STANDING COMMITTEE ON ESTIMATES AND FINANCIAL OPERATIONS

2016–17 BUDGET ESTIMATES HEARINGS

TRANSCRIPT OF EVIDENCE
TAKEN AT PERTH
THURSDAY, 16 JUNE 2016

SESSION ONE
DEPARTMENT OF HEALTH

Members

Hon Ken Travers (Chair)
Hon Peter Katsambanis (Deputy Chair)
Hon Alanna Clohesy
Hon Rick Mazza
Hon Helen Morton

Hearing commenced at 9.30 am

Hon DONNA FARAGHER
Minister representing the Minister for Health, examined:

Dr DAVID RUSSELL-WEISZ
Director General, examined:

Mrs REBECCA BROWN
Deputy Director General, examined:

Professor TARUN WEERAMANTHRI
Assistant Director General, Public Health, examined:

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

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

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

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

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

Mr ANDREW JOSEPH
Group Director, Resources, examined:

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

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

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

I might go straight to Hon Sue Ellery, if everyone is happy with that.

Hon SUE ELLERY: Thank you very much, chair, and good morning to everybody. I want to start by asking some questions about paediatric services. I will hang it off the total cost of services on the front page of the budget papers, but that is just where I am going to hang it. I want to ask about the paediatric implementation plan, which I understand was developed for the purpose of coordinating and rolling out paediatric services around the state. Can you confirm that that plan has been shelved?

Hon DONNA FARAGHER: I might ask the director general to answer that.

Dr Russell-Weisz: Thank you. Through the minister, the plan has not been shelved. The paediatric implementation plan was put in place some years ago. It is actually alive and well, and working well. We have seen a slight decrease in what we expected to come through our emergency department at Princess Margaret Hospital. We have seen an increase in paediatric presentations at Fiona Stanley Hospital, at Midland hospital and also at Joondalup hospital, which was all around about the paediatric implementation plan. It is making paediatric services and not just emergency department services more accessible to patients of those areas that I have just mentioned. If I may, through the minister, I might ask Professor Daly to make some further comments on this from a paediatric perspective.

Hon SUE ELLERY: Before we go to Professor Daly, maybe I can ask you to consider this in your answer. It has been put to me that there has been some shift in the way that that plan is being treated or used and, as a result of that shift, whether it is shelved or some other decision has been made about how it should apply, that junior doctors at the outer hospitals doing paediatric work are not getting the same level of training that they would have received at the Children's Hospital.

Dr Russell-Weisz: I will start with that, if I may, through minister and then pass to Professor Daly. Obviously we have junior doctors at all our teaching hospitals. We have junior medical officers at Princess Margaret Hospital. There will be junior medical officers at the new Perth Children's Hospital and they will receive, certainly, tertiary level paediatric experience, and training and teaching at PMH and at the new PCH. There is, clearly, paediatric experience and teaching and training to be had at the other hospitals—certainly more in the generalist nature of paediatrics. There is a whole suite of paediatrics that comes through the door at Fiona Stanley Hospital, and at Joondalup and Midland and junior doctors who are employed there now in paediatrics will get some of that experience and they actually should be seeing more and more. But certainly, junior medical staff will still continue to be trained at Princess Margaret and also Perth Children's Hospital as well. In relation to the numbers of junior doctors and how we actually split that up, I might ask Professor Daly to comment in his answer.

Prof. Daly: Through the minister, thank you for the question. I might make some general comments first about the paediatric implementation plan, if I may. Until 12 months ago, the paediatric implementation plan was a project run out of the Child and Adolescent Health Service with collaboration and trying to seek influence with the other health services. As a subcommittee of the clinical services framework steering committee, 12 months ago the paediatric implementation steering committee was brought in to the system manager. It comprises senior planning and executive members from each of the health services, including the WA Country Health Service and to date, it has been chaired by myself. It also has a member of the community and the chair of the CAHS—the child and adolescent health community advisory committee is on the committee also. The system manager purchases paediatric activity from each of the health services. It does so with reference to the clinical services framework. The objective of the paediatric implementation steering committee, which is now meeting quarterly, is to make clinical reference and advise the clinical services framework and therefore the purchasing intentions for each of the health services. The other important step forward that has been made is that, prior to the 2015–16 financial year, there was not transparent data about the quantum and value of paediatric services purchased and delivered around the state by hospital or by health service. That data is now analysed and digested

by that steering committee, and disseminated among the health services to ensure that we are both getting the purchased activity and, if you like, the budget, but also delivering the paediatric activity appropriately. The paediatric implementation plan has not been shelved; it has actually been more formalised in a statewide process that recognises the different roles of the health department and the area health services.

With regard to junior medical doctors, the Child and Adolescent Health Service does second a number of junior doctors out to other health services and other hospitals. From memory, the number is up to 28 at any one time RMOs who are employed by our health service are seconded to other areas. Obviously, they can receive general paediatric training at those sites. In the 2017 calendar year, there will be a reduction in the number of junior doctors employed at Perth Children's Hospital compared to what was our normal employment number for Princess Margaret Hospital. That change reflects the different role, architecture and models of care with the new Perth Children's Hospital compared to the old hospital. The number of reductions is modest. Half the reduction that is being made is through improved models of care that reduce overtime. In the month of April 2016, 17 FTEs out of 198 FTEs exerted or deployed in junior doctors was, in fact, overtime. There are three key objectives for the new junior doctor workforce model at PCH. Number one, and obviously paramount, is the best possible quality of care for patients and good experience. Number two is appropriate training and, as a supplement to the training budget in ABF, our health service receives a supplement for PCH of $19.8 million. A total of $7.9 million of that has been quarantined for the employment and support of a number of junior doctors so that their training posts are protected in the future. The third important objective of our endeavour with the model is that we actually have improved rostering of junior doctors. The new model, although there are slightly fewer junior doctors, has more JMOs working after hours during our peak periods of activity. The paradox to date has been that our unplanned activity peaks at about 8.00 to 9.00 pm at the time we have the lowest number of staff on the wards ready to take and look after those patients. The new model has very specifically designed the workforce to fit with patient demand.

[9.40 am]

Hon SUE ELLERY: On the same issue, can you confirm what has been put to me that, operationally, as a consequence of whatever has happened, whether it is a restructure around the oversight of the plan, as you have just described with the committee et cetera, training for junior doctors in paediatric services at Armadale, Rockingham and Peel hospitals has been reduced, diminished or changed in some way? Are you able to comment on that?

Prof. Daly: I am not aware of the exact number of junior doctors deployed at those sites—they are in the South Metropolitan Health Service. But I can comment on the purchasing of activity across the system as a result of the paediatric implementation plan, but not of those details at the operational level.

Hon SUE ELLERY: Maybe, before you do that, can someone tell me whether there has been a change or is proposed to be a change operationally for paediatric services at Armadale, Rockingham and Peel hospitals? If you are not able to, perhaps you could take that on notice and establish whether or not there is any basis to that.

The CHAIR: Can anyone answer that question?

Dr Russell-Weisz: If we do not know the exact details about Armadale and Peel, and you mentioned one other hospital —

Hon SUE ELLERY: Rockingham

Dr Russell-Weisz: — Rockingham, we would obviously come back to you, and ask you through the minister whether we could take that on notice. But I will ask Dr Robyn Lawrence, who is the chief executive of south metro, to make any comment.

Dr Lawrence: There is no substantive change to paediatric services at those sites; in fact, those services are continuing to grow in volumes. I think we can take on notice if there are any changes to the workforce and the rotations, but to the best of my knowledge, no

Hon SUE ELLERY: And perhaps to training that junior doctors would get in paediatrics at those hospitals? Thank you.

Hon DONNA FARAGHER: I indicate that we can take that on notice.

[*Supplementary Information No A1*.]

Hon SUE ELLERY: Some information was provided about paediatrics at Fiona Stanley Hospital. Are you able to tell me if paediatric orthopaedics, ENT and ophthalmology is being provided at Fiona Stanley Hospital?

Dr Russell-Weisz: I ask Dr Lawrence to make a comment about the specifics on that, but obviously if children turn up with an ENT or ophthalmological issue, they will clearly be treated and referred into Princess Margaret Hospital, should they need specialist tertiary help. When it comes to that sort of surgery—paediatric eye surgery and paediatric ENT surgery—it is very likely to be done, if it is very specialised, at the main tertiary hospital, but we are doing some of that surgery at other sites. I cannot tell you exactly where; I might ask Dr Lawrence to comment about FSH.

Dr Lawrence: There is no ophthalmology at FSH for paediatrics or adults, so that is not being done there. For ENT and orthopaedics, there are small volumes being undertaken. We obviously do not have paediatrics-specific specialists in those areas employed, but we do have specialists, some of whom can operate on paediatric patients within their scope of practice, so it tends to be less complex stuff. Some of the simple paediatric orthopaedics can be retained at FSH if there is a surgeon who is competent and on duty on the day they come in, but it is not large volumes and it is the low acuity.

Hon SUE ELLERY: Chair, I am ready to move to my next area.

The CHAIR: I just have a quick follow-up question: do PMH doctors rotate through the paediatric ward at Joondalup Health Campus; and, if so, how does that operate?

Dr Russell-Weisz: Generally we rotate quite a lot of junior doctors through Joondalup and Midland. The general framework is that the junior doctors rotate and then Joondalup or Midland Health Campus pay us for the junior doctors, but the junior doctors do not see any change to their employment terms.

The CHAIR: It is only at the junior doctor level that you rotate through Joondalup? It is not registrars or any others?

Dr Russell-Weisz: I would have to check, but I always consider junior doctors to include registrars, so junior doctors are registrars, some are senior registrars and what we would call resident medical officers. But, through the minister, I ask Mr Daly to make a comment about paediatric rotations to Joondalup.

Prof. Daly: The director general is correct. I do not have the exact number of junior doctors who are rotated every term, but generally junior doctors are employed on a six, 12 or 24-month basis. As part of their contract with Princess Margaret Hospital they are rotated out to other sites, which include Joondalup. Usually the rotations are of six months' duration and during that time they work in that unit but their salary costs are recouped from PMH.

The CHAIR: Maybe you can provide details.

Prof. Daly: On numbers? That is absolutely fine.

[*Supplementary Information No A2*.]

Hon SUE ELLERY: I want to turn to the mythical redevelopment of Royal Perth Hospital. Up until the midyear review in December, an amount of some $200 million was in the budget papers for the redevelopment of Royal Perth Hospital. Now at "Works in Progress" on page 336 some $9 million is spread across the forward estimates. There is a fabulous sign now out the front of Royal Perth Hospital, which says, "RPH redevelopment, stage 1, commitment by government of Western Australia". It has a figure of $19 million and it lists a range of the elements of that redevelopment. As I understand it, of that $19 million, $10 million has been spent to date on what I think is best described as minor capital works that addresses some ongoing maintenance issues at Royal Perth. Then there is the $9 million that is across the forward estimates in the budget papers that we are looking at now. What I really want to pull out is how the government is able to say that the list of things on that sign, which includes things like lift upgrades, patient ward fire safety upgrades and patient catering food delivery system upgrades—which I think is *Utopia*-speak for food trolleys, but I will get you to confirm that—is in any way equivalent to the promise it made back in 2008 and again in 2013 that it would put serious money into the budget papers. And it did put some $200 million into the budget papers, but that $200 million has disappeared and what is happening is that trolleys are being upgraded and that is being a considered a redevelopment of Royal Perth Hospital.

Hon DONNA FARAGHER: I will defer to the director general, but I just indicate that in terms of the schedule of works, yes, there has been an allocation in this year's budget of some $19 million for a number of enhancements and operations to RPH. They include, as I think the member mentioned, major lift upgrades, upgrades to the emergency generator and a number of other important improvements as well. I will defer to the director general though, who might be able to provide some further detail.

Hon SUE ELLERY: Thank you for that. I appreciate what the director general might be able to offer in terms of technical details. But a political decision was made to take $200 million out of the allocation for the redevelopment of Royal Perth Hospital at the time of the midyear review just six months ago, so I would be interested in policy comment from the government about the shift from telling WA that it was going to spend $200 million to telling WA that it was going to put $9 million across the forward estimates in this budget document. That was a political decision.

[9.50 am]

Hon DONNA FARAGHER: Can I just indicate again that $19 million has been put forward as part of the 2016–17 budget. As I understand—you will appreciate that I am not the responsible minister—it was deemed that the improvements that were to be undertaken as part of that $19 million were seen as the priority by health to be undertaken, and that is the funding that has been provided. The government has a commitment to retain Royal Perth Hospital. There has obviously been some reconfiguration of services following the opening of Fiona Stanley Hospital, and I think that is understood. In terms of the current budget, it is my understanding that the request was with respect to priority works, and that is the funding that has been provided in this financial year. I am happy for the director general to add some further information. I appreciate what you are saying in the policy sense. I have provided you with that information. The director general could provide you with some further information.

Hon SUE ELLERY: Before we get to the director general—I appreciate any information you might be able to give me, including the cost of the sign—are you able to tell me if there is a shift in the policy? There is a substantial difference between $200 million and $19 million. Has a policy decision been made that says that the government has changed the extent to which it is committed to redeveloping Royal Perth Hospital?

Hon DONNA FARAGHER: No. As I said in my previous answer, there remains a commitment by the government to retain Royal Perth Hospital. Again, the $19 million was for priority works that were identified by the Department of Health as being required to be undertaken this financial year.

Hon SUE ELLERY: My question was not about retaining; it was about redeveloping.

Hon DONNA FARAGHER: I will refer this to the director general.

Dr Russell-Weisz: If you go back over the last probably two years, there has been not only that commitment to retain Royal Perth Hospital as a tertiary hospital up to 450 beds—it was originally, as you know, 400 beds and then there was a change to add an additional 50 beds to Royal Perth Hospital—but also there was the commitment for the $19 million, as the minister has outlined. There are some other redevelopment commitments and they are not minor works because minor works would not normally make up those issues. It would not fall into the minor work bucket to do a huge amount of lift upgrades. That is where the $19 million has gone. There are some other areas that we believe are high priority that we are working with Treasury on in relation to Royal Perth Hospital, and they will hopefully be in the next tranche of upgrades to Royal Perth Hospital. As opposed to a major redevelopment of Royal Perth Hospital, that has to be considered when we consider every hospital and the future clinical service planning for the state. From the department's perspective, there is a commitment to retain Royal Perth Hospital as a tertiary hospital, and that is what we have done.

Hon SUE ELLERY: Can you confirm that "patient catering food delivery system" is trolleys?

Dr Russell-Weisz: Through the minister, I might ask Dr Lawrence to comment on that. I will take that on notice. I would imagine that unless there were major upgrades, normally simple trolleys would fall into "equipment".

Dr Lawrence: It is the upgrade to the catering systems. It is the rethermalisation system. Yes, it is a system on wheels.

Hon SUE ELLERY: It is a trolley!

Dr Lawrence: It is more than a trolley because it is the contemporary way of heating and chilling food, which has been rolled out in some of the other hospitals. It provides better quality food to the patient. It is not just a metal trolley; it is the heating and cooling component which is the criticality of the upgrade, not the trolley itself.

Hon SUE ELLERY: Sure. Can someone tell me the cost of the sign?

Hon DONNA FARAGHER: We would have to take that on notice.

[*Supplementary Information No A3.*]

Hon SUE ELLERY: I refer to page 336, "Works in Progress", "Perth Children's Hospital—Development". There have been some reports in recent days around burst water pipes. Can somebody provide an answer as to the extent of the damage and the cost of remediation of the damage?

Hon DONNA FARAGHER: I will ask the director general to respond to that question.

Dr Russell-Weisz: Yes, there have been reports, which I will pass on to Professor Daly. From experience of all these large commissioning projects, there are going to be these occurrences during the building of such a complex facility. We had certain of these issues at Fiona Stanley Hospital, not just the well-publicised bellows leak, and this was not a bellows leak that we had after the opening of Fiona Stanley Hospital. This does actually occur sometimes in current hospitals. We do have leaks. I can think of quite a few in our current tertiary hospitals that happen on occasion and we respond to them and do repairs to them. I understand this was a small water leak in the basement of Perth Children's Hospital. There was minimal damage and there will be no cost to the state. Through the minister, I will pass on to Professor Daly for his comments.

Prof. Daly: I am not sure I can add very much detail but flexible joints between a pump and a fixed pipe in the basement carrying water that was hot but not boiling at a temperature of 65 degrees burst or failed yesterday. It occurred in a plant room that is designed to house and contain leaks with a gib

floor. You have a step between there and a larger area. There was some water leak obviously onto the floor. There were comments in the press about steam. Because of the cold ambient temperature, there was a significant amount of condensation both in the room and in the corridor outside. The managing contractor, who of course is managed by strategic projects and asset sales through Treasury, contained, isolated and of course is repairing the leak. Such defects are at no cost to the state.

Hon SUE ELLERY: Does it add anything to time lines? Was work disrupted? Was other work disrupted?

Prof. Daly: I have been informed that there has been no change to their major build program, which is aimed for early August handover.

Hon HELEN MORTON: I note that there is nobody present from the east metropolitan health service. Where are we up to with the establishment of the east metropolitan health service?

Dr Russell-Weisz: We have made very good progress with the east metropolitan health service. The east metropolitan health service only comes into being on 1 July. There is actually somebody here from the east metro. We have Dr Robyn Lawrence, who is the current chief executive south metro and is looking after the future east metro very well. A chief executive has been appointed.

Hon HELEN MORTON: Are you able to say who that is?

Dr Russell-Weisz: Yes, I am. Liz MacLeod was appointed on 30 May and is currently in that position but the actual governance and responsibility for all the hospitals in the new east metro remain under Dr Lawrence's control until 1 July. There has been a lot of work done through the Department of Health with south metro and with north metro in establishing a new east metro health service, which would include Royal Perth, Kalamunda, Armadale, Bentley and also the new Midland Health Campus and the contract management for that hospital. There has been a lot of work in relation to splitting up or making sure we have the patient flows as robust as possible, and also the activity. We are now finalising a service agreement with all the area health services, but there is now a service agreement that will be signed by the new board chair on, hopefully, 1 July for the east metropolitan health service. I am really pleased by the work that has been done by south, north, people in new east and the department establishing east metro.

[10.00 am]

Hon DONNA FARAGHER: We are very pleased to hear that as members of east metro region.

Hon HELEN MORTON: We are. Can you also indicate where the area health services administration body is going to be located?

Dr Russell-Weisz: It is at Royal Perth Hospital. I cannot tell you exactly where in Royal Perth Hospital, but there is space there. I would say that there has been no increase in executive appointment and executive positions between the south metro and east metro. We have been very clear to have a very lean structure looking after both health services, but the area health service executive will be based in Royal Perth Hospital.

The CHAIR: Will there be any fit-out costs?

Dr Russell-Weisz: I would actually have to defer through the minister to Dr Lawrence. It would be very minimal I would imagine.

Dr Lawrence: There has been a very small amount of fit-out cost, the figure of which I am just trying to find for you.

The CHAIR: Small in the health department's budget could be a lot by everyone else's standards.

Dr Lawrence: Yes, but, no, it was not. We made an absolute commitment to generate the east with as little additional cost to the system as possible, and as the director general has said, particularly for the human resources in an ongoing component that we would deliver under or at budget

compared to what we had this year, and we have done that. In fact, there will be a small saving on the corporate structures shared between east and south; it will be moved forward. Off the top of my head, the fit-out for the offices I think was around the order of about $28 000, but if you want a more specific cost, if the minister agreed, we could provide that.

Hon HELEN MORTON: I do not need it.

You would be expecting me to ask this question about the smoking review in Sir Charles Gairdner Hospital mental health unit. One of the things that I recall was that a review was being undertaken to look at a dedicated area for smoking in the secure area of Sir Charles Gairdner Hospital. I recall that also there was a request for the Mental Health Advocacy Service to be involved in that review. I would like to know the extent of the Mental Health Advocate's involvement in the review, whether the review is completed and what the outcome is.

Hon DONNA FARAGHER: I will I ask Mr Salvage, who is behind me, to say a few words in response.

Mr Salvage: Yes, there is some background to this that the member will be aware of. There was an internal review undertaken by the North Metropolitan Health Service mental health service to assess the ability of the facility to meet the smoking exemption guidelines, and that internal review concluded that it was not possible to meet those guidelines. We have subsequently initiated an independent review that is being undertaken by the licensing accreditation review unit from within the Department of Health. As the member indicated, the Mental Health Advocacy Service has been invited to be part of that review. The review is ongoing at the minute. I do not have with me the time line for its completion, but I would be happy to provide that and an indication of when the review will be completed by way of supplementary information.

Hon HELEN MORTON: I actually would like that.

[*Supplementary Information A4.*]

Hon HELEN MORTON: The first part of this question is going to be a little bit controversial I think. What services do the Child and Adolescent Health Service, to my understanding but I might have it wrong, cover in the role of Princess Margaret Hospital? Does it have a role outside Princess Margaret Hospital for children and adolescent health services? What is the extent of that?

Hon DONNA FARAGHER: Yes, it does, but I will refer to the director general to provide more information.

Dr Russell-Weisz: If I can just make one overarching comment and then defer to Professor Daly who can talk about the different services. The Child and Adolescent Health Service is certainly not all about Princess Margaret Hospital. It provides, as the member would be aware, mental health services as well through the Bentley unit and across the sector. It also provides significant community services, so the Child and Adolescent Health Service right across the metropolitan area provides those services, and it collaborates very closely with the WA Country Health Service in providing those services. We always focus, I think, on the hospitals, but it is actually a very broad based community service. If I could hand over to Professor Daly.

Prof. Daly: The child and adolescent mental health services comprise both inpatient and ambulatory services. In annual budget terms, the budget for the total services is approximately $60 million per annum, of which only about $15 million is exerted towards inpatient services. The remaining $45 million is used for ambulatory and outpatient services. Those associated with child and adolescent health services stretch across the entire metropolitan area, reaching almost as far north as Yanchep down all the way through to the southern reaches of the metropolitan area and the Peel region down to Waroona. There are approximately 11 hubs where outpatient services are run from, many of them co-located with child and adolescent community health and child development services as well.

Hon HELEN MORTON: Sorry, can I just interrupt? Are those also under the children's service?

Prof. Daly: They are. They are also under the same area health service, yes. There are a number of specialist services—for example, the acute response team and acute community intervention teams which are undergoing a review currently to have a bed sparing objective in that they are there to try to acutely intervene in either emergency departments or in the community when there is an acute crisis to try to prevent admission to hospital, which obviously we regard as being a very last resort. I can provide some further details, and I do not have a briefing note to hand, but in addition to general access to the community and to young people and families, and obviously referrals from other primary care providers, the child and adolescent mental health ambulatory services provide some specialist services. For example, in Shenton Park there is a service, whose name escapes me just for the moment, that I visited just a few weeks ago where children with significant learning issues and chronic mental health conditions can come into a day program in a classroom environment with both mental health professionals and education professionals to have very small focused group assistance for learning in the context of a chronic mental health issue with children of school age. So there are a number of specialist services. Those services have undergone over the last three or four years a major redesign process. They have, like all of our other services, seen a significant increase in demand—from the top of my head something of the order of a 20 to 25 per cent increase in referrals over the last three to four years, with obviously not a commensurate increase in activity or budget. They have done an enormous amount of work around redesigning the referral initial assessment and then a partnership approach with patients and families so that now rather than waiting several months to be seen for a first assessment they have KPIs to see patients after an assessment for initial assessment and triage, if you like, with the KPIs expressed in days. It has been a great success.

Hon HELEN MORTON: I am just following up a little bit on children services. This has also a link with the Global Health Alliance that operates out of Health. With the decommissioning of Princess Margaret Hospital, I am aware that there have been commitments made for some of the decommissioned equipment and furniture to go via Tanzania to Zambia. I will be in Zambia myself within a fortnight having a look at that program operating under the Global Health Alliance. I am very interested in what time frame it takes for the decommissioning to occur, and the actual process. I have not got any feel or understanding of how the hospital that is operating absolutely perfectly one day, before the children and the staff are moved to the new hospital, with all of this first-class equipment—how does it actually get decommissioned and some of it put into containers and sent across to Tanzania? I am very interested in that.

[10.10 am]

Hon DONNA FARAGHER: I will refer to the director general but, yes, you are correct. The previous Minister for Health made the decision to enable that equipment to be released to go to Tanzania. I will defer to the director general.

Dr Russell-Weisz: Thank you, minister. Obviously, the decommissioning goes hand in glove with the commissioning of Perth Children's Hospital. As we commission Perth Children's Hospital, starting on 24 October and then the final move day being 20 November, at that stage, after 20 November on the final move day, Princess Margaret will be considered closed, or not open to patients. This is very much like what happened at Swan's hospital. Once all Swan's patients had moved to Midland hospital, the hospital was still under the control of the health department, or the health service at that time, because we needed to go in and make sure that items of medical equipment that were no longer required either went to new sites or were decommissioned. That took, from recollection, from around about November until about March, but Mr Salvage might need to help me out. Clearly, once a hospital is closed, it will need security; it will need to be fenced off, and there will be a period of months while we go through the hospital and make sure everything that has not needed to be transferred to the new Perth Children's Hospital is disposed of,

either going to Tanzania or being decommissioned, and then, at the appropriate time, it is then handed over to the other arm of government that will look after the disposal of that site. I might ask Professor Daly to make some comments about the dates and the plans for the decommissioning.

Prof. Daly: As the director general said, there does need to be very careful planning to ensure that we have the appropriate equipment and staffing, medications and fixtures at the old hospital even while we are commissioning the new hospital, so that we can provide a full suite of services, especially emergency services, right up to the very last day when we move, which is planned to be Sunday, 20 November. We anticipate that that move of the very last patients will take approximately four to five hours. On the morning of that day we will close the emergency department, most likely at eight o'clock that morning, and at the same time simultaneously open the new hospital emergency department at exactly the same time. It is quite a sad and emotional time for staff. The last patient is likely to leave the front entrance of the hospital around about 11.30 in the morning, and at that time PMH will be officially closed.

On that day, there will be a sweep through the building to render it safe. That is doing things like securing all remaining medications, closing off and isolating medical gases, removing any equipment and making sure that we have appropriate security, around not only the perimeter of the building but also each of the buildings itself, because as you can understand Princess Margaret Hospital is quite a convoluted and fenestrated site, with lots and lots of different entrances. After that initial process, you will almost certainly see a chain-link fence erected and locked around the middle of that day, Sunday 20 November. In the following days and weeks it will be under the control of Health. Obviously, the equipment, which is already obviously known to us, is tagged and monitored as an asset. Those assets, which have already been identified, will be moving to the new hospital—there are some 4 000 to 5 000 pieces of equipment, furniture and fixtures that will be moving to the new hospital—or they will be marked for disposal. There is a process, which we have used before with Shenton Park hospital, Kaleeya hospital and most recently with Swan District Hospital, with contemplating the donation of equipment that is surplus to our needs and no longer can be used within WA Health to other charitable organisations. After the closure of those hospitals I mentioned, quite a bit of equipment, I understand, was donated to overseas developing countries. I cannot describe that exact process, but it is designed to obviously first allow those assets to go to other health services or hospitals within Western Australia, and then to identify how the best use can be made of them in a fair, equitable and transparent manner.

Ultimately, the PMH site will be disposed of under the government land asset sales program, which obviously is coordinated by the Department of Lands and the land asset management services. The site is not a singular lot; it is actually multiple lots, and I imagine that there might be some rezoning, but that is an issue for government.

Hon HELEN MORTON: We have touched before on a review of the acute response team and the acute community intervention team in the Child and Adolescent Mental Health Service. I understand the need for review, and all services need to be reviewed all the time; and I certainly understand the need for that. I guess I am really asking for some indication whether you have a view that this service, in whatever reformed way it needs to operate to make it as efficient as possible, will continue to provide those services to people in the community.

Hon DONNA FARAGHER: I will ask Professor Daly to respond to that question.

Prof. Daly: I might begin by just saying that there is a commitment to continue those services in one form or another. Whether they retain that nomenclature, I am not sure at this stage. As mentioned earlier, these are acute intervention services designed to precede and hopefully prevent either escalation to hospital services, or even admission. The acute response team is a team of clinicians who provide an on-call service and are able to go out to other emergency departments or areas in the metropolitan area and assess young people in distress, who are in either emergency departments or those sorts of settings. Similarly, the acute community intervention team, again, is

on-call and available to these community-based services to intervene when things escalate and cannot be handled by the more regimented outpatient and ambulatory care processes.

It is true that we are working in a challenging funding environment. Traditionally, these services have been funded through the acute mental health funding stream, obviously via the Mental Health Commission, which also funds inpatient services. That includes also psychiatric consultation or liaison services. Obviously, the objective was to make an investment in those services outside the hospital to spare or minimise utilisation of inpatient services, primarily because that is better for patients, but also obviously it makes the best and most efficient use of our valuable resource, being the capacity in the hospitals.

Were you seeking comment about funding numbers?

Hon HELEN MORTON: No, I think I got what I was seeking, which was some kind of confirmation that the service will continue in whatever reformed way it needs to.

The next question I have is around the state price for the weighted price for activity in hospitals. At the moment it is $5 767 for the state price. I am interested in how far above the national efficient price that is, and is that gap getting less, or getting greater, and at what time frame do we expect to see the national efficient price reached?

The CHAIR: I ask you not to just repeat what is contained in budget paper No 3 about this issue.

[10.20 am]

Hon DONNA FARAGHER: I ask the director general to respond.

Dr Russell-Weisz: To start, I would like to say that we are very pleased that the commonwealth has retained activity-based funding through the agreement reached between all states and territories and the commonwealth on 1 April this year. We have embraced activity-based funding in Western Australia over the last two to three years. It has given us much more clarity on our costs right across the sector, in not only the tertiary sector or in the metropolitan area, but also in the country sector.

We certainly have departed from the national efficient price. If you look at when activity-based funding came in, the expected price increases for all jurisdictions was expected to go up. They have gone up but their rate of increase as an average is substantially reduced, so the expected rate of increase has not been there and that is because other jurisdictions, specifically Victoria, New South Wales and Queensland, have become more efficient but have reduced their costs. We have done a bit of analysis recently. We are about 18 per cent up on the national efficient price. We are not, I would say, the most expensive—that is the ACT—but we have actually done some analysis really looking at what is in our control and what is not in our control. The initial analysis we have done—around about 50 per cent, and I think it will be a touch higher—is in relation to wages policy. We have had significant greater wages growth over the last few years than other jurisdictions have had, and that is in how we pay all our staff; that is, medical, nursing and allied health, right across the board.

There is another component in that WA has unique factors, such as those remote areas that tend to be by the IHPA, the Independent Hospital Pricing Authority, which tends to be looked at in buckets. When I talk about buckets, you look at, say, a town like Port Hedland that gets compared to towns in Victoria and Queensland, which we do not believe are comparable. We believe there is an argument for a better remote weighting; we think that is probably around about the 15 per cent mark, and then I would say that is not particularly in our control. But there is around about 40 per cent in our control, and that is efficiencies; that is, efficiencies in our coding, length of stay and the way we staff. There is no doubt that eastern states have continued to do more activity potentially with less staff and still have the same safety and quality or improving outcomes. In our journey in making ourselves more efficient there is not going to be any compromise to patient

safety, but we actually have to make ourselves more efficient; and, if anything, my focus will be on reducing that 40 per cent over the next few years.

We have made major inroads this year. Health has grown expenditure-wise by around about 10 per cent over the last few years. Last year, expenditure growth was 8.6 per cent and this year we are expecting it to be 4.4 per cent. We have done six per cent more activity and we have had no increase in FTE. We are well established on that journey to shrink that gap. I would say that Treasury have listened avidly to us, because we have said that if we are paying way over the going rate for wages, we cannot reduce that cost difference overnight and, therefore, they have decoupled us from the national efficient price. It does not mean that we are not measuring ourselves against that; we are, and we will continue to do so. But it will be unreasonable for Health to expect negative growth if we were actually going to get to the national efficient price. Therefore, we have the price that you mentioned this year and further price increases as we go into the forward estimates.

The CHAIR: For homework, members can read pages 98 and 99 of budget paper No 3 that shows a lovely graph about it all.

Hon NICK GOIRAN: Through the minister, can you advise the committee if in Western Australia we perform operations for people diagnosed with hydrocephalus?

Hon DONNA FARAGHER: I will ask the director general to respond.

Dr Russell-Weisz: I would want to take that on notice, but I would say, yes we would. I might ask my colleagues if they can think of wherever they would do that. I am sure we do that and when we do it in relation to operations on hydrocephalus. I will pass to Dr Lawrence.

Dr Lawrence: Obviously, there are lots of different causes of hydrocephalus and different treatments, but the main aim is to drain the fluid from the brain to reduce the pressure within the brain. They typically do that with a shunt. That is my very basic knowledge. If there was a specific issue, it might be a very different answer. But the basic answer is, yes, we can; we have the techniques to do it. It is not a very complex piece of work.

Hon NICK GOIRAN: Would you describe our standard of care for these people in Western Australia as first class?

Hon DONNA FARAGHER: Yes. I suppose I am not quite sure where we are heading with this, Hon Nick Goiran. If there is a specific example that you might be heading towards, or something, then perhaps we probably need to be aware of that. But I would say that in a general sense we have a very good and first-class health system here in this state.

Hon NICK GOIRAN: I would agree that we do have that across the state. I am just interested in this particular technique and operation. Are we aware of anything that might indicate that our standard of care in Western Australia is not to a first-class, world-class standard?

Hon DONNA FARAGHER: Can I indicate to the member again, because there is probably not a specific budget item that we can refer to, we are not aware of any particular issues. That is the initial advice I have. If there is more detail that we need to get to you, I am happy to take it on notice; if we can be clear on exactly what information that you would like to receive. Nothing has been presented to me at the moment that there is a particular issue, but if there is something that you are aware of that we need to be aware of, we would appreciate to hear that.

Hon NICK GOIRAN: Minister, the reason I asked whether we perform the operations is that plainly if we perform the operations in Western Australia, those operations come at a cost and there is a very significant Health budget appropriation in this set of budget papers; hence, why I am asking the question. The response that has been provided is, yes, we do undertake it in Western Australia so clearly there would be a cost implication for undertaking the operation.

The CHAIR: Member, if I think the question is out of order, I will advise accordingly. At the moment I think your questions are clearly within the framework of a budget estimates hearing.

Hon NICK GOIRAN: Thank you, Mr Chair. I understand that the evidence to the committee is that we do perform these operations in Western Australia and that the witnesses are not aware of any reason why we would not describe our standard of care in this area in Western Australia as first class.

Hon DONNA FARAGHER: I have not been advised otherwise.

Hon NICK GOIRAN: Through the minister, can you advise whether we perform any operations in Western Australia for people diagnosed with hypoplastic left heart syndrome?

Hon DONNA FARAGHER: I ask the director general to respond to that.

Dr Russell-Weisz: I would have to take that on notice. We do perform the operation and we do perform the operation to relieve pressure on the brain. In relation to that specific operation, I am going to look at my colleagues to see if they can answer it. I would probably rather take it on notice if they are not sure.

Hon DONNA FARAGHER: Professor Daly.

The CHAIR: There were more quick handpasses than you see in football just then!

Prof. Daly: I think I would have to take that on notice the exact number of procedures related to hypoplastic left heart syndrome.

[*Supplementary Information No A5.*]

Hon NICK GOIRAN: Except I am not asking for the number of them, I am asking: do we perform the operation in Western Australia?

Prof. Daly: If the number is greater than zero, I would have to take that on notice.

Hon NICK GOIRAN: There is no witness here today who is aware whether or not we perform that operation?

[10.30 am]

Hon DONNA FARAGHER: I think we will have to take that on notice.

Hon NICK GOIRAN: Okay; that is fine, minister.

Through the minister, can I ask the witnesses: what is the treatment that is normally provided to Western Australians with spina bifida?

Hon DONNA FARAGHER: I will ask the director general to respond.

Dr Russell-Weisz: So are you talking about just generally the treatment that may be provided to children born with spina bifida?

Hon NICK GOIRAN: Yes.

Dr Russell-Weisz: Again, I would have to say through the minister that I am no expert on this. I might be a medical practitioner, but I am no expert on this. There are a number of treatments available for spina bifida, and I would probably rather put it on notice and give you a very full answer. But some of the treatments would span from operations—some significant operations—to correct the spina bifida, to non-operative treatment if it was not so severe. Obviously, not just operative treatment, but people with spina bifida and people who had be operated on or children who had been operated on would potentially need significant and intensive physiotherapy, and they would need intensive medical nursing and allied health care. But there is such a spectrum of spina bifida and a spectrum of spina bifida treatments that it could go from the acute, very intensive multiple operations over many, many years with a lot of medical input, to very, very minimal medical input where the disability is not severe. If I can, through the minister, ask any of my medical colleagues whether they can add to that.

Prof. Daly: The director general has already stated that spina bifida is a congenital or birth defect related to the spinal cord and the coverings of the spinal cord—so it is related to the backbone. It can be a wide spectrum from what is called spina bifida occulta, where there is no lesion seen at the skin but you have incomplete closure of the neural cords and coverings and the spinal column, all the way through to a devastating congenital disorder that is not compatible with appropriate neurological development or life. Those children born with spina bifida can undergo a range of treatments—again, I am not an expert—for surgical closure of any fistuli or opening to the outside world, and then of course the rehabilitation or the physiotherapy and supportive rehabilitation services to improve the function if there has been any spinal cord or neurological impairment associated with it. There are a couple of other conditions associated with this which are called meningoceles and so forth, which are outpouchings, if you like, or balloonings of some of those linings of the spinal cord. It is a wideranging condition. It is thought to affect more people than is often estimated, so I believe that something like two, three, up to five per cent of the population may have some degree, for example, of spina bifida occulta that may be not diagnosed or incidentally diagnosed later in life.

Hon NICK GOIRAN: We have no choice as to where we are born, so would the witnesses be comfortable to say that a person with the good fortune of being born in Western Australia, albeit with spina bifida, would have access to best treatment available in the world?

Dr Russell-Weisz: If, again, I may ask Professor Daly to make a comment about that. If and when patients are born with spina bifida, obviously all treatment would be provided to them. As Professor Daly did say, there are some very acute forms of spina bifida that are incompatible with life. Again, I am not an expert, but if patients are born with it and it is compatible with life and everything can be done, then it will be done here. If it is any particularly specialised treatment—I mean super-specialised treatment—that is not provided in Western Australia, there is the ability to seek that in the eastern states. We do have a method of doing that not just for this area but for other medical conditions, because there are some very high-complex, low-volume medical treatments that you would not provide in Western Australia because the volume is too low and you have singular sites in Australia. But I might have to ask Professor Daly to provide any more comment.

Prof. Daly: I do not know how much I can offer in specific comment, other than to say that the correction of spina bifida defects is normally within the scope of practice of a paediatric neurosurgeon; we have such specialised practitioners operating at Princess Margaret Hospital. Similarly, the management of children with spina bifida is within the normal scope of practice of our neurologists and our specialist rehabilitation physicians at Princess Margaret, and of course all the allied health personnel around them. I am sorry to provide a double negative, but I am not aware that there are any services that are not available in Western Australia and for which a child or a family might have to seek services elsewhere.

Hon NICK GOIRAN: Yes; that is because we have a first-class health system here in Western Australia. I understand the evidence to the committee this morning is that if a Western Australian has hydrocephalus or hypoplastic left heart syndrome or spina bifida, there is a range of first-class medical treatments available to them here in the state.

Dr Russell-Weisz: Yes, there would be, I would say. On your question about hypoplastic left heart syndrome, I cannot be sure that every patient—this is a very rare condition; I cannot remember ever seeing it in my career —

Hon NICK GOIRAN: Sorry; Mr Chairman, I will withdraw the remark with regard to that particular condition, because you did indicate that you were going to take that on notice and that is going to come back.

The CHAIR: Sorry; so which bit are we taking on notice? Is this the earlier one?

Hon NICK GOIRAN: It has already been taken on notice, yes.

Hon DONNA FARAGHER: Before we continue, Mr Chair, we are finding it just a little bit difficult to hear Hon Nick Goiran. I do not know whether or not it is the microphone, but that is why we are all sort of leaning forward. I am finding it just a little bit difficult to hear.

Hon NICK GOIRAN: I have been known to be accused of mumbling from time to time, minister.

The CHAIR: I often cannot hear his interjections, which disappoints me greatly! If the member could try to speak up and into the microphone, that would be great.

Hon NICK GOIRAN: I am going to refer to the answers that have been provided to the committee to the questions that were provided prior to today's hearing.

Hon DONNA FARAGHER: The answers already provided as part of earlier questions on notice?

Hon NICK GOIRAN: Yes, that is right. I am hopeful that at least one witness might have them available. I asked a series of questions, and I specifically want to turn to question 5, which deals with the issue of designated officers authorised with respect to the posthumous collection of gametes. The answer provided indicated that there is a new reporting regime in place. What was the cause for the creation of a new reporting regime?

Prof. Weeramanthri: I believe there was a parliamentary question at some point within the last 12 months or so that asked for the number of occasions on which this has happened.

The CHAIR: I think that may have been a question from this committee. I think it may have been that we kept the details of the information private after discussions with the minister, but have provided it to the member who asked who is the member currently asking questions. I issue that as a word of caution to everyone. I think it may be that all the details of that answer have not been made public at this stage.

Hon NICK GOIRAN: I might just indicate, Mr Chair, for the benefit of facilitating this discussion, and also to assist the witness, that I did question on notice 2548 on 17 March 2015 on this area.

The CHAIR: Yes.

Hon NICK GOIRAN: Does that conclude the answer?

[10.40 am]

Hon DONNA FARAGHER: Just so that we are clear, I will ask the director general to say a few words first and then we might defer to Professor Weeramanthri.

Dr Russell-Weisz: It was more to go back to the member's last comment about hypoplastic left heart syndrome and hydrocephalus. Whilst for hydrocephalus or spina bifida or any of those conditions there are services in Western Australia, and I have got great confidence in the ability to provide services to patients, there is a whole spectrum of those conditions. Those conditions can be severe enough that they are incompatible with life. Again, I am no expert, but there is a whole spectrum of conditions that can be treated and that cannot be treated and I think it is just worth noting that comment here before we go to the next question on the gametes.

Hon NICK GOIRAN: Back to the question that we are on, which is about the reporting regime, does that conclude the response?

Prof. Weeramanthri: To carry on with the answer: because of that question, we had to then go and find the answer to that question. We obviously have designated officers for those purposes in the various hospitals and what we had to do at that time was ask each of the hospitals and those designated officers whether they had actually approved such a procedure. Because it is such a rare event, we did not have an ongoing system at that time that would have given us the answer immediately, and so we put in place a system as a result of having been asked that question where we could, in future, have an annual reporting of that information back to us from the designated officers. So it was a direct result of the asking of the question that we put in place the system to be able to answer it.

Hon NICK GOIRAN: What is the reporting period that is now in place?

Prof. Weeramanthri: It is on an annual basis. I am not sure from which month to which month. I can find that out.

Hon NICK GOIRAN: We can find that out?

Hon DONNA FARAGHER: We will take that on notice.

Hon NICK GOIRAN: Mr Chairman, can we take on notice the reporting period that will now be in place.

[*Supplementary Information No A6.*]

Hon NICK GOIRAN: Further to that, are you in a position to indicate, minister, or through the witnesses, how many designated officers are currently in place that will be participating in this new reporting regime?

Hon DONNA FARAGHER: We will have to take that on notice.

[*Supplementary Information No A7.*]

Hon NICK GOIRAN: When the report is made, and we will find out in due course what that reporting period is—let me phrase the question this way. I take it that the first annual report has not come into existence as yet.

Prof. Weeramanthri: What we have instituted is a system of annual reporting to the Executive Director of Public Health. That is not quite the same as saying there will be an annual report on that. I have not got a position on whether there will be an annual report on that. Because of the sensitivity of the information, we have to look at that and see whether that is a reasonable thing to do under the legislation.

Hon NICK GOIRAN: Sure, but because the information will now become available, the department may be in the position to answer future questions in this area.

Prof. Weeramanthri: That is correct.

Hon NICK GOIRAN: No further questions.

The CHAIR: I was going to go to Hon Alanna Clohesy but she has indicated that she would like me to go to Hon Sue Ellery, so I go to Hon Sue Ellery.

Hon SUE ELLERY: Thank you very much, chair. I wanted to ask some questions around environmental health and in particular in relation to some evidence that we got in estimates earlier this week when the Metropolitan Redevelopment Authority appeared before us. We had a conversation with them about the circumstances leading to the opening of the water park at Elizabeth Quay. In particular, I want to begin by referring to the issues around the communication between the CEO of the Metropolitan Redevelopment Authority and Mr Jim Dodds at the Department of Health on the day that the water park opened. Mr Kinsella from the MRA said to us that there were two, perhaps three, phone calls from him to Mr Dodds and that Mr Dodds was at the time of those phone calls engaged in a very important phone hook-up relating to the Zika virus and Australia's response and Western Australia's response to the Zika virus. Can anyone confirm if that was the case?

Hon DONNA FARAGHER: Professor Weeramanthri?

Prof. Weeramanthri: Mr Jim Dodds is the director of environmental health and reports to me as the Executive Director of Public Health. I have not asked Mr Dodds whether he was or was not involved in a teleconference on Zika virus on that day. It was a hot issue at the time so it is perfectly conceivable. What I can say is that I have spoken to Mr Dodds in the last few days and we just clarified some of the issues that were being discussed on that day between himself and Mr Kinsella. Again, just to put a little bit of context in terms of answering this question, the decision around the

opening of Elizabeth Quay and the public health considerations contained within that decision, that decision is made by the Executive Director of Public Health, which is my position, or by their delegate, which includes Mr Dodds. Because of the large number of such applications and authorisations—just in the aquatic facilities area we have got 2 000 aquatic facilities across the state in 1 200 locations—these are matters that need to be dealt with administratively, and we have a delegated system of approval. The final approval for the opening of Elizabeth Quay was signed by Mr Dodds as my delegate, but I take responsibility for that decision because we were in phone contact because of the importance of the issue—he and I were discussing it. He discussed the decision with me before the approval was given so I am responsible for that decision. I had no contact whatsoever with the Metropolitan Redevelopment Authority prior to the opening or the decision. The first time I met Mr Kinsella was some time after that when I think we did a press conference after the first closure of Elizabeth Quay. Mr Dodds oversees the environmental health directorate, which had a number of his staff working closely with the Metropolitan Redevelopment Authority and their consultants in the weeks prior to the opening. That is part of being a good regulator; that is, you have experienced staff who understand the act, who understand the codes and who share their experience regulating across the multiple sites with the proponents of new applications. That is best practice regulation. So he was talking to his staff. There was the legitimate business of administration from the public health side working with the MRA and their consultants. In the course of that there were a number of issues identified. I would go to the "Report on the Opening, Closures and Water Quality Issues of the BHP Billiton Water Park—Elizabeth Quay", which was tabled in Parliament on 15 March and is dated 14 March, which gives a complete account of our decision-making process, and also has attached to it a full spreadsheet of all of the water quality measurements, the dates on which they were ordered and the dates on which they were returned, so Parliament can scrutinise those. One of the issues that had arisen was around lighting of Elizabeth Quay. This was not around water quality. Water quality was one issue but there were also issues around lighting. It was in the nature of the understandings between environmental health and the Metropolitan Redevelopment Authority about what was adequate lighting and whether that would constitute a condition on the approval or not that was the subject of the phone calls between Mr Dodds and Mr Kinsella. There were two approvals given on 29 January. The first was one by another one of my delegates, who is a water quality specialist who gave an initial letter of approval.

[10.50 am]

In fact, that letter was not consistent with an understanding and an undertaking that Mr Dodds had given to Mr Kinsella around what would be an appropriate risk management for the lighting issue that we had identified. We had already agreed on between the department and the MRA a set of conditions that would minimise any risk in terms of the hours of opening, any risk in terms of people slipping on the water and adequate lighting. We had come to an understanding that was acceptable to us around public safety. That understanding was not captured for various administrative reasons in the initial letter we issued. Mr Kinsella received that approval and then rang Mr Dodds and said, look, this is not consistent with what we had already agreed. Mr Dodds agreed with that; we had made a mistake in terms of that initial letter. It was nothing to do with water quality, it was about the lighting conditions, and we issued the letter under Mr Dodds' signature that actually captured accurately our belief about how best public safety should be guaranteed. It was a simple issue of communication around a matter of lighting.

Hon SUE ELLERY: Thank you for that. If I can continue, that is contradictory evidence to that given by Mr Kinsella just on, I think, Tuesday. The evidence given by Kinsella—I do not have the transcript in front of me, but I was asking him the questions—was that the reason that he needed to chase up getting a certificate was related to water quality. He did not mention lighting at all. His evidence before us—I do not want to verbal him and I do not have the *Hansard* in front—but my recollection of his evidence just two days ago was that the reason for the phone calls was that

there had been a test in respect to the water quality on 25 January. There had been a negative—I have to be careful how I used the word "negative". There had been a response in that test that meant that a certificate could not be issued. My recollection of Mr Kinsella's evidence before us on Tuesday was that he was then chasing up with Mr Dodds whether or not a certificate could still be issued. In the end what they relied on—I think this was the subject of a question in Parliament, I think maybe yesterday, that the Minister for Health answered—was that the Department of Health was going to use another provision of the regulations, section 20, to effectively issue a certificate because section 20 had more flexibility—I will use that word. Effectively, the department could issue a certificate relying on the provisions of section 20 to satisfy itself that all the issues related to water quality had been met. The information we had had in Parliament prior to that was that in fact the ED of Public Health—I think it was Mr Dodds, but I might be wrong—had said there needed to be a further test in which a negative result was to be received in respect of the water quality before the certificate of compliance could be issued. We now know because of material that has already been tabled in Parliament that the next test done after 25 January was not until 5 February, which was after the opening. We understood on the basis of evidence that has been provided to Parliament so far, including yesterday, that in fact what the Department of Health relied upon to issue the certificate of compliance was not doing another test to see if it got a negative response, but using the broader, more flexible provisions of section 20. The question of lighting as being the trigger or issue of concern as to why a compliance certificate could not be issued has not been raised to the best of my knowledge. This is new information. Mr Kinsella certainly on Tuesday, I think it was, was talking about the issue about the compliance certificate being water quality. This is a new bit of information. With the greatest of respect to you, I made the point to the minister the other day that every time we ask questions about this, a little bit more complexity is added. This is the first time that I have heard that lighting was an issue. I will put that to one side for a minute and go back to communication on the day that the actual certificate of compliance was issued. I will put lighting to one side and just deal with communication and who was speaking to whom. I have no reason to disbelieve Mr Kinsella when he said that he understood Jim Dodds was involved in a teleconference in relation to the Zika virus. I will take that on face value; I am sure that was the case. Who else was involved in the communication? As I understand it from what you have said to us, on the day you were in conversation with Mr Dodds. Were you or anyone else in Health in communication with the health minister or the Premier or anyone in their respective offices on that day?

Prof. Weeramanthri: There are a number of points there which I might just address, because there was one point that I would like to correct as a matter of fact, and that was the statement that was made in Parliament yesterday something along the lines that the Executive Director of Public Health had said that this approval would not be given unless a repeat test was done. That is not correct. I am the Executive Director of Public Health and I did not say that. I had to make a decision about whether the water park was safe to open in terms of public health. What I think you are referring to is one part of the administrative correspondence that was made by one of the officers within the Environmental Health Directorate, one of the emails that was going around, where something to that effect was a reference to the code was made and that point about needing a repeat test was made. That was not by myself as Executive Director of Public Health.

Hon SUE ELLERY: Just on that issue, whether it was by you or someone else in the Environmental Health Directorate, was the statement itself correct?

Prof. Weeramanthri: What we have to understand is that there was a lot of correspondence. What I am trying to outline is a process here whereby there is good legislation, good codes of practice, experienced people working as regulators and having the full facts in front of them and working with the proponents of any application, as you would expect, in terms of best-practice regulation. Ultimately, a decision has to be made, and all of that thought, experience, skills and facts have to come together in terms of a decision about public safety. Now that is a decision that I am responsible for, and, frankly, it is completely not in my DNA to put public health anything

other than first. When we are looking at the whole process, it has to lead to a decision. You want people to be debating the actual risks and the risk mitigation strategies and come up with an assessment about whether or not it is safe. There are various elements to that. People at times will have differences of opinion, but the facts are changing. So in that week prior to the opening of the water park, a lot of work was undertaken by the MRA and its consultants to change a number of the things that we had identified in earlier assessments. The cumulative decision-making process culminated in a decision on the Friday. That is a decision that I am responsible for. That had to take into account—the water quality issue, of course, was absolutely central to the decision around opening. There is no contradiction between the statements I made about Mr Kinsella's and Mr Dodds' comments around lighting and the water quality issue. Both of those things were being discussed. I gave you the explanation around the lighting, because that was the reason that Mr Kinsella rang back Mr Dodds after the first approval was issued, because we had not captured in that initial undertaking we had given that we thought that this was adequate so we redid the letter.

[11.00 am]

I am trying to give you an additional explanation about why Mr Kinsella might have called Mr Dodds back. Of course, most of the debate up to that point was around the water quality issues. There were two main tests, and it is all tabled in the parliamentary report, which is already before you. There are two types of organisms that we routinely test for in aquatic facilities. The first type of organism is E. coli, which is an indicator of faecal contamination. We had tested on four occasions prior to the opening. The test that we were awaiting on the Friday was actually the test for E. coli from the previous day's sample. We had taken a sample on 28 January and the E. coli results came back at 1.30 pm on 29 January, and that was clear. We had to wait until that point to make sure that that result was clear and we could not issue a permit to operate until we had got that clearance.

The other indicator organism was Naegleria species. Again, we had tested—and they had been positive—but we have to distinguish is between generic Naegleria species that are widespread in the environment and the unusual but very important species *Naegleria fowleri*, which causes amoebic meningitis. When I was trained in Western Australia more than 30 years ago, it was absolutely drummed into us how important this amoeba is and how we must avoid it in terms of risk at all times. I am very, very well aware of the importance of *Naegleria fowleri*, but it is one of a much bigger group of Naegleria species. I was convinced— and we had detected Naegleria—and the first sample taken had already come back as negative for *Naegleria fowleri* prior to our decision to open, so I knew that. The second thing was that the MRA and their consultants had superchlorinated the system to achieve levels of chlorination way beyond those required to kill any Naegleria species. That had happened overnight on the 28th. We had to have confirmation that that had happened. We knew already that the Naegleria species from the first sample was negative for *Naegleria fowleri*. The speciation from the other samples would take longer, but we knew that any Naegleria in the system would be killed by the superchlorination. On the basis of that, I felt that there was no risk in terms of Naegleria to the public and there was no risk in terms of E. coli, because we had never detected any, but I had to wait until 1.30 pm. Based on the modifications that the MRA had made, we felt then, at the time, that it was safe to open the water park. Subsequently, all of those Naegleria species came back and they were negative for *Naegleria fowleri*. So my best judgement proved to be accurate in terms of *Naegleria fowleri*.

Hon SUE ELLERY: Can I just stop you there for a minute? When you say "subsequently", it was after the certificate had been issued?

Prof. Weeramanthri: Correct, because at the time we issued the certificate, I knew that *Naegleria fowleri* is a very unusual organism. There were plenty of reasons why environmental Naegleria could have got into the water park because it lives in basically damp soil and fresh water, so it was very plausible that it could have occurred as part of the construction phase and the

environmental contamination. Things had happened to limit that contamination in the previous days. We knew that the first sample was negative for *fowleri* and the MRA had superchlorinated. So, in terms of a risk assessment, I thought the risk was not there in terms of any risk to public safety and that was subsequently borne out. We had to make a decision about whether it was safe to open and we did, and that is a decision I will stand by.

Hon SUE ELLERY: I respect your professionalism and I hope you do not think that I am questioning that, but I am trying to understand the process and the regulatory framework. When the officer, who was not you, wrote in an email chain that we need to get a negative test before we can issue the certificate was that officer referring to a particular regulation? What caused that officer to write that?

Prof. Weeramanthri: Through the minister, there is a code of practice which has been written by our staff and which is then applied and gets revised, which sits under the aquatic facilities regulations, which sits under the Health Act. All of these things are related together and they are very complex documents. It is not a matter of a kind of automatic process where you just tick a series of boxes and you achieve an outcome. There are people involved exercising their best judgement around risk all the time. With 2 000 facilities, each one of them will be slightly different, so the code of practice gives you strong guidance. In that code, there is a statement about requiring a second—a negative test result, but that is in a very big code as part of the regulations under the Health Act. In all public health decision-making, there is discretion to apply code to the particular circumstances to be fully informed of the facts and to make judgements about risk and risk mitigation. It is the totality of the information that has to be before the decision-maker. It is not a decision that is made purely in reference to a single line out of a code, and so there is a reference to that. We felt that that was not necessary in terms of risk mitigation because we already had a negative *fowleri* from the first test and the levels of chlorine were way high enough to kill any Naegleria. Taken in isolation, if that had been the first test of a Naegleria and there had been no mitigation, you would not have opened on the basis of you: need to make sure that it is not *fowleri*; but given everything else, it was a reasonable decision to open because there was no risk to the public.

Hon SUE ELLERY: I appreciate you saying that the code of practice itself is a large document. Do we have the relevant bits in respect to water quality? Have they been tabled in this house or the other house?

Prof. Weeramanthri: Through the minister, the code of practice is a public document. I think we are the only state—we were certainly the first state, because of the expertise of our staff who are incredibly experienced, to write a specific section on aquatic facilities because they are an emerging phenomenon, if you like, in terms of society.

Hon SUE ELLERY: I appreciate that.

Prof. Weeramanthri: That code is public. We can table it.

Hon SUE ELLERY: It would be great if you could table the relevant bits.

Hon DONNA FARAGHER: We will take that on notice.

[*Supplementary Information No A8.*]

Hon SUE ELLERY: Can I ask then, if you say what you have to do is take into account the code of practice and you take the regulatory framework in place—and I think in the answer the Minister for Health provided to the house yesterday, he said that, ultimately, having considered all of those things and on the basis of the professional capacity in the department in the section that you lead, you made a judgement that section 20 enables you to satisfy yourselves that—I am reading from the document that was tabled in question time yesterday. It says —

> **… Section 20 enables the EDPH to satisfy themselves that other operational arrangements are equal to those required by the Code.**

I want to ask: do you regularly or have you previously relied on section 20, particularly in respect to water parks, because the examples that were given in the contentious briefing note that was issued yesterday talk about section 20 being relied upon in respect to fencing requirements—proximity to water protection–type fencing—and spas in respect to bed and breakfasts, small residential-type facilities. My question is: have you relied previously on section 20 in respect to water quality issues?

[11.10 am]

Prof. Weeramanthri: Water quality issues and aquatic facilities are one subset of an amazing array of different regulatory decisions we make in public health. There are broader aquatic facilities, broader water issues, and issues around pesticides, radiation and food et cetera, all of which literally encompass thousands of decisions made every single year. They are all incorporated under the Health Act; that is the legislative power. There is clearly discretion that is built into the operation of the Health Act to benefit the public so that those decisions are tailored to individual applications and made on a case-by-case basis. Part of the requirement is for skilled people to be in those positions to make those assessments. I think the public would expect that decisions are made within frameworks but with attention to the individual case before the decision-maker. The very requirement for the Executive Director of Public Health to have particular qualifications reflects that requirement for judgement as well as just good policies. I think the Minister for Health tabled three examples yesterday in the lower house and one of them was around Forrest Chase.

Hon SUE ELLERY: Hyde Park.

Prof. Weeramanthri: Hyde Park was it? Sorry.

Hon SUE ELLERY: Yes, you probably do not have it in front of you. Trust me: the tabled paper states —

> Section 20 of the Regulations has been utilised on previous occasions:
>
> - to exempt the water playground in Hyde Park from fencing requirements …

Okay, also it refers to Forrest Chase. It continues —

> - to exempt the Forrest Chase … from fencing requirements …
> - a "class exemption" for spa pools associated with small single residential bed and breakfast accommodation …

Prof. Weeramanthri: I think that is a good example that we regularly use discretion to tailor sometimes a whole class exemption.

The CHAIR: But the question was regarding water quality.

Hon SUE ELLERY: Yes, water quality. So with the greatest of respect to you—I respect your professionalism—my question was whether you had relied on section 20 with respect to water quality issues. The answer given yesterday referred to water playgrounds and relying on section 20 in respect of fencing requirements around water playgrounds. I am asking about water quality and relying on section 20 in respect to water quality.

Prof. Weeramanthri: I can ask my delegates whether that has ever been the case. Obviously I do not get to make or see the vast bulk of these decisions, so we can take that on notice and come back to you with an answer on that.

[*Supplementary Information No A9.*]

Hon SUE ELLERY: I had asked earlier, and you provided a lot of other information but you did not specifically address this: who, if anyone, communicated with the health minister or the Premier or anyone in their respective offices on the day the certificate was issued?

Prof. Weeramanthri: I can answer for myself. I clearly was going to be the person responsible for that decision because it was an important decision to be made. I also have to make sure that my staff feel supported at the times—most of the things they are going to be dealing with on a routine basis but there is a pyramid of responsibility and I am used to dealing with complex decisions that have to be referred up the chain to myself for a final decision, so that is what I do. This fell into the category of an important decision to be made and I need to be involved. I am going to rely on my staff and their expertise. I have one person in environmental health who has spent 15 years pretty much dedicated to aquatic facilities, so they are part of the process. I have let others in my staff —

Hon SUE ELLERY: My question was about communication to the Premier and the minister's office.

Prof. Weeramanthri: It was clear that I was going to make that decision. I did not have any single conversation with the Minister for Health or with the Premier prior to the opening and that decision-making. And if I did not, I am pretty sure that none of my staff would have. I had a couple of conversations with the director general, basically letting him know that I was going to be making the decision and that I would be accountable for it, and I would let him know when that decision was made.

Hon SUE ELLERY: Would the director general not normally assume that you would be accountable for a decision of your area?

Hon DONNA FARAGHER: It sounds like it was a courtesy advice.

Prof. Weeramanthri: There is a no-surprises ethos in any senior executive.

Hon SUE ELLERY: That is a good policy to have.

Prof. Weeramanthri: So I am going to let him know if there are issues on the table that may attract attention in whatever way. These are important decisions. I would not have taken on the decision myself unless it was an important decision, and if I am going to take it on, I owe it to the director general to let him or her know that.

Hon SUE ELLERY: The reason I query that is that up until the first sign went up at Elizabeth Quay that the water park was closed, nobody outside government knew that there was any question about the water quality. I am not sure why you would have felt that that was a need to know. There was no public pressure. Was there pressure coming from somewhere else about the opening of the water park?

Hon DONNA FARAGHER: When you refer to the need to know, are you referring to the contact with Professor Weeramanthri and the director general? From what I am hearing, it is simply advising the director general, which, to be frank, I do not find unusual. I just want some clarity on what you are actually referring to. Are you talking about that conversation?

Hon SUE ELLERY: Yes, it is about that conversation. The point I am trying to get to is, if this was normal practice—"nothing to see here, folks"—I am not sure why the need to know policy was being applied, because nobody knew until some days after the opening when the first sign went up that there was any potential controversy. Nobody knew anything. There was no media attention or political attention on that—there was nothing.

Hon DONNA FARAGHER: I will ask the director general to say a few words in response to your question.

Dr Russell-Weisz: Professor Weeramanthri answered it very well: it is a no-surprises approach. For example, yesterday—we have already talked about the minor water leak at Perth Children's Hospital—I was contacted by Professor Daly.

Hon SUE ELLERY: That got some media attention on the day.

Dr Russell-Weisz: No, not necessarily. It is just an example of a no-surprises approach. My chief executives will contact me whether there is media or no media. More importantly, if there is any issue or substantial opening, Professor Weeramanthri contacts me, not on a daily basis, but we would speak probably on a weekly basis about any, I think to quote him, "topic of the day". The opening of Elizabeth Quay was a substantial opening, a bit like the opening of other facilities, and he was just letting me know. I think I do need to say here that where it is very different is that he holds a statutory authority as the Executive Director of Public Health. He has exemplary qualifications, is a very experienced individual with vaster experience in public health than probably anybody sitting behind me, and has worked right across the country, and I have no ability to direct him one way or the other in relation to his call as the Executive Director of Public Health. I have 100 per cent faith in his call. In that sense, when he did contact me—I cannot remember that day because I was contacted by a couple of chief executives about other issues going on at the time—to let me know that that was happening, as the Executive Director of Public Health, he would make that call.

[11.20 am]

The CHAIR: Listening to your evidence just then, my sense is that the fact that you needed to get the approval made that day was known to you. That is why you were trying to find a way of approving the path and ensuring its safety at that time or is it normal? That is my impression that I have taken out of what you are saying. I just want to make sure that I am not wrong in that—that there was a sense that if we can, we needed to find a way of getting this approved and if that means going outside the code of conduct, as long as we do it safely, we will do that. Is that right?

Hon DONNA FARAGHER: I will let Professor Weeramanthri respond to that but I do not think that is the correct assumption to take. I will refer to him so we can clarify it.

Prof. Weeramanthri: It was clear that a decision needed to be made one way or the other. It was a matter of public record that Elizabeth Quay was due to open on 29 January. We clearly had been involved with the MRA around a number of issues to do with the opening and they needed a permit to operate. They needed a decision before that. I had to make that decision one way or the other in time for the opening.

The CHAIR: I will leave it there and we will take a break until 11.30.

Proceedings suspended from 11.21 to 11.35 am

The CHAIR: We will get underway again. I believe Hon Sue Ellery has one more question on this area and then I will move to Hon Peter Katsambanis.

Hon SUE ELLERY: I will give my commitment that I will ask it quickly, and hopefully I will get a quick response. I am still on the question of environmental health and Elizabeth Quay. During the evidence that the committee got on Tuesday, Mr Kinsella from the Metropolitan Redevelopment Authority reiterated on a number of occasions that to the extent that there was a problem with the bacteria, it was only in the backwash area. That is what he described it as. However, my recollection of the material that has been tabled previously by the Minister for Health is that the bacteria had been found in two areas—in the balance tank and also in the backwash area. Is somebody able to confirm that it was found in both the backwash and the balance tank or one?

Prof. Weeramanthri: Yes, I can confirm that, as evidenced in the spreadsheet already tabled in Parliament, Naegleria species was detected in the balance tank from the sample taken on 25 January 2016.

Hon SUE ELLERY: It was in the balance tank. Was it in the backwash area as well?

Prof. Weeramanthri: Yes. The backwash was positive in samples taken on 21 January, also in the sample taken on 26 January and the backwash was also positive in the sample taken on 28 January. I will emphasise that they are all for Naegleria but not for *Naegleria fowleri*.

Hon PETER KATSAMBANIS: I have a number of issues that I want to raise. I refer to page 319 and "Continued Investment in Public Hospital Services". Obviously, the government has made a massive investment in public hospitals over the last eight years. The first dot point shows that in that period of eight years, inpatient separations increased by 31 per cent through the system and emergency department presentations increased by 29 per cent throughout the same period. Obviously, some of that increase can be ascribed to population increase but it is significantly more than the population increase. In those two areas—inpatient separations and emergency department presentations—do you break down those figures further by the nature of the presentation or ailment to identify where the growth is coming from and what particular issues are driving that above-population growth?

Dr Russell-Weisz: Thank you very much for the question. As the member states, there has been significant growth in the activity that we have done right across the sector over the last 10 years really. In relation to those presentations coming through the emergency department, we do break it down in relation to what sort of category they are coming in—the triage category 1s to triage category 5s, so 5 being the least acute or lowest acuity, the least complex, and category 1 being the most complex and the most urgent. It is an urgency category. We have certainly seen the increases across the board. There are lots of reasons for this. There are more patients with chronic conditions. There is a growing population, as you have said. There is an ageing population. We still have the lowest number of GPs per head of population than any other state in Australia. Whilst we are now filling our GP training places, which we were not 10 years ago, it still has not flowed through. There has been significant investment in GP services in the country as well as through the Southern Inland Health Initiative, so it is not just talking about the metropolitan area.

[11.40 am]

Some of it is probably unexplainable. If you look at emergency department attendances, WA did lead the way in what they called the NEAT, which is now called the WEAT. It is not that we have abandoned the four-hour rule or the national emergency department target; the commonwealth is no longer measuring it. Western Australia has led the way. We are still the best performer. Therefore, you will be seen—at least it varies between 75 per cent and 80 per cent; some hospitals are at 90 per cent—and discharged within four hours. It is 80 to 90 per cent whereas years ago that was about 40 to 50 per cent. There has been a huge improvement in our efficiencies and our caring for patients in that time. I think there is an element there that attracts patients to the emergency department. We have noted, for example, that Fiona Stanley Hospital has seen many more patients than we envisaged, probably between 10 000 and 12 000 more patients per annum, and that is not necessarily in the high acuity or the urgent sector; a lot are in the triage 4 and 5s, where some of those patients will need to be admitted, but the majority will not. It must be related to the lower numbers of GP services in the community. I would say that we have made inpatient separations; that is driven a lot by emergency departments, but inpatient separations are also driven by our elective surgery. We have made huge efforts in elective surgery over the years. Obviously, they are categorised in relation to category 1, 2 and 3; it is based on urgency. Even in the last year we have improved; we are aiming for 100 per cent of all category 1 cases to be done within the 30 days. This time last year we were sitting at about 90 per cent; we are already up to 95 per cent, and we are seeing more. As I said earlier, we have seen a six per cent increase in activity over the last year and our aim is to get all the patients in who need to be seen, so the most urgent first, and that is why you have seen an increase in many of the inpatient separations.

Hon PETER KATSAMBANIS: That is all good, but if the trend continues, effectively the current 40 per cent spend of Western Australian taxpayers' funds on the health system will increase to 50 and 60 and 70 per cent, because the trend is continuing to be well above just population growth. I understand the issues that you have raised—all of them are legitimate—but what are we doing to actually reduce this trend in growth?

Dr Russell-Weisz: Thank you; that is a very good question. We were at 24 per cent of the budget; we are nearly at 29 per cent of the state budget now, and much of that has not just been investment in services, but also in infrastructure over the last few years. As you quite rightly say, we cannot see this exponentially increase, and that is why a lot of the focus has been over the last few years on providing much better services in the community. We have seen through mental health over the last few years significant improvements in community care, rather than just purely relying on inpatient care. But we have come through a boom; we have come through significant population growth. Yes, it is settling at the moment. That population growth does cause greater demand right across the sector, both in the community and the hospital sector. We need to focus as much on building brand-new hospitals and our infrastructure as on prevention and our subacute sector. Again, I will probably pass to Professor Weeramanthri on this in our prevention. We have got some very good statistics in prevention. Our smoking rates, while still too high, are still one of the best in the nation. Our vaccination rates are improving. We were the leaders in pertussis vaccination. But a lot of our efforts, I think, were no different in Western Australia to everywhere else. A lot of our investment does go into the hospital sector. To actually reduce this demand, we need to be concentrating as much, if not more, on prevention, and also on the subacute environment. We have done that. I have mentioned mental health. The chief executives will talk very much about where patients do not need an emergency department, do not need the most complex care, but can still have their operations, they should be operated on at our secondary or specialist hospitals. That is why the investment has been in places such as Joondalup, Midland, Rockingham and Armadale. We have hospitals such as Fremantle and Osborne Park that do not have emergency departments and that focus on mental health, elective surgery and rehabilitation. One of the investments in Victoria many years ago was subacute care, so it is not just about being efficient in a technical sense; it is also about making sure we have a better balance of investment going into the subacute chronic sector and also into the preventative sector. That is where our focus will be. It is a long journey and hospitals do tend to gobble up a lot of the money because patients do need hospital treatment, but they do not all need tertiary hospital treatment.

Hon PETER KATSAMBANIS: I will move to page 321, under the heading "Building a Better Health System for Patients". The third dot point talks about improved models of care for community child and adolescent mental health services that have led to a significant increase in patients accessing the services, of 52 per cent, and a 71 per cent increase in those engaging in treatment. Over what period of time are those increases?

Hon DONNA FARAGHER: I will ask Professor Daly to answer that question.

Prof. Daly: I have some notes that should be able to clarify the time frames, and, if not, perhaps I can find some similar statistics to give you some concept, if you just give me a moment.

Hon PETER KATSAMBANIS: Perhaps while you are looking for that —

Prof. Daly: I apologise; I will not be long.

Hon PETER KATSAMBANIS: I am trying to clarify whether that is over one year, four years or eight years.

Prof. Daly: No, it will not be over one year. I apologise; I cannot find my notes. I will take it on notice, but I think I was answering a similar question earlier about growth in services, and this is most likely over four years. I will take that on notice and provide clarification.

Hon PETER KATSAMBANIS: If you could take that on notice, I would appreciate that, if we give it a number.

[*Supplementary Information A10.*]

Hon PETER KATSAMBANIS: I think that is a fantastic story. We are talking about families and children with really significant needs, and to have that sort of increase and be able to provide that sort of treatment and service to patients is fantastic. I just want to know what period of time it is over. Is there further projected growth in child and adolescent mental health services over the forward estimates?

Prof. Daly: The requirement for child and adolescent mental health services fairly closely mirrors population growth in the zero to 15 age group; however, in some services it does outstrip that. The challenge for our services has been to accommodate that growth within, obviously, our budget settings. Those tremendous results have been possible through the redesign of those services in the last two to three years through a program called the choice and partnership approach program, which is a program of an initial assessment of a child on induction into the service and then a triage, if you like, into an appropriate partnership arrangement with that service. The other thing is also that the service is unable to carry a large cohort of patients for a significant period of time, so it has also been about providing targeted and directed therapy to children and their families, but also appropriate and timely referral to other services beyond our own so that we can accommodate the next wave, if you like.

[11.50 am]

Hon HELEN MORTON: How far is what is being referred to as CAPA being rolled out into the non-metropolitan area? Is that being undertaken in country areas as well?

Hon DONNA FARAGHER: I will ask Mr Moffet to answer that question.

Mr Moffet: Through the minister, no, not to my knowledge.

Hon PETER KATSAMBANIS: In the same section, there is a dot point around the middle of page 321 in relation to the patient assisted travel scheme. Over six years, this has grown from 53 000 trips to 93 000 trips. That is almost doubling the number of trips funded, which is great for people in rural and remote regional areas to access treatment, but what is driving that phenomenal growth? Again, it completely outstrips population growth, or even ageing population or any of those figures.

Hon DONNA FARAGHER: I am going to ask Mr Moffet to answer that question.

Mr Moffet: It is a number of things. Obviously, we have been through a very busy resource investment and population growth phase in country Western Australia. That is one aspect that has seen population-driven growth. The most significant element has really been the revision to the PATS guidelines, the investment through government improving subsidy rates, changing eligibility requirements, and removing some of the pre-tests around accommodation payments et cetera. There is been an improvement in access to the scheme. I think we have seen significant uptake, particularly around improved rates of rebate for road travel from inner regional areas, rather than just the traditional long distance. One had to contribute $50 upfront, for example, to the cost of your travel. That was removed from the means test at that point of time around the improvement to the program, which meant that a significant number of people in inner regional settings can now have access to rebates. That drove a significant amount of the increased volume.

Hon PETER KATSAMBANIS: So the scheme has been expanded to more people—so people who were otherwise travelling anyway now have access to the scheme. That is a good thing.

Mr Moffet: That is right, yes.

Hon PETER KATSAMBANIS: I have got a couple of other —

The CHAIR: We are running out of time, though, and there are other members who have questions.

Hon PETER KATSAMBANIS: I have had 10 minutes.

The CHAIR: You have had 15, actually. I have been monitoring it, and, to be honest with you, many of these —

Hon PETER KATSAMBANIS: I will just sit here to make up the numbers, then. We are required —

The CHAIR: As I did for many years when I was a member of the government, and in fact the opposition members did not even come into the quorum. We will not get into that debate, so I am going to Hon Alanna Clohesy.

Hon ALANNA CLOHESY: I want to ask some questions about the state Quadriplegic Centre. Is the $500 000 noted for planning in the budget for the Quadriplegic Centre to be used for planning the new facility at Bedbrook Place?

Hon DONNA FARAGHER: Mr Salvage will be able to answer your question.

Mr Salvage: It is an allocation to develop a business case for the future development of the Quadriplegic Centre.

Hon ALANNA CLOHESY: A business case that was promised three years ago.

Mr Salvage: The business case will be delivered before the midyear review. As the honourable member will recall, there was a very in-depth review conducted of the model of care at the Quadriplegic Centre towards the middle of last year. That recommended, in fact, that there be no replacement facility at all, and that we move to a model of care where patients with acquired spinal injury would eventually return to the community or to their own homes. That is a highly desirable future model of care, but we do need to deal with the fact that there are a significant number of people at the current Quadriplegic Centre who elect to remain there.

Hon ALANNA CLOHESY: I am sorry; I am going to run through this really quickly, because of the time. Has the government provided a response to the 2015 review of the Quadriplegic Centre?

Mr Salvage: In terms of responding to the individual recommendations, no, but what has occurred is that there has been the establishment of the steering committee chaired by Professor Bryant Stokes, with broad membership, and that steering committee is informing the development of a business case that will now go to midyear review.

Hon ALANNA CLOHESY: If the government has not provided a formal response to that report, how can the planning proceed if the government has not provided some sort of information or direction as to what is to happen with that centre?

Hon DONNA FARAGHER: I will ask the director general to respond to that question.

Dr Russell-Weisz: I will respond, through the minister, first, and then Mr Salvage might want to answer a couple of specific questions. The review was done and provided some options and a model of care. There has been more particular analysis in relation to the clients at the quad centre, which is happening at the moment. The steering committee chair actually met all the clients, or the majority of the clients, over the last couple of weeks.

Hon ALANNA CLOHESY: So transition plans are being developed for those people?

Dr Russell-Weisz: Yes, transition plans, and we are working with the Disability Services Commission and we are also working with the Department of Housing, because we want a plan for the future. We know that there may be some long-term residents who stay there, and some transitional residents who will need to stay there and then move out to the community, because really the aim would be to do as the Queensland model would say, and try to get as many people out

into the community as possible. There are people with these sorts of injuries that actually now move directly from the State Rehabilitation Service at Fiona Stanley Hospital straight into the community. Not everybody goes to the quad centre.

Hon ALANNA CLOHESY: That is right. Fourteen new people have been admitted in the last 12 months, and the government knew, particularly, that this place is "out of date, antiquated and an absolute disgrace." However, 14 people have been admitted to that absolute disgrace of a place in the past 12 months.

Dr Russell-Weisz: I think what they are referring to—it has always been a priority—is the infrastructure. I do not think the service that is provided is a disgrace. The service that is provided by the Quadriplegic Centre staff is magnificent. I think it is great.

Hon ALANNA CLOHESY: Okay, I appreciate that absolutely. I am not questioning the level of service. However, why has $1.3 million being cut out of the operation budget?

Hon DONNA FARAGHER: I will ask the director general again.

Dr Russell-Weisz: The budget for the quad centre is based on the number of clients they have. It is a historical budget; it is not based on activity-based funding. Over the years, there was a time when the Quadriplegic Centre had round about 85 to 90 patients.

Hon ALANNA CLOHESY: Currently they have 55.

Dr Russell-Weisz: Fifty-seven.

Hon ALANNA CLOHESY: Fifty-seven, okay. Last year they had 54. The budget has been reduced by $1.3 million with the same number of clients, presumably with the same level of needs.

Hon DONNA FARAGHER: The director general was in the midst of an answer, so perhaps you might let him finish and then ask another question.

Dr Russell-Weisz: Everybody is changing their model of care. I think things are changing. The Quadriplegic Centre has not come to us and said, "Look, we haven't got enough money to be able to function properly and look after our patients properly." We expect the Quadriplegic Centre to be looking for efficiencies, just like every health service is doing. If possible, through the minister, I might refer that to Angela or Andrew, who may want to comment about why that reduction has occurred, but we are not seeing any reduction in service, I can assure the member.

Hon ALANNA CLOHESY: Particularly if the comments could be around: Can the government guarantee that no resident will sustain any further injuries as a result of the state of the building or the equipment, as has resulted, in the last 12 months, in two residents being severely injured because of faulty equipment? Can the government guarantee that no further injuries will be sustained as a result of the cut of $1.3 million?

Hon DONNA FARAGHER: I will just ask the director general to say a few words in response.

Dr Russell-Weisz: I could not sit here and say that there would be any guarantee in any site that there would be no injuries, even in a new site such as Fiona Stanley Hospital. We always learn from occupational health and safety risks. There have been upgrades over the years in relation to the Quadriplegic Centre, but really the facility does need a complete rebuild.

[12 noon]

If I can, I will take the question on notice about the reduction. Budgets go up and down and I can assure the honourable member that the Quadriplegic Centre will have the budget to be able to deal with all their clients.

[*Supplementary Information No A11.*]

Hon ALANNA CLOHESY: I am very sorry I had to rush that, but I am under pressure from the Chair.

The CHAIR: I wanted to go to Hon Nick Goiran, so I appreciate the member's understanding.

Hon NICK GOIRAN: I have a couple of quick questions following on from the answers given in advance of today's hearing. The third question was talking about the annual costs associated with the panel of six medical practitioners. The answer that came back said that the costs of the panel are not individually captured. Are you able to advise if members of the panel are paid?

Dr Russell-Weisz: I do not have the actual answer in front of me, but if the member can give me a quick minute. They are not individually captured. I would have to check on this, but the majority would be potentially those practitioners working in our system. They would be working in our system as medical practitioners. They would be paid and this would be as part of their roles, so we would not pay them separately. It is not able to capture that. What we are saying is that they do not get a stipend for this work or an additional payment. It think that is the right response, but if the member would like me to check, I shall take that on notice.

Hon NICK GOIRAN: Yes, if we could take that on notice, Mr Chairman.

[*Supplementary Information No A12.*]

Hon NICK GOIRAN: I anticipated that you will want to take this on notice: can you advise how many neonatologists are currently in practise in Western Australia?

Hon DONNA FARAGHER: We will take that on notice

[*Supplementary Information No A13.*]

The CHAIR: Hon Alanna Clohesy, did you have a couple of extra questions because I cut you short?

Hon ALANNA CLOHESY: In the planning and in the steering committee that is chaired by Professor Stokes—I am pleased that he is the chair, because he has a good understanding of this site and the lives of people living there—what involvement do the residents and, where appropriate, their families and advocates have in the steering committee? How often does the steering committee meet and are the minutes public?

Dr Russell-Weisz: I will make a comment and pass to Mr Salvage through the minister. I believe there has been very good communication with the residents. I think there are community members also on the steering committee; I will ask Mr Salvage to confirm that. The most important thing is for us to finalise the business case. The steering committee are giving us significant input to that because we are going through all the residents to see what are their needs, the current residents, and then to see what the flow through of new patients is each year. But we need significant input from the Disability Services Commission and also the Department of Housing in relation to the possibilities and requirements of those two departments. They have been very cooperative. I will pass to Mr Salvage to answer the specific questions about community membership on that steering committee.

Mr Salvage: I can confirm that the membership of the steering committee is, as has been indicated, chaired by Professor Bryant Stokes, as interim board chair for the North Metropolitan Health Service. The members comprise: Dr Hannah Seymour, who is a rehabilitation specialist working at Fiona Stanley Hospital; myself as chief executive of north metro; Mr Greg Cash, who is general manager of service delivery for the Department of Housing; Ms Marion Hailes-MacDonald, who is executive director of strategy with the Disability Services Commission. Those two individuals in particular are intended to ensure there is a very good collaboration across Health, Housing and Disability to ensure that what we come up with through the plan is robust and deliverable. In terms of other membership: Ms Mallika Macleod is a community representative and someone who lives with a spinal cord injury; Mr Richard Wright is a representative, client and also on the board of the Quadriplegic Centre; Ms Samantha Jenkinson, the executive director of People With disabilities

WA Inc; Mr Shane Yensch the executive director of the Spine and Limb Foundation; and, Ms Marita Walker who is the state manager of the National Disability Insurance Scheme.

The steering committee meets on a monthly basis. Certainly, its conversations are recorded. It is not our practice to distribute the minutes beyond the membership of the committee, but in view of the interest, it might be for the steering committee to consider whether it puts out a statement from time to time about some of the things that it believes are important in terms of the planning process.

Hon ALANNA CLOHESY: I am sorry. I missed the last bit from "statement from time to time".

Mr Salvage: I think the issue is around communication from the committee. There is a communication plan in place. A key component of that, as the director general referred to, was the chairman of the committee Professor Stokes meeting the clients of the Quadriplegic Centre. That started last week. If it would be of interest, the committee could produce a short-form summary of its conversations each meeting and circulate that certainly to members, to the clients of the Quadriplegic Centre.

Hon ALANNA CLOHESY: I am happy to take this on notice. How will the $500 000 be spent? What is the budget for the $500 000; take that on notice?

[*Supplementary Information No A14.*]

Mr Salvage: Immediately we have had to provide some internal resource within the North Metropolitan Health Service to drive the project. That is a relatively small cost over the period of time, but we can come back with further details on how the balance will be spent.

The CHAIR: Before I go to the next question, can I take the opportunity to welcome what I think is the Currambine Primary School into the chamber, an excellent north metropolitan school, and to the Parliament and the estimates process today.

Hon ALANNA CLOHESY: I am also happy to take this on notice: the nearly $1.3 million that has been cut from the operating budget of the centre, can I get an indication of what has been lost through those cuts?

[*Supplementary Information No A15.*]

Hon ALANNA CLOHESY: Have transition plans been put in place for the additional 11 people who are resident there for less than five years?

Hon DONNA FARAGHER: Mr Salvage will answer that question.

Mr Salvage: The process that has been kicked off with all the residents of the Quadriplegic Centre, as of last week with Professor Stokes' meeting, is intended to commission individual transition care plans for each of the clients. That will go to the question about whether there are members of the existing Quadriplegic Centre who want to go to a devolved model of care, if that is the recognition through the business case, or how many would like to remain in a redeveloped centre on the current site.

The CHAIR: I might take the opportunity to ask a couple of questions about a couple of matters. We have not received a number of answers to questions that I put on notice, but some of them I did ask of both the Department of Health and the Mental Health Commission, regarding the length of time people are waiting in ED departments or observation wards for the period starting from 1 March to 28 February. I did that because it was a period of time that was asked in some questions back in 2012. I note that someone made the comment earlier today that there has been significant improvement in community care for mental health and that that was one of the ways in which you were saving money. But something that concerns me when I look at the length of time people are spending in ED departments or an observation ward, the amount of times seems to be increasing. Using, say, the Joondalup Health Campus as a starting point, in 2011–12 the longest people were staying, there were fewer than five people staying for four or five days and nothing beyond that, and

yet the figures we get today is that we have fewer than five people both on four to five days and five to six days. Am I right that we are seeing people having to stay in ED departments longer, and that that is increasing; and, if it is, why is that the case? Is it because there is a problem of beds to move them to? I ask that in a generic sense, and I also pre-empt that I am also going to be asking whether there are particular areas, such as adolescent health, where there is a bed shortage that prevents people being moved out of the ED departments into those beds? That is focused on the metro area, but I also note that in regional areas we now have—we never seemed to have it before—people waiting up to 10 days. Is that, again, about there being no access to sufficient beds to allow them to be moved out of the ED department or the observation wards?

[12.10 pm]

Hon DONNA FARAGHER: I will turn to the director general. I think in the first part of your question you referred to Joondalup —

The CHAIR: Yes.

Hon DONNA FARAGHER: So I will just indicate —

The CHAIR: I am asking specifically about Joondalup, more generally about the metropolitan area and particular subsets, and also regional.

Hon DONNA FARAGHER: With respect to Joondalup, I think it was last week that the government announced a $7.1 million construction of a new 10-bed mental health observation area.

The CHAIR: I am aware of that, minister, but what I am asking about is how we get them out of there and into proper care—not proper care, but appropriate care.

Hon DONNA FARAGHER: I appreciate that, but just for the benefit of all members of the house I advise them of that.

The CHAIR: We are running out of time, so I would like —

Hon DONNA FARAGHER: That is fine. I have been pretty quick in my answers, and I think it is appropriate that I do mention that, but I will now refer to the director general.

Dr Russell-Weisz: There are still patients who do wait in our emergency departments for mental health beds. If patients are waiting for a few days, which is rare, that is clearly too long. That is why, as the minister has said, there will be investment in a mental health observation area at Joondalup. Joondalup has had specific challenges with its demand coming through in relation to mental health. I would say that generally emergency department patients wait longer—we tend to call it access block, so waiting longer that eight hours; we do not use it so much anymore—but that has substantially improved generally over the last 10 years. Our access block generally at this stage is potentially sometimes down to about seven per cent, and it was as high as 60 per cent. That is for all patients. There is no doubt that occasionally patients are waiting, certainly longer than a day or two days, for mental health beds and every effort is made to move these patients to either appropriate mental health observation areas or mental health beds in the system.

In relation to your question about whether that is getting worse, I would probably need to take that on notice. You mentioned about adolescent mental health, and Professor Daly may want to make a comment on that. We still have, obviously, some adolescent mental health beds at Bentley Hospital. There will be an expansion of the beds when Perth Children's Hospital opens for child and adolescent mental health to a 20-bed dedicated unit. At Fiona Stanley we made the determination that youth mental health was of significant importance and that part of the 30-bed mental health unit should be beds for adolescent mental health. All of those beds are not open at this stage because we have done lot of activity; the activity we thought was going to come in and require all those beds has only required a number of beds to come in. However, we are in final discussions with the Mental Health Commission to receive funding from them to open the remaining beds at

Fiona Stanley Hospital. Through the minister, I might ask Professor Daly, or maybe even Jeff Moffet, to talk about the country.

Prof. Daly: This is a complex and vexing problem. Admission to hospital is always a less than optimum outcome, and obviously presentation to an emergency department or a short-term admission represents a crisis that obviously involves not only the patient themselves but their families. Admission to an emergency observation unit sometimes does have a specific aim, and it is not necessarily just a holding pattern. Especially with new clients and their families, it represents an opportunity to do a cross-sectional full assessment of the situation. Some of these cases, especially in the youth stream—above the age of 16 and into young adults—have complicating factors such as intoxication and overdose as well, which requires medical clearance and clarification prior to formal mental health disposition.

In young people, we see three very specific, different groups; I will not make generalisations. We see a group of children under the age of 12, and they have very different needs and requirements in terms of their admission facilities, staffing and supervision from those who are older, and they are children. Then of course we have an adolescent cohort between the ages of 12 and 15, who again have a unique set of requirements. Then we see an older youth stream, aged between 16 and 24, which the state, through the Mental Health Commission and through the Department of Health, has identified as a group that requires specific management. You can imagine that a 16-year-old or a 17-year-old has different requirements and should be managed in a different area to a young person who is maybe a young adult of 24. They are quite different in terms of their growth.

The CHAIR: I understand all that, but I guess what I am trying to get to—and I understand there may be clinical reasons for keeping somebody in for a day or two—is whether there is a problem in terms of the reason some of the people are staying that length of time. Is it because there are not beds available? Clinically, they are ready to be moved out of the ED department, but there is simply not a bed available in the system to move them to and that is why they are held in the ED departments.

Prof. Daly: Yes, there are two issues at play here. First of all, there are a limited number of beds in the system for each of those cohorts. I think the director general summarised the numbers. You need to manage these people in an age-appropriate setting. It is most inappropriate to manage a 15-year-old in an adult setting for any period of time, and, conversely, we would not want to manage an eight-year-old in a setting with adolescents.

The other issue that is less prominent but is a really important clinical issue is that of cohorts of patients. We definitely see a phenomenon in the youth and adolescent group where a cohort of young patients—maybe three or four—with similar presentations and levels of psychiatric arousal can actually, if you cohort them together, escalate issues and work together as a cohort to be disruptive in the unit. Considerable effort is made to ensure that the patients put together in a unit are not going to make each other worse and pose a threat to not only each of those individuals, but also the staff looking after them. Sometimes these cohort issues emerge in a small environment. For example, the mental health intensive care unit at the Bentley adolescent unit has only three beds, and we have to be very careful about the mix of young people in that unit. Often, a risk mitigation strategy is to manage those cohorts very carefully, and sometimes if another patient is in the system waiting we have to manage that cohort such that we do not get a certain mix occurring. That can mean that patients are sometimes having to be managed in another setting.

The CHAIR: I think there was an indication that you may take some of that question on notice.

[*Supplementary Information No A16.*]

The CHAIR: I have another area I want to turn to. We talked earlier about Royal Perth Hospital and the upgrade—the $9 million that is to be spent.

Hon DONNA FARAGHER: The $19 million?

The CHAIR: It is $9 million in this financial year. I think some has been spent, so I am asking about the money. You gave us a list of some of the areas, and you have talked about there being a more generic, sort of, pool of money. Do we have any more information about what that money will be spent on at Royal Perth —the $9 million—in this financial year?

Dr Russell-Weisz: For the actual money and the $9 million, there were those generic areas like lift upgrades that I mentioned —

The CHAIR: And the food, where we could not work out whether it was a food cart or not.

Hon SUE ELLERY: It is a warm trolley.

The CHAIR: Are there any other areas where there will be upgrades at Royal Perth as part of that $9 million?

Dr Russell-Weisz: I might ask Dr Lawrence to answer the specific $9 million for this year.

Dr Lawrence: There is a very long list of things, and which ones fit on the money that has already been expended versus the next one, they are crossing over. If you are asking me specifically what is in the exact $9 million, I would not want to tell you that today because I could easily get it wrong. But there is a long list. We have talked about lift upgrades, there is central cooling towers, replacement of emergency generators, new emergency generators, replacement of componentry that fits with that, mechanical and electrical high-risk, including fire services, so there is a big piece of work around that. There are central steam boilers, rooftop cold water storage tanks, high-voltage breakers, and switches. The refurb we have talked about. There are some infrastructure enhancements in our acute medical and acute assessment units to make them better fit for purpose. There are some safety projects, and tunnel washers in our central sterilisation department and some CCTV upgrades.

[12.20 pm]

The CHAIR: If we make that A17 on notice, you can give us more detail about what we are spending. Is any work required on the helipad at Royal Perth Hospital to ensure that it can continue to accept the emergency helicopters that are coming into operation in WA?

Hon DONNA FARAGHER: I will ask the director general to respond.

Dr Russell-Weisz: I will start. Yes, it is well known we do need to do some work on the helipad. We are doing some more work and will be returning to the midyear review with a robust business case to seek funding for the work that does need to be done on the helipad.

The CHAIR: Is that because we are getting bigger helicopters starting to be used and we need to strengthen it, or is it just that it has aged? Why do we need to replace it? As I understand it, it is pretty important because it is the trauma centre.

Dr Russell-Weisz: That is right; it is very, very important. I think it is mainly ageing, but also there are some compliance issues and, within time, we have to meet certain CASA guidelines. It is an ageing helipad, but I might ask Dr Lawrence if she can add any other details.

Dr Lawrence: Yes, it is ageing. The fundamental issue is that it is currently rated to take helicopters up to 5 400 kilos. It needs to be rated to 7 000 kilos to maintain its CASA registration licensing process. That is because helicopters are getting bigger and CASA has changed its rules, basically.

The CHAIR: Is there a helipad at Fiona Stanley, and what is that rated to?

Dr Lawrence: Yes, there is. I cannot tell you the exact weighting, but it can land a Black Hawk on it, so it is pretty highly rated.

The CHAIR: That is obviously more than Royal Perth. Do we have an idea of the estimated cost of the upgrades at Royal Perth? The estimated cost of the upgrade for the helipad I am talking about.

Dr Russell-Weisz: For the helipad. I can find it.

Dr Lawrence: Off the top of my head, it is estimated at around $7 million, but that is a very rough estimate at the present time.

The CHAIR: Ballpark it is $7 million; it is still sort of a big part. Of that $9 million, none of that is currently allocated for the helipad, so you have to get another $7 million. When do we have to have the upgrade completed by? If you are saying it is about meeting standards, when do we need it completed by in terms of the standards? Obviously it is not compliant at the moment. Do we have a date by when we have to have it completed?

Dr Lawrence: I do not believe we have been given a drop-dead date at this point in time; we just know it is critically urgent, and that is why it is our number one priority for Royal Perth.

The CHAIR: Why was it not a part of your budget submissions for this budget, then, if it is critically urgent?

Hon SUE ELLERY: It was not on the sign.

The CHAIR: I would have thought a helicopter on a sign would have looked pretty good. It would look great as an emoji.

Hon SUE ELLERY: Better than a trolley.

Dr Russell-Weisz: It was flagged in our budget submission, but there was more information required so we are providing that for the midyear review.

The CHAIR: Does it have any corresponding flow-on effects to, say, FESA and their not being able to upgrade their helicopters? I think they branded them as the RAC but they are actually provided by FESA. Does it mean that they have to delay their upgrades to their helicopters until you get the upgrade to the Royal Perth Hospital helipad?

Hon DONNA FARAGHER: We would have to take that on notice and, again, there might need to be some dialogue with FESA.

The CHAIR: Yes, but do any of your officers know whether there have been discussions with FESA to date about, you know, "Don't buy the new helicopters yet because we haven't got the helipad to do it"? That is not an issue that any of your officers are aware of?

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

The CHAIR: I will ask you to take that on notice. So you did put in a submission but you were required to get more information.

Dr Russell-Weisz: Yes.

The CHAIR: What sort of additional information was required?

Dr Russell-Weisz: Off the top of my head I cannot tell you in detail what information was required, but we had been asked to go back. It is the highest next priority for Royal Perth, so we will go back with that information.

The CHAIR: If you can make that all part of the supplementary information A17; and if you could also provide the information as to what was required.

[*Supplementary Information No A17.*]

The CHAIR: Does it have any impacts on the rest of the hospital operation—the issue with the helipad at the moment? Because of its nature, does it have an impact in terms of the way in which you can operate the hospital because of the issues around the helipad?

Hon DONNA FARAGHER: I will ask Dr Lawrence to respond.

Dr Lawrence: No, it is functioning just fine.

The CHAIR: This is the final question I have. Again, I had put in a number of questions on notice regarding future planning for hospital beds and population projections that your clinical services framework was based upon. Can you let me know why they were not able to be provided in the time available to this committee? They seem pretty straightforward. They are all asking for more information about your clinical services framework and your future planning, which I would have thought would be front and centre of your operations.

Hon DONNA FARAGHER: I understand, and behind the chair I did make some inquiries in relation to this prior to the start of estimates because this question had been raised. As I understand it, there were a number of questions that were put on notice. This is not an excuse for why not all of the answers were provided. However, I understand that the vast majority have been answered and that there are a small number that are yet to be signed off, but will be done so within the next couple of days. In fact, I actually think during the break there were some further answers provided. That information that I am providing to you was based on advice before estimates started at 9.30. During the break I understand some further information was provided, but I will take back to the minister's office that you did not get all of the answers back.

The CHAIR: I am intrigued to know what was the complexity. I am happy for you to take that on notice as A18. In terms of the questions around future planning and the detail that goes to make up your clinical services framework, I am intrigued to know why that would take an extensive period of time.

[*Supplementary Information No A18.*]

The CHAIR: I had intended to go back to Hon Peter Katsambanis but in light of his not being here, I will ask one more question. You mentioned earlier that the issue around the growth in ED was around issues with GPs. That was one of the factors. What impact is the potential freeze on GP funds by the federal government going to have in terms of exacerbating that issue for ED departments?

Hon DONNA FARAGHER: The director general will respond.

Dr Russell-Weisz: I would have to say my personal view is that obviously we do want to see as many patients as possible who can be adequately treated and well treated in general practice seen in primary health care. As an ex-general practitioner myself, you would want to look after your patients and not send them to hospital unless they really needed to go. I cannot answer whether the issue in relation to co-payment would have an effect. We do know that in —

The CHAIR: So you have not done any work on what the impacts would be? You mentioned the whole issue of access to GPs being a driver. Surely potential impacts on the funding of GPs and people using them would be something you would want to monitor and try and predict what the potential impacts would be?

Dr Russell-Weisz: But I think it is particularly difficult to impact. I think the question was saying that if a GP did bulk-bill and then chose not to bulk-bill because of the co-payment that the federal government may put in, how would that then have an effect on —

The CHAIR: Or just the freeze so that they have to stop bulk-billing and start asking for a co-payment.

Dr Russell-Weisz: Exactly—would that be one? That may be one factor, but there are also other factors at play here about how patients get treated in ED. Also, patients do know if they go to the emergency department they get care—they get great care, they get free care and they get care—the majority, within four hours. So there are loads of reasons. That may be one. We have in the past seen where private health premiums have gone up there has been a shift from private to public. We have seen that—that is there—but I do not think it is the only factor.

[12.30 pm]

Hon HELEN MORTON: I was obviously quite pleased to see that a liquor licence for Aldi was knocked back on the basis of the cheapness of its liquor. Did the Department of Health have any role in providing advice to not support the liquor licence for Aldi; and, if so, does that mean that you support minimum pricing on alcohol?

Prof. Weeramanthri: We are referring to the Aldi Harrisdale liquor store. There was also an application for Aldi to open a liquor store at Butler. In relation to the Aldi Harrisdale liquor store, we did intervene in the application in November 2015—that is not the same as an objection—and the grounds of the intervention were around the association of alcohol products with everyday grocery items and the provision to the public of very low priced products compared to the market. Our intervention also suggested a range of harm minimisation conditions be placed on the licence. It is important to understand that in this case the decision-maker, as in all cases, is the director of Liquor Licensing, and one of the particular matters before that decision-maker was that there was a concurrent application for another liquor outlet in the same Harrisdale shopping centre. I am not speaking for the director of Liquor Licensing, but clearly they made a decision that one application would be supported and the other would not be supported as they did not see any reason to have two new liquor outlets in that same location.

Hon HELEN MORTON: The latter part of my question was about support for a minimum pricing regime for alcohol.

Prof. Weeramanthri: Through the minister, that is a policy decision for the federal government.

The CHAIR: I have one last question about the helipad. Is there a date by which we have to have it upgraded? Is there a date by which we know we need to have it upgraded?

Dr Lawrence: Through the minister, I think I said that we do not have a definitive drop-dead date at the present time; we have an indication, which indicates somewhere in the vicinity of 2018 to 2020.

The CHAIR: How long will the work take?

Dr Lawrence: I cannot answer that.

The CHAIR: On behalf of the committee, I thank you for your attendance today. The committee will forward any additional questions it has to you in writing after Monday, 20 June, together with the transcript of evidence, which includes the questions you have taken on notice highlighted on the transcript. Responses to these questions will be requested within 10 working days of receipt of the questions. Should you be unable to meet this due date, please advise the committee in writing as soon as possible before the due date. The advice is to include specific reasons as to why the due date cannot be met. If members have any unasked questions, I ask them to submit these to the committee clerk at the close of the hearing. Once again, I thank you for your attendance today.

Hearing concluded at 12.32 pm