STANDING COMMITTEE ON ESTIMATES AND FINANCIAL OPERATIONS

2014–15 ANNUAL REPORT HEARINGS

TRANSCRIPT OF EVIDENCE
TAKEN AT PERTH
THURSDAY, 10 DECEMBER 2015

SESSION ONE
DEPARTMENT OF HEALTH

Members

Hon Ken Travers (Chair)
Hon Peter Katsambanis (Deputy Chair)
Hon Liz Behjat
Hon Alanna Clohesy
Hon Rick Mazza

Hearing commenced at 9.30 am

Dr DAVID RUSSELL-WEISZ
Director General, examined:

Ms ANGELA KELLY
Assistant Director General, Purchasing and System Performance, examined:

Professor FRANK DALY
Acting Chief Executive, Child and Adolescent Health Service, examined:

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

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

Mr GRAEME JONES
Group Director, Finance/Chief Finance Officer, examined:

Mr JEFFREY MOFFET
Chief Executive Officer, WA Country Health Service, examined:

The CHAIR: On behalf of the Legislative Council Standing Committee on Estimates and Financial Operations, I would like to welcome you to today's hearing. Firstly, I ask the witnesses to confirm that they have read, understood and signed the document headed "Information for Witnesses"? If there is any of your staff who are not able to sit at the table now, if they can indicate if they have read and understood that document, if they might be brought forward.

The Witnesses: Yes.

The CHAIR: Witnesses need to be aware of the severe penalties that apply to persons providing false or misleading testimony to a parliamentary committee. 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. The hearing is being held in public, although there is discretion available to the committee to hear evidence in private, either of its own motion or at the witness's request. 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. Government agencies and departments have an important role and duty in assisting Parliament to review agency outcomes on behalf of the people of Western Australia and the committee values your assistance with this.

Do any witnesses need to make an opening statement? If not, we will go straight to questions.

Dr Russell-Weisz: Straight to questions, Mr Chair.

Hon SUE ELLERY: Congratulations on your appointment. I have not seen you since then. Some might say it is the poisoned chalice or the kiss of death, but I am sure you will do a fantastic job.

The first series of questions I want to ask is around reconfigurations and restructures. There are several page references in the document, but that is generally what I want to ask about. The first one

goes to the structure of the metro area health service. Since the annual report set out the structure for us, there has been an announcement of a new east metro area, so I will ask some questions about that. As I understand it, the new East Metropolitan Health Service will include Bentley, Royal Perth, Midland, Kalamunda and Armadale. How many FTE are going to be allocated for that new health service? What is the budget for the creation of than service, and what will their operating budget be? Given that you are in a budget period now, you will have to restructure that. What is the salary level of the new chair of the health service, and where will the new health service's offices be based?

Dr Russell-Weisz: Shall I go in and answer as best as I can?

Hon SUE ELLERY: Yes.

Dr Russell-Weisz: Thank you for the question. It was announced by the Minister for Health that the East Metropolitan Health Service will be established from 1 July 2016. Currently, the structure remains in place and the responsibility for those hospitals you mentioned either reside in north metro or south metro until 1 July. It was only announced two to three weeks ago. We have set up two project teams to construct the east metro health service—one in the Department of Health and one in the current south metro health service—under the leadership of Dr Lawrence. We see two things happening here as we move to July 2016. There will be a movement of the contract management of the new Midland Health Campus from north metro now to the new east metro from 1 July 2016, and there will be a movement of those sites currently in south metro health service to the east metro health service. I cannot tell you the exact number of FTE at the moment, because that work is actually being done as we speak. We are thinking, as one example, for consolidating the contract of the management of Midland Health Campus between north metro and east metro. Contract management is a rare but extraordinarily important skill set. Therefore, whilst the contract management may be based currently at QEII, they will deal with both sites and, basically, report to two chief executives. The other hospitals are slightly simpler to move into an east metro health service, but it also has to be done pragmatically from an area health service perspective, which members of the current south metro health service will move to, to make a new east metro health service. Also, the purchasing plan will move as we move into the budget for next year. The work is currently starting on that, and that will determine activity and the budget, and we will have a much better idea of full-time equivalents within the necessary two to three months.

There have been five interim chairs appointed under the new governance legislation changes, which we aim obviously to get through by 1 July, to create then five new statutory health authorities by 1 July next year. The interim chair for east metro is Ian Smith and the interim chair for south metro is Rob McDonald. They are already appointed and are working with the Department of Health and the current two chief executives to make sure that we set up the east metro well. We will be advertising for a chief executive of the east metro health service within the next couple of weeks, as with the other current vacancies as well. I may pass, if I can, to Angela to give any more details about the process for budget and FTE in relation to east metro and what is happening in the department.

Ms Kelly: Thank you. We go through a service level agreement process with the health services to allocate the activity for each of the health services and, therefore, then the price that goes with that. We commenced the process probably six to eight weeks ago. We now obviously have to go through a bit more detail with the south metro and with north as we create the new east metro. That work has commenced. As Dr Russell-Weisz has indicated, we have created a project team. That will be fully operational next week in the department. It will have some really good project rigour to it. We will have some key milestones that will pick up on all of those elements. We are still a little away from giving you the exact detail, but it is definitely on course.

Hon SUE ELLERY: Have you allocated a budget to the project teams, so that they have taken the money that they will need to do the work to create the new service?

Dr Russell-Weisz: Everything is being done internally. We have project resources in the department. We are just giving an additional activity to them and that is similar to what is happening in south metro as well. There is currently a deputy chief executive in the south metro health service—I put out a global a couple of weeks ago—who will now have responsibility for the new east metro health service and setting it up but will still be working with Dr Lawrence as the chief exec, because for the moment the responsibility remains for south and north up to 30 June.

Hon SUE ELLERY: I appreciate you doing it internally, but what is the budget you have given the project teams to do this work?

Dr Russell-Weisz: If I cannot answer that exactly, maybe we will take that on notice. This is not going to be a significantly large project team to do it. We just want to do it in the short time frame we have because, as Angela said, we are putting out service level agreements. We do not want to be putting a budget out for east metro later than the new south metro and north metro health service, but I will ask Angela if she can give any further details.

Ms Kelly: Perhaps I can give you some more info. I have actually pulled a senior person offline to lead that project with our reform team. Each of the key areas in the department has provided some resources from the BAU and discretely for the project. It is largely around ensuring that the interdependencies across all areas of the department and the health services are picked up. We do not want to miss anything. You want to get this right from day one, and it is critical as we put in place the interim chairs and then the chairs from 1 July. We have used the resources internally. A lot of them have worked through the process, so they are quite aware of the key areas and the elements that need to be picked up.

[9.40 am]

Hon SUE ELLERY: If you are able to provide me with a dollar figure that could attach to it, maybe I could take that on notice.

[*Supplementary Information No A1*.]

The CHAIR: Just before you move off the creation of the East Metropolitan Health Service, was a business case prepared regarding the creation of the extra bureaucracy?

Dr Russell-Weisz: There was no formal business case prepared, but there was a lot a preparatory work that went between the department and the minister in relation to the creation of an east metro health service and in relation to which hospitals that would or would not include and what it would mean.

The CHAIR: Is there a document that identifies the reasoning behind the creation and what you hope to achieve by creating a third metropolitan health service?

Dr Russell-Weisz: There are clearly cabinet documents—we have gone to cabinet for approval in relation to an east metro health service.

The CHAIR: Yes, but is there a document you can provide us that is not cabinet-in-confidence that actually would tell us why you have created it and what you hope to achieve by the creation of it? Is it about efficiencies or cost savings?

Dr Russell-Weisz: I think there is information we can provide you that would be outside a cabinet document in relation to the rationale for why an east metro was created now and not in a few years' time. Just to summarise, we are obviously going through the governance changes now that will create statutory health authorities by 1 July 2016. That is a considerable amount of work, with new legislation that has to be put before the Parliament that year. That work and the creation of the area health services, and the five area health services instead of four, was felt best to occur now and not sort of halfway through, once we actually got governance changes in place. I think the other key rationale is that south metro health service now is a very large health service. It deals with two significant tertiary hospitals in Fiona Stanley Hospital and also Royal Perth Hospital. It has

a significant number of other smaller, but significant hospitals, and it was certainly felt that the east metro for the future would need its own hub at Royal Perth Hospital and serve the growing corridor in the east metropolitan area.

The CHAIR: If you are able to take on notice and provide any documentation you can on whether there are savings or the objectives or how we will measure it as a success in the future—the creation of this—compared to having just the north and the south.

[*Supplementary Information No A2.*]

Hon PETER KATSAMBANIS: Just on the same subject, overall, with the creation of this new service will the cost of administering the health system increase, decrease or stay the same?

Dr Russell-Weisz: As you well know, there are going to have to be efficiencies within the health service, but in creating this, it has been very clear that this will not create a number of additional administrative positions. The administrative positions that have to manage the area health service will come from the existing pool of administrative positions in both south and north. There is an additional cost with a fifth board—so a fifth statutory health authority comes with a chair and about eight members of a board—but that I would see as the main cost of an additional health service.

The CHAIR: So, your executive team will not increase?

Dr Russell-Weisz: There will be an additional chief executive. We are looking at this at the moment in detail from the south metro and north metro health service perspective. My aim would be to take those executives from current positions already in the south metro and north metro health service and not to create more. We have to constrain costs.

Hon PETER KATSAMBANIS: I take it from your answer that there will be a slight increase in the overall cost of administration if everything stayed the same.

Dr Russell-Weisz: A slight increase because there is a fifth board and a board has costs. Also, there will obviously be a fifth chief executive.

Hon PETER KATSAMBANIS: What specific measures will be put in place to make sure that things do not stay exactly the same and that efficiencies are driven, firstly, at an administrative level so that the overall cost of administration can start coming down?

Dr Russell-Weisz: That is not necessarily just an east metro health service issue.

Hon PETER KATSAMBANIS: No; I am asking across the board.

Dr Russell-Weisz: We have recognised that across the board we are through the massive reconfiguration that we have gone through. There is an excess number of staffing and that is across the board, not just in the area of health services, but in the department, and we will need to make savings in all of those areas. So, the two measures will be that we have not created another level of administration; we have also probably constrained it even further than the current level of four area health services, and we have also delivered better health care—we have even improved health care to the patients of the east metro. With Midland Health Campus, one of the KPIs, and clearly related to the contract there, is that Midland Health Campus retains a greater percentage of the patients who present to the Midland Health Campus area. If we found that more patients were coming in from Midland, say, to Royal Perth, I think everything that we were trying to do from 2004 and under Reid, would not have been achieved. So, yes, there are financial KPIs we need to meet, but it is also that we have either done as well clinically in our clinical and safety KPIs, and even better by creating an east metro health service.

Hon PETER KATSAMBANIS: Just to finish on this point, having created a third service in the metropolitan area, do you have any specific competition-by-comparison measures between the services to ensure that any gains or efficiencies or learnings, to use one of the buzzwords of the modern era, are transferred between those services, or do they operate as silos?

Dr Russell-Weisz: That is a very good question. Even before we moved to the new governance arrangements, we as a department will be setting down clinical policies and frameworks, as we have now. For example, we have a clinical services framework that says we are doing this service in this area, not in another area. We would not want to see duplication. If east metro suddenly said, "We are going to create a brand-new neurosciences centre", we know the main neurosciences centre is at QEII and that is what has been determined, because it is better to coalesce your high-complex neurosurgery and neurology at one site. An east metro will not be able to go it alone and say, "We are going to do this." It is very much set down by the budget they have and the services that are determined through the clinical services framework. I think that will set the policy framework. That will determine, as you say, that they cannot go off and actually act as silos, but one of the key KPIs of any of our area health services would be that more patients would be retained in the secondary areas such as Joondalup, Midland, Rockingham and Armadale, and not coming into the tertiaries. That will be a challenge, but we are up for it.

Hon SUE ELLERY: Still on reconfiguration generally, can I ask about the Fremantle Hospital reconfiguration? Is it the case that management of Fremantle is going to be shifted to come under Fiona Stanley?

Dr Russell-Weisz: In a minute, I will pass on, if I may, to Dr Lawrence, who can take us through some of the details. Yes, the actual management of Fremantle will come under the Fiona Stanley group, which will be the Fiona Stanley–Fremantle group. It is actually very similar. We are not doing anything, I think, radical, for we are moving to something that we know has worked in the northern corridor for over 10 years now, where we do have a Sir Charles Gairdner–Osborne Park group. I worked there for six years; I know it works well. It is really about the flow of patients between the tertiary and a secondary site, and if we find that we have divisions that are not silo-based within a tertiary sector but can work across tertiary and what we call our specialist hospitals, we can move patients much more easily between the two and have much better use of resources. I will pass to Dr Lawrence and she can take us through the actual governance changes.

[9.50 am]

Dr Lawrence: The simple answer is yes, it is going to come under the group structure and for all intents and purposes. In the short term at least, the proposed structure is that it basically merges in underneath Fiona Stanley and becomes integrated so that the specialties align with the service streams within Fiona Stanley and we move to one head of department. We will be going through the HR processes around that this week, so that the staff are aware of exactly what is happening at the highest level. For the clinical staff, it just means they are pointing somewhere different in the short term. The aim is, as Russ has said, that we will then have a single point of accountability. So general medicine will have beds at Fiona Stanley and across at Fremantle, and they can move their patients between them. Ultimately, we need to better utilise Fremantle. It is under-utilised presently. It is the main growth factor currently for the southern corridor, and I want that to be through a single point of accountability so we get better utilisation.

Hon SUE ELLERY: And are there savings out of doing that?

Dr Lawrence: Yes, there are.

Hon SUE ELLERY: Can you quantify them?

Dr Lawrence: I cannot quantify them. We have put some estimates until we finish the HR process, but you are taking out a tier of executive and plugging it into an existing executive structure. We do need some on-site management, so you cannot take everything out, but it will look slightly different —

Hon SUE ELLERY: But positions like directors of nursing and the clinical leads at Fremantle, is that the tier you are talking about?

Dr Lawrence: There are co-directors at Fremantle currently. Mental health, obviously, is a big service at Fremantle, so it is slightly different, but there are co-director positions that will be impacted. The director of clinical services and the director of nursing will be impacted, although we will retain what we are proposing to be a deputy director of nursing on-site, so that we maintain senior nursing on-site. We will retain some senior medical on-site but less than what is there currently. We will have a site operational manager so that there is someone in charge of the site and managing the service day to day. Executive director roles and some of those other administrative positions will come in and fit under the FSH; they will go and then plug into the FSH structure.

Hon SUE ELLERY: In terms of your management of non-clinical services at Fremantle, is there any loss of positions there?

Dr Lawrence: No, not at this stage. You cannot plug that into Fiona Stanley because it is a completely different service. There are some things that we may look at actually bringing together, particularly in the new south—things like fleet and how do we manage that, and it may be that we manage that across Rockingham and Fremantle in the future. But we have not made any decisions around those yet. The non-clinical service at Fremantle will report through the line management on-site.

Hon SUE ELLERY: So we are not going to see Serco people in the corridors at Fremantle Hospital?

Dr Lawrence: No, absolutely not.

Hon SUE ELLERY: That is good to hear. Can you tell me about ICU at Freo? Are there any proposals to close that unit at Fremantle?

Dr Lawrence: I think what I would say about the services across Fremantle and FSH is that we have got to work out how to use them more efficiently. Fremantle is over-budget, despite its significant under-activity, and everybody is aware that FSH is over-budget. We have got to bring those two services together and use them much more efficiently. The ICU at Fremantle has a very, very low occupancy rate and it is a very expensive facility to run because of the high medical costs. It does not matter if there is one patient there or 10; it costs me the same. So I have got to look at that very seriously. We have not made a final decision yet, but just the same as every other service, we are looking at what is the most effective way when you have got an integrated service across two sites.

Hon SUE ELLERY: And what is the timing? What sort of project time line have you given yourself to do that work on how the two integrate?

Dr Lawrence: At the highest administrative level, we are aiming for an early February transition. The remainder of what happens to clinical services is obviously a slightly longer time frame.

Hon SUE ELLERY: Can you confirm or otherwise that there is a 28-bed ward that includes a mixture of orthopaedic and geriatric that you are looking at closing at Fremantle as well?

Dr Lawrence: I cannot confirm that specifically. Fremantle currently has been amending its ward configuration and its requirements based on its need, because it is not doing the activity that we have anticipated, so they have rightly been closing beds temporarily to reduce the cost that is not actually doing anything.

Hon SUE ELLERY: As part of the media attention about the whole bed black situation, the director general, I think, was quoted as saying that, as a result of the bed black situation at Fiona Stanley, you would need to consider opening more beds at Freo and Fiona Stanley to fix the situation. That is kind of at odds with maybe looking at cutting at Fremantle as a consequence of bringing Freo under Fiona Stanley. Are you able to elaborate a bit on that?

Dr Russell-Weisz: Again, I think we will do this together, but I will just go back to the bed black status. It was a shame to see with something that is actually normal process people getting mixed up

between codes and bed statuses. A code is an emergency in some way. A code purple is a bomb threat. A true code black is a personal threat. So if there was a code black, we all have dongles and we would have a look at what a code yellow means and what a code black means. A bed status black is just a part of normal process. It has been in as long as I have worked in Perth in hospitals in a normal process of escalating when hospitals are getting fuller. I think the real shame here is that the staff probably felt that they were being criticised for actually following what is actually good process and actually good for patients. What it means is that when you have bed status green, you are okay—red and then black. It alerts staff to do certain things if you are busier at the time, and that is exactly what happened. I think from a question that was answered, you would see that actually Fiona Stanley probably had less bed status blacks than, say, Sir Charles Gairdner Hospital. Again, there is no competition here; it is just a normal process of how we alert staff to a hospital that is actually becoming fuller.

One of the things we recognise is that, as hospitals go into summer months, they do not need as much capacity and we have to be nimble about opening and shutting capacity. We had a very busy period at the end of November and therefore there was a need, as we are doing now, to open up some additional Fiona Stanley Hospital capacity. However, also in Fremantle, there is obviously capacity there that has been under-utilised. I think, to answer your question, it is actually the best use of both. It is probably being flexible enough to increase capacity at Fiona Stanley for when we really need it, but also pulling that capacity down when we can actually better require those patients to be at Fremantle Hospital, because it is meant to be the sister hospital of Fiona Stanley, like Osborne Park is of Charlie's, where you can actually move patients to and from. I might ask Robyn just to comment a little bit more about the actual bed status that you have raised at FSH and also Fremantle.

Dr Lawrence: At that particular time, FSH had closed beds. They had closed a ward, which maximises the efficiencies they gain from doing that, and that was in anticipation of the summer drop-off that we get. For some reason, it did not come in November. Interestingly, this week we have had a massive drop in ED attendances compared with those weeks in November, so they had beds closed. Unlike closing pods, it is very hard to rapidly reopen a ward, but if you want to maximise your efficiencies, it is the whole ward you have got to close. So they could reopen beds. Fremantle, likewise, can reopen beds if we want to. What we have got to do is exactly what Russ said: you have got to have enough capacity through Fiona Stanley to take the acute work but we have also got to have enough capacity to decant. In an ideal world, you actually maintain your capacity at your decanting end as a stable platform and flex up and down in your tertiary end, and that would be my aim.

Hon SUE ELLERY: I guess my next questions are around orthopaedics at Fremantle. Are you looking at changes to orthopaedic surgery at Fremantle—stopping it at Fremantle and maybe moving it to Fiona Stanley?

Dr Lawrence: As I said before, we are looking at all clinical options at the minute. Orthopaedics at Fiona Stanley is very busy; there is no doubt about that. The orthopaedics unit at Fremantle is effective and it is, in fact, the same surgeons across both sites. They like the service at Fremantle because it is isolated from the emergency department. My challenge is making sure that the acuity matches with what we end up with. If we made a decision to close the ICU and they are insistent they need ICU, we will have to reconfigure it. But we do need to continue doing surgery at Fremantle because we cannot fit it all back at FSH. So it is going to be a balance, ultimately, across all of the services, not just orthopaedics. There is vascular and there is general surgery. General medicine is obviously spread across both sites and aged care and rehab is over at Fremantle. So it is a balance of getting the right services in that site. It is a bit like Kaleeya; it took some time to get that right, but they got a very effective service, and that is what we are aiming for.

Hon SUE ELLERY: Again on the reconfiguration, but this time I am going east to Swan's and the new hospital —

Dr Russell-Weisz: Midland?

Hon SUE ELLERY: Yes, Midland—but what are we supposed to call it?

Dr Russell-Weisz: It is St John of God Midland Public Hospital.

Hon SUE ELLERY: St John's public hospital, which some might say is tautology —

The CHAIR: Surely you have come up with an acronym!

Dr Russell-Weisz: MHC or Midland. I call it Midland.

Hon SUE ELLERY: We get into trouble if we call it Midland in Parliament.

The CHAIR: It is a good thing Alyssa is not here today!

Hon SUE ELLERY: Yes, it is! Talking about the transition of services from Swan's to, as instructed by the director general, the new Midland hospital, I note that Swan's previously provided a community aid and equipment program for that Swan–Kalamunda catchment area. That service has not transferred, as I understand it, to the new Midland hospital and is now going to be managed out of Charlie's.

[10.00 am]

Was there any loss in FTE in that swap? Did any FTE from Swan associated with that program—that is the program that provides people with mobility equipment and a range of other equipment—go over to Charlie's? Why did you make the decision to move that service to Charlie's? Is there any change in the eligibility for patients getting home visits from that service, now that the service is being run out of Charlie's? I have one final question I would ask you to address. Often those patients who need to get that kind of equipment from the public health system need to get it from the public health system because they are low on financial capacity; often they are on Centrelink payments et cetera. If it is the case that they now physically have to travel from their local area—the Swan–Kalamunda area—to Charlie's, what are we going to do to assist them in their costs? This is quite often the group of people for whom an extra train trip will make or break the weekly budget. Can you give me some comment on that?

Dr Russell-Weisz: Yes. I think I will make one statement about Swan staff generally who, say, did not go to St John of God Midland Public Hospital and were clearly placed in the system, mostly in north metro health service. There was a group of Swan staff who either chose not to or did not get a position there, and obviously we looked after those staff by placing them in the public health system. I might pass to Wayne Salvage, the CEO of north metro, to talk us through that specific service, and we might need to take a question on notice in relation to travel assistance.

Mr Salvage: I would like to take on notice the specifics around the service. What happened at the closure of Swan District Hospital was that arrangements were made for all those services that needed to be provided on an ongoing basis, and pragmatic decisions were made about where they needed to be located across the service. My understanding is that that would be on a no-disadvantage-to-patients basis. We will look into the specifics of the service that you have asked about.

In terms of the reallocation of staff, as the director general has said for those staff who elected not to take up positions at the new Midland Public Hospital or who were not offered positions we introduced a quarantining arrangement in August of this year, so that for all permanent appointments within North Metropolitan Health Service the redeployed staff would receive, basically, preferential placements. At this point in time 103 ex–Swan District Hospital staff have been found permanent employment within other services within the North Metropolitan Health Service. That is the position that has been taken.

Hon SUE ELLERY: Just on that then, was redundancy part of what people were offered? Was a voluntary redundancy part of what people were offered?

Mr Salvage: Subsequent to the closure of the hospital, there were of the order of 190 redeployed staff that we took into interim placements. At the point the hospital closed I communicated with each of those members of staff and indicated that there was the option of voluntary redundancy, and invited them to express an interest in that as an option. Numbers of them have done that and we are working through that process.

The CHAIR: I think you were going to take the actual cost of the service on notice.

Hon SUE ELLERY: It is around whether there is any change in eligibility for home visits for those patients using that equipment program, and whether there is any assistance for them if now they have to travel to Charlie's. Did we get the FTE in that particular program? How many FTE in that particular program were at Swan, and how many FTE from that program at Swan transferred to Charlie's?

[*Supplementary Information No A3.*]

The CHAIR: That includes the cost of the service.

Hon NICK GOIRAN: Director, I want to refer you to page 131 of the report.

Dr Russell-Weisz: Which report?

Hon NICK GOIRAN: I think we are here to talk about the annual report for 2014–15.

Hon SUE ELLERY: Indeed they are, if you are talking about the Department of Health.

Hon NICK GOIRAN: Yes.

Page 131 of "Department of Health: Annual Report 2014–15" is titled "Ministerial directives". The ministerial directive section there reads —

> WA Health has received no Ministerial directives related to this requirement.

If the minister asked—directed—that he would like to see a new report prepared annually from within the department, would that be a ministerial directive?

Dr Russell-Weisz: From my experience, probably not; it would just be a request, and I would provide a report. Briefing notes and reports are requested by ministers at regular intervals, and I would dutifully provide it, or my department would.

Hon NICK GOIRAN: Is a ministerial directive only if some voluntary agreement has not been reached between him and the department, and he or she needs to escalate it to a directive? Is that how it works?

Dr Russell-Weisz: I may need to take that on notice. If I look here, because there is a Treasurer's Instruction—I might ask my colleague Graeme Jones, the chief financial officer, to answer. Under that it might be a ministerial directive under a Treasurer's Instruction. If there are those, that is clearly a directive under a Treasurer's Instruction. Do you want to comment on that, Graeme?

Mr Jones: Yes. There is actually a specific requirement in Treasurer's Instruction 902 (12) that outlines information that needs to be disclosed in your annual report relating to ministerial directives. Unfortunately, I am not across the actual detail of that specific instruction so we are happy to take that question on notice and outline the requirements under which a ministerial directive would be recorded in your annual report.

[*Supplementary Information No A4.*]

Hon NICK GOIRAN: To continue on that, there was, as I understand it, a circumstance in the reporting period when the minister did direct that there should be—I use "direct", but it is a request, I suppose; let us use that word—the minister requested that a new annual report would be provided

to him with regard to what I will refer to as late-term abortions, but specifically post-20 weeks. Are you able to confirm that that did take place?

Dr Russell-Weisz: I would have to check definitively. We are talking about 2014-15 when I was not in this role; I was in a different role. I would maybe ask Wayne to comment. The minister, I know, has been provided information on this when he has requested it, but I am not sure it would be classified, one, as a ministerial directive, or a report.

Mr Salvage: I am not aware that a report had been prepared, but we can check.

Hon NICK GOIRAN: Could we take that on notice to confirm what exactly was requested? That would be good.

[*Supplementary Information No A5.*]

Hon NICK GOIRAN: While you are doing that, could I ask you to have a look at a letter that the minister wrote to me on 27 February this year, specifically the third paragraph where he says —

> The EDPH —

Which is the executive director of public health —

> proposes to provide me with the first annual report in August 2015 in order to capture the data collected for 2014-15.

It is certainly my understanding there was a request for a report. Could we clarify whether that is also your understanding and whether it was actually provided? I take it that no witness is able to indicate to us today whether the report was done and provided?

Dr Russell-Weisz: I would have to check it, I think. I am sure that if that was something that the minister requested of the Executive Director of Public Health it would have been provided, potentially, as a briefing or report. I think it is certainly not a ministerial directive and it may not be a formal report, but it would certainly be as a briefing. We can check on that.

Hon NICK GOIRAN: He refers in the letter to the "first annual report", so obviously that would seem to indicate that this will be something we will continue to see in the future?

Dr Russell-Weisz: Yes.

Hon NICK GOIRAN: When you come back to us, could you just indicate what will be the mechanism to ensure that this is indeed an ongoing recurring annual report?

[10.10 am]

Dr Russell-Weisz: Yes.

Hon NICK GOIRAN: While we are at it, Mr Chairman, through you of course, would it be possible to provide the committee a copy of the report?

Dr Russell-Weisz: I would need to check with the minister.

[*Supplementary Information No A6.*]

Hon RICK MAZZA: Looking at page 4 of the Department of Health annual report, towards the bottom of the page under the heading "Caring for individuals and the community" it talks about a vaccination program for whooping cough and states that more than 5 000 women being vaccinated. How many were not vaccinated?

Dr Russell-Weisz: I would have to take that on notice. I would hate to make a guess on that. I would have to check with my executive director, public health. We could provide that easily but it is not something that I would remember.

[*Supplementary Information No A7.*]

Hon RICK MAZZA: The last paragraph refers to childhood immunisation, and the fact that more than 90 per cent of children between one and five years are vaccinated, and that in fact Aboriginal children are exceeding vaccinations over non-Aboriginal children, which is good news. What programs are in place to improve the vaccination rates in children?

Dr Russell-Weisz: Would I be able to pass that to Professor Daly?

Prof. Daly: Through the Chair, I do not have a specific briefing in front of me to give you specific figures, but immunisation in the metropolitan area is managed by the Child and Adolescent Health Service. There is a specific immunisation program which comes to us through a line item funding—special purpose funding—agreement in our annual service line agreement. I do not off the top of my head, the aliquot of funding. Currently that is done by our community health nurses who provide a program of child health checks from right at birth, in the neonatal period, right up to the school-age children. There is a targeted group of seven child health checks, which include the immunisation schedule. There are different rates of penetrants of immunisation in different physical areas. There has been some publicity that, for example, in some of the regional areas—and that is more Country Health Service's area—that there are lower immunisation rates, and we certainly know that in the metropolitan area we have some areas where they have lower immunisation rates. We have recently commissioned a review by Professor Karen Edmond to look at the public health and paediatric health implications of our child health check and immunisation schedule. That was tabled internally in the health service in September this year, so a few months ago. That makes a number of recommendations about aligning better our immunisation schedules in the metropolitan area and our child health checks so that they are more efficient and we get higher immunisation rates. If you have any specific questions about immunisation, or the dollar aliquots associated with that program, I am happy to take those on notice.

Hon RICK MAZZA: Ten per cent of children who are not vaccinated is still a very big number, and you are saying that it is higher in regional Western Australia, which is a concern.

Prof. Daly: In some areas of regional Western Australia. Through the Chair, if I can make a comment, in some areas that is due to parental preference rather than access.

The CHAIR: Was there anything we were going to take on notice or are you happy the answers?

Hon RICK MAZZA: I am somewhat satisfied with the answer. My view is that, more or less, it is a shame that more people are not taking it up. Talking about country and regional areas, are tonsillectomies still performed by accredited doctors in regional areas?

Dr Russell-Weisz: I can answer that, and I might ask my colleague who is the chief executive of Country Health Service to come up, if we can squeeze him in. In our public hospitals, both in the metropolitan and rural regions all doctors have to be credentialed for a scope of practice, so most tonsillectomies will be carried out by ENT surgeons. There is a very robust credentialing system in WA Country Health Service that was starting to be developed over 10 years, that has matured, and they can be either salaried doctors or visiting medical practitioners or visiting specialists who will visit an area and will carry out tonsillectomies, and other procedures. Before we let them operate on any patients, they have to have adequate credentialing. They go through a process, and, obviously, if there were any concerns, which I am inferring from the question, that would be picked up by Country Health Service. I might ask Jeff to comment.

Mr Moffet: To add to Russell's response, it is certainly one of the most common procedures—tonsillectomies—for our ENT visiting services. They are mainly done by visiting ENTs and contracted surgeons with supporting teams. One of the risks of tonsillectomies is post-operative bleeds, so it does take a longer visit for them to be planned and well managed in the days following surgery. But, yes, we routinely perform tonsillectomies through country WA.

Hon RICK MAZZA: The reason for my question is that, as I understand it, there were country GPs accredited to undertaken tonsillectomies. Has there been a shift away from those country GPs being

able to do the tonsillectomies to more of a situation where you have ENTs who actually visit the hospitals?

Mr Moffet: In short, yes; that has happened over several decades, to be honest. The old GP–surgeon has a much more limited role in contemporary practise in country right across Australia. There are still some GP surgeons doing particular procedures but not generally tonsillectomies. Tonsillectomies are quite high risk in terms of the bleed rates afterwards, so they are almost always done by ENTs. I am not aware of any in country WA being done by non-specialists. There may be but I am not aware of any.

Hon RICK MAZZA: How regularly would an ENT surgeon visit particular regional hospitals? Is it a demand-based thing or do they regularly go around to different hospitals?

Mr Moffet: I would have to provide you specific information on the visiting schedules. I do not know that detail off the top of my head, but it is demand based. In the Kimberley, for example, it will be probably two or three times a year that we will batch up kids in the East and West Kimberley because they will need to come from remote communities for pre-operative checks. In terms of schedule for country, I would have to provide detailed schedule information on notice, but it is demand driven, as you indicated. For example, in the Kimberley we would have two to three visits a year in the East and West Kimberley, which is based on getting kids from remote communities and towns into particular sites for pre-surgical work and making sure that they get the right post-surgical follow up. The frequency varies. Obviously it is quite frequent in the south west, where we have pretty reliable access to services; but, fundamentally, it is demand driven.

Hon RICK MAZZA: How long would the specialist usually stay after he has performed the operations?

Mr Moffet: It varies depending on the surgical skills that are resident within the town as well. If there is an agreement between surgeons about post-operative care, it can be a shorter period of a couple of days; other times, it can be up to a week—five or six working days. It will vary depending on the list and the risk and the arrangement between medical staff onsite.

Hon RICK MAZZA: On page 25, towards bottom, there is a line item "Average cost per client receiving contracted palliative care services". It would appear that the actual has exceeded a target by some $531. Can someone explain why there is an increase?

Dr Russell-Weisz: I will pass to Angela Kelly, through the Chair.

Ms Kelly: I refer you to page 108, which goes through it in more detail in the report. It is largely to do with some additional funding that we received through the "Sustainability Funding (Component 2)" funding; so we had some more funding available to do that. So it is different from the previous year.

[10.20 am]

Hon ALANNA CLOHESY: Is the St John of God, Bunbury–Busselton dialysis unit the only dialysis unit in the south west?

Dr Russell-Weisz: I may ask, through the Chair, Jeffrey Moffet to come back and answer that question.

Mr Moffet: Yes.

Hon ALANNA CLOHESY: Why is it not accepting new patients?

Mr Moffet: All our dialysis units have a certain number of beds. We have contracted volumes, as you heard, in terms of service level agreements. We have a contract with St John of God in relation to a number of clients who access the services. They actually manage the volumes as part of their contractual responsibilities. We adjust volumes year on year, depending on demand. We have

a fixed volume currently under contract. We had one for last year as well. To my knowledge—we actually had a conversation about this last week—there is only one or two, I think, people awaiting transfer, which were not confirmed for transfer in terms of dialysis at this point in time. I am not aware of any waiting list in Perth, unlike the waiting lists we have seen in the Pilbara and Kimberley at various times over the last few years.

Hon ALANNA CLOHESY: Why was a patient told to relocate to Perth to undertake dialysis?

Mr Moffet: I am not aware of any patient being told to relocate to Perth.

Hon ALANNA CLOHESY: Can we take it on notice?

Mr Moffet: Yes.

[*Supplementary Information No A8.*]

Hon ALANNA CLOHESY: As I understand it, the contract you currently have with St John of God does not allow for any increase in local services; is that right? There is a max number of patients it can take and it does not allow for any flexibility or increase in services based on need.

Mr Moffet: Like all of our services, there is a fixed contractual volume that we deliver based on our contract with the department and then we subcontract, in this instance, to St John of God in Busselton and Bunbury. Yes; there are specified volumes and there is a responsibility for demand management by the provider as well. We regularly review renal dialysis volumes around the state and we have actually successfully returned a lot of people home over the last couple of years—a significant number. We have an investment program to increase the chairs right across country Western Australia. Most of our demand does not sit in the south west. There is demand in the south west. We also encourage modalities of care that are not just satellite, so home dialysis is a very effective, safe and value-for-money way of delivering care.

Hon ALANNA CLOHESY: But it is not suitable for all patients, is it? It is suitable only for those that are on a, comparatively speaking, low risk?

Mr Moffet: The proportions of people on home dialysis vary. In the south west, for example, our rates there are probably in the order of one, maybe two per cent. Fifty per cent can be achieved in regions like the goldfields. One of the things that we would like to see more of in the south west is increased rates of home dialysis because we have got quite capable people who are able to undertake that service, so we are certainly working as a service provider to encourage that.

Hon ALANNA CLOHESY: How long has the service been operating above its funded capacity?

Mr Moffet: To my knowledge, it is not operating above its funded capacity.

Hon ALANNA CLOHESY: Maybe you might want to take that on notice then, I think to —

Mr Moffet: I am happy to take it on notice, but we have had discussions about this issue very recently as well. We contract in volumes. We paid for the actual occasions of services in the 2014–15 year, and there were no unpaid occasions of service and those volumes have been carried forward to this year and we are currently undertaking contract discussions with St John of God.

Hon ALANNA CLOHESY: Certainly, the information that some of the professionals are providing the local member, Mick Murray, with are that they are operating above capacity and have been for some time, so can I just take that on notice how long they have been waiting?

Mr Moffet: Yes.

[*Supplementary Information No A9.*]

Hon ALANNA CLOHESY: Are you aware of any offers from the Collie community to fund a dialysis unit—fully fund a dialysis machine, I am sorry—but there has been no support from the department regarding the provision of funding for staff to manage that unit?

Mr Moffet: No; I am not aware of that.

Hon ALANNA CLOHESY: If such an offer were to be made in a formal way to the Department of Health, would the department consider an offer?

Mr Moffet: We often get approaches from individuals, family members or organisations around either home or satellite dialysis. The important thing is we have a structured satellite dialysis plan for the state and we provide it in certain locations because we cannot provide it in over 100 towns across the state, so there is a planned approach to the delivery of satellite dialysis. It is high cost, it is high acuity and it needs specialist skills to support. Home dialysis is different; that is why there is a statewide home dialysis program. I am not sure whether it was a home dialysis issue.

Hon ALANNA CLOHESY: To be run out of Collie Hospital.

Mr Moffet: In the past, we have run supported home dialysis out of some hospitals as well, such as Fitzroy and Wyndham. It can still be home dialysis out of a clinical setting or if it is a satellite unit that requires appropriate planning and configuration and, generally speaking, we would not operate below four chairs, which require a demand of around 16 patients.

Hon ALANNA CLOHESY: Can you tell me what the demand is in Collie, Bunbury and Busselton currently for both unit and home dialysis?

Mr Moffet: I will have to take that on notice, but we can provide that information.

[*Supplementary Information No A10.*]

Hon ALANNA CLOHESY: I do not think my next set of questions involve you. I want to move on to the quad centre.

Dr Russell-Weisz: Yes.

Hon ALANNA CLOHESY: When was the business case proposal for the development of the centre commenced?

Dr Russell-Weisz: Through the Chair, can I pass the questions on to my colleague, Wane Salvage, who is across the detail of this significantly better than me?

Mr Salvage: I think the committee will be aware that North Metropolitan Health Service commissioned a study for development of future model of care for patients who are currently treated through the Quadriplegic Centre. That report was provided to us on 19 August.

Hon ALANNA CLOHESY: I have a copy here; thank you for providing it.

Mr Salvage: That provides, if you like, a missing piece of the jigsaw as far as the future for provision of care for spinal injury patients are concerned. It is a very good, robust piece of work which has been provided back to us. We commenced work on a proposal to pick up on the recommendations of that review and we are aiming to get a proposal, if you like, into the 2016–17 budget process for consideration.

Hon ALANNA CLOHESY: That is the business case that you were referring to in the questions I asked prior to the hearing. That is going into the 2016–17 —

Mr Salvage: Yes.

Hon ALANNA CLOHESY: Definitely going into the budget round or —

Mr Salvage: The minister has identified it as a priority. My role is to respond to that by providing him with something that he can deploy into the 2016–17 budget and that is what we are doing.

Hon ALANNA CLOHESY: I might come back to the business case if I do not get the information I am looking for out of the next lot of questions. Has this report been made public; has it been sent to the people who participated in the interviews and focus groups?

Mr Salvage: It has been provided to the Quadriplegic Centre and to a number of people we have engaged around a system and the Disability Service Commission in order to formulate a response to

it. It has not been, I think, released more broadly than that at this stage. It has not been released more broadly than the initial consultation with stakeholders at this stage but the intent will be to do that with a clear indication of what the response is to each of the recommendations.

Hon ALANNA CLOHESY: I do not want to pre-empt that response, but what has been done to commence the reference group's steering committee that was recommended in the report?

Mr Salvage: I brought together a group of stakeholders from the quad centre and from the state rehabilitation service Disability Services Commission in order to start to formulate the response we need to make to that report. We worked with that group in order to help us develop a business case that we have been putting forward. We have also finalised, in discussion with the minister, the structure of an ongoing reference group, which will respond to one of the recommendations in the report. We would see that as being the overarching group that would see the process going forward.

[10.30 am]

Hon ALANNA CLOHESY: Who do you think will be on that steering committee reference group?

Mr Salvage: We are still finalising that with the minister. Once we have confirmation of the membership, we will be able to provide that to you.

Hon ALANNA CLOHESY: Can we take on notice when the reference group will be established, who will be on it, how often it will meet and how it will be facilitated?

[*Supplementary Information No A11*.]

Hon ALANNA CLOHESY: What discussions have taken place with NDIS or NDIS My Way regarding devolution?

Mr Salvage: None to this point in time in terms of that initial response but we have identified that NDIS representation in that broader group will be necessary going forward.

Hon ALANNA CLOHESY: What discussions or plans have taken place regarding the development of a peer support program around those residents who currently live there and, more broadly, the people with spinal cord injuries across WA?

Mr Salvage: There is nothing specific on that item of the recommendation within the report, so the focus of the work to this point has been to pick up the broad model, which is, as the report indicates, a transition through different stages of rehabilitation closer to someone acquiring a spinal cord injury. The facility response that the government needs to consider in relation to that would be concerning the future of the Quadriplegic Centre. It has really been focused around the facility response, accepting that there are broader service issues raised by the quadriplegic review board and that will have to be part of the ongoing model.

Hon ALANNA CLOHESY: What mechanisms are in place to keep the public informed of the developments of the outcomes of this report, particularly the people who live in the quad centre and people who are interested and support them as well?

Mr Salvage: We have not given consideration to that aspect of it. I think the focus really has been on developing the facility responses I have indicated. Once we do have that broader reference group in place, which we hope to be in place for the early part of 2016, that is a matter that we need to defer for their consideration.

Hon ALANNA CLOHESY: The report stated that at the time the researchers were investigating this, 51 people were living at the quad centre. The answer to the question on notice that I put to you prior to these hearings indicated that there were 57 residents. That would suggest that between August and now there has been an increase of six residents. Is that the case?

Mr Salvage: I know that the Quadriplegic Centre has raised the issue around the accuracy of the number that was quoted in the report. Their view is that it was not an accurate number at the time that report was concluded. I will have to take advice from the Quadriplegic Centre about the current

number. There was some movement in terms of discharge in the early part of the year. A number of additional support packages were provided through the Disability Services Commission—a total of 11. That will obviously affect the numbers that were resident at the Quadriplegic Centre as they are able to be discharged.

Hon ALANNA CLOHESY: I would hate to think that an actual intake has occurred between any time in the last 10 years and now. That would be extremely concerning.

Mr Salvage: The whole issue through the report, as you would appreciate, is that we have essentially had a situation in which there has been a broad reach, if you like, at the point where people have been discharged from the Quadriplegic Centre. The direction going forward is for a flow, so ultimately the expectation is that as many people as possible with acquired spinal cord injury will be able to go back to their own homes or live in their own communities with the appropriate support.

Hon ALANNA CLOHESY: Can we take on notice the number of residents currently by length of tenure? Can we also take on notice the number of people who currently have transition plans? From the time since I asked that last question, how many residents have found more appropriate accommodation?

Mr Salvage: Relating to the availability of the additional packages, it might be helpful to provide you with the point in time in August when the review report was completed versus the current situation.

Hon ALANNA CLOHESY: And an explanation of the difference between what was in the report and the information that I was provided on notice prior to this hearing.

[*Supplementary Information No A12.*]

Hon ALANNA CLOHESY: And also to let you know that I will be asking the same question every month next year.

Hon SUE ELLERY: And you should basically just demolish that building. It is hideous.

Hon ALANNA CLOHESY: I was going to say that Professor Stokes would have encouraged me to ask those questions every month because the last time he appeared before this committee, he did suggest that a bomb was needed.

The CHAIR: He was not just going to demolish it; I think he had a more explosive —

Dr Russell-Weisz: I think that was a different building, Chair. That was a different hospital.

Hon ALANNA CLOHESY: No; he also had severe concerns about the quad centre.

The CHAIR: He was not licensed to have dynamite because there were a number of Health buildings he was going to get rid of!

Hon PETER KATSAMBANIS: I refer to page 25 of the Department of Health's annual report and the key effectiveness indicators and the key efficiency indicators. The one that really stands out is the average cost per client receiving contracted palliative care services. It is more than 10 per cent above target for the year. What is the explanation for that?

Dr Russell-Weisz: I can pass this to Angela. I think she has covered this in relation to page 108. There is an explanation on page 108.

Ms Kelly: I think that is a similar question to the one we answered before. We have received some additional funding through component 2. This is sustainability. We got some additional funding through that, so the costs were able to increase because we had the funding to offset. The target did not change.

Hon PETER KATSAMBANIS: That challenges me. I am trying to phrase this in the nicest possible way. We got extra funding so we spent more. Does that mean we were not providing the

appropriate level of service prior to that extra funding being provided or did we spend it just because we had it?

Dr Russell-Weisz: No. All palliative care patients would get the correct treatment. I would not expect there would be any downgrading of quality of care. If this explanation is not good enough, I would happily take this on notice. Two things happened. There was a variance of target as on page 108 to the increase the government's sustainability funding for the not-for-profits but also there was a greater number of patients to be supported by palliative care services. Obviously, more patients are provided care but the cost has gone up as well for this year. It may be prudent to see what we believe the costs will be for this year as a comparison.

Hon PETER KATSAMBANIS: It is the average cost and it has gone up by more than 10 per cent. It is not more patients; it is the average cost. Again, I accept that more funding was put into the system; that is great, but are we doing things less efficiently because we have more money?

Dr Russell-Weisz: I would have to look into this in more detail.

Hon PETER KATSAMBANIS: I would appreciate that. It is not really an issue, as you said, if the answer was not sufficient. The answer is the answer. I am just trying to get to the bottom of it.

[*Supplementary Information No A13.*]

Hon PETER KATSAMBANIS: Do you track or have a measure for what are known as avoidable admissions?

Dr Russell-Weisz: We track a number of parameters in our health service performance report. When you say "avoidable admissions", we certainly track the number of admissions that come in within 28 days of being admitted as a patient—if somebody comes back in after being a patient within 28 days. Maybe I should clarify the question. Are you asking about "avoidable admissions" from a previous hospital admission or from just something that has happened in the community?

[10.40 am]

Hon PETER KATSAMBANIS: I left it open specifically and I will give you the context. I believe that during the COAG round later this week the Victorian government will be putting a proposal up to change the funding mix for public health, based around states doing better in relation to what they call "avoidable admissions". I struggle to work out how you would have a direct measure of avoidable admissions, which is why I have asked you that question, whether you track that. In the context of that debate, do you have a measure that would provide some sort of clarity around what the Victorians might be proposing to do with our funding?

Dr Russell-Weisz: I think the context has very much helped. I have seen papers over the last four months from going to the Australian Health Ministers' Advisory Council meetings. Clearly, the commonwealth are very focused on chronic disease and hospital avoidance and also there are a number of models, I would say, being proposed by a number of jurisdictions, or being contemplated, in relation to ongoing hospital funding. I would say at this stage they are models that are only being proposed. I would not imagine they would be locked in this week, because I would imagine they would go back to the COAG health council and to the health ministers and to the federal health minister who is also looking at this. Clearly, there is and there always has been a focus on reducing hospital admissions or reducing patients going to hospitals where they do not need to be. We do this the whole time. If patients can be treated at their local hospital, they should not go to the tertiary hospitals. If they could be treated by their GPs, if they could be treated in the community, they should not go to hospital at all. Obviously, we are very keen to avoid patients re-presenting who have been in hospital within the 28-day period. There is evidence all around, as you well know, in relation to smoking, obesity et cetera that will always reduce if we get the right hospital admissions. I think that is where the focus is on. We have that one measure in relation to the 28-day readmission period, but I do not think that actually goes to your question which is the more general: do we know avoidable admissions? We certainly can tell you how many patients are

admitted with complications of diabetes. We can certainly tell you how many people come in with cardiology-related disease. But I might, if I am able to through the Chair, pass to Dr Lawrence and see if I have missed anything in that response, as a clinical colleague.

Dr Lawrence: I think as the director general has said, there are models around what is an avoidable admission and you can pull it from your DRG-coded activity. We do track from time to time and if we are looking at performance at different times and why we may be under or over it is something you would look at. But it is a model and it is based on your coding. I think the one thing I would say is I would never be 100 per cent certain it was comparable to Victoria, because they are very skilled at their coding, and I can only imagine if they want to reduce the funding for that, they have got a different model that they want to bring into it. We can measure it, because it is based on DRGs about what is in hospital, but we do not track it regularly.

Dr Russell-Weisz: DRG is a diagnostic-related group, so it is a conglomerate of coded clinical cases.

Hon PETER KATSAMBANIS: Just picking up on what Dr Lawrence said, I think you said that Victorians are really good at their coding. Why are we not as good?

Dr Lawrence: I guess this is only my own perception. They have been using activity-based funding for a lot longer than we have and if your funding is based on what prints out on your coded sheet, you are going to get very good at it.

Hon PETER KATSAMBANIS: All right. This is not going to go away. Obviously, there is going to be pressure from the commonwealth and, obviously, some states are going to want to make themselves look better than others in this whole debate—whether they are or not, it is different. Would something like those measures of avoidable admissions be a good measuring tool for the operation of a public health system?

Dr Russell-Weisz: Certainly, my view is yes. Anything that can tell us—it is not just hospitals; it is about the collaboration with the primary health sector. The new commonwealth-funded WA Primary Health Networks. We have to collaborate with them to make sure we have got the right care going into the right place. If we can reduce people coming into hospitals when they do not need to because of earlier intervention in the community, be it at a public health or even a primary health general practice community level—absolutely. Just to add to Dr Lawrence's point about coding, we have actually seen a huge improvement in our coding, in our response for coding as one; we brought in activity-based funding over the last few years. There is more to go, but we need to get there. If we can get something that is reliable and you do not have clinicians challenging the data or others challenging the data, I would welcome it.

Hon PETER KATSAMBANIS: Then the obvious next point if we do go down that path is the national efficient price and how are we going in relation to that and how can we continue to drive towards meeting that national efficient price? I will leave that as the first question. I do have a follow-up, depending on what you tell me.

Dr Russell-Weisz: Yes, and I might share this question with my two colleagues sitting on my right and left. The national efficient price—now we are all on activity-based funding for a great component of our funding and our performance, we are now comparable to other states. It is for that activity-based funding part of the hospital we measure, and we are high. I have been very clear we are more expensive than other states and some for good reason, or for reason, in that some of that is driven by salaries and wages and because we would pay more in this state than we do in others, across the board in all our clinical groups, that would drive up our price in comparison, say, to Victoria, to New South Wales. As Dr Lawrence said, Victoria and New South Wales have been really very skilled at this case mix funding and have been used to it for many years. We have gone into this space in the last two or three years and we have now got very much more robust data that we can compare hospital to hospital now, even interstate.

I think there probably needs to be more benchmarking with interstate hospitals that we will need to do over the years. Saying that, there is only a component and we think around 40 per cent. A recent review, a couple of years ago, looked at what was the disparity between national efficient price and our price, or our cost; what was it? Around about 40 per cent was salaries and wages. There was a small component that related to our challenges in country areas, a rurality sort of index. We have been working with IHPA, the Independent Hospital Pricing Authority, to make sure that those issues are captured. But there is a component there that is around efficiency that we certainly can drive down and Treasury have given us a goal to reach national efficient price on a glide path. As I said, it is not a blunt tool. One, there are things out with our control, we believe, because there are salary rates which are different to other states. That is not the only issue. Where we need to concentrate is our efficiencies. We know other states can provide safe patient care for lower ratios of staff and that is what we have been trying to do. Again, not a blunt tool, not compromising patient care, but making sure we are better at rostering, we are better at call back, we are better at overtime, we can reduce agencies. Again, it may not be a reduce in headcount, but it might be a reduce in those other factors that make up full-time equivalents. Also, our revenue, so it goes away from staffing as well; what can we do better with revenue? While we have made huge improvements—10 years ago, I can remember where five per cent was revenue. It is now in certain hospitals up to 13, 14 per cent. I think Fiona Stanley Hospital is exceeding its revenue target this year, but we know other hospitals can make sometimes up to 20, 25 per cent. That changes your whole net cost of service and will eventually change your price. There is an argument about revenue, as well as how we actually staff. It is a glide path, it is not a blunt tool, we will not make it—I would be misleading you if I said that I expected to get to national efficient price by next year, because that is not going to happen and nor have we been given that task through Treasury.

[10.50 am]

We have been given a glide path to make it, and we need to make sure that clinicians and administrators in our hospitals and health service have robust data. I saw some very robust data today that shows clinicians length of stay, and shows clinicians what their consumables are and can they reduce their consumables through better procurement. It is all those sorts of things. It is a whole suite of activities and not one issue.

Hon PETER KATSAMBANIS: I understand that, and correct me if I am wrong, but taking out the salary component and the allowance—there is no point in arguing about whether it is measured correctly or not—once you take out the salary component and the distance component, the length and breadth component, there is around about 40 or 45 per cent that is just broader inefficiency. I think that is a rounder measure, is it not?

Dr Russell-Weisz: It is a broader measure. I would say, just to clarify, broader inefficiency or unknown. In the original paper that was done—I have not got it in front of me, but I concede there were really some unknowns, and we are refreshing that at the moment. I think you are absolutely right. That needs to be our focus, that 45 per cent. There might be areas that we will struggle to make a difference in. But that is a good—if I can reduce the 45 per cent, I have done —

Hon PETER KATSAMBANIS: That is a great start, and then you have got a good argument. So, there is a glide path for that?

Dr Russell-Weisz: There is.

Hon PETER KATSAMBANIS: Where do you report that glide path? Where do you reflect it? Obviously a glide path will have some targets, or some signposts at least. Where do you report that?

Dr Russell-Weisz: I will pass to my colleague, Angela.

Ms Kelly: The national efficient price for 2014–15 that came out of the Independent Hospital Pricing Authority, and again it is a bit of a moving feast, because it is on data that is a couple of years old and then it gets escalated, was $4 971. The state price given in the budget was $5 486.

We believe we will finish the year, and again we are still finalising it, at probably somewhere about $5 600. So not only do we have some inefficiencies; we also have some additional costs above the state price. The glide path that government has provided to us is based on 2020–21, so that is when we believe the full reform program will be in place. So we should have effectively embedded a number of the strategies and efficiencies that we are looking for. There is a state price every year that we are allocated in budget. At this stage for the coming budget process, based on last year's budget, it is set at $5 676, and I think that would be the optimistic price, because we are unclear, again. IHPA will change their price, and the modelling that Treasury and ourselves do is based on the latest IHPA information, which comes towards the end of February. Does that answer your question?

Hon PETER KATSAMBANIS: It does, and I will twist it around now and I think you might start seeing where I am coming from on this. We go over to Canberra—when I say "we", I mean globally; government goes over to Canberra—and we get beaten up about these things. You said that we are aiming towards 2020–21, which is only five or six years away. Given that the old case mix, for want of a better term, has been running in Victoria for around 21 or 22 years—it is almost 23 years—and given that it has taken them that long to get to where they are going, are we being ambitious in setting 2020–21 as the target, given the performance so far?

The CHAIR: Before you answer that question, I am just trying to be clear. In 2020–21, are we expecting to be reaching the national efficient price —

Hon PETER KATSAMBANIS: No.

The CHAIR: — or are we going to be the national efficient price plus—and what is the percentage?

Hon PETER KATSAMBANIS: Plus externalities.

Ms Kelly: The glide path that is used to get to national efficient price by 2020–21.

The CHAIR: To be nationally efficient?

Hon PETER KATSAMBANIS: So, even more so, are we being ambitious?

Ms Kelly: Yes, possibly. But if we do not put ambitious targets on, we will never aim to get there. We have already put a number of processes in place. We know that we are under-coding, and we have had conversations around that, so we are improving that. There is an element in that analysis that related to coding of about $70-odd related to that component. We know that we are also not counting, so we have improved our counting, and we have particularly done that through the outpatient occasions of service this financial year. So that we can do things better, we have got processes. We have put a lot of effort into getting what we are calling business intelligence tools so that at the coalface the clinicians can see what is happening in a real-time basis, so they know what costs are coming through. As the director general has indicated, once you start putting comparative data in front of senior clinicians, it makes a difference, and we know that; that has been proven. We are putting in, as you know, the activity-based management, which is an outcome of that as well. So we actually push it out to those staff on the floor so that they understand. It is the staff on the floor that can put in place these efficiencies. They know better than most of us how it can be achieved.

Dr Russell-Weisz: If I can just add to that, yes, it is ambitious. My first aim will be that 45 per cent, or whatever that gap is. That is my first aim, because other aims will have to be through government wages policy et cetera, because we have to reduce our costs, and we have to better realign activity, our full-time equivalents, the revenue, and other goods and services savings as well. I would make one final comment, and we saw this when we started with Rockingham. I will take Rockingham hospital as an example, when we built Rockingham, going back to probably 2009–10, a new hospital. There are some inherent efficiencies when you build new hospitals. Things take time to settle down. I am not saying no people were challenged. We have gone through this massive

reconfiguration, probably unprecedented in Australia, to build all these new facilities, and also change other facilities. It is not simply old to new. It has been a huge configuration, not only in the metro but also in the country. I think we are seeing at the moment, and some of the challenges that you are probably outlining, that we are here and we have to get down to here—that is quite a steep glide path. I think some of the challenges are compounded just because of the huge reconfiguration change that the whole system has gone through. I think it is better for it, clearly, because we have much better facilities, but it takes some time to settle them.

Hon PETER KATSAMBANIS: Sure. On that, do you create or measure or report price by hospital or by service or do you just leave it as one global price in this respect, just focusing on this efficient price?

Dr Russell-Weisz: Mr Jones.

Mr Jones: Thank you, honourable member. We actually report monthly to each of the local health networks that the board established, so at our monthly board meetings we report a comparison to the state efficient price and the average cost of operations of the local health network, which is all the hospitals within that network. At this stage we actually do not report down at an individual hospital level; we just do it for the local health network.

Hon PETER KATSAMBANIS: Is there any desire or ambition to start reporting at a hospital level?

Mr Jones: We are reviewing our reporting processes and, as my colleague mentioned, we are looking at establishing a business intelligence tool that will be able to provide more detailed information at an individual hospital level. Currently we can only capture that information through the general ledger of our finance system. We can actually get the accurate cost once a year when we complete our data submission to the commonwealth, but that is only on an annual basis. So currently we model that information monthly through our finance system to provide all the information in the health system. To actually go down to an individual hospital site is probably more complex because there would be a number of assumptions that we would have to overlay to capture that information. So at this point of time we are just focusing on ensuring each health service information is captured accurately and we can report that through.

Hon PETER KATSAMBANIS: I understand that all this is fraught with danger, and I am not suggesting that it be used to compare one hospital to the other and whack them, because there are assumptions and there are imputed costs that can be argued.

The CHAIR: That is exactly what they are planning to do!

Hon PETER KATSAMBANIS: But unless you have a price for the hospital, how can you drive the efficiency within that hospital I think is where I am getting at? That is where I think the great gains are going to come from. Forget about comparing one to the other, because it is apples and oranges, and sometimes it is apples with not even fruit.

Dr Russell-Weisz: If I can answer that, we have done—maybe both Graeme and Robyn can comment on this—some benchmarking in relation to how many what we call NWAUs, or occasions of service per full-time equivalents, say comparing Sir Charles Gairdner to a Fremantle to a Royal Perth. So we do have some measurements of efficiencies or inefficiencies in this state. Also, while the model price or the model cost has to happen until you bring this all together, individual divisions and departments have their own budgets. I was looking today at a department at Fiona Stanley that I just happened to have in front of me, and I could see where they were in relation to their budget for other goods and services, where they were in relation to their budget for salaries, and where they were in relation to length of stay. Soon we will have actual individual clinician's performance on length of stay, outcomes et cetera per commission, like they do in the UK and like they do in some areas over east. Yes, it is very important to focus on price and cost, but

also I need to equally, if not more importantly, focus on safety and quality outcomes of each individual department. I do not know if Robyn wants to comment from the operational perspective.

[11.00 am]

Dr Lawrence: I think, at the hospital level, we know what our budget is and we know how that relates to the price at the start of every year, and we tell our staff that. They then get their budgets allocated down to them under the devolved management structure down to head of department level—they do not always necessarily understand that that is what has happened—but they do. We can track performance across the year. We do not need to know necessarily in August—I am averaging around a weighted price per case—because I can see on my budget whether I am on track or not. I do not see that as a critical thing for operational management during the course of the year. At the end of the year, it is nice to know where you have landed, but if you have landed on budget, you know you have met the price. That is probably the most critical thing. We are driving a focus on saying, "You've got a budget to manage." We can model FTE to say roughly what that should be for your service, but, in fact, if you can bring down your variations in the way you manage your care, in the prosthetics you use, and that brings you in on budget, that is absolutely terrific. It is all about matching what you have got to spend to your activities. They have an activity budget and they have got dollars they can spend to deliver that. There are just two simple focuses.

Hon PETER KATSAMBANIS: I can keep going on this, but I will not. I will let other members ask questions.

The CHAIR: I have a couple of questions to follow up on that session, and if anybody else has questions on this session, then I propose we have a 10-minute break and we will come back and start with Hon Sue Ellery. It is a three-hour session, and we like to have a break.

Hon PETER KATSAMBANIS: No, it is two hours, Chair.

The CHAIR: We will not have a break then—my apologies.

You mentioned that you want to get by 2021 to the nationally efficient price. I think you also talked about 40 per cent and our figure being above the nationally efficient price of salaries. So 45 per cent of that is efficiencies. I assume that means we have to get our wages cost structure to the same level as the other states by 2021. Am I right there?

Dr Russell-Weisz: Yes; or as I think Dr Lawrence said, there are other things. I mean, if wages are above, we have to bring in additional revenue —

The CHAIR: Other efficiencies?

Dr Russell-Weisz: — other efficiencies or additional revenue that is going to offset and deliver the net cost of service that marries up to the national efficient price. I would say, on the figures we have quoted, we are refreshing this paper, because I want to challenge myself and the team to say: is it 40 per cent or 45 per cent? We have seen some quite large wage growth, where CPI has been falling, and it might be that the wage component is slightly greater than we think; it might be less. We are actually refreshing that.

The CHAIR: When will you have that refreshed figure?

Dr Russell-Weisz: Probably in the next couple of months. I am hoping for a really robust —

The CHAIR: It still says to me that what you have to do is drive down your salary costs to meet an efficient price. Obviously, that is either by, basically, having a cap on salaries and allowing inflation to cap it and catch up to it, or it is about reducing staff numbers; or is it a combination of those?

Dr Russell-Weisz: It is a combination, but we will not reduce staff numbers to provide unsafe patient care. Nobody in this room would compromise on patient care. Focus is first; let us talk about 45 per cent on that. That can be revenue, staffing levels—all the things we have talked about. If we are going to be comparable to over east then, yes, there would need to be, let us say, a moderation

or adherence to government wages policy. Obviously, government will decide that. If we continued at the same rate, it clearly would be a challenge to get to national efficient price.

The CHAIR: But you have set yourself the goal, so how do you get to your goal?

Dr Russell-Weisz: It has been set for us.

The CHAIR: Under that goal, how do you get to that position?

Dr Russell-Weisz: We concentrate, number one, on the things that we have control over.

The CHAIR: But because salaries and wages are such a high component of it, how do you get there when they are such a high component of it?

Dr Lawrence: If I might, in south metro we are addressing some of that up-front. We have a very clear process where we have mapped that to a point in time where we were affordable and in budget. We have said: what did our workforce profile look like at that time? Then, matching against the current activity, modelled that forward. That gives you a model of roughly what your workforce should look like. You then look at what you have actually got and cross-compare. Our aim is to right-size our workforce according to our activity. You can double-check that then against other sites and say: Does this look safe? So, are other sites working at the same number of doctors per weighted activity unit as we would be if we reduced our workforce to this? If the answer is, "Yes, that looks about right", then you can go, "Well, that is probably safe", if their outcomes are the same as what we are currently delivering. That will bring us to a level which we think is reasonable around state price. However, obviously that state price is trajecting down. The next step of that process is—and you do not want to keep cutting your workforce to a level, or reducing overtime, or whatever it might be, to a level where you become unsafe—we have to start doing more benchmarking with other places in the east coast, where we can measure our workforce levels—not the dollars associated to them but the number of doctors, nurses and allied health, and say, "Do we match them?" Once we get to a point where we are matching the best players in the country, you have a really clear idea that you have a gap left in your wages per head, so your salary component, basically, and what is in their industrial agreement is the gap. Your OGS is in the gap, so you have to minimise the variation around your utilisation of those sorts of things, and we have a separate program of work around that to drive those down and make sure your fixed overheads are at its lowest level. Obviously, there are some issues for us around that with sites that do not do a lot of work but are very big sites. You have got some inefficiencies in that and we need to identify those. The first is actually working with workforce to right-size it to match the activity.

The CHAIR: Which says that at least a large chunk of that 40 per cent is because, comparing it on a national basis, we have too many staff in the health system. Is that right?

Dr Lawrence: That is sitting in the 45 per cent, yes.

The CHAIR: It is sitting in the 45 per cent, not 40 per cent?

Dr Lawrence: Correct.

The CHAIR: So the 40 per cent is just different wages.

Dr Russell-Weisz: Yes.

The CHAIR: Is there a nationally efficient price for the different groups of your employees—obviously, doctors and medical, allied health, support workers, patient care? How do we compare WA to the other states by type of employee?

Dr Russell-Weisz: It is something we might be able to seek from the Independent Hospital Pricing Authority to say, "Take that price per state and then break it up into different costs; what is the cost weighting for doctors, nurses, allied health?" What we have are simple comparisons to other industrial agreements. We can say an entry level nurse in Western Australia is paid X per cent

higher than an entry level nurse in Victoria. We have that information. We can say that an entry level doctor is paid —

The CHAIR: Do you have that in a form you can provide to the committee across the different categories of employees that you have?

Dr Russell-Weisz: We do have that information as the department has analysed it; it is not through the Independent Hospital Pricing Authority, but is due to what we have analysed. But I can provide that separately.

[*Supplementary Information No A14.*]

The CHAIR: The other thing I was going to ask for is the glide path that you referred to earlier. Is that a published document or something you can provide to us—the glide path you are being asked to achieve between now and 2021?

Ms Kelly: Mr Chair, can I just check that that is available to be released and, if it is available, we will send it to you. I just need to check with the minister.

The CHAIR: Obviously, if it is something you want us to keep private, you can ask for that as part of giving it to the committee and requesting the reasons why you would want it kept private. I imagine it is a fairly linear process over the next six years, so we could probably just divide where you have got to get to from where you are and do a one-sixth calculation each year.

[*Supplementary Information No A15.*]

[11.10 am]

Prof. Daly: We should be able to release it.

Dr Russell-Weisz: I am sure we could.

The CHAIR: Which is one of the reasons I would be interested: there is sort of a point at which there is a range of reforms and then you expect in year three a significant drop, whereas you will not expect in the next two years for the reasons you have outlined that you are not going to achieve it, whether it is reconfiguration or whatever, but in year three X will happen.

Hon SUE ELLERY: I want to ask about Fiona Stanley and the split between tasks being allocated to clinical and non-clinical staff. Are you able to tell me whether or not it is the case that nursing staff are being asked to serve meals and drinks to patients in emergency and then anywhere else in the hospital?

Dr Lawrence: I will do my best to answer that. On wards, like every other hospital, there is a ward housekeeper who takes the meals to the patients. In the emergency department and other day areas where patients may stay longer than expected, because you do not usually expect to feed patients necessarily in those short-stay areas, it would not be unusual for a nurse to request a meal or go to the fridge and get the snack box out and take it to the patient. That would be standard in all of my hospitals.

Hon SUE ELLERY: I am a frequent flyer, because of various members of my family, in the emergency department at Charlie's, and my experience there is that if someone is going to be in there for a while, the nurse will say, "I will go and see if I can find you a sandwich, a snack box or whatever." That is my experience. What has been put to me about what is happening at Fiona Stanley now in emergency is that a trolley is coming in and nurses are then being asked to distribute what is on that trolley, which is different from a nurse realising, "You know what; you have been in here for six hours. I'm going to go and see if I can find you a sandwich."

Dr Lawrence: I cannot answer that, to be honest; I would have to go and find that out. I would be surprised that a trolley would be wheeled in, because it should be an unusual event where a patient has been there that long that they need a meal, and I would have expected it is as you said, that someone goes away and gets the snack box rather than the trolley being wheeled in.

Hon SUE ELLERY: Can you investigate that and find out whether it is the case?

Can I go back to my reconfiguration theme? I ask about Bentley and maternity services thereat. What is the time frame for closing maternity services at Bentley; and, is it the case that consideration has been going to a new way of delivering the service so that deliveries will happen at Fiona Stanley, but pre and post care will be delivered at Bentley? Can you talk about that?

Dr Russell-Weisz: I can, and I will make one overarching statement and pass to Dr Lawrence, who is across this in more detail about Bentley. At Bentley you are obviously referring to one of the recommendations from the Con Michael review, one of which relates to Bentley and Fiona Stanley obstetrics. We are putting together a project plan, as we do for these reports when they come out with multiple recommendations, which will go to the minister towards the end of this month, it will actually go prior to Christmas, and there will then be an implementation plan in relation to all the recommendations and time frames. I might pass to Robyn in relation to Bentley.

Dr Lawrence: It is exactly, as I say, that we are putting together the project plan currently, with the aim of having it to the minister before Christmas, dovetailing into the bigger project with all the recommendations. The intent is, obviously, for the deliveries to move to Fiona Stanley. What is then being looked at is what models you need to support that, what is possible with the staffing and whether you can run it. There is certainly a preference to attempt to run antenatal and postnatal clinics at Bentley for that local community, but it has just got to be worked through with the staff to see whether it is a model that we can make function in a safe way, that they have the appropriate backup and that we have the staff to support it. So, it is part of the project planning.

Hon SUE ELLERY: Can I ask some FTE-type questions? How many FTEs are currently employed at Bentley? For those looking to move, I guess, what are their options in terms of redeployment elsewhere? Will the department guarantee the redeployment of existing staff at Bentley to other hospitals if they want to transfer? If they do not want to transfer, will voluntary redundancies be offered? Then I want to move on to some more service-related things. Is Bentley still accepting new referrals from women who live in the catchment area? Given what you have just said about the decision-making about whether you are going to do the whole continuum of care at Fiona Stanley, are you able to guarantee women who are pregnant now and going to Bentley for their prenatal that they are not going to have a baby then at Fiona Stanley and then maybe go back to Bentley? Are you able to offer them continuous service? I just want to get you to reiterate for me the timetable for completing the closure plan around Bentley.

Dr Lawrence: Starting at the FTE, the one I cannot answer is total FTEs at Bentley at the minute; we can certainly provide that on notice if you wish.

Hon SUE ELLERY: Can you take that on notice, then? Can you allocate a number, Chair?

[*Supplementary Information No A17*.]

Dr Lawrence: With respect to where those staff may like to move to, I think it is fair to say that that particular professional group is highly sought after, so I would be very sad if we lost any from the system. We need them to expand the service at Fiona Stanley, and I think there are other sites around the system that would gladly take them if they would prefer to go to another site. There is a voluntary severance scheme, having said that, available for south metro, which has been announced this week and put out to the staff. I did say to a forum yesterday that I would be sad if I lost a midwife to that scheme and we would have to look at that very seriously if some put in an application, because it is an area of need to us and I would prefer to keep them employed in WA Health. The question about the time line—the plan is aimed to go to the minister, as the director general said, before Christmas. Provided it gets endorsed, in the process we are aiming to transition the service for the commencement of the new financial year, which potentially means that you could have a mum being accepted by Bentley through the current process, because that is where the capacity is currently, who would then transition to Fiona Stanley for their delivery. On the

question of whether people have to go backwards and forwards, I would want that to be a choice for mums, and that is why it is about making sure we have got the right volumes. If there is demand that people want to have antenatal and postnatal care at Bentley and we can provide that safely, backed up by the other site, and we have good rotations of staff, good education and support, we will aim to provide that. If there is no demand, then obviously we would obviously have to reconsider it. We are told that there is a demand for the local population, but if a mum said, "Look, actually it is easier for me; I would rather just have all of my care at FSH", then we would be accommodating that.

Hon SUE ELLERY: I am going to jump now. I refer to the Metropolitan Health Service annual report, page 73. I have to preface my question by saying that I do not have a hard copy here. I just tried to download it on my iPad and it is freezing. My notes to myself say it was on page 73 and there is a reference to the security component that shows $2 million was spent on security in 2014 and $1.2 million in 2013. I now have a copy. It is note 15 down the bottom and "Security services". It talks about $1.2 million in 2015, which is down from just over $2 million in 2014. Given there has been, I guess, attention drawn to security issues, including around Fremantle Hospital, can you explain the difference—why the reduction in expenditure on security? Then, can someone talk to me, particularly in relation to Fremantle, about what is being done to keep staff vehicles safe. I understand that there has been a state of smashed windscreens and that sort of thing. I understand there are intruders hiding in the building scaring staff and others. Can you talk to you about security at Fremantle in particular, but perhaps start with the explanation of why there is the reduction in expenditure?

[11.20 am]

Dr Russell-Weisz: I pass to Graeme Jones.

Mr Jones: Thank you, honourable member. In relation to the security services, this report is for the metropolitan health service, so it actually covers North Metropolitan Health, South Metropolitan Health and Sir Charles Gairdner, plus some components of the department. We will actually have to take on notice to clarify the reduction, because it may not be for security services at Fremantle or Fiona Stanley Hospital; it covers the whole metropolitan health service. We can take that on notice and clarify why there has been an $800 000 reduction in the security services. In relation to Fremantle, Dr Lawrence.

Dr Lawrence: I am not specifically aware of this issue at Fremantle. I would have to take it on notice, to be honest. To the best of my knowledge, we have not significantly decreased the ground security. The security would have decreased inside the hospital around the emergency department. Obviously, mental health would have continued. I will have to seek further information.

[*Supplementary Information No A18.*]

Hon NICK GOIRAN: Director, in the annual report to which we referred earlier, there is much talk about the collection of health statistics and the like. In the middle of the year—24 June—I asked some questions at the estimates hearing and the department responded back to the committee. Specifically, it was question 13 on 24 June 2015 and it was around an issue probably not very well understood to do with the posthumous collection of gametes. I will read you the question and then the answer so you have got the context —

> *How many women have successfully sought posthumous collection of gametes for reproductive purposes in the terms described by Justice Edelman in Re Section 22 of the Human Tissue and Transplant Act 1982 (WA); ex parte C [2013] WASC 3, by recourse directly to a hospital's designated officer under S4 of the Human Tissue and Transplant Act 1982?*

The response that came back was —

> This information is not reported to the Department of Health. The designated officers are appointed by the Executive Director, Public Health … under the *Human Tissue and Transplant Act 1982*, which does not require the EDPH to collect information on the activities on posthumous collection of gametes.

My question this morning is: are you able to tell us how many designated officers have been appointed?

Dr Russell-Weisz: I am sorry, not offhand. I do see this come through on my desk occasionally where officers are taken off—not maybe for this—and other ones put on. I would have to take that on notice.

Hon NICK GOIRAN: Before you take it on notice, would you imagine it would be a small number of such people?

Dr Russell-Weisz: Yes.

[*Supplementary Information No A19.*]

Hon NICK GOIRAN: How many of these designated officers were actively serving a term of appointment during the reporting period 2014–15? That would be terrific. Given that it is a small number of individuals, is it something that you are able to ask them to say, "How many of these have you, as a designated officer, authorised"? My best guess is it is a fairly uncommon thing.

Dr Russell-Weisz: Yes. It is not my area of expertise, but certainly we can, if we can provide that information, go to the designated officers and see if they collect it.

Dr Lawrence: I have been a designated officer for many years. They tend to be medical directors and senior medical people in the hospitals. I have never been asked that question.

Hon NICK GOIRAN: That is good.

Dr Lawrence: I would say it is very uncommon. If someone has been asked, they might recall it. I do not know that we record it, though.

Hon NICK GOIRAN: No, and I suppose that is the issue. That was my point of exasperation in the middle of the year. I would like to think it is a small number that we are talking about—hopefully, zero from my perspective. Nevertheless, I just want to know how many are happening.

The CHAIR: We will make that all part of A19, member.

Hon NICK GOIRAN: We are just basically asking the small number of officers how many times they have approved such a request.

Dr Russell-Weisz: For the 2014–15 financial year?

Hon NICK GOIRAN: Yes.

The CHAIR: I want to put some questions on notice to you, so I just want to clarify it so I can get the right terminology in the questions on notice. I asked a question earlier in the year about the transition care or the temporary transition care program, and you were saying that the average wait time is 10 days. I declare a personal interest. I have seen it be a lot longer than that. I am intrigued to know, in terms of putting in a supplementary question, at what level you collect those statistics. Do you do it on a hospital-by-hospital basis and would you be able to provide the average waiting time for temporary care placements on a month-by-month basis? I am trying to find some ways of saving you money, because the difference between someone being out in care and being in a hospital is significant. What level of detail can you drill down to in terms of being able to provide information on that?

Dr Russell-Weisz: I am sure we can provide it per hospital.

The CHAIR: And on a month-by-month basis?

Dr Russell-Weisz: Yes. Are you asking for the 2014–15 financial year?

The CHAIR: Yes, and if you can bring it through to year to date as the most current, I will put that as a formal supplementary question.

Dr Russell-Weisz: That will be for the teaching hospitals or for all the hospitals?

The CHAIR: For all your hospitals, yes.

With the second one, I just wanted to clarify if you record in your clinical services framework the level of service that the hospital is operating at. I cannot find where you report that between the release of clinical services frameworks. Is there a place where you report the level that the hospital is operating at publicly? I will be up-front. The reason I am asking is that in your 2010 clinical services framework, you had Joondalup coming up to a level 5 by about now in a whole range of areas. In your 2014 one, it had dropped back, but it is now saying up to 2018–19. I am intrigued to know why we are holding Joondalup back from reaching that level 5 and when it will actually reach the level 5 that was originally recommended in the 2010 clinical services framework.

Dr Russell-Weisz: Obviously, 2014 will be updated to reflect any changes, and I would need to look at the specific areas that you are referring to that were 5 and are being pushed out, and that might be for a number of reasons. I would imagine it is probably only a couple of areas. It might be reference to those services still being at Royal Perth. I am sort of guessing here a bit. I would need to know exactly the areas —

The CHAIR: But is there a point where you publicly release where the hospital is in terms of the matrix—the figures that you use? It is only when the clinical services —

Dr Russell-Weisz: It is only when the clinical services framework comes out.

The CHAIR: I will put that as a question to you.

The other one goes to questions that we put on notice through the committee system. Regarding car parking at QEII and the cost of the subsidy, you said you were not able to tell me what it would be in the 2015–16, 2016–17 and 2017–18 financial years. Surely you must have a budget figure of what you expect or you have a plan for reducing the subsidy. I would have thought that you would be able to have some sort of budget figure you could give us as to either what it is going to be because you are going to take some action to reduce the subsidy or, if you are unable to reduce the subsidy and it follows its current trajectory, what the subsidy will be in the 2015–16, 2016–17 and 2017–18 financial years; and, if you cannot, why not?

Dr Russell-Weisz: Whilst I was au fait with all the parking for many years, I have passed that mantle on to Mr Salvage, so he might be able to help us.

The CHAIR: It would not be an estimates without me asking about it!

Mr Salvage: This relates to obviously the gap that the state is obliged to pay between the cost of staff car parking at QEII versus the model cost when we struck the deal with Capella. In 2014–15, the effective cost of the subsidy associated with that was about $1.3 million. I understand that we are on track to be an equivalent amount this year. The convergence point in the future is what it will be when we actually get back to the point where the cost of car parking accords with the rate that was struck in the original Capella agreement.

The CHAIR: So is there a glide path for achieving that or not?

Mr Salvage: I would not guess at that. That is a point that perhaps I could come back to you with more information on.

The CHAIR: I would have thought that either you would have a glide path about how you bring back the price paid by staff versus the price that Capella are entitled to, in which case you would have a budget figure reducing, or you do not intend to bring the two back, in which case you would

be able to tell me whether or not the glide path stays the same at $1.3 million or whether it expands or contracts.

[*Supplementary Information No A20.*]

[11.30 am]

The CHAIR: The final one is with regard to the strategic asset plan. You have said that you could not provide that because it was cabinet-in-confidence. Has it ever been provided as part of a cabinet submission, or is it simply used by you to inform cabinet deliberations?

Ms Kelly: To answer your question, it is used to inform the decision-making. It is part of the strategic asset management framework that government has put in place that every agency has to have their strategic asset plan.

The CHAIR: Why, then, can it not be provided to the committee? Under FOI it has been very clear what is a cabinet document and what is not. How does it suddenly get classified as cabinet-in-confidence if it has not been a part of a cabinet submission?

Ms Kelly: I will have to go back and have look at that response that we have provided to you earlier, and we will come back to you on that.

The CHAIR: Other agencies have provided them to the committee.

Ms Kelly: Yes; we will come back.

The CHAIR: And also whether or not you received any directions from anybody such as DPC not to provide it to us.

Dr Russell-Weisz: We can certainly check whether we can release it as well.

The CHAIR: All right.

[*Supplementary Information No A21.*]

The CHAIR: Having said that was my last one, I will throw you one last one. Once you go to the three boards, will you —

Dr Russell-Weisz: Five.

The CHAIR: Five boards. Will that mean an additional annual report, and will we need to find an additional seat at the hearings for you?

Dr Russell-Weisz: There might be a few. My colleague Mr Jones will answer.

Mr Jones: Mr Chairman, currently we produce three annual reports, as you know, for the Department of Health, the metropolitan health service and the WA Country Health Service. In the future we will need to prepare a report for each legal entity, so that will be for the five health services plus the Department of Health, and that will be a sixth annual report. Most likely—it is yet to be confirmed—we may have to prepare a consolidated annual report as well.

The CHAIR: Which is an additional cost, I would have thought?

Mr Jones: It would be an administrative cost because we would have the operational resources already within the department and the health service in relation to the preparation of the annual report. But, yes, it will go from three documents to, potentially, seven documents.

The CHAIR: Will your budget statements then be allocated by each of those areas, or will your budget still be consolidated in the annual budget?

Mr Jones: That is a good question.

The CHAIR: Because you are just going to drive me crazy if you tell me you are going to have one budget and six annual reports.

Mr Jones: Okay. Currently the department, as you know, prepares a consolidated budget statement. There have been some changes to the accounting standards in relation to the budgetary process. In particular, Treasurer's Instruction 945 requires agencies that prepare a consolidated budget to disaggregate that budget for subsequent legal entities. That disaggregation needs to be at an income state level, a statement of financial position and a cash flow statement level. We are currently looking at options on how we are going to disaggregate our budgetary information in the future. Our intention is still to have a consolidated budget for WA Health for annual reporting purposes; however, we will have to disaggregate our budget to show opening balances in the annual reports so that you can compare your actuals with those figures.

Hon SUE ELLERY: I am going to put some questions on notice, but I just want to explain the context to you before you get them. My questions are around wait times for allied therapies, such as occupational therapy, speech therapy, paediatricians—I know they are not allied—physiotherapy and psychologists in child and adolescent health services. There is a sense of frustration growing amongst some of my MP colleagues that they have constituents coming to them saying, "I am waiting now; here is the letter that says I am waiting 17 months, 19 months for an appointment", with one of those services. When we have asked questions—the most recent was in the last week of Parliament—we are given averages. The highest wait I think we got for speech pathology was 15 months in the answer we got last week. I have a series of questions that I am going to put on notice, and I would urge you to make sure that the information matches what the practice is that we are seeing. I understand that when you answer some of our questions and you give us average times, of course there is something at the top and something at the bottom, but increasingly numbers of us are getting constituents coming to us saying, "It's 19 months to get an appointment for speech pathology; by that time my kid will be four and we have wasted a whole lot of time." In some cases the child then becomes ineligible for the consequential flow-on services. You will get that pile of questions, and I hope you will give me as accurate answers as you can.

Hon NICK GOIRAN: A lot of questions have been taken on notice today; what is the custom in terms of a response time?

The CHAIR: I will explain all that as I read my closing statement.

On behalf of the committee, the committee will email a transcript of evidence, which includes the questions you have taken on notice on the transcript, to you in the next couple of days. The corrected transcript will be requested to be returned within five working days of receipt. I highlight that that is shorter than before. We used to ask for 10 and had the questions at the same time; we have now changed it to try to get the transcripts finalised. That is just a simple corrections process within five working days. The good news, in answer to your question, Hon Nick Goiran, is that the answers to questions taken on notice will be requested by 11 January because of the Christmas-new year break. Any additional questions the committee has for you will be forwarded via the minister next week, and will also be requested by 11 January. Should you be unable to meet this due date, please advise the committee in writing as soon as possible before the due date. The advice is to include the specific reasons as to why the due date cannot be met. If it is a complex issue, we understand that. In the event that you are unable to meet the due date, the committee would still expect that you provide as many answers to questions as possible by the due date; do not hold up all of them. If members have any unasked questions, I ask them to email them to the committee staff by midday on Monday, 14 December. On behalf of the committee, I thank you for your attendance today.

Hearing concluded at 11.36 am

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