent tests, I would probably have to take that question on notice. There is a very rigorous process of flushing going on at the hospital as we speak at the moment. That flushing is to see if we can literally flush any contaminants, including lead, out of the water. We did have the same issues—not in relation to lead—at Fiona Stanley. They were biological contaminants that needed to be flushed right away through and that was very successful. There is a process. It is the responsibility of John Holland, as the managing contractor, to resolve this issue and to resolve this issue through flushing or through whatever means possible. I can say that there is good liaison between the Department of Treasury, the managing contractor and also the Department of Health's Environmental Health Division,

which is the regulator in this sense, so the regulator is already involved. For any further details, I might pass to Frank.

Hon SUE ELLERY: I want to move back, if I may, just to make sure that I understand the time line. Once you get control of the site, how long does it take you to complete your commissioning plan?

Dr Russell-Weisz: Can I pass to Professor Daly.

Prof. Daly: Thank you, and through the chair, once we receive a definitive date of practical completion and are very close to that date, we will assess our progress against our commissioning plan at that point and analyse the deliverables that we need to still complete and, obviously, the testing that we need to do. At this stage, hypothetically, if practical completion were to occur in the next week, then there would still be approximately eight to 10 weeks of work to be done in the clinical commissioning and ICT integration testing and workflow testing before we opened our outpatient services. Then, from then, there would be the four-week phased opening from outpatients, to elective surgery, and finally to final move date. At this point, practical completion would be somewhere between 10 and 12 weeks before final move date. Having said that, once we get more proximal to the actual date, we may have completed more work, so it may actually be less than that. It will depend on our progress at that point.

Hon SUE ELLERY: Thanks. If I understand it right, once you get the control of the site, it is eight to 10 weeks to complete clinical, ICT and workflow issues till you can open for outpatients, then potentially plus four weeks till —

Prof. Daly: Final move.

Hon SUE ELLERY: — final move. Final move and full opening is within that four weeks.

Dr Russell-Weisz: Final move is final opening.

Prof. Daly: It is four weeks after opening of outpatients, as currently scheduled.

Hon SUE ELLERY: So potentially, it is up to 14 weeks—eight to 10 weeks, then plus a potential four weeks. At the longest, it is 10 weeks to do the ICT, clinical and workflow, plus four weeks to move and open.

Dr Russell-Weisz: That is correct. I would also like to make a comment there. Obviously, there is a very rigorous process in commissioning. Frank and his team will be doing a lot of workflow tests and clinical scenario testing. We have planned that no issues will come up during that time but, obviously, like we have done at Fiona Stanley and other hospitals, you do that rigorous testing and if something comes up, then it may delay it, but we think it is between the eight and the 12 weeks. But there is a very rigorous "go/no go" process during that commissioning period.

Hon SUE ELLERY: If I may, given where we are in the calendar year now and Christmas, what happens? If you got the tick off from Treasury next Thursday, which is 4 November, that potential 14 weeks takes you to the other side of the general Christmas–New Year break. Can you be working—doing the commissioning plan—during that period?

Dr Russell-Weisz: I will answer that, then over to Frank. We certainly did that at Fiona Stanley. As you remember, there was a stage 1 opening, then a stage 2 just before Christmas of obstetrics and then elective surgery. Then the main opening was in February. There was a huge amount of commissioning activity going on in January. There might have been a little bit of downtime over Christmas, although I do not think we did have much. There will be some downtime, but it can be mitigated. I pass to Frank.

Prof. Daly: Through the chair, the commissioning program at the moment assumes normal work on every working day. Obviously, it assumes that we are not doing normal work on public holidays.

Other than that, there is no downtime for those three days between Christmas and New Year, or general downtime in January because of "holidays".

Hon SUE ELLERY: I want to flick back, if I can, to the other issue that got some attention around the construction, and that is the asbestos issue. Are you able to tell us now, categorically, that all of the asbestos has been removed from the ceiling panels or that those ceiling panels have been removed?

[1.40 pm]

Dr Russell-Weisz: As I understand it, through the chair, the majority of the ceiling panels have been removed. It was my advice earlier this week that in early November—that is, the first week of November—it is expected that all panels will have been removed and all panels will have been remediated.

Hon SUE ELLERY: Can I ask about the ongoing finalisation of the building and the defects? Information has been given to us that as many as 45 000 defects have been identified. It is a big project. It is a big building. There are always defects when you are constructing something, but 45 000 is a big number. The other thing that has been put to us is that, as they are being corrected, about half of those are not being corrected to the appropriate standard. Is there anybody who is able to comment on that?

Dr Russell-Weisz: I will say a couple of words. That is not my understanding of the numbers. At the moment, there are still defects being closed out, as there would be on any project of this size and complexity. Again, I should not be speaking on behalf of the Department of Treasury, but I am sure that they would agree; they would not take practical completion unless all the defects have been closed out contractually. You can have some minor defects that go past practical completion. I have not heard the figure of 45 000. I have seen on the reporting that comes to the task force that there has been a significant close-out of defects over the last few months. There are more to go. I might ask Frank to see if he has got any further update this week.

Prof. Daly: I am not an engineer, but I once heard that in a large infrastructure project, you might expect up to one defect per square metre of the project. The PCH represents 128 000 square metres. I believe that the number of about 45 000 is probably about accurate in that, at their peak, there may have been 45 000 defects that needed to be closed out. Currently, there are approximately 10 000 defects that need to be closed out; 2 000 to 3 000 of those defects represent replacement of the external Yuanda vitreous enamel panels on the external facade of the building and are not material to practical completion or our commissioning of the hospital.

Hon SUE ELLERY: The green things?

Prof. Daly: The green and the white things. We have always stated that they would be replaced in a program over a number of months after the hospital is opened and they will have no effect on the operation of the hospital. There are currently approximately 1 500 defects that have been remediated by the managing contractor but are still "in dispute" with the state in that there still is some conversation to have about their close-off. That is not unusual and is routine, I believe, in such projects. My understanding is that there are approximately 2 500 defects currently at play that need to be remediated to the satisfaction of the state prior to practical completion.

Hon SUE ELLERY: Are you able to comment on the information that has been given to us that about half of them, as they are being corrected, are actually not being corrected to standard?

Prof. Daly: I do not think the numbers suggest that. To me, the numbers on paper look like 15 to 20 per cent rather than 50 per cent. I cannot give a more accurate answer than that.

Hon SUE ELLERY: I appreciate the numbers of them. Is there a list of the kinds of categories of those defects that are still to be corrected? As opposed to listing every single one of the green panels on the outside, is there a list of the categories that you could provide to the committee?

Prof. Daly: I do not have it available to me.

The CHAIR: We will take that on notice.

[*Supplementary Information No D2.*]

Hon SUE ELLERY: My last question for now with respect to Perth Children's Hospital is with respect to chairs in the hospital that were found to be not fit for purpose. The information that was provided to me was that there was some $150 million spent on chairs that were found to be not fit for purpose and had to be replaced. I am interested in, if that is correct, what about them is not fit for purpose and what is the cost of replacing them and who had to meet that cost?

Dr Russell-Weisz: I have not heard that. I will pass to Frank if he has heard anything about that.

Prof. Daly: It is true that there are some chairs that have been delivered that do not fit the specific purpose, and I can think of an example. There might be half a dozen chairs in the medical day unit that do not lie completely flat. My understanding is that in the Perth Children's Hospital development budget, the total FF and E budget for such things —

Hon SUE ELLERY: FF and E?

Prof. Daly: — furniture, fixtures and equipment—is only $103 million. I do not believe that we have purchased $150 million worth of chairs. That would be hundreds of thousands of chairs. But I am aware that there are some chairs that we are replacing as a matter of course because they do not fit the design specifications.

Hon SUE ELLERY: Do you have a dollar figure or a percentage, like "We know we have to replace about 15 per cent of the chairs that are not fit for what we thought they would do"? Do you know what the numbers are?

Prof. Daly: I apologise; I do not.

Hon SUE ELLERY: Are you able to find that out?

Dr Russell-Weisz: We would certainly try. Can I just clarify that the majority of the FF and E is being procured through the managing contractor. We are happy to take the question on notice, but I might have to defer it to my Treasury colleagues to answer it properly.

[*Supplementary Information No D3.*]

Hon SUE ELLERY: Just so I understand the relationship between you and Treasury, how often is the task force that you have already referred to meeting?

Dr Russell-Weisz: That is meeting weekly.

Hon SUE ELLERY: Who is on that?

Dr Russell-Weisz: On the task force there is the Deputy State Solicitor, there is also a Department of Treasury rep and also a Department of the Premier and Cabinet rep and it is chaired by the director general—myself. But the responsibility for the construction of the building is clearly under the Department of Treasury's responsibility, but the Department of Treasury and the Department of Health are clearly working very closely and have been ever since this project was established.

Hon SUE ELLERY: With the greatest of respect to you, it does seem extraordinary to me that with such a high level group that is meeting weekly, and probably members within that group talk more frequently than weekly, you have a projected completion date of 10 October and what is today—27 October? That group has met at least twice, if not three times, since then and you are not able to tell us an updated projected date.

Dr Russell-Weisz: I can clarify once again that the Department of Treasury has reported at task force that it has sought an updated date from the managing contractor and continues to seek a robust and realistic program from John Holland literally on a weekly basis since that date was not met,

which was 10 October. As far as I am sitting here today, they either have not received it or have not interrogated it as yet to bring to task force a new date of practical completion.

Hon SUE ELLERY: Did you know before 10 October that they were not going to meet 10 October?

Dr Russell-Weisz: It was very apparent, I would say, a week before 10 October that they were struggling to finish certainly the managing contractor activities.

Hon PETER KATSAMBANIS: Thank you for coming along today. I think I am going to ask questions in areas that I have asked before, so nothing will be a real surprise. At page 30 of the annual report under "Managing funding reform and cost efficiencies", there is a reference in the last dot point to the implementation of key national activity-based funding reform initiatives. I think it is well known that we in Western Australia are well outside the national activity-based funding framework, and there are good reasons for that. But given the actual cost of the health budget, driving efficiencies is critically important. What are the key national activity-based funding reform initiatives that you are going to implement? Do you have a list of those?

Dr Russell-Weisz: Through the chair, thank you. It is a very broad question. I start by saying that the WA health department has been under activity-based funding now for a number of years. We have a robust activity-based funding framework, and this reflects how we are funded by the commonwealth. We have begun to understand over the last few years specifically the pressures in WA in relation to pricing and costs and efficiencies and effectiveness.

[1.50 pm]

As you quite rightly said, we know that we were, at least, nearly 18 per cent above the national efficient price for very good reasons. The reform initiatives really are up to us. The activity-based funding gives us a framework to be able to measure ourselves in relation to our eastern states colleagues. We are not the most expensive state—that is the ACT by 33 per cent above the national efficient price—but we have done a number of things in the last 15 months. The budget has clearly grown in Health from 24 per cent of the state's budget to 29 per cent now. We have put in place over the last year a financial sustainability strategy to make sure that we provide the best quality care in health and the best clinical performance, but we are financially sound as well. Over 2015–16, our reforms through this—and being driven really through, as you mentioned, the activity-based funding framework—have been to constrain our expenditure growth. Health has grown at around about, on average, 10 per cent a year over the last few years. In 2014–15, it grew 8.6 per cent; last year, it grew at 4.7 per cent. So, we have made some real inroads and it is the first time it has been under five per cent in 11 years. At the same time, the area health services, now the health service providers, provided 6.1 per cent more activity and our staffing growth was basically flat. If you look at how we are now getting closer to the national efficient price, we have certainly dropped.

On the last figures I have, I think we are just above 16 per cent, but it obviously takes a while to flow through. A large component of the difference between ourselves and the national efficient price is staffing costs. Nearly 50 per cent of that is because we pay our staff higher wages than in the eastern states. Other areas of the difference relate to specific WA-unique factors. We have large remote areas that naturally cost more than other states such as Victoria and New South Wales, and we have to date had a more expensive labour market in WA than in other states. About 12 per cent of the difference is under management control and what is really pleasing to see is the way that we have, as a team, made differences in length of stay. Length of stay is how long on average people stay in hospital. We were one of the big outliers 10 years ago; we had the longest length of stay if you look at the tertiary hospitals and how they compare to their peers. Now, it looks like we are one of the best, and so really in that area we have found there is not a lot more to go. There are specific areas, and I am sure the chief executives know the specific areas they are looking at at the moment. We know our coding can be better. The difference between our costs and the national efficient price, we actually understand now why we are different. That is why I think it was very

important that through the enterprise bargaining agreement process we stuck to government wages policy, which is what we have done. There is a lot further to go in relation to the journey that we have just started, but with the prime consideration being safety and quality for our patients.

Hon PETER KATSAMBANIS: I understand that, but are there any targets as to where we want to go towards the national efficient price?

Dr Russell-Weisz: The first target would be to keep expenditure growth under control. We had expenditure growth last year of 4.7 per cent. It would certainly be my view to keep expenditure growth at that level or less. We know that 12 per cent of the gap is within our control—within the health service providers' control—and that is where they are focusing on at the moment. The other area that relates to wages is all about wage outcomes. Clearly, if wage outcomes over a number of years can come down because of the changed situation in Western Australia, then that gap will come down. What we will not do is compromise patient care, if there is a gap because we are unique; this was recognised by Treasury in the last budget, in that we were decoupled from the national efficient price because there were key areas that we would never get down, that we would never close, and these were the WA-unique factors.

Hon PETER KATSAMBANIS: For someone like me who spends an inordinate amount of time looking at figures and, I guess, for people like yourselves who have to respond to these national benchmarks, it would be good if at some point in time someone provided a figure or at least a fence around what is the uniqueness figure, if you like. I am not sure whether you have got it. If you do not have it, I do not think we need to spend a hell of a lot of time on it today, but it would be good at some point in time if we could get some sort of indication of where we say that X amount of dollars is the uniqueness factor—all of the uniqueness factors put together—and the rest is stuff that we can work on, because otherwise these figures will get published annually and we will get results that look outliers when we know, when we interrogate the figures, that they are not.

Dr Russell-Weisz: I might ask my colleague Andrew to comment, but on the gap between national efficient price and our current cost, nearly 50 per cent is WA-unique factors. I can list these. One is inadequate recognition of the remoteness costs within the national ABF model. So, the first thing is that we are measured or compared at the commonwealth level—for example, a hospital such as Port Hedland is compared potentially with a hospital in Victoria that is very close to Melbourne. Although the ABF model is good, there are some inadequacies. We have had very good liaison with the commonwealth recently in trying to correct those inadequacies. Also, there are certain things such as hospital efficiencies in rural remote locations. We do not have large regional centres. The biggest one is Bunbury at 40 000. Queensland has much larger regional centres where there are greater economies of scale. We did, and probably still do to an extent, have a more expensive labour market, and there is also a higher need in WA to cater for the high-cost, high-complexity but low-volume services—for example, providing paediatric cardiothoracic surgery in Western Australia or providing heart transplants here. They are very low volume, very, very high complexity and therefore high cost. Some of those you will never get away from, but the gap, I can say, out of that is 50 per cent.

Hon PETER KATSAMBANIS: That is recognised nationally?

Dr Russell-Weisz: It is recognised in Western Australia. I am not sure whether the commonwealth have recognised it; we are working with them.

Hon PETER KATSAMBANIS: I will move on to another area that I have asked questions about before and I am really keen to see how we can improve performance even more—that is, page 21 in the KPIs, "Percentage of fully immunised children". The target there was 90 per cent, and we have realised the target of 90 per cent. We have got there; that is good. That unfortunately means that one out of every 10 children in this state is still not fully immunised. Is there anything more that we can do at a state health service or state government level to increase those rates?

Dr Russell-Weisz: I might pass to some of my colleagues on this. I do not have the assistant director general of public health here today—he is not in the state today—and he may provide better context than me. But what I would say is, number one, through much better education. We do educate; we have a high vaccine rate in this state. We need to be out there educating as much as we can that vaccinations prevent certain diseases and I think we have made significant inroads over the last few years. Of course, one would want to be at 100 per cent; that is always our aim. I think certainly refuting any of the opinions that are out there where there may be an anti-vaccination approach if those things are not true. We know with certain vaccinations that they will provide significant coverage for patients. So there is more to do and there are pockets in certain areas that are probably less than 90 per cent. Looking around the table, I might ask my medical colleague Dr Daly to provide any further comments on that.

Prof. Daly: I think we had a discussion about this year ago. The child and adolescent health service deals with immunisation in the metropolitan area through the child and adolescent community services branch. We estimate that we deliver about 20 per cent of the children's vaccinations, and that 75 per cent to 80 per cent of those vaccinations are delivered in general practice. Aboriginal medical services and other local government providers are probably a very, very small minority. In the last financial year, we delivered 70 813 vaccinations through 32 000 occasions of service.

[2.00 pm]

Professor Karen Edmond, in October 2015, delivered a report on improving community childhood services. Part of that was also to look at the child health checks that are done and targeting vulnerable families, not just for immunisation but for the more broad social determinants of health. I think that in terms of trying to improve from that 90 per cent, especially in those vulnerable groups, certainly in the metropolitan area, at certain age groups Aboriginal immunisation is lower than 90 per cent. Her recommendations, which we are implementing over the next couple of years, include targeted health services, screening, and support and advice to families, either refugee families, Aboriginal families or those with other types of social or economic deprivation. We estimate that approximately 25 per cent of families in the metropolitan area might have a service that is greater than the normal statutory checks and that one per cent of families require quite an intensive and holistic approach, either through our child health or Aboriginal child health services. Immunisation is part of that initiative to bring those rates up.

Hon PETER KATSAMBANIS: I understand about improving access and informing groups in the community, particularly to the CALD groups, that may not necessarily understand what services are available to them and/or what these services may be able to provide for them. I think we all need to continue doing more work in that path. But there is a group in our community who either actively choose not to immunise their children or simply through apathy do not get around to it, which exposes another group of children to significant risk. What can we feasibly do to address those two groups, either the blindly apathetic, the could-not-care people, or those who are actively making what all public health officials tell us is a very, very poor choice for their children?

Prof. Daly: I think that one group you defined as being apathetic or those who are not highly motivated, opportunistic immunisation whenever you can capture people at a consultation is very important. That is part of the child health checking program. Also, paradoxically, children with chronic illness and disease have lower immunisation rates than others. There is a misperception that they maybe should not be immunised as it may compromise their underlying illness. Certainly, at the new Perth Children's Hospital we are developing a model of having a drop-in immunisation clinic in the hospital to provide specialist consultation and services for those children that are coming through the door for other things. In terms of the second group, those that are opposed for philosophical or other reasons, I am not a public health physician and perhaps I am not qualified to discuss that, I am sorry.

Hon PETER KATSAMBANIS: Have you found that any of the stick approaches—the welfare removal or lack of access to welfare approaches—work in increasing immunisation rates, either as a sugar hit or across the board more generally?

Dr Russell-Weisz: Again, I would be speculating. It has proven to work in some jurisdictions but again I would be happy to take the question on notice and ask Professor Weeramanthri to give us his opinion.

[*Supplementary Information No D4.*]

Hon PETER KATSAMBANIS: As I said at the outset that welfare side is mainly federal, not state, and that is why I asked initially what we can do as a state.

The CHAIR: We will go back to Hon Sue Ellery.

Hon SUE ELLERY: Good on you, chair; thank you very much. I want to talk about Fiona Stanley Hospital. In the department's annual report is a reference on page 115 about capital works, but that is just a reference; I do not think it takes us anywhere. The first question is maybe about some technical issues around surplus equipment and storage. Can somebody confirm whether it is the case that in the sort of shell space behind the theatres, which is set aside for future expansion of the theatres I think, is it true that up to 1 000 chairs are being stored in there because although they were new, they were considered not appropriate or fit for use? Is somebody able to let us know if that is the case?

Dr Russell-Weisz: This is me answering that question and I may need to take the update on notice, but I can say to the honourable member that there were some chairs at the time—this is going back two years when I was in a different role—that were procured that needed remediation. I do not know if there were 1 000, but a lot of them got remediated or had some modifications and then were put out on the wards and used in a number of places. These were chairs, as I recall, that were—I am going to use the word—"recliners" that were for comfort and some of those chairs had to be remediated. I am not sure how many chairs now are being stored at the Fiona Stanley site.

[*Supplementary Information No D5.*]

Hon SUE ELLERY: I am not sure if you are going to be able to answer this and perhaps we can add it to D5 if we need to. Is it also the case that there are 20 medical fridges that are not being used and a large number of paper scanners that have been purchased but are not being used and are also in storage?

Dr Russell-Weisz: I would have to take that on notice.

The CHAIR: We will add that to D5.

Hon SUE ELLERY: Can I ask whether or not there is a planned maintenance program at Fiona Stanley Hospital? The information I have been given is that as equipment is breaking down, it is just being, effectively, thrown out and that there is not a planned maintenance program that checks that that equipment is fit for purpose and is suitable to be used, and what is happening is that equipment is being thrown out as opposed to being identified that it needs to be fixed or remediated. Let us start at the beginning: is there a planned maintenance program?

Dr Russell-Weisz: There would be, as I understand it, a planned maintenance program because that is through the facilities management contract with Serco. I cannot recall the absolute details of that equipment replacement program. The majority of equipment, from recollection, was brand-new so there would have been a defects liability period—again, the same as the Perth Children's Hospital— and if large equipment broke down it would be covered by that. If, now that we are getting out of that, there was an expectation—certainly a contractual expectation—that equipment would be looked at and would be remediated, I would be very concerned if equipment, which can be anything from a syringe pump through to a CAT scanner, was being thrown out just because it was not working.

Hon SUE ELLERY: How would you throw out a CAT scanner?

Dr Russell-Weisz: You could not, no; but if the equipment is small. I am not sure what is being referred to.

Hon SUE ELLERY: If you are able—you might need to take it on notice—can you give us any details about exactly what kind of maintenance program the contractor is expected to provide, and if they have any documentation themselves of what the maintenance program looks like, are you able to provide the committee with that?

Dr Russell-Weisz: I will take that on notice.

[*Supplementary Information No D6.*]

Hon SUE ELLERY: I am told there are three water storage tanks at Fiona Stanley Hospital. I want to confirm whether it is the case that earlier this year it was found that only one of the water tanks was actually functional and that the others had stagnant water within them that had to be flushed from the system, and then the tanks had to be cleaned? Is anybody able to comment on that and whether there were costs associated with getting all three of the water tanks functioning to how they were required to be functioning?

[2.10 pm]

Dr Russell-Weisz: I might ask Geraldine Carlton, the acting chief executive of South Metropolitan Health Service, to answer that.

Ms Carlton: There has been an issue with some of the water storage tanks and they have been remediated, and the cost of that, as I understand it, was incurred by the contractor.

Hon SUE ELLERY: Are you able to—this is, kind of, "Hospitals for Dummies"—explain what water tanks would be used for?

Ms Carlton: It would be "Ex-nurse by Dummies", but heating, obviously washing, steam generators and power generators. That is the key ones.

Hon SUE ELLERY: You might have said this: are you able to advise what the cost was or —

Ms Carlton: No, I am not able to.

Hon SUE ELLERY: Can we take that on notice.

[*Supplementary Information No D7.*]

Hon SUE ELLERY: This might reflect my lack of understanding about the water and the use of: was there at any point risk to patients as a consequence of what was discovered in the water tanks?

Ms Carlton: There was no operational impact at all to patients or the direct services.

Hon SUE ELLERY: Thank you. I am moving along. This is not unrelated to water, but this time it is related to handbasins. I wonder whether you are able to give me some information. I have been told that about 1 000 sinks have been installed in Fiona Stanley—there is a similar design at Midland, I think—and that there is a design flaw that, if left unremediated, creates an infection risk. Is someone able to comment on that? I am also told that a tool was specifically designed to deal with that design flaw—to clean out the mould, basically—and that that is not working to the required degree.

Dr Russell-Weisz: I am sorry, chair, I would have to take that sort of level—I have not heard of any particular significant issues that would affect the operations at both FSH and Midland in relation to that issue, but we will take that on board.

[*Supplementary Information No D8.*]

Hon SUE ELLERY: One of the features of the design of Fiona Stanley was around being a big energy-efficient operation. As part of that, there was the trigeneration plant. Perhaps let us go back

to the explaining hospital workings for dummies again: can you explain to me how the trigeneration plant assisted with energy efficiency? I understand it is to do with producing the electricity, the water and steam to lower the running costs for the hospital. That is my understanding, but somebody should confirm whether I have that right or not. Is it the case that there were any problems with commissioning the trigeneration plant? Did it not meet standards when it was first inspected, and things had to be fixed as a result?

Dr Russell-Weisz: I will answer that very briefly. I think you explained very well what a trigeneration plant does.

Hon SUE ELLERY: Thank you.

Dr Russell-Weisz: I would rather come back with a proper engineering explanation—I am not an engineer—rather than me guessing, but I think that was a very, very good explanation. I do recall that there were some issues with the operation of the trigeneration plant some time ago. I am pretty sure they had been remediated, but I cannot give you any more details of that. It was a very specific issue at the time, going back many months.

The CHAIR: Is that something you want to take on notice?

Hon SUE ELLERY: Yes, I will; thank you.

[*Supplementary Information No D9.*]

The CHAIR: We will to move Hon Kate Doust, but before we do I have a question on the country health service in relation to services provided. As I understand it, there are not any GPs who do tonsillectomies anymore in country health hospitals; it is visiting ENT specialists. I wondered what the wait times were for country people who wanted to have something like a tonsillectomy done?

Mr Matthews: I will have to take that on notice.

Dr Russell-Weisz: I can answer a little bit of that in relation to tonsillectomies. A tonsillectomy is an operation that sounds simple, but you need very good coverage before and after—specifically after surgery because of the risk of a post-tonsillectomy bleed.

The CHAIR: As I understand it, there were a number of GPs who were accredited to do that, but that has now changed?

Dr Russell-Weisz: That could be for a number of reasons. While we are training more procedural GPs—when I talk about procedural GPs, as an ex-procedural GP many years ago there were many people doing anaesthetics, obstetrics and general surgery, and some of those doing surgery would do tonsillectomies. There are probably less being trained now, although we have actually got much better procedural cover the bush. Over time I am sure it has been decided that it is prudent that ENT specialists—so that is specialists who visit country areas—do the actual operations because, whilst it sounds easy, they are very important operations. They are usually on children and they do need very good post-operative coverage. What I can say, looking at the elective surgery performance of the WA Country Health Service, is that their elective surgery performance is exemplary. There are very few numbers of category 1, 2 or 3 patients waiting. But I think it would be a clinical safety issue that determined that GPs no longer do tonsillectomies, and it is more done by ENT surgeons who visit than anything else.

The CHAIR: Yes, and I accept that. Do large campuses like Bunbury actually have ENT specialists who are resident there?

Dr Russell-Weisz: I will pass to Shane on this one.

Mr Matthews: Yes, they do. There is a range of visiting services into Bunbury from the metropolitan area, and there are some resident ENT specialists within Bunbury as well.

The CHAIR: I just have one other question for Country Health. I refer to page 95—I know the numbers are all different, depending on where you got your copy from—and there is a schedule

there with some $409.5 million being spent on upgrading country hospitals in the 2015–16 year. I note that Broome hospital has had a Broome mental health 14-bed unit built. Have there been other mental health units built in other country hospitals within the state?

Mr Matthews: Yes, there is a 14-bed unit within Broome. The most recent unit built would be in Albany Hospital. We are talking around, I think, a 16-bed unit within Bunbury, four of which are closed beds. Obviously we have a seven-bed unit in Kalgoorlie hospital. If I get my numbers right, within Bunbury Hospital we have a 28-bed facility.

Hon KATE DOUST: I just want to come back and talk about Perth Children's hospital that was raised earlier. I just have a couple of specific questions around that. They go to issues around the Department of Fire and Emergency Services. Can you confirm whether or not the Department of Fire and Emergency Services has done a complete audit of the new Perth Children's Hospital, the site?

Dr Russell-Weisz: I cannot confirm that they have or have not. I would confirm that, through the construction program, we cannot reach PC unless the Department of Fire and Emergency Services are happy with the construction build. I might ask Professor Daly to see if he has anything to add.

Prof. Daly: No, I do not.

The CHAIR: Is there any information you need on those, member?

Hon KATE DOUST: I would like to have that information provided on notice, please.

[*Supplementary Information No D10.*]

Hon KATE DOUST: Following on from that: are you able to confirm whether the DFES has connected the building site to the WA fire brigade?

Dr Russell-Weisz: I would have to take that on notice.

The CHAIR: Do you want to include that in D10?

Hon KATE DOUST: Yes, please. It will probably be the same for the next two parts. Can you also confirm whether the DFES has received all of the building and test plans for the various systems that need to be submitted for review before the final inspection?

Dr Russell-Weisz: I cannot confirm if that today —

The CHAIR: We will include that in D10.

Dr Russell-Weisz: Yes.

Hon KATE DOUST: The final part to that is: can you confirm whether the DFES has approved the building for occupancy?

Dr Russell-Weisz: I would imagine at this stage that they would not have done, and that is only what I think because we have not reached practical completion yet.

The CHAIR: In that case, you might include that in D10, just to get an accurate answer.

Dr Russell-Weisz: All those questions, because they are linked to successful practical completion, would be issues I would be seeking the Department of Treasury to answer in full.

[2.20 pm]

Hon KATE DOUST: I have a second question. I refer to page 106 of the annual report. It comes under the broad heading of "Other legal disclosures", but this page specifically deals with freedom of information. I refer to the dot point about epidemiological, survey and statistical data/information. I refer to the approval by the Executive Director of Public Health to establish a system of annual reporting by designated officers of the authorisation of the posthumous collection of gametes. Firstly, what information that is being collected from this new system of annual reporting is able to be made available?

Dr Russell-Weisz: I think we are on the wrong page. Could we find the page? Is it in the Department of Health's annual report?

Hon KATE DOUST: Yes, under "Freedom of Information".

The CHAIR: The internet copy has a very different number.

Dr Russell-Weisz: That is why. Sorry, could you repeat the question?

Hon KATE DOUST: I refer to the approval by the Executive Director of Public Health to establish a system of annual reporting by designated officers of the authorisation of the posthumous collection of gametes. What information that has been collected from this new system of annual reporting is able to be made available?

Dr Russell-Weisz: I would need to take that on notice and will make available, through the Executive Director of Public Health, any information that is publicly available.

[*Supplementary Information No D11*.]

Hon KATE DOUST: That might flow for the next two parts to this question as well. I will put them on the record anyway. Can a version of the report be provided that redacts any sensitive identifying information? I ask that because I know there has been an issue in the past about providing any information.

Dr Russell-Weisz: Whatever we can provide we will provide through the Executive Director of Public Health.

The CHAIR: We will add that to D11.

Hon KATE DOUST: Sure, thank you. The third part—again, I would expect that you would have to provide this on notice—is: what statistical data can the department make available that can clarify the extent to which the posthumous collection of gametes is occurring in Western Australia?

Dr Russell-Weisz: I will take that on notice.

The CHAIR: We will put all that on D11.

Dr Russell-Weisz: I know in the past there have been some parliamentary questions in relation to the posthumous collection of gametes and they have been answered. I would expect that these questions would be answered in the same way or with updated information, but we will take that on notice.

The CHAIR: I will move to Hon Alanna Clohesy.

Hon ALANNA CLOHESY: Thank you. How many people are currently resident at the Quadriplegic Centre?

Dr Russell-Weisz: Could I pass to Wayne Salvage, chief executive of the North Metropolitan Health Service.

Mr Salvage: Hello, how are you?

Hon ALANNA CLOHESY: Hello, Mr Salvage; it is good to see you again.

Mr Salvage: Thank you, honourable member. If you want an accurate, up-to-the-minute number as of today, we would have to provide that on notice, but at the time the business case was submitted to the midyear review there were 48 residents at the Quadriplegic Centre.

Hon ALANNA CLOHESY: So that is down six residents from last.

Mr Salvage: And it will continue to go down as they are offered alternative accommodation in the community.

Hon ALANNA CLOHESY: Okay. Of those residents, how many were admitted in the last 12 months?

Mr Salvage: I would have to take that particular question on notice.

[*Supplementary Information No D12.*]

Hon ALANNA CLOHESY: So the business case has been completed?

Mr Salvage: Yes.

Hon ALANNA CLOHESY: Is it possible for that to be tabled?

Mr Salvage: It is being submitted through the budget process. Our role at north metro was to develop the business case and submit it through the budget process, and we wait to hear the outcome.

Hon ALANNA CLOHESY: So is it possible for us to take it on notice?

Dr Russell-Weisz: Because it is going through the budget process and through a cabinet process, I would have to seek some advice from my minister on whether it could be released at this stage. I would imagine not, because we do not know the outcome of the midyear review process. Andrew Joseph, my colleague, might be able to say something.

Mr Joseph: The business case was submitted to government as part of the midyear review and as such it has cabinet confidence and EERC protection. Documents submitted as part of the budget or midyear processes are generally not released to the public.

Hon ALANNA CLOHESY: I might remind you that this committee is not the public. I might suggest that you refer to this committee's report on the provision of information to Parliament.

Dr Russell-Weisz: I will seek advice from my minister.

The CHAIR: We will take it on notice and you can respond as to what the advice is from the minister on whether a section 82 notice will be issued on it.

[*Supplementary Information No D13.*]

Hon ALANNA CLOHESY: When we last met, some advice and consultation was being sought. Did the government actually provide a formal response to the report "An Enhanced Service Model For People With Spinal Cord Injury In Western Australia"? Was there a formal response to that?

Mr Salvage: The government's response was to commission the business case to seek clarity about the scope of the redevelopment options for the Quadriplegic Centre. We await the outcome of government's deliberation through the midyear review obviously, but I do note that there was some public commentary by the Premier in the middle of August about the likely intent in this area.

Hon ALANNA CLOHESY: So did the business case provide policy settings as well?

Mr Salvage: The process of developing the business case, as I think we might have touched on in estimates, involved a steering committee established under the leadership of Professor Bryant Stokes. I think I read into *Hansard* at the time the membership of that steering committee. It did include a number of people with lived experience of paraplegia and quadriplegia. It was a very good process. Part of the development of the business case was to have engagement with all of the current clients of the Quadriplegic Centre to assess the extent to which they wanted to pursue options to perhaps move into the community, into alternative accommodation, or to remain together on the site. Again, I think in the comments the Premier made in August it was recognised that there are a significant number of current residents of the Quadriplegic Centre who wish to remain in a very supported environment, and that is a key focus of the proposal that is under consideration.

Hon ALANNA CLOHESY: So for those residents, will the centre that is to be constructed be their residence or will it be the 12 additional dwellings that are to be constructed?

Mr Salvage: Roughly, in terms of numbers, of those clients currently at the Quadriplegic Centre, 30 expressed the view that they wished to remain in an intensive supported environment. That would be the focus for the redevelopment, if it is approved, that would still be at Shenton Park,

we would hope. Outside of that—and this goes back to the review that the Queensland team did for us—the future for these services is more of a transition model, so a person who acquires a spinal cord injury will receive intensive treatment at Fiona Stanley Hospital and will spend a period of time in the state rehabilitation service, but the expectation ultimately would be that they would be able to go back to their homes and their communities. That component of the model was missing in the past because of the existence of the Quadriplegic Centre. To be clear, we are dealing with two very different cohorts of patients—those for whom, effectively, the Quadriplegic Centre is their home, who are expressing the view that they wish to remain in that very supportive environment, and perhaps future clients of that kind of service for whom we should be planning a more transitional model back to the community.

Hon ALANNA CLOHESY: So for those, though, are the 12 units that are being constructed going to be on the same site and are the current buildings going to be demolished? How is it going to happen? Is it a redevelopment or a new construction?

Mr Salvage: The term "speculatively" is being used a little bit today. Pending confirmation of a decision on the outcome of the business case, necessarily anything that I say will have to be prefaced by acknowledging that the matter is still before government. But the parameters were that for those residents who expressed a preference to remain in that supported environment, the Shenton Park area was indicated as a preference for that replacement group facility, if you like. For the transitional component of the model, the intent would be that that would be on a dispersed basis—you do not need to bring everyone to the one area as part of their transition back to the community.

Hon ALANNA CLOHESY: I have seen various estimates—some say $20 million, some $30 million and some $40 million. Which ballpark are we in?

Mr Salvage: Again, I can only refer to the comments by the Premier, which are on the public record. I think he quoted a value of between $20 million and $30 million for the core facility and perhaps a total figure of about $40 million for the total package. That is what has been put into the public arena.

[2.30 pm]

Hon ALANNA CLOHESY: He also said that some of that would be funded from the sale of land at Shenton Park. When I asked the Minister for Health which piece of land that would be, he referred me to the Minister for Lands. When I asked the Minister for Lands which piece of land that would be, he said that there were no pieces of land for sale, it was all crown land and that it was all reserved for the Spine and Limb Association. Can you enlighten me which piece of land will fund the construction of this?

Mr Salvage: There is a crown grant that has been vested in the name of the Spine and Limb Foundation and that is the land on which the current centre is constructed. It is under the ownership as of right currently of the Spine and Limb Foundation. Obviously if that were to be factored into any future developments, there would need to be negotiation around that.

Hon ALANNA CLOHESY: So I am clear: no-one is selling any land to fund the redevelopment and the extra stages of the program?

Mr Salvage: I think they are two separate issues.

Hon ALANNA CLOHESY: Is that a yes or a no?

Mr Salvage: We have put together a business case to government which identifies the capital cost for achieving a certain outcome and that capital cost will deliver the outcome that we have sought. That is not dependent, as I understand it, on any sale proceeds from any assets.

Hon ALANNA CLOHESY: I have a lot of other questions which I might put on notice because it is actually about the number of people with spinal cord injuries which other members might find of benefit.

The CHAIR: We will resume a little later. We will take a 15-minute recess until 2.45.

Proceedings suspended from 2.32 to 2.45 pm

The CHAIR: Now that everybody has refreshed, we shall recommence.

Hon SUE ELLERY: There is a reference in the Department of Health's annual report to the parent and child centres. Is somebody able to answer those questions? Specifically what I wanted to ask about was the parent and child centres were established, particularly in areas of low socioeconomic status, to provide really a prime opportunity to get to kids very early. One of the promises that was made at the time of the last election was that child and parent centres would be located on school sites in areas of need, providing a one-stop shop for a range of services and support including child health nurses, GP services, therapy services and parenting programs. Are you aware of GPs operating out of child and parent centres?

Dr Russell-Weisz: Could I defer this to Professor Daly?

The CHAIR: Yes.

Prof. Daly: Thank you for your question. I am not aware that the Child and Adolescent Health Service is directly employing general practitioners as part of our childcare centres. However, I am aware that on a number of sites our centres are co-located in general practices.

Hon SUE ELLERY: We might be talking at odds here. I am talking about the child and parent centres on school sites—not your local child health nurse out in the community; the ones that are run by NGOs on school sites and they provide three-year-old programs, play groups and a range of other things including speech and other therapies. The promise was that they would include GP services. I am wondering whether you know anything about that.

Prof. Daly: I will take this on notice to make sure I have not missed something, but I am not aware that we are commissioning or planning directly for general practice services on these school sites.

[*Supplementary Information No D14.*]

Hon SUE ELLERY: I wanted to ask about the low immunisation rates. On my copy, Indigenous kids are on page 99 in the outcomes section of the Department of Health's document. Table 9 is "Percentage of children fully immunised, by selected age cohort, by Aboriginality, 2011–2015". In my copy, it is page 99. If you look at the number of Indigenous kids—we touched on immunisation earlier on in the conversation—it really is an appalling state of affairs. Arguably—not that it is an acceptable argument—you could mount a case that for those Indigenous children living in remote communities, you might expect delivery of services to be harder. That is not acceptable, but that is an explanation for historically what has happened. I do not know how we maintain that argument about metropolitan Indigenous kids, and I welcome any comment on why we have made so little progress on that cohort of children.

[2.50 pm]

Dr Russell-Weisz: I would make an overarching comment and then pass to Professor Daly. Overall, as the honourable member says, the immunisation rates in metropolitan Perth are better for non-Indigenous kids than they are for Indigenous children, but they have shown steady improvement over the last three years. The most recent national data indicates that overall coverage rates actually exceed the national benchmark rates at one, two and five years. However, coverage for Indigenous children at one and two years remains below. I think the child health initiative and the Child and Adolescent Health Service has increased immunisation nursing staff clinic locations and improved processes. In 2015–16, CAHS administers over 70 000 vaccines or 32 000 occasions

of service. CAHS provides an estimated 20 per cent of childhood vaccinations. The acronym CAHS is Child and Adolescent Health Service. Aboriginal medical services and local government are also other providers. There is certainly a challenge ahead for us, but we are all going in the right direction. I do not know if Professor Daly wants to provide any further comments.

Prof. Daly: Yes, I would acknowledge that in fact the paradox now in the national data is that immunisation in Aboriginal children is lower in metropolitan areas than in country or regional areas. This has been acknowledged for a few years now. I think we discussed this before in this committee meeting. The Child and Adolescent Health Service, as the director general points out, provides about 20 per cent of total immunisation to children under the age of five. However, we do make it our priority with our immunisation and our child and health programs, as I think I discussed earlier, to identify, target and assist vulnerable families, and that includes Aboriginal families. Within the Child and Adolescent Health Service in the metropolitan area, we have an Aboriginal health team which has been brought together in the last couple of years specifically to try to provide a comprehensive and culturally secure service and to enhance the Aboriginal uptake and support in both child development assessments but also in things like immunisation. It is certainly a challenge for us. There are a number of epidemiological reasons why it seems that access and uptake of immunisation seems to be difficult in this cohort, but it is acknowledged that it is a problem.

Hon SUE ELLERY: I am going to jump around a little bit. In the Metropolitan Health Service report—on mine it is in the "Governance requirements" section on page 132, I think. In table 39, "Metropolitan Health Service advertising, by class of expenditure", there is listed under market research, "Press Ganey Associates" and some $783 000. My question is: can you provide to the committee a copy of the reports that I understand were into consumer satisfaction?

Dr Russell-Weisz: I will take that on notice and provide those reports.

Hon SUE ELLERY: Okay.

[*Supplementary Information No D15.*]

Hon SUE ELLERY: I also wanted to ask—in the metropolitan one—about the auditor's qualified opinion. It is around about page 36 of mine, but it could be anywhere because the page numbers were actually a bit skew-whiff. The heading of the top of page of that bit of the auditor's report says, "Report on Controls". And there is the, "Basis for a Qualified Opinion" —

> Controls over medical practitioners' treatment charges were deficient as there were inadequate procedures in place to ensure that all revenue associated with medical practitioners' treatment of private and overseas patients has been brought to account. As result, I was unable to determine whether all patient charges that should have been billed were billed.

That is not new; every year you get a qualified opinion as to controls over the collection of revenue associated with medical practitioners' treatment of private and overseas patients. My question is: can you explain what it is that you can actually do to make sure that we do not just keep getting qualified opinions—that we actually do something about it? Have you been able to quantify the loss of income that might be arising as a result of practitioners failing or being unable to bill private patients' insurance companies or overseas patients?

Dr Russell-Weisz: Thank you for the question. I, firstly, would like to say there were no financial qualifications for the Department of Health Metropolitan Health Service or WA Country Health Service 2015–16 annual reports and there actually have been, in the past, financial qualifications for the same issue that the honourable member outlined in the question. As you have said, there was a continuation of qualification on the controls to the medical practitioners' treatment charges. There has been significant effort over the last few years across the Metropolitan Health Service and WA Country Health Service to make sure that we are collecting all the revenue that is due to us. I think, by seeing that there are now no financial qualifications to the MHS or WA Country Health

Service, that has shown that we have made improvements. The Auditor General has clearly said there is still going to be a qualification on controls.

We have done a number of things across the last few years and, ostensibly, over the last couple of years, and that is making sure that all medical practitioners on arrangement A—and the majority are on arrangement A—where they get an allowance to bill for private patients and the revenue comes back to the health service, that they have to do so. They have to do it to the fullest extent; it is in the industrial agreement. We have slowly, and I do not have the actual numbers here, over the last 10 years we have increased the percentage of private patients in public hospitals—and we are not going out there to seek private patients for public hospitals but making sure that if patients with private health insurance who come through the door and are seeking to use their private health insurance, they are able to do so. That means the doctors have to bill for those patients who are privately insured. For a small group of doctors who are on arrangement B, they can actually keep the revenue, but that is a very, very small group. There has been extensive effort, I can confirm here, in relation to this. We have got pockets, I would say, of excellence, where we have significant revenue capture and other areas where there is more work to be done. I may pass on to Peter May, the Chief Finance Officer, to give his advice on what potential revenue would be lost, but I do not think I could ever sit here and say that on every single occasion of service where there was a private patient who wanted to come in privately that we would get all their revenue. Just yesterday, I had a colleague, a medical practitioner, ring me and say, "I am being chased to confirm and to sign that I actually saw the patient because they came under my bed card and they bill privately. They said, 'We should bill privately.'" This doctor said to me, "But I actually didn't see the patient." I said, "Well, you certainly can't bill the patient and if you didn't see them, it must be another doctor", and it was. So certainly there is that. We have had assistance from the Australian Medical Association in this, to actually say to all doctors on arrangement A, "You need to bill." Now, we need to assist you in those procedures to bill and all the chief executives have in place now, they know, that they need to provide that support for the medical practitioners to bill. We are not out of the woods yet, but there is more that we will continue to do because we are, potentially, missing out on revenue. But over the last 10 years, it has extensively improved.

If I could, I ask Peter May, the Chief Finance Officer, to make any other comment.

Mr May: That was a very extensive answer, Russ. The only other further thing I could add to that is that we have in the past provided an indication of how much lost revenue we have not collected. We are able to undertake that exercise again and provide that as a question on notice, if you like.

Hon SUE ELLERY: Okay. So can we take that on notice?

The CHAIR: Yes, we will take that on notice.

[*Supplementary Information No D16.*]

[3.00 pm]

Hon SUE ELLERY: I refer to school dental services in the metropolitan report—it is page 22 of mine—there is a table. It is in your summary of key performance indicators. Halfway down the table it refers to rate of childhood dental screening. As I said, it is page 22 of mine, table 5, but there is actually kind of, four and a bit, versions of the table. Have you got the bit that I am —

Dr Russell-Weisz: Yes.

Hon SUE ELLERY: What it tells us is the percentage of eligible schoolchildren who are enrolled in the dental service, which is great. But my question is about whether you collect the stats; if you do not have them with you now, perhaps you could provide them. What proportion of children actually receive regular checks as opposed to being enrolled in the program? Because I think being enrolled is a function of their eligibility and the school they attend. It is not a measure of how many children are getting the regular checks.

Dr Russell-Weisz: I will ask Wayne Salvage to make comment in relation to dental services and then I may make a comment as well, generally.

Mr Salvage: I think the school dental service is one of the unsung heroes, to be honest, of the WA health system. They do a terrific job in providing basic primary dental care to children across the state. I think I am right in saying we are relatively unique in having that service here in WA and it is something that we are very proud of. In terms of the specific question that the honourable member has asked, we will have to come back with some specific data. I understand what she is asking for, which is the relationship between those who are enrolled and those who are receiving the regular checks, and we can provide that on notice.

[*Supplementary Information No D17.*]

Dr Russell-Weisz: If I can add a couple of comments, as Wayne has said, the school dental service is a great service. The dental health service is the main provider of public dental health care provided by metropolitan health service for the state and the state government provides approximately $75 million a year to fund a safety net for the public dental services. This includes a free general dental service for children aged five to 16 and then a subsidised general dental service for health care and pensioner concession card holders.

We have actually over the last national partnership agreement with the commonwealth — Between 1 January 2013 and March 2015, WA Health treated an additional 25 000 public patients and reduced the public dental waiting list time by 70 per cent. We did recruit more staff and certainly we have had a focus on children as well. There is currently a commonwealth reform to replace the current national partnership agreement with a new child and adult dental scheme, which WA supports. It believes there will be more funding and eligibility here. It widens the eligibility. I understand it was in the federal omnibus bill but was withdrawn and it is going to go into Parliament again. This would, I think, allow to us expand the provision of dental health services to an even greater amount of children. If this goes through, it will actually build on the good work that the school dental health service has done. We are certainly not there yet, but we have reduced the waiting list substantially.

Hon SUE ELLERY: If I can, still on children, go into the number of child health nurses. I do not know where to find a reference in the annual reports, but what I am particularly interested in drilling down a bit into is the government's election commitment to employ 155 full-time equivalent school nurses and an additional 100 child health nurses. If you have got this information available, what are the current FTEs of school nurses in each region—and you had better tell me if that is Health region versus Department of Education region, because they are different—and what are the current a number of child health nurses by FTE in each region as well?

Prof. Daly: I only have total number for the metropolitan area not by health regions or regions so I can bring that back on notice.

[*Supplementary Information No D18.*]

Hon SUE ELLERY: If you have the total numbers in front of you now, though, you could share that.

Prof. Daly: Sure. So, for school health nurses, the 2013–14 budget commitment was for, in the metropolitan area, an additional 110.6 FTE of school health positions, which included eight speech pathologists and five nurse manager positions, and the recruitment of those was meant to be over four years. The 63.5 school health FTE funded to June 2016 have all been fully recruited and we have funding in this next financial year for a further 47.1 FTE, of which 45.1 are school health nurses and two are speech pathologists, and we are currently endeavouring to recruit to those numbers. That is school health nurses. Now, in terms of child health nurses, I will just see if I can find the numbers here. In the 2015–16 financial year, we recruited to the full amount of 62.5 FTE by February 2016, and that entailed 97 new nurses being employed.

Hon SUE ELLERY: Thank you. Still on child health matters, are you able to tell me what is the percentage of children receiving child health assessments by region for 2015 and to date in 2016, if that is available; I have the different categories: newborns, zero to 42 days; then three to four months; eight months; 18 months; and then three to three and a half years?

Prof. Daly: I do not have those figures available to hand by region, only some indicative overall figures.

The CHAIR: Did you want them by region, member?

Hon SUE ELLERY: I do.

[*Supplementary Information No D19.*]

Hon SUE ELLERY: On Aboriginal children, there was an election commitment around glue ear. Funding was removed from the Telethon Speech and Hearing bus and we were told that it was going to be picked up internally. Are you able to tell us what proportion of Aboriginal children, by region, are currently being screened for ear health; and what has the investment in the glue ear program been, however you measure it, financial year or calendar year, whatever you have got, since the decision was made to cease providing that funding to the Telethon Speech and Hearing ear bus?

Prof. Daly: You are correct that the contract with the non-government provider was ceased in September 2015. They had been providing—I do not have a brief in front of me but, from memory, they had been providing—a service throughout the metropolitan area and within some key rural areas for a number of years. That contract was renewed, I think, on six occasions, but I might get some clarification on that, and state procurement and supply commission protocol did not enable us to roll that contract over any further. So, the non-government organisation was given appropriate notice that that would be ceased.

We did an analysis at that time and it was coincident with both some work that was done within the Child and Adolescent Health Service but also, more broadly, in the Department of Health around ear strategies and, in particular, Aboriginal glue ear, and it was determined that we would be able to provide a cost-effective alternative solution in-house.

As part of both our community and Aboriginal health strategy, we employed a cohort of personnel to specifically provide that service through CAHS and that started in January of this year 2016. I will get the figures on notice as to the exact number by region of those who received the service.

[*Supplementary Information No D20.*]

Hon SUE ELLERY: Can I just check: between September 15 and January 16, effectively nobody was providing a service; is that right? You stopped, drew a line under the Telethon Speech and Hearing ear bus on 15 September, I thought you said, and then you contracted people to start on 16 January; is that right?

[3.10 pm]

Prof. Daly: Through the chair, Telethon Speech and Hearing continued to provide services independently of our funding stream, and I believe they do so today. We are providing a service through schools, and so coordinating the commissioning of our new service with the commencement of the new school year in 2016.

Hon SUE ELLERY: The information I want to know is the proportion of Aboriginal kids by region currently screened for ear health and what was the investment in the glue ear program from the Department of Health?

Dr Russell-Weisz: Through the chair, I think Mr Matthews may have some additional information.

Mr Matthews: Through the chair, from a country perspective there was a commitment in the 2013–14 budget of $6 million over four years for ear, eye and oral for Aboriginal children living in

remote communities. Between April 2015 and 30 June 2016, 2 955 children aged between zero and five living in the Kimberley, Pilbara, midwest and goldfields received a service through 462 clinics across that time. The funding has effectively been allocated to community-controlled organisations. There is the equivalent of 11 full-time equivalent Aboriginal health workers working within that sector, largely in small communities. Around 0.1 or 0.2 of a person is dedicated to this initiative. Another six FTE are to be rolled out in 2016–17, because there is a total of 18 FTE across the entire program.

Hon SUE ELLERY: That is for country. Professor Daly, I think, is going to provide me information for the metro area; is that correct?

Prof. Daly: Yes.

Hon SUE ELLERY: There are no other country areas that are not covered by what you have just given me?

Mr Matthews: We have a range of buses rotating up in the Kimberley, but I do not have that data with me.

Hon SUE ELLERY: I will leave that so that I get the fullest answer that you think that I want.

I have to ask questions about case-mix; it does my head in, but I am going to do it anyway! The reference is in the metro health service. I do not know whether you need to look at it. For "Average cost per casemix adjusted separation for non-tertiary hospital" the figure is significantly different. Why has that increased so substantially on the last year, whereas the actual same cost in a tertiary hospital has gone down?

Dr Russell-Weisz: Through the chair, I might, firstly, ask Andrew Joseph if he has any comments and then we may need to ask Rob Anderson.

Mr Joseph: Through the chair, can you please repeat the question?

Hon SUE ELLERY: Yes. The table that I was referring to—bear with me while I find it—it is on page 21 in my document of the metro health service, in the summary of key performance indicators. On the second table, the second KPI down is "Average costs per casemix adjusted separation for non-tertiary hospital", and the variation is some $1 900. My question is: why the difference? Why is there such a substantial difference on last year?

Mr Joseph: I might ask my colleague Rob Anderson to elaborate on the answer, but I might start off through the chair. The target for 2015–16, as I understand, was probably established prior to the Midland hospital being commissioned and, therefore, the half-year commissioning effect of the Midland hospital had a cost impact on the average cost that year—the actual.

Hon SUE ELLERY: You think that is the answer, or that is the answer?

Dr Russell-Weisz: If we are not sure, we will take it on notice. I think we will take that on notice. It is a very good pick-up. There will be an explanation for that. Our costs would not have jumped that greatly because of the Midland hospital commissioning.

[*Supplementary Information No D21.*]

Hon SUE ELLERY: I was not able to find any stats—but maybe you can tell me there are some—on length of stay. Maybe you can point them to me; but, if not, are you able to tell the committee the average length of stay for WA metro tertiary patients, both those who come from the country and those who come from the metropolitan area?

Dr Russell-Weisz: We would take that on notice. I am not sure we would even have it in the metropolitan report, but it is those patients, I understand the question to be, in our metro hospitals from metro versus country.

Hon SUE ELLERY: Yes.

[*Supplementary Information No D22.*]

Dr Russell-Weisz: The only thing I would say is that our length of stay when we looked at the gap between the national efficient price and our costs, none of the difference was attributed to differing length of stay. Our lengths of stays are now extraordinarily competitive with the eastern states, if not better.

Hon SUE ELLERY: Elective surgery category 1 and 2 patients—in the metro health service report there is a reference to that on page 23. The category 1 patients who are admitted within the clinically recommended time has fallen significantly, with category 2 patients' performance also falling. Are you able to explain what has happened there?

Dr Russell-Weisz: Yes. In the year 2015–16, obviously it was one of those years because of the commissioning of Fiona Stanley and the opening date, which was the final opening date of 4 February, we took down a lot of elective surgery because of Royal Perth. It was not just about Fiona Stanley being commissioned; it was Royal Perth being recommissioned and also Fremantle Hospital being changed. So we saw a reduction in elective surgery numbers and times. That was always expected over that time as we wanted to do things safely. Obviously, when you open a new tertiary hospital, you do not suddenly ramp up to normal levels in the first week; it took us some time, but it got to normal levels within four to six weeks. What I can say is that in 2016, if you look at our current performance to date, our overall performance to date is around about 93 per cent—I think it is 93.8 per cent overall in ones, twos and threes. In the year to date, we have also done nearly another 4 000 procedures more than we did this time last year, so we are doing more elective surgery. More people are coming onto our lists. The actual elective surgery waitlist has increased. There are a number of reasons for that, but the key priority for the area health services is, irrespective of the number of people on the waiting list, to perform surgery within the recommended time. It is not across the board; our focus is on category 1s. Our focus has to be on category 1s, and if somebody slips by one day—they are over 30—they go to 31 days. That means they would be in the numbers not actually performed within the recommended time.

We have specific challenges in plastics and ear, nose and throat, and we have now got strategies in place. Both south metro and east metro health services have now got strategies in place that are about to start for our plastics waitlist. We are also having a focus now—what is not reported there—on what we call our "unreportables". There is a component of the cases that do not get reported through the commonwealth that we have to focus on. The bowel screening program, for example, through the commonwealth, has provided a large waiting list of patients who require endoscopies, colonoscopies and gastroscopies. We have a huge focus on that. Now 84 per cent of people are being seen within the recommended time. It was way lower than that a couple of years ago. It is a real priority of mine and the team around me that we perform our elective surgery within the correct time frames. There are certain pockets where we need to put specific strategies in place and we are aiming to do that, but the explanation is that in certain specialities there are challenges to do these within the correct time, but we are aiming to pull those times up, and they are improving.

Hon SUE ELLERY: I am advised that the monthly report in July on elective surgery showed that one in five category 1s did not get their operation within the clinically recommended time. Are you able to provide an explanation as to what happened then?

[3.20 pm]

Dr Russell-Weisz: Yes. I think in July there were obviously increasing waits on the list. There were, as I said, specific areas. This would not have been across the board. I cannot tell you exactly, but in general surgery, for example, I do not believe there was anybody or very few numbers that were not seen within the recommended time.

But in specific areas, such as, say, ear, nose and throat and plastics, there were, but they did not—they were still a priority. They would have been done at 32 or 33 days. We are still one of the best

performers out of all the states, but we also had a significant increase in emergency department load during the winter season, which is not related to July, but as I said in other forums we have had more of our beds actually taken up by aged care patients who do need to be in a bed, but they should not be in our tertiary hospitals. As of two or three days ago, it was 158 cases, or patients, and that is nearly four wards full of patients who need to be outside. That does put a strain on the patients you are able to take in. That is not an excuse, and we have had a huge focus on elective surgery wait times over the last three months, and we have seen an improvement over the last three months. If I may, I might pick Mr Salvage to make a comment on what they are doing at each site to address the waiting list.

Mr Salvage: I am just looking at the performance for the North Metropolitan Health Service for the current period to provide some assurance that the focus that the director general referred to on category 1 in particular is paying dividends. For my health service in September, the figure for category 1 was 95.66 per cent, so it is on a rising trend. Category 2 was 90.34, and there is obviously a fair amount more work to be done in that space. It is contingent on what else is happening in the sector, so when you do get pressure coming through emergency departments, that does affect the ability to deal with the elective side of the business, and as we have noticed we have had a relatively late winter, but quite an intensive one, but the figures that I see indicate that they were back in a rising trend.

Hon SUE ELLERY: Emergency department performance—so in the metro report pages 24 to 25 in my document: the Australasian College for Emergency Medicine did its nationwide snapshot in September, and it said that ED overcrowding is at much the same substandard level as it was at this time last year. The exception is WA, where conditions have continued to worsen significantly. September was also the third month in a row where we had ambulance ramping of over 2 000 hours across metropolitan hospitals. Are you able to explain the reason for that comment, that we are worsening significantly?

Dr Russell-Weisz: I can say that that report was a snapshot on, I think, one of the worst days that we have had. I think it was 29 August. The emergency college of physicians—I remember that date because we were very busy—takes a snapshot at 10 o'clock that morning of every hospital. It is a snapshot, so it is on that day, and as Mr Salvage has said we had a very late winter. It was one of our highest days with influenza patients coming in, and a very high day with aged care patients in our beds—the average. On average now, we are sitting at 110, where three or four years ago we were sitting at 60-odd aged care patients in our beds, so that is a difference of 40 or 50. I would say that WA is still leading the nation, on average, in relation to its four-hour rule and its emergency department performance. Year-to-date is 74 per cent. Our aim is obviously 90 per cent, but there are a lot of other states who are faring worse than us.

When we look at our four-hour rule or our emergency department performance, we look at it as a system, so we take the non-tertiaries, the tertiaries and we take country hospitals, and we have performed as highly as 79 per cent. The focus is definitely back on. If we improve our emergency department performance we actually improve ramping, so the focus is very much on our flow-through of hospitals. It is actually not so much on the emergency department, because the emergency department is the receiver. It is actually the back end of the hospitals that our focus has to be on. We have been very successful in the four-hour rule. We are still being successful, but we need to really increase the bar. I know the chief executives are fully onto this. We do have some outstanding performers at the moment. Clearly King Edward and Princess Margaret are in the high 80s and 90s, and I noticed that even Armadale in the last couple of weeks has been sitting at 85 per cent. I might ask Liz MacLeod from east metro to comment on some of the initiatives that they are pushing in at Royal Perth, so you can see that this is very real, and we aim to pull ourselves back up.

Mrs Macleod: Obviously, it is a concern, and I think it is a reflection of both, as Russ has said, the front door of the hospital, being the ED, and what sits behind at the back door. We are taking a whole-of-hospital and a whole-of-health-service approach to it. We have waited until after the very busy time in winter, when the emergency demand has now started to subside, but the teams have fully prepared a range of project plans to identify to work through what we need to do. Armadale's has come through to fruition. It is not as complex an environment; it does not have the same high admission rate, obviously, as some of our tertiary hospitals, so the processes that it can put in place are more straightforward, but it is good to start seeing it now having more sustainable improvement. Royal Perth has got a project plan again, starting right at the basics. We are looking at mapping out the process and where the gaps are, which is all the work that was done several years ago when we did the four-hour rule, and we think it is timely to go back and revisit some of that, so some of the changes are the start of identifying that and having a look at it. Royal Perth's figures remain a little bit up and down, which shows that they can make some improvements, but obviously it is not sustainable, so we are looking to do that. It is something that we are involved in very closely, and will be obviously keeping a very close eye on, but we would expect it to take, realistically, some months to get some sustained improvement from the tertiary hospital in east metro, being Royal Perth. It is not just a quick semi-fix; we would like it to be embedded in the change.

Dr Russell-Weisz: If I can just add to that, I think the other thing to say is: I do not want to give the impression that we do not have a focus on ramping—we do. If I look at the ramped ambulance count in 2013 in the tertiaries for five months between February and July it is 5 291; in 2016 it is 3 429, and hours of ambulance ramping is still down between those years. We put a huge amount of effort this time last year into ramping and into ED performance, and we got a lot better. There have been some other challenges. As I said, what we have also done this year is we have procured an additional 19 transitional care placement beds. That means we are up to about 316 beds now that we actually fund 33 per cent of those, and I am going to buy another 75 transitional care placement beds. This is a responsibility of the commonwealth, but we cannot sit on our hands here. At the moment we have got the lowest number of aged care beds pro rata than any state. The average is about 79; we are at 68. We need to take control of this, and we are liaising with the commonwealth. The minister has met with minister Ken Wyatt as well, to see if they will continue to fund their proportion of the transitional care placement beds, but we cannot just continue to say that it is a commonwealth responsibility. This is, I think, a significant issue that is affecting our performance in both elective surgery and emergency demand.

Hon SUE ELLERY: Right, thank you for that. I now move to workforce management issues, I guess. There is a section in the Department of Health—it is page 30 of mine—that talks about workforce challenges. I particularly want to ask about nurse graduate placements for 2016. That is the reference; I do not know whether it is going to help you provide your answer. What I particularly want to know about is, I am advised that there is a reduction in those graduate placements for 2016—496 compared to 567 in 2015—and I wanted to ask: how many applications for placements were received by way of registration on GradConnect in 2016 and how many in 2016?

[3.30 pm]

Dr Russell-Weisz: I would have to take that question on notice.

[*Supplementary Information No D23.*]

Hon SUE ELLERY: I might be done, Mr Chairman.

The CHAIR: That is good. In that case, we will move to Hon Sally Talbot.

Hon SALLY TALBOT: Thank you, Mr Chairman. I have a couple of questions. I start with page 6, under "Chronic Disease Services".

Dr Russell-Weisz: Sorry—which report?

Hon SALLY TALBOT: Department of Health, under "Chronic Disease Services". Under that heading, about two-thirds of the way down the page, you talk about an increase in the proportion of people who are ageing, combined with increased levels of chronic disease and co-morbidities. You have a dot point there that says you have employed a geriatrician to service the great southern region. Is this just one person?

Dr Russell-Weisz: I will ask Mr Matthews to make a comment. I would say it may be one geriatrician who is specialist in aged care medicine, but it would be an addition, because normally in country locations we would rely on general physicians, so more generalist but with a specialist workforce. I understand, and I actually spoke to this geriatrician the other day in Albany, that it is an additional appointment. So it is one appointment, who will work with all the other doctors—work with the GPs.

Hon SALLY TALBOT: One additional specialist, joining a team of specialists?

Dr Russell-Weisz: A team of specialists.

Hon SALLY TALBOT: Can I get more details about that?

Mr Matthews: I do not have the details with me but we can certainly provide that.

[*Supplementary Information No D24.*]

Hon SALLY TALBOT: I want to know how many are in the specialist team; where are they located; and with whom do they work in the communities?

Dr Russell-Weisz: We can provide that in relation to Albany. Normally we would have, as I said, a general physician, a surgeon—maybe two surgeons—and an orthopaedic surgeon. In country locations, a lot of the clinical work is done by general practitioners working with the hospital physicians. I know this is a new appointment, because obviously we have got an ageing population down there, but they will not see all the aged care patients, because obviously GPs will see those patients, but be assisted by the geriatrician.

Hon SALLY TALBOT: So perhaps you could start in the question on notice by looking at the team that is based at the Albany hospital campus. Then I would like the information in relation to the rest of the great southern—so, for example, if you live in Denmark or Walpole, what services are available to you there? Then perhaps you would also take on board—you might just need to refresh my memory about your region. I know that you do the great southern. Do you do the south west?

Dr Russell-Weisz: Yes, the south west.

Hon SALLY TALBOT: And Peel?

Dr Russell-Weisz: No. Peel is metro. The Peel Health Campus is the south metro health service.

Hon SALLY TALBOT: So anything that is within the south west, so I am talking about Mandurah to Albany, essentially.

Dr Russell-Weisz: Okay, south west and great southern. We will provide that on notice.

Hon SALLY TALBOT: Thank you. I take you to page 5. It is actually under "Prevention and Community Care Services", which starts at page 3. The penultimate paragraph under that heading, which is at page 5, talks about the Stokes review and says that you have completed 72 of the 76 recommendations, and you say the remaining four recommendations are due for completion in 2016–17. Which four have not been implemented?

Dr Russell-Weisz: I would have to take that on notice in relation to the four, because they would have been not completed.

Hon SALLY TALBOT: I know they have been accepted. We are talking about the 76 endorsed recommendations. Which are the four that are due for completion in 2016–17?

Dr Russell-Weisz: I would have to take that on notice.

[*Supplementary Information No D25.*]

Dr Russell-Weisz: I do know those four, as we were trying to close off. As we went to the new Health Services Act, which came into being on 1 July, we wanted to take a picture of where we were with all the Stokes recommendations, and we knew that there were four which would need further implementation work, and I can advise how they are being implemented and at what percentage.

Hon SALLY TALBOT: Thank you. That is all.

Hon ALANNA CLOHESY: I go to page 116 in the Department of Health report, the table we were looking at before, "Major capital works in progress in 2015–16". It is table 17. Kalamunda Hospital—redevelopment stage 2 has "TBA" under expected completion date.

The CHAIR: Your page number is not the same as mine.

Dr Russell-Weisz: It is on my page 112.

Hon ALANNA CLOHESY: What is that redevelopment stage 2, and why is it TBA?

Dr Russell-Weisz: From recollection, there was additional capital works in relation to Kalamunda, and there was some work done there going back over a few years. I might ask if either Mr Salvage or Ms MacLeod can help me out.

Mr Salvage: I might give it a go. In the budget in 2016–17, there is a figure of $8 million quoted as the estimated total cost of service for works at Kalamunda. However, the majority of that funding is found in the out years, so it is not visible in that sense in the budget papers. There is an allocation but no committed expenditure in relation to that. As the director general referred to, there were works undertaken there a little while ago to upgrade the procedure room to do gastroscopy work. Kalamunda was one of the services that transferred with the creation of the East Metropolitan Health Service. I think pending that development there was little work undertaken, certainly in north metro where the service existed, about plans for the future allocation of those resources, and so when I gifted the service to my colleague Liz MacLeod there was no capital works plan as such for Kalamunda but there is an allocation there for consideration.

Hon ALANNA CLOHESY: So the allocation 2017–18 is in the out years?

Mr Salvage: In the papers?

Hon ALANNA CLOHESY: It was in the actual budget 2014–15 and it got shifted to the out years 2015–16 and 2016–17.

Dr Russell-Weisz: I will just ask, can you check that out? Would you have that on you?

Mr Salvage: We can tell you which years in the forward estimates, where it is, but maybe on notice.

[*Supplementary Information No D26.*]

Hon ALANNA CLOHESY: Can I have what the actual scope of works is for the remaining redevelopment stage 2? Will it stay the same as what was announced for the redevelopment stage 2?

Mrs Macleod: I believe they do, and some of the work is around the fixing of the roof repairs, but we can get more detail for you if we take that on notice.

[*Supplementary Information No D27.*]

Hon ALANNA CLOHESY: Can I ask the same questions about Armadale–Kelmscott?

The CHAIR: Are they all one and the same question?

Hon ALANNA CLOHESY: No, but the information might be here—it might be available. What is the redevelopment for Armadale–Kelmscott? Under capital works in progress, it says expected completed date TBA. When will that be completed?

Dr Russell-Weisz: I do not like taking all these questions on notice, but will do; I would rather answer them here. This is very much about the Armadale stage 2 works. I am not sure that they have been fully defined, but there is a budget allocation in the forward estimates for those stage 2 works. In relation to exactly what they are, I am not sure. There were certainly upgrades to certain parts of the hospital, but I would have to see where they are in the forward estimates.

Hon ALANNA CLOHESY: Okay, because it was reported in 2014–15 about $15 million, and the estimated total cost in the 2015–16 budget was $15.4 million. So we would expect that that work would have progressed, because it is in the budget, and that there would be a completion date—similarly with Kalamunda, of course, as well.

[3.40 pm]

Dr Russell-Weisz: My understanding is that there were original works done, as Mr Salvage said, at Kalamunda. Original upgrades were done at Armadale—quite substantial ones going back a few years. My understanding is that the second stage of both hospitals has not been approved yet even though there is an allocation within the budget.

Hon ALANNA CLOHESY: Could I have an expected completion date and scope of works for that?

[*Supplementary Information No D28.*]

Hon ALANNA CLOHESY: Under Osborne Park Hospital, reconfiguration stage 1, there was $26 million in the budget for 2014–15 and also 2015–16. Do we have a completion date for that?

Dr Russell-Weisz: Mr Salvage, do you want to comment on Osborne Park?

Mr Salvage: I think there is no funding currently in the budget for Osborne Park other than the development of the car park, which is now progressing with an expected completion in about mid-December. That is valued at about $3.3 million. We recently let the tender for that. The previous project, which had appeared in earlier budget statements, is no longer evident. It might be that money had been put into the out years, but I do not have that particular information with me.

Hon ALANNA CLOHESY: There was $26 301 000 reported in 2014–15 and also in the budget at 2015–16. Where has that money gone? Why is that money not in the budget anymore?

Dr Russell-Weisz: I am actually looking at the budget and looking at Armadale. Mr Salvage is right; if I look at Osborne Park, it has $2 million for 2016–17 and then $315 000 for 2017–18, and if there is any further money, it would be outside the forward estimates. If I look at Armadale–Kelmscott, there is nothing in 2016–17 but in the forward estimates, there is $1 874 000 in 2018–19.

Hon ALANNA CLOHESY: My point, for three of those, is: for Armadale, in the budget for the year 2014–15 and in the budget for the year 2015–16 there was an amount of $15 million.

Dr Russell-Weisz: Yes.

Hon ALANNA CLOHESY: It was in the budget. Where is it now?

Dr Russell-Weisz: We will take that on notice. In the budget papers I have, we would need to check that and come back to you.

Hon ALANNA CLOHESY: And why has it been removed?

Dr Russell-Weisz: Yes, sure.

[*Supplementary Information No D29.*]

Hon ALANNA CLOHESY: It is the same question for Armadale. For Kalamunda, it was actually in the budget; it is on your schedule of capital works in progress. Where is the money and why has it been taken out? Similarly to Kalamunda for Osborne Park, it was actually in the budget for this financial year as a work in progress. Where is it now?

Dr Russell-Weisz: Okay.

The CHAIR: I have just a couple of questions referenced here. On page 5, you refer to the Fight the Bite mosquito program, which I heard about on the radio on the way here today. Seeing as mozzie season is on its way —

Hon ALANNA CLOHESY: It is already here!

The CHAIR: How do you measure the success of the Fight the Bite program?

Dr Russell-Weisz: Again, without the assistant director general, Public Health, here, it may be better that I take that question on notice and get you a full response. If you can give me one minute, I will find some additional information from this because I do have Fight the Bite in here.

The CHAIR: Yes.

Dr Russell-Weisz: In relation to Fight the Bite and the high mosquito rates predicted in WA, there is an increase predicted in mosquito numbers and associated risk of mosquito-borne diseases in the south west and Perth. There are extensive local government mosquito-management programs, which are well underway, with mosquito activity and associated disease-risk likely to increase further in late spring and early summer. We know that some Ross River has now been detected in the Peel region and that is why we have a very extensive Fight the Bite campaign. The campaign promotes the message, as you would be aware, of covering up, repelling and cleaning up. We do do mosquito surveillance in recognised Ross River virus risk areas of the south west; we look at the mosquitoes and see how much Ross River they have. Then, we obviously do some control of the mosquitoes in that area. We also monitor, through the Executive Director of Public Health, local government mosquito management programs to see how effective they are. How we would do that is obviously measure the amount of virus that is found in the mosquitoes. Obviously, we also measure, if it is reported, how many patients get confirmed Ross River virus but whether we can actually link that to the mosquitoes, that is not as easy.

The CHAIR: There has been some media—I think it came out of Queensland—where they are doing some work with mosquitoes and I think uninfected mosquitoes are being released, or something like that. They have found that there is no Zika virus and actually their Barmah Forest virus is going down. Do we have any research like that in this state?

Dr Russell-Weisz: I would have to take that on notice, I am afraid.

[*Supplementary Information No D30.*]

The CHAIR: On page 3, there is the new Public Health Act. Has that strengthened WA's capacity to deal with global epidemics?

Dr Russell-Weisz: Certainly, it is a completely new Public Health Act that replaces the Public Health Act 1911. Even though we have a Health Services Act now, the 2016 act replaced an old 1927 act; the old public health act is way out of date. It is much more adaptive in relation to epidemics and also the powers of the Executive Director of Public Health. Although I might not be able to answer that question specifically, it is a contemporary act that is actually there for the protection of the community.

The CHAIR: Do members have any other questions?

Hon ALANNA CLOHESY: I will put them on notice.

The CHAIR: We will wrap it up there, I think. On behalf of the committee, I thank you for your attendance today. The committee will forward a transcript of evidence that highlights the questions

taken on notice together with any additional questions in writing after Monday, 31 October 2016. Responses to these questions will be requested within 10 working days of receipt of the questions. Should you be unable to meet this due date, please advise the committee in writing as soon as possible before hand. The advice is to include specific reasons as to why the due date cannot be met. If members have any un-asked questions, I ask them to submit these to the committee clerk at the close of the hearing. Once again, I thank you for your attendance today.

Dr Russell-Weisz: Thank you.

Hearing concluded at 3.47 pm

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