GOVERNMENT OF
WESTERN AUSTRALIA

Climate Health WA Inquiry

Inquiry into the impacts of climate change on health in Western Australia

Inquiry Lead:
Dr Tarun Weeramanthri

Witnesses:

Mr Ian Smith PSM
Board Chair, East Metropolitan Health Service

Ms Liz Macleod
Chief Executive, East Metropolitan Health Service

Thursday, 31 October 2019, 1.00 pm

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HEARING COMMENCED

PROF WEERAMANTHRI: Mr Smith, Ms MacLeod, I'd like to thank you both for your interest in the Inquiry and for your appearance at today's hearing. The purpose of this hearing is to assist me in gathering evidence for the Climate Health WA Inquiry into the impacts of climate change on health in Western Australia. My name is Tarun Weeramanthri and I've been appointed by the Chief Health Officer to undertake the Inquiry. Beside me is Dr Sarah Joyce, the Inquiry's Project Director. If everyone could please be aware that the use of mobile phones and other recording devices is not permitted in this room, so if you could please make sure that your phone is on silent or switched off.

This hearing is a formal procedure convened under section 231 of the *Public Health Act 2016*. While you are not being asked to give your evidence under oath or affirmation, it is important you understand that there are penalties under the Act for knowingly providing a response or information that is false or misleading. This is a public hearing and a transcript of your evidence will be made for the public record. If you wish to make a confidential statement during today's proceedings, you should request that that part of your evidence be taken in private. You have previously been provided with the Inquiry's terms of reference and information on giving evidence to the Inquiry. Before we begin, do you have any questions about today's hearing?

MR SMITH: No.

MS MACLEOD: No.

MR SMITH: Thank you.

PROF WEERAMANTHRI: I would like to state for the record that since leaving full-time employment with the Department of Health in October 2018 and commencing work as an independent consultant, I have completed a number of paid consultancies for the East Metropolitan Health Service, and I'm currently undertaking paid consulting work for the East Metropolitan Health Service. None of this paid work relates to the terms of reference of this inquiry. For the transcript, could I ask each of you to state your name and the capacity in which you are here today?

MR SMITH: Ian Smith. I'm the Board Chair of East Metropolitan Health Service.

MS MACLEOD: Liz MacLeod, Chief Executive, East Metropolitan Health Service.

PROF WEERAMANTHRI: Mr Smith, would you like to make a brief opening statement?

MR SMITH: I was going to get Ms MacLeod to do that.

MS MACLEOD: Thank you very much. So from our perspective, there are three facets in our organisation and how we interact, I suppose, with climate change. But obviously there's an impact of climate change on our health requirements and health demand, and our readiness to actually meet those demands. We are a large organisation, we are an industry, and we have a contributing factor to climate change. So it's our ability to influence that. And the third component and facet is we are a large organisation with a large number of staff, and so have a role, we believe, in leading and advocating for the impact on climate change of what we do.

PROF WEERAMANTHRI: Thank you. Establishment of this Climate Health WA Inquiry was a specific recommendation of the Sustainable Health Review, which also made separate recommendations for the health system to reduce its environmental footprint as a matter of priority, and begin transparent public reporting on its footprint by July 2020. How do you see the issue of climate change, getting to ideas of sustainability, more broadly, and is there a window of opportunity for the health sector to progress more quickly in this area than previously?

MR SMITH: Can I go first on that answer, please? The answer is yes, from our perspective, and I think the most single powerful tool was also mentioned in the sustainable health review, and that was about the maturation of the purchasing model which the Government uses to buy activity from health services. The current model does not add sufficient – I'll use the word fat – in there to allow lots of new initiatives beyond the incremental improvements which everybody in the organisation is keenly pursuing. So the opportunity arises to do something quickly, is to move the maturation of the purchasing model into a whole range of different areas, which will get the benefits in a much earlier time frame with accountability linked to it.

PROF WEERAMANTHRI: And we might come back, Mr Smith, to that in a bit more detail later. I might ask Ms MacLeod just to address that issue. We've talked about sustainability for a long time. We've talked about climate change for a relatively shorter time, at least in the health services. Is there anything we can learn from that broader thinking about sustainability that goes back some years?

MS MACLEOD: If we think about sustainability from our services, and we often talk about it in an economic sustainability… that has been our focus, and I think there are a couple of aspects of that, then, that are related to the climate change. One is about our utilisation of services and products. If we look at programs that we put in place, such as Choosing Wisely, which is about the amount of tests that we do, and about the amount of imaging requests and so on, I think we're doing that around a minimisation of interventions from a patient perspective, but also from a cost perspective, so that is that sustainability. But equally, if we're minimising the utilisation of

packaging and ignore the procedures, it has got an environmental impact as well, and I don't think we're making those connections around the breadth of it.

The other pieces of work that you'll be familiar with is around some of the population health and how we actually look at some of the work we do around urban planning, and taking a population health approach to, perhaps, in our urban planning. And if we look at some of the new developments that are coming in the outer Metropolitan suburbs, we're keen to start having conversations about building in some of the population health component, which again will contribute in a positive way to an environmental footprint.

PROF WEERAMANTHRI: That's very helpful. So there's two kind of big concepts in there, I think, that are important. One is that shifting from hospital to less intensive environmental spaces, such as the community care, in and of itself is a major environmental benefit. So all the things we've been doing for years - - -

MS MACLEOD: Yes.

PROF WEERAMANTHRI: - - - in terms of out-of-hospital care, and focus on prevention, which came through the sustainable health review. The other point was your first one, which is around – you might not have a direct environmental intent for something that reduces duplication or improves efficiency or aims for patient safety and quality, such as Choosing Wisely. That might be not why you're primarily doing it, but it has a massive environmental positive impact, and often that's not even measured or thought about.

MS MACLEOD: Correct.

PROF WEERAMANTHRI: So it doesn't actually matter if you're aiming for the environmental impact or you hit it indirectly, if it's having the same effect.

MS MACLEOD: Yes. So it's how we relate all of those, some of the other initiatives that we're doing around the out-of-hospital care, and really trying to build up our digital aspect of that. And again, we're not doing it for environmental reasons, but if we can get better mechanisms in place to do… some of the work we're doing is remote monitoring, if we can improve our tele-health services, it's been done from a patient access perspective, and a safety and quality, but again, less people driving into their appointments, which again, should have an environmental impact. So if we can factor all of the other contributing things we can do, and perhaps as we're doing it, think about how we can enhance that even more than what we're doing at the moment. We're not even recognising it, we're reaping some benefits. But there might be more we can do if we looked at that as well. We don't even take it into consideration, really.

PROF WEERAMANTHRI: Thank you. Mr Smith, the Minister for Health wrote to your Health Service Board and other Health Service Boards in April this year, encouraging membership of the Global Green and Healthy Hospitals network. That network is an international community of hospitals and health services dedicated to reducing their ecological footprint. And to join, an organisation needs to send a letter of intent indicating support for the GGHH agenda, and/or a commitment to working towards two of 10 sustainability goals. Have you been able to engage with the Global Green and Healthy Hospitals network and/or its agenda since then?

MR SMITH: Yes. And the one we're going down is Pharmacy and Procurement. And I would like to add that both of these streams actually respond to clinical demand. So part of this deal will be ensuring that we empower clinical change, so that there's the benefit that will come through the procurement and the pharmacy, a bit like what Ms MacLeod said, the less drugs we can use, the less impact we'll have.

PROF WEERAMANTHRI: Can you tell us a little bit about the process? Like, you received this letter April and it was on the back of a two-year or so sustainable health review. What happened in terms of the organisational process? Was that already a lot you could, kind of, tap into, or was it a fairly new idea to go in and join this network? Do you have people who were quickly champions? I'm just interested in the pace of change here and how that happens.

MR SMITH: That's a two-prong response. That came to the Board, came to me. The Board quickly had Ms MacLeod come to the Board and say, "Yep, this is something we should do", so it was endorsed. Then the executive took it and ran with it and - - -

MS MACLEOD: What we've done with it since is, as we were preparing for our submission for this Inquiry, we went out and did a survey of our staff. And we were pleasantly surprised that we had some reasonable number of responses back. So we think, in terms of implementing what we're required to do around the Global Green and Healthy Hospitals network, is it would be good if it's lead from the teams on the ground. So we're now going back to the people who put in their submissions for this and asking them how they would like to be involved in actually leading the procurement and the pharmaceutical streams. So we're going back to the people who actually need to make the changes. So really trying to engage the staff on the ground to do it, rather than it being us directing people to do it. We had a good response, so we will be assuming that we'll get a lot of staff who will be interested, and I'd suspect that will build some interest and some momentum, as well.

MR SMITH: If I may add something to that, Professor. The new governance model with the five Health Service Boards creates an opportunity that hasn't been in existence before for the Minister—for this

annual statement of the expectations process to be pretty blunt and forthright with Boards to what they should deliver. This one will be, I'm sure, in the next statement of expectations which we then report on, the following year, directly to the Minister. So you have a very powerful tool there, now, to get organisations to be focused on what the Government's agenda is.

PROF WEERAMANTHRI: That's helpful, and we hadn't had that pointed out to us before, so thank you. So you've done this consultation, found out a bit more about what's happening inside the organisation. At an operational level, are there any examples of positive change that you can share, and are there any programs that are planned or in the early stages.

MS MACLEOD: At the moment, our most significant initiative is that we're having an energy audit undertaken. So this has been something we've been working on for about 12 months. So we're going out – and it was good timing in terms of the energy audit and the sustainable health review recommendations. So the intent of the review is, really, to do an analysis of our energy utilisation, and what options we have around reducing it and other methods of delivery for that. So that audit is underway at the moment, and we should get the response to that in February. We'll have the audit done, and that will, as I said, give us some recommendations as to options we've got around other methods of delivery and of the energy. It will also potentially tie into, then, some of our minor works and whether there's things we can do going forward. But that's the biggest item that we have underway.

We have been talking about alternative methods of energy provision, solar panels and so on. But without having done the energy audit, we didn't really have the right information to be able to proceed. There are a number of smaller initiatives occurring throughout the hospitals in terms of recycling, and they're happening in individual departments, but we otherwise don't have anything that is systematic throughout the service.

PROF WEERAMANTHRI: No, that's great. And part of what we're discovering, as we go through this process, is the tools that are available and best practice in using those tools. And this method of utilising an audit process, or something like energy, or waste, or whatever you choose, is actually recommended as a good way to generate momentum for knowing what the problem is and addressing it. Has it been a positive process so far?

MS MACLEOD: It has been to-date. It's been reasonably restricted, at this stage, to being more of a desktop analysis. So I think when we get the audit findings, that'll be the time to start engaging more with our staff about what our options are. So it's been fairly restricted at the moment in terms of engagement and staff. But I would see it being quite positive based on the positive feedback we've had to-date.

PROF WEERAMANTHRI: And as Mr Smith said, with the new Government's arrangement for the health services, there is a bit of natural

competition, for want of a better word, between – and sharing of best practices between health services and, you know, what you're doing actually isn't being done in most other health services. So there can be some learnings for others from what you're doing, and I'm sure there'll be other things you can pick up from other health services. So it's quite useful to get a sense. This energy audit is actually quite significant in the scheme of things, when we look at it from outside.

MS MACLEOD: That's good. No, we're quite interested to see – it will be the first time – we've had a broader scope to start with, which looked at some of those other things you'd mentioned as well, but actually did bring it back to the energy component. And depending on how we can address it, we might then go and step our way through some of the other audits as well, going forward.

MR SMITH: There's an obvious follow up to that, if we compare it to clinical practice. We do lots of clinical audits in different wards all over the place, and we find if we don't constantly audit, then performance often drops away. So if we're going to do, and we have done, the audit, we also need to make sure, for the out-years, that we have it appropriately scoped so it can actually be measured at local areas where we get the most buy-in of the staff to be very diligent about energy use.

PROF WEERAMANTHRI: So I might just stay with that data issue, Mr Smith. So with respect to data, if some form of carbon accounting is introduced, and/or monitoring of waste or recommendations to that effect, we're keen that this not just be a reporting to the system, but actually a tool for action, identifying hotspots and actually doing something useful with the data. You just mentioned that yourself, just now, with regard to the energy audit. Have you got any views about broader data East Metro might want to share with the Department System Manager and/or suggestions about what you might not want to be asked to do? We're starting to have those discussions about what this data exchange might look like, who's it for, who it goes to.

MR SMITH: Well, under the current governance model, I want the responsibility to sit with the Boards to deliver whatever the Government sets us, as in a KPI target. I think we need to fuse accountability back to the Department and elsewhere. You miss the opportunity to make change beyond what that target is, as well. So no doubt, I want it to actually sit with the Board, and that would be through a normal KPI process. That would also allow the Boards to be advocating to the Department on what would be an appropriate pricing model to deliver on that, because none of these audits, targets, maintenance, staff engagements come cheap. So assuming we still have to maintain the same clinical standards and activity, we've got to be conscious that we can only go to the well so many times in this process. And there's some opportunities around ring-fencing – and a whole range of our funding to make sure we get a time-limited, if need be, change in practice.

PROF WEERAMANTHRI: So one of the things we're grappling with at the moment is the difference between metrics and targets. So it might be that you have a metric that is relatively easy, system-wide, to measure, and then you might have metrics inside a health service which are yours to develop, et cetera. But you may or may not have a system-wide target. And that goes back to, you may wish to set a target from inside East Metro, or inside a ward, or inside a theatre, or wherever you wish, but what's the value of the system setting a target? The system might set an expectation around action, around metrics of some sort, but then not have an explicit target. Because you may not want to go beyond that.

MR SMITH: Look, and what you've described is going to be the challenge, there's no doubt, because something like an energy audit target, with Royal Perth being 150 years old, or some areas of it, versus Fiona Stanley, will not be an equal comparison whatsoever. So I don't know what the mechanisms would be. I was more concerned about what the philosophy and the principles should be, and where the accountability should sit.

PROF WEERAMANTHRI: You're clearly saying the accountability should primarily sit with the Boards in this devolved government structure.

MR SMITH: Absolutely. And we're very happy to take on the accountability for whatever the Government does, and if we don't think the appropriate financial capacity sits there, then we have a different issue to deal with versus where the accountability should sit.

PROF WEERAMANTHRI: Thank you. So we're going to move from the operation and we're going back up to the policy strategic level, and then come back to your initial comments about procurement. So at a policy level, when the East Metropolitan Health Service deals with the Department of Health, what role could the Department play in supporting health services, in a policy sense? So how would you like to see the Department support you to, you know, play out your accountability? Because if you've got private accountability, the Department of Health still has a role, as System Manager. So how can they best support you?

MR SMITH: I need to ponder that, if I may, a moment. You've asked it in a different way to my mind is actually working - - -

PROF WEERAMANTHRI: Sure.

MR SMITH: - - - at the moment. Would you just say it again for me, please?

PROF WEERAMANTHRI: Okay. So you've said that the Health Service Boards have a specific accountability.

MR SMITH: Yes.

PROF WEERAMANTHRI: Yes. But the Department of Health, in our terms of reference, were asked also to make some recommendations about how the Department of Health should play a leadership role. But it also has an existing System Manager role. Those two things might be slightly different. So, but just from a System Manager role initially, how could they be supporting you going forward in this area?

MR SMITH: There's an enormous coordination role in this process. And there will be… as Ms MacLeod said, there are some conflicting previous policies which are in place which have an impact on what we would do or could do. An individual health service is not in a position to make all those changes. So a well-led approach to it by the Department, but still allowing accountability to sit with the health service providers, but again, with an engaged methodology about how we would do the measuring, would be of great assistance. I still will come back to it, and I know you said we would get to it, part of this deal is the national efficient price and the WAU[1] funding issue, which is a real challenge in the current environment. So there's a role there for the Department to find an incentivisation process beyond current business to allow more than incremental change to occur, which is occurring now by once good design and the staff engagement. So if we're looking for a quantum leap, then it needs something supported, led – and I don't want to use the word funded, but, you know, supporting that sort of approach to getting the quantum leap we all want.

PROF WEERAMANTHRI: But there are policies that potentially are barriers at the moment, that's what you implied?

MR SMITH: We built up what we have over 100 years, and particularly on single-use expectations and things like that. So there are policies, but there might not be strict policies, but there's an accepted practice, because that's what everyone's good practice is. Whether that's still the best practice in light of what we need to reduce, is more of a systems responsibility to start to drive and change and assess, versus a single-health service, or by five doing it five times? It's that sort of aggregation of, I think – we were discussing it, was it? It was the - - -

MS MACLEOD: The curtains, the single-use curtains. And I think it's the breadth of policies. It's not just about looking at the climate change policies and what that might look like, it's actually about looking at all of our policies and checking the validity of the policy. And some of those have been introduced in response, or about minimising, you know, or improving care, but the consequences of all the single-use might actually have a more detrimental effect than the policy of which it's trying to address. So at some point, we have to weigh up all of the different policies for… because I don't think the totality of what we're looking at through policies has ever included the environmental impact. So I think that's actually the piece around the

[1] WAU refers to Weighted Activity Unit

policies. Not to look at these policies in isolation, but our infection control policies are obviously requiring us to use a significant amount – either the policy or practice, but a significant amount of single-use items everywhere.

PROF WEERAMANTHRI: And we're going to raise some of these issues with the Department of Health when we talk to them as well, later in this process. But those are particularly good examples for us to take.

MS MACLEOD: Some of it would be checking the evidence for how people have come up to having, now, what is considered such standard practice, and really making sure the evidence is there to support the widespread practice that is in place.

MR SMITH: And in no way am I criticising the Department. It's an opportunity, going forward. And if I use a very personal example. Many years ago in the country, I got a fish hook in my leg, as you do, and I went to ED and the guy got the stainless-steel tweezer things – that's not the word I'm looking for – forceps, pulled the hook out and then chucked the hook and the forceps in the bin. And I said to the specialist consultant, why aren't you sending it for sterilisation? It costs most to sterilise than to replace. So that's part of those drivers which are perverse incentives – no, it wasn't a safety issue, it was a pure cost issue.

PROF WEERAMANTHRI: Thank you. So the scope of this Inquiry is broader now and includes fishing, thank you.

MR SMITH: No problem. I didn't catch anything, either.

PROF WEERAMANTHRI: So Mr Smith, I might ask you this specifically. At a strategic level, has this issue been discussed at a Board level, and then if so, or not – and, you know, if so, has it been identified in specific risk assessments included in asset evaluations, capital or other planning processes, you know, the nuts and bolts financial decision-making at a Board level? Has it found its way in there?

MR SMITH: A multi-faceted question which I'll try my hardest to unpick. Yes. One of our board members, Professor Kingsley Faulkner, has been absolutely passionate around the climate change issues and sits on some national board, and constantly brings it to our attention the need for that process. We don't have a mechanism now where we currently do a climate change assessment to a business case process. So it hasn't been at that level. But yes, the risks to our organisation of the consequence of climate change are through our Audit and Risk Committee, and are dealt with in that. And the organisation's response to the risk, but that's more of a service delivery risk than our contribution to developing that risk… the problem. So yes.

I would also go to say, in a little defensiveness, the East Metro is only three and a half years old, and we spent the first year actually forming up. So years one and two, we have been absolutely focused on compliance and performance issues, particularly around financial performance. And it's only been in the last year where we've been able to move more into our strategic asset planning process, our planning for Byford and those sort of areas as well. Plus, also, where we want to go with the digital strategy, which is what Ms MacLeod was talking about, trying to change patient movement. It's only now we're trying to get into the more value-added longer-term issues. So I think it's been a very good trajectory of performance by the Board in the organisation, but we felt pretty, you know… I know when we look backwards, we thought, "Perhaps we should have done more earlier around this particular area". But we are where we are.

PROF WEERAMANTHRI: Absolutely fair. And all Boards are grappling with this and, you know, the community as a whole is grappling with this set of issues. And the health sector as a whole is probably very, very early in its understanding of these issues and its commitment to thinking through them and acting on them. So I don't think you're in a very much different position to other Boards. But I think it's important to ask the question, so as to be realistic about where people are at, just to be honest about the kind of conversations people are having, and then to see how this is, kind of, percolating through to the Board level, and how Boards are dealing with it, so thank you.

MR SMITH: And I would also like to have done far more around obesity, healthy eating choices and also the first thousand days of a child in the maternal – but we're doing what we're doing, and we'll get as we can.

PROF WEERAMANTHRI: Thank you.

MS MACLEOD: We've got the two risks that we've got on our strategic register.

PROF WEERAMANTHRI: Please.

MS MACLEOD: Yes. So the two risks are – so these have been on the strategic risk register since 2018. Our failure to reduce carbon emissions and harmful waste. So that risk recognises East Metro as a significant user of energy and creator of waste. And then the other risk is the failure to ensure that East Metro is able to respond to significant impact of climate change and climate-driven events. So they've been on our register for a year or so.

PROF WEERAMANTHRI: Thank you. We haven't heard previously of other health services having that identified on their risk register, so we will ask, thank you. So can we get back to this issue of procurement? And in your

written submission, you talk about the concept of sustainable procurement. And the real question for us at the moment is, can this be achieved to current procurements frameworks and policies? And we've had some evidence to suggest that it can, but there's nothing much wrong with current procurement frameworks, except people haven't got the, kind of, cultural propensity to use them to their maximum effect for the environment. Or are there specific provisions or constraints that are barriers to sustainable procurement? And we've heard two views on this. Like, are there real issues with the policies, or it's just that we could be using them, or we just haven't, kind of, utilised them to their full potential?

MR SMITH: I'd probably like to have done… Ms MacLeod answered the more technical component of it. The one thing I would say about our procurement policy it is only as effective as the end users' preparedness to change practice, or to use something different in that process. And that's not an easy thing in a clinical area where there's custom and practice and people have been trained on certain things. So it's a hard thing to get an absolute pure procurement model in a health environment, when clinicians actually carry their own personal liability for the outcome of those patients' outcomes. So there's an element in there of, we can have a very good process, we can do the right measures, but we also have to have a much more powerful heart and souls approach to it for people to understand the importance of changing whatever the outcome is, because it's going to have a better environmental outcome.

MS MACLEOD: So I think the challenge will be around… you know, procurement is often driven from safety and quality and value for money. And I think it's the breadth of thinking that makes up both of those factors. And I think they are within the current procurement framework, but it's been how people apply safety and quality, and I suppose the breadth of thinking around either the immediate safety and quality, as opposed to the long-term safety and quality, if you can see some of the really long-term impacts, and likewise, our value for money assessments will be based on how much that unit cost compared to that unit, as opposed to a value for money assessment around, what's the cost impact of the climate consequences of doing that. And I don't know that there would be a mechanism for people to honestly be able to do that. So I think that's going to have to be somehow informed for people to be able to make a choice and factor that in, but I don't otherwise know how people will honestly be able to do it.

PROF WEERAMANTHRI: So this is an extremely complex area, which we're trying to, kind of, improve our understanding of. But that element of the clinical demand and the clinical culture hasn't been raised with us before. It kind of seems obvious now you've said it, Mr Smith, like you're running a clinical service. So it's not just a matter of asking the facility managers or whomever to change the procurement practices. But how do you address this issue about supplies and procurement for clinical practice? You know, for other reasons. You might want to save some money or change the clinical

practices for reasons other than environmental reasons, but you've still always got the clinicians. How do you engage them?

MR SMITH: Well, most of the product selection processes have chosen clinicians participating in that process. And sometimes that's totally successful, and sometimes you still have people who want to do something else because that's how they were trained, or the degree of familiarity. I don't think there's any secret. There's been lots of discussion over many years about the orthopaedic – what's the word I'm looking for - - -

MS MACLEOD: Replacement.

MR SMITH: - - - replacement joints and whatever. There's so much confusion, disagreement about which one it should be. And I suppose if we had a comprehensive hearts and souls approach to this, and a better life cycle costing, including the component within the life cycle costing associated with the climate and the environment, we would, over time, get people moving easier. Again, I think part of what I'm saying is that it's also about engaging much better, like we do now with our more junior clinical staff coming through, who are far more passionate about their long-term futures and the climate. So, you know, we deal with technology. We target the more IT, mobile, techno younger, and they take the older with them, not the other way around, which is contrary to what happens in everything else in clinical practice.

MS MACLEOD: And I think in that, I think the important bit will be when we get the metrics and the targets, is being careful not to impose targets in a way that will be seen negatively by people who are going through this procurement process, and people will work their way around them. So the information needs to be provided in a way that we engage people who want to work with us. So I think it's going to be really important how we pull all of that together. And coming back to trying to engage our teams on the ground, rather than imposing something on them, but giving them the information and some strategies to be able to really do it themselves, will be the way we should be going about it. They do it at home, it's just how they can do it at work.

PROF WEERAMANTHRI: I might switch tack a bit to something I haven't given advance notice of, but it's in your written submission, which is about the role of the health services, the role of your particular health service, in trauma. Because I think you run the State Trauma Service, and we've heard from a range of witnesses around heat events, extreme weather events and the response capacity of the system as a whole. And it would be good to hear a little bit about what the State Trauma Service is seeing coming in terms of just a straight demand on it. I mean, is this an issue for them?

MS MACLEOD: I haven't seen anything in the reporting that they've done that would make me think that there's any changes as a

relation to climate. The reporting is changing, certainly we're seeing a change in demographic now. And it's more in relation to falls, certainly, which is more as a consequence of the aging population. So there's nothing that I've seen in any of the most recent reports that come through, but very happy to ask the question and provide a written response, if that's helpful.

PROF WEERAMANTHRI: That would be good, because there's quite a lot of information coming through to the State Emergency Management Committee - - -

MS MACLEOD: Yes.

PROF WEERAMANTHRI: - - - Department of Fire and Emergency Services, and a range of other agencies, that they probably would interact with around future projections, scenario modelling, around heat, particularly, but also extreme weather events and, you know, how that could impact in different parts of the state.

MR SMITH: May I add something?

PROF WEERAMANTHRI: Yes.

MR SMITH: We will take on what you've said and go forward. But it's very important that we have that delineation of roles in this process. We actually deliver what the Department of Health purchases from us. So we can help them – we can provide them information to allow them to make good predictive modelling in conjunction with the other agencies you mentioned, but we only have the capacity to respond to what they purchased us in the quantity they buy. We're accountable for the quality, but they are accountable for the quantity.

PROF WEERAMANTHRI: That's great. Thank you for the clarification. Okay. So we've covered most of the questions that we wanted to ask you. Your submission is broader than that. Is there any particular learnings or insights you've had as you've been working through this process over the last year or so that you'd just like to share with us? Because I think we're all learning here about our approach to this, and how to connect it up and join it up and different roles, et cetera. Is there anything you'd like to reflect on?

MS MACLEOD: I think we have a lot of staff who do want to do this. I said earlier, they do it at home, and I think everybody is – you know, we're just not making it easy for people to actually do it in the workplace. So I think it might be quiet, but I think there is a lot of people and a momentum to make this happen. So I think if we give people the right information, the right tools, I think we'll be able to make some change or gather support reasonably quickly. So that would be one of the things, I think

it's – and even as we started, we've had more people asking questions now about what we're doing. So I think that's all really positive.

PROF WEERAMANTHRI: If I can just ask a follow-on. Do you think you're good, as a health service, of letting small bits of innovation flourish? So people want to do something at a ward level or a unit level, do you think there's a, kind of, capacity, Managers would say, "Yeah, try that, see what happens"?

MS MACLEOD: We'd like to think so. I think so. Some of the things, the advice that people have given they're doing, they're happening on wards. And I think that's where people are trialling different types of recycling bins and other types of things. So that's all the good things that, again, you really want to happen at a ward. And then they tell someone else, and how we can then support people to do it more broadly. So I would hope that people would feel encouraged to do something at a local level.

PROF WEERAMANTHRI: Mr Smith?

MR SMITH: Outside of what we've, sort of, said, I just wanted to touch on a couple of things, I think. I think what excites us is that we're trying to move into the digital world, and that command centre with remote monitoring. This is all about better patient outcomes, but it has an enormous impact, then, on reducing the amount of patients coming into the hospital. I said earlier, I'd like to see the maturation of the purchasing model. Because we really do need to incentivise hospital avoidance versus activity, and the model we have at the moment – and the Sustainable Health Review picked it up – only the wards, those that had more and more activity coming through the door. And that's something, I think, we need to get on top of sooner than later, because that causes no end of grief.

The other thing, as part of the remote monitoring, is that better linkage to primary health care. Because if we're looking at the consequences of climate change, and we have some communities in trouble now, and you add in obesity, I don't have the solution, but if we don't get a better linkage to primary health care, we're just going to get more and more of these patients ending up in our hospitals. So we need to do something there as well. The other one, which Ms MacLeod touched on earlier was, there's no, sort of, health impact assessment of urban planning. And we often, amongst ourselves, joke about the newest suburbs have the least trees and the most kids, and the most social isolation. And I know that won't be popular with developers or whatever, but that strikes me as… when we go into areas where the sea breeze is not quite as early, that can be a particularly uncomfortable environment. And we really leave ourselves with that challenge… is how would the more vulnerable patients cope with climate change consequences? And I'm sorry we don't have the answers today.

PROF WEERAMANTHRI: We might close it there. Thank you both very much. A transcript of this hearing will be sent to you so that you can correct minor factual errors before it is placed on the public record. If you could please return the transcript within 10 working days of the date of the covering letter or email, otherwise it will be deemed to be correct. While you cannot amend your evidence, if you would like to explain particular points in more detail or present further information, you can provide this as an addition to your submission to the Inquiry when you return the transcript. Once again, thank you very much for your evidence.

MR SMITH: Thank you.

MS MACLEOD: Thank you.

HEARING CONCLUDED