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:

Hon Jim McGinty AM
Board Chair, North Metropolitan Health Service

Dr Robyn Lawrence
Chief Executive, North Metropolitan Health Service

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HEARING COMMENCED

PROF WEERAMANTHRI: Mr McGinty, Dr Lawrence, 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 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've 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?

DR LAWRENCE: No.

MR McGINTY: No.

PROF WEERAMANTHRI: For the transcript, could I ask each of you to state your name and the capacity in which you are here today.

MR JAMES McGINTY: James McGinty, Chair, North Metropolitan Health Service Board.

DR ROBYN LAWRENCE: And Robyn Lawrence, Chief Executive, North Metropolitan Health Service.

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

DR LAWRENCE: I don't think we need to make a statement, Tarun.

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 connecting 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?

DR LAWRENCE: Thank you. I think we believe that if it's going to be connected it's got to be connected via a performance framework and consideration of things such as a triple bottom line looking at the economy, environmental and social impacts of the sustainability programs which might be able to be put in place.

Some of the things that we've tossed around and have had feedback that might be viable, cost effectiveness, improving environmental performance for reducing waste and greenhouse gas emissions, the social obligations in relation to health and wellbeing of both staff and patients, and as I've mentioned, combining the triple bottom line in performance measures going forward.

It's probably also an opportunity for the system manager leveraging off the sustainable health review to determine what sort of lead it wants to take and there are obviously examples of that around the world including the Sustainable Development Unit modelled on a UK model. I think the challenge around those sorts of things going forward is how do you prioritise all of those things against all of health's priorities and how do you resource them, particularly given the very tough financial circumstances we have been travelling through in the State and as HSPs have had very, very small growth and have been able to contain our cost growth. But there's no scope in there to do additional things. While some things will eventually reap you some financial benefit, most things need an investment up front.

PROF WEERAMANTHRI: We'll come back to some of those issues and explore them in a bit more detail later. The Minister for Health wrote to the North Metropolitan Health Service Board in April this year, as well as all of the other boards, encouraging them to join the Global Green and Healthy Hospitals Network. This is an international community of hospitals and health services dedicated to reducing their ecological footprint. 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 ten sustainability goals. Have you been able to engage with the Global Green and Healthy Hospitals Network and its agenda since then?

DR LAWRENCE: Yes. In fact, some of our sites had been doing so in the lead-up. But as of this date we've got Sir Charles Gairdner Osborne Park Health Care Group have joined and their focus areas are in waste, water, transportation and energy, and the Women and Newborn Health Service which encompasses King Edward as its main site has joined, with their focus being on leadership, waste, food and pharmaceuticals.

PROF WEERAMANTHRI: For the record, I might just read out the ten goals in the Global Green and Healthy Hospitals Network and just noting

that Sir Charles Gairdner Hospital has picked up four of them and Women and Newborn Health Services has picked up another four?

DR LAWRENCE: Yes.

PROF WEERAMANTHRI: The ten goals are: leadership, chemicals, waste, energy, water, transportation, food, pharmaceuticals, buildings and purchasing. So that gives quite a kind of a broad scope for health services to look at. What's the process you've used to ask the components of your health service to look at the options and how do they run that process and come back to you and how have you shared those learnings?

DR LAWRENCE: In its infancy, I think it's fair to say. So when the letter came in I discovered that one of the sites had already joined up so they were down that path and working. So Charlie's has had a small group working particularly on waste for some time. They've got their own small group and that has been working for some time. I don't think we're particularly connected to anything else except via word of mouth to individuals who had an interest and were kind of naturally coming together.

When the letter came up we took it to our executives and we had a discussion about it and from there Women and Newborn moved off and we've kind of grown it. We've made an undertaking to look at moving towards a more North Metro model around the processes, but in fact these guys determined amongst their own executives their priorities that they thought were achievable in their own environments, rather than it trying to be designed at an AEG level, that's Area Executive Group.

PROF WEERAMANTHRI: Are you aware of particular exemplars of positive change either in those two services or in any other services in North Metro Health Service that you can share and are there any programs that are planned or in the early stages?

DR LAWRENCE: I've got some small pockets, I think it's probably best to call them—so the Sir Charles Gairdner Hospital's Waste Management Committee has been functioning since 2012 and that was the nidus of that group really forming. They've formed a good relationship with our waste management contractor, Suez, and they were a finalist at the Infinity Health Award in 2018 in the Commercial and Industrial Waste Award for their program, operating theatre anaesthetic waste showcase.

There have also been… a couple of our clinicians have been working in conjunction with colleagues in Victoria so that's Mat Anstey from ICU and Sally Forrest, our Public Health Physician, and a medical research student from Curtin, undertaking a research project on current energy use including the proportion of renewable energy in hospitals across WA. So there's some preliminary findings coming out from that which we can share, such renewable energy generation on site ranges from zero, which is actually the majority, to

only the very small 5 per cent which is obviously in one of the brand new hospitals.

Smart water, gas and electricity metres would assist with accurate measuring and us adapting energy usage and while switching energy sources is seen as financially expensive and a barrier, in Victoria 54 hospitals, which is about 25 per cent, are currently using alternative energy sources, the majority being co-generation.

There's a couple of other things we'd like to showcase. We do have representation from North Metro their health and climate change community of practice meetings which is co-chaired by the Department of Health and the Department of Water and Environmental Regulation. We've got some interested people attending that. One of our North Metro health physicians is organising a speaking engagement with David Pencheon from the Sustainable Development Unit in the UK during his visit to Perth in April next year.

We are in the planning phase for the establishment of a North Metro Health Service climate and sustainability committee which ultimately, we hope, will help us drive those initiatives, monitor them and actually implement them as one of the key factors.

PROF WEERAMANTHRI: Thank you for sharing that with us. There is a real sense in which the whole health system is learning about these issues as we discuss them and I'm certainly becoming aware of more and more things. I think no one's pretending that any one health service is doing a whole lot in a whole lot of different areas, but people are keen to find out what people are doing and learn from it and build from there.

I'm interested to see the Sir Charles Gairdner Waste Management Committee and its focus on the operating theatre anaesthetic waste issue. David Fletcher from the Royal Australasian College of Surgeons came and spoke to us a couple of weeks ago and talked about the large impact surgical theatres have within the hospital. So it could be 20 or more per cent of a whole hospital's emissions because they're very intensive foci of usage of materials and production of waste, et cetera, and the anaesthetic gas issue. As the chief executive or as the chair, as you've found out about these things has it surprised you, because I certainly have been surprised at some of the figures that come through as I read various articles on the health system, where the waste is, or where the emissions are? I'm just kind of keen, because this is an early stage, all of this, as people produce their examples, how we learn from them, and I think partly to acknowledge where our starting point is.

DR LAWRENCE: What I would say is I think we are really in the infancy and so whilst people, I think, intuitively would have said there's masses of waste generated and therefore the flow-on would be that you would expect it would be an area of high impact, if you can reduce it. I don't think we would have known the figures. I think it really has generated a

conversation we haven't had before anywhere and even amongst the chief executives group—as they all go—what are we doing here. So I think we are stunned, but it's more than just what's happening in the hospital. It's the whole bigger picture really that for the first time quite a lot of us have gone, "I can see now how all of this lines up and the timelines and what are we going to do about it."

PROF WEERAMANTHRI: Have there been any particular bits of data that have come out? I presume… did you say you'd done an energy audit of some sort?

DR LAWRENCE: No. There's a piece of research being done. No, we haven't done an energy audit.

PROF WEERAMANTHRI: Was there a finding from those submissions that those kinds of bits of high-level data being collected suddenly then shift a bit of attention on to the issue and I'm sure you've got data within your health service that's doing that.

Then going back to your original statement around how this all fits together within a performance framework, et cetera, and relationship to a triple bottom line and the system manager role. I just want to kind of build up from the operational examples which are coming to us—congratulations on that waste example in Sir Charles Gairdner Hospital—but then build up to the policy level and ask, if you like, beyond the North Metro Health Service what are the barriers, enablers that are not in your control and what role could the Department of Health play in supporting health services to make changes, obviously at a level which you can control, but then there's other policy positions that are impacting on you?

MR McGINTY: There's perhaps a level above that again and I'm thinking of one of the ten areas that you've referred to before in relation to the Global Green and Healthy Hospitals Network and that is the buildings. So if you start there with the sort of physical environment of health campuses, my limited experience in the past has been that the cost has been the driver rather than necessarily the environmental outcome when designing new facilities. People looked at the green ratings, the energy efficiency in the building design, but I don't know that that was then necessarily a significant factor in the way in which the building was designed. Perhaps you could look at more recent hospital constructions which haven't been friendly on that front.

There's also the question, on some campuses, of the ability to be able to become greener rather than more concrete there and I think that's an important thing. So this is beyond health because the funding of these things occurs at a Treasury or Governmental level and health is then left with a certain pocket of money with which to construct new hospitals. Whereas you ask for things beyond the HSPs' control and perhaps in the control of the Department of Health, I'd go one step further and say that things beyond health's control.

In addressing the outcomes of your inquiry I think there needs to be things for the whole of Government to address and that particularly goes to the funding of facilities to ensure that the capacity is there to minimise waste, to maximise green spaces, to minimise the energy consumption and by and large my impression—and I wouldn't put it any higher than that—is that most of our hospitals are not very energy efficient in the way in which they're designed. That sort of is a further issue again than the one you raised.

PROF WEERAMANTHRI: Thanks, Mr McGinty. I'd actually like to just stay there for a little while because we haven't had too many other people talk about that as an issue and I think it is important.

We just heard from the Child and Adolescent Health Service and clearly the building of the new children's hospital did incorporate a range of environmentally friendly features which they were able to list.

MR McGINTY: I'm surprised.

PROF WEERAMANTHRI: I'd ask two questions: one is about… there's obviously a difference between building a new facility and changing an existing or retrofitting environmental measures on to an existing facility which is presumably more expensive just like it would be for a house or something to change it. So your experience there with the existing facility but also your thoughts about planning of the new King Edward Memorial Hospital and where you are in that process. If you could put your mind to both those things.

MR McGINTY: Just before Dr Lawrence comes in on that one, can I just say this—and this is looking to the future and there are things to be learned from the past. But there are three very significant areas of capital works expenditure coming up within North Metropolitan and I suspect that they're probably the most significant capital works confronting health. They're each quite different. The new Women's Hospital on the Sir Charles Gairdner Hospital site, I think, will need to be looked at through the prism of environmental sustainability on an already very congested site. It really is important that one of the outcomes from that be additional green space on the whole of the hospital campus as well as energy efficient design in the way in which that's done.

The second and radically different proposal, no, a commitment is the closure of Graylands in the mental health space. There will be a whole range of facilities, I should imagine, built to replace Graylands, some in the community, some on existing hospital sites, but significantly I suspect that they will be new builds. But they're on a small scale and, I think, therefore very capable of small-scale adaptation of energy efficient measures in particular. I think that could well be an important criteria to address there.

The third capital works area involves the private sector, Joondalup. It's a public hospital but administered by Ramsay Health Care. Again, there are particular challenges there of getting that interface with the private sector, Governmental outcomes through that particular mechanism. They're each radically different.

Dr Lawrence can perhaps add a bit more detail.

DR LAWRENCE: I might work backwards on those if that's okay. Ramsay will build the new extension to the Joondalup Health Campus election commitment. Without going into the building, one of the challenges with that—and I suspect you see it in all of the private hospitals—that one of the levers for staffing is free parking. Whilst that remains a lever for staffing you start to feel like you're chasing your tail. In Government hospitals we've had our parking capped for some time so we've had a push, and as a result our priority when we start to build things is we still need more car parks, there's no doubt about that, but we have a much greater focus than I feel is outside of us in health on end of trip facilities and those sorts of things.

My suggestion in this bill was, no, we're not going to spend that money on a car park, spend it on a fabulous end of trip facility. No, we need free parking for staff. So that's one thing I think one thing that goes beyond the public sector.

Graylands probably there's not a lot to say. Yes, there will be a lot of buildings around those and there are good opportunities.

With respect to King Edward, probably the biggest issue around all of these things is the procurement process which isn't managed by Health either. It doesn't have a requirement to measure in any strong way the environmental sustainability or the environmental impact of whatever it is you're procuring. It doesn't have a value in the procurement process. If it had a weighting that was similar to our other things then you might end up with different outcome at the end of the day.

There's certainly lots of examples but the key one I recall on the QE II campus of retrofitting was that we needed to replace chillers and we could buy the more environmentally friendly ones or the ones we put in, but we weren't given the money to buy these ones. It goes back to the Treasury perspective. But had the weightings of the procurement been different we might have got a different outcome. But Government still has to provide the money.

With respect to the new Women's Hospital, it's in the very early planning phases I have to say. We don't actually entirely know what the scope is yet and I'm trying to work through that. However, I can say that we have got on our criteria for building that the environmental sustainability and impact is important as a criteria, and I presented to the Premier this week, and that was on one of my slides. He goes: "what does that mean"?

We are thinking about it in advance which might be the first time that I can recall where we've actually had it so far early in the process to be thinking about what are we going to do about this. How many more car parks do we really need? What is the end of the trip facility going to look like? What are staff open meeting places going to look like so that we can bring people out into the open. Once we get the scope nutted down we'll be going from there.

MR McGINTY: Just one point to add to that, the QE II site is very poorly served by public transport other than buses and unlike Fiona Stanley or the Murdoch complex which is brilliantly served. I would have thought that in order to reduce the dependence on private transport the public transport option, whether it be light rail or otherwise, needs to be closely looked at there to link that campus with the university and the city.

PROF WEERAMANTHRI: I'm going to ask a question. Both of you are vastly more experienced in this area than I am so I'm just going to say it so you can correct me or not. Our understanding, having talked to health support services and others around particularly some of the procurement issues, and having read some of the documents around capital works planning, is that we are told through this Inquiry that the procurement frameworks are actually there in terms of sustainable procurement and various facilitatory frameworks and the issue around weighting is that it's possible to give weights to environmental factors, but it's not mandatory to give weights to environmental factors. If a health service did choose to weight it then the frameworks are at least allowing that to happen. You may not have the funds to do that and there may be a discussion that goes back and forth between yourselves and Treasury, but essentially you could use that system at the moment and tinker with it to get better outcomes, how you weight funding for the weighting, et cetera.

Whereas on the other side, the capital works situation is a little bit more complex in that there's a greater separation between the conditioning of the building, the responsibility for overseeing that and the Health Department or the health service having less direct input except in the planning of it. Is that a fair summary?

DR LAWRENCE: Yes. The big capital works projects technically aren't managed by Health. We're a partner in them and we often lead the committees and things, but the building is managed by whatever it might be called now—but the equivalent of Building Management & Works.

PROF WEERAMANTHRI: Thank you for giving us some details around the various capital programs. Just going to King Edward, and I understand that it's in the planning stage, but you did mention in your written submission that current procurement policies constrain the health systems' ability to purchase and build in an environmentally friendly sustainable way. My question is: exactly how? Is it just to do with the funding envelope or is there something in the policy itself?

DR LAWRENCE: It's probably more to do with the funding envelope and I guess the fact that maybe we've just never seen it. It might be an urban myth. But the fact that we've never seen it weighted in a capital works project. My experience when we've tried to go down that path over the last 10 years is that it has been problematic. I accept that PCH did get some stuff into their building, whether it ever works or not—and SCH did too to a certain extent but I still don't know whether that's actually up and operational, their co-gen plant.

But one of the most basic things is solar, which no one's got yet. I know East Metro is trying to but I guess my understanding is that from a hospital perspective actually we're in the best place to use solar energy because we use all our energy during the daytime, which is quite different to the way we operate at home. There would be some simple things like that which we don't seem to ever have in. Maybe that's our own scope choice, but I guess it's a bit like when you know you can't get something, you go for the things you know you're going to be able to get.

PROF WEERAMANTHRI: Child and Adolescent Health Service did tell us that solar panels were installed on the new Children's Hospital, for the record.

MR McGINTY: Yay. I didn't know that.

PROF WEERAMANTHRI: There is an issue around having a conversation here within the health system across government around expectations to maybe change some of the culture and leadership and maybe some things become a bit more possible and weighted in a decision-making sense. Is that right?

DR LAWRENCE: Yes, and I think the other thing that's happened, and it's good in some ways and bad in others, is that we've separated out… when we put in business case now for a facility we purely put in a business case in relation to the capital. The operating component of that going forward has been removed from those business cases and that's beneficial in some ways. But it's detrimental if you're looking at the ongoing operating cost of that building. I guess it's return on investment, isn't it, when you're going to get that return on investment, I think, from the limited knowledge I have… growing evidence around actually the upfront cost repaying itself in quite a short time in fact when you look at the life span of a health building.

PROF WEERAMANTHRI: That's an interesting separate point in that even if you took the environmental considerations away just the pure financial considerations you could consider as the upfront cost and then the maintenance costs or running costs over the lifetime of whatever you're building.

DR LAWRENCE: Yes.

PROF WEERAMANTHRI: From a financial point of view it might be kind of short-sighted just to focus on the upfront costs and then you add in the environmental impact and it's even more a reason to look at all the range of financial and environmental costs and that calculation of your lifespan becomes different, doesn't it?

DR LAWRENCE: Yes, it does.

MR McGINTY: Two things involving relatively recent—and by that in the last decade—major constructions that I would find instructive is to look at the earlier discussions of Fiona Stanley Hospital, look at energy efficiency and reducing dependence upon fossil fuel generated power and the extent to which that became a reality at the hospital. The second would be at the Children's Hospital, the beautiful design and the extent to which that has added to the problem and I'm thinking of windows in particular.

PROF WEERAMANTHRI: But also potentially the savings, the direct monetary savings if you had, for example, renewable energy you're going to recoup those just like you would with a house down the track.

Just shifting slightly and to the kind of strategic level and I might ask Mr McGinty in the first instance. Has this issue been discussed at a board level? Then has it been explicitly identified in any risk assessments or in any asset valuation, capital or other planning process? You talked about capital processes. Just the kind of the nuts and bolts of the financial statements, the reporting, the risks.

MR McGINTY: To be frank, the new board in North Metro has been there for 16 months and we've had our hands full of 1,001 other issues. It is certainly an issue when it comes to looking at the future and the capital works programs that I've alluded to that I think the board and certainly myself would be very keen to be looking at. But we've had a whole host of financial integrity and other matters that we've had to give priority to in North so that has not rated highly.

PROF WEERAMANTHRI: We absolutely understand that issue of prioritisation. I suppose we're also aware of the growing literature or information that comes out into the public domain around directors' duties in this area and various bodies instructing and financial bodies telling people, particularly in the private sector, about their risk management and now an emerging literature on the duties of public authority directors. So I think this is a space that's changing fairly quickly; would that be your…

MR McGINTY: It is and we want to be part of that change now that we've dealt substantively with some of those more pressing issues first up.

PROF WEERAMANTHRI: Just to state that this Inquiry really notes that and really values the boards being honest about their positions and what they're doing. I think this is helping drive that, and will help the whole sector as we all get across the various risks and potentially liabilities as well.

Data is really interesting. We've heard from the Child and Adolescent Health Service around some of their experiences trying to collect data around emissions, waste and how difficult it actually is. Have you had similar experiences yourself?

DR LAWRENCE: I don't think we've tried to collect that data, to be honest.

PROF WEERAMANTHRI: The broad issue is around carbon accounting, so I'm struck that often carbon accounting is viewed as a kind of whole of system reporting. But equally it could be used to drive particular action within health services and it seems to me that's as useful, if not more so, identifying hotspots, say, in theatres and then trying to address the priority issues, to get back to the issue of prioritisation. Have you had a chance to think about how you might start a process of measuring and what you'd do with that information?

DR LAWRENCE: Not really. I think at a high level, putting aside how you would go about measuring, because somebody can tell us that, we can get advice on that. It comes back to the challenge of once you've got the information what can you do about it and I expect there's some stuff we can do. The waste production group is already looking at those sorts of things, so clearly there is. There's things on the way you use your energy to keep your temperatures right and have we got them set to the right temperatures.

Theatres again are a high user when it comes to temperature. The challenge in the old buildings is that temperature monitoring is pretty average and slow so I know that if I step outside theatres there's a massive lag, even in the new buildings actually, from the change in the external temperature and the building and the temperature goes up and then the air-conditioning catches up and there's an overshoot. We must waste heaps of energy in doing that. I think whatever you could develop, a methodology, and you could come up with some measures. The question is how do we actually make a difference if there's no resourcing to support it beyond what might seem simple?

My second concern about that, and I guess it comes into what does the system manager do with that data and if it's flogging the HSPs it soon will become

something that nobody wants to play in that space if they don't have the right tools to be able to deliver on it.

PROF WEERAMANTHRI: So to go to that issue about the relationship between the department system manager and the health services as the providers of the services, this data issue seems to be fairly critical in that you don't want to be in the situation you've just said where it's seen as an imposition, a whole lot of monitoring is imposed on HSPs without evident benefit to those HSPs, and that's not the way the UK Sustainable Development Unit did it, for example. We've heard just recently from direct conversations with them that they allowed HSPs to kind of tell them what they were capturing and recording and why, and then kind of built the higher-level reporting system up from there.

The Inquiry is particularly interested in recommending something that's useful, that is not onerous and that helps build up strength, build on the strengths of the organisations and where the system manager role is supportive as opposed to creating resistance.

Is there any other recommendations you can give the Inquiry?

DR LAWRENCE: They'd have to give something up. We can't just keep adding things to the things we have to do. We don't have the capability and capacity to stretch, to keep stretching. If this is a priority that's fine, I think the HSPs would agree, but you just can't keep adding to what the expectation of what the HSP is to deliver within the same resourcing structure. It's just that something will give.

PROF WEERAMANTHRI: Are you talking about performance data or you talking more broadly than that?

DR LAWRENCE: Even more broadly than that. In the sustainable health review there's 30-odd recommendations and they've all got to be implemented in a really short timeline. This is just one of those coming out of that. I just don't know how we can deliver it and I think for me that's the biggest single issue. What is the priority across Government, then further within each agency?

PROF WEERAMANTHRI: It's a point taken but if I could just ask you as a health service, you face the job of prioritising within your allocation every day. If there was an opportunity to kind of realise financial savings, improve patient safety and quality of care through say leaner practice or not doing stuff, or looking at high value care only, whatever frame you want to put it, that benefits the environment and also benefits population health, isn't that something you would look for where you got capacity yourselves to make some reallocations because you are going to be able to generate some savings?

DR LAWRENCE: Sure, I don't disagree with you if it was as simple as that, but it never is. If I reallocate people that's fine, I can reallocate them over here. But tomorrow I'll get something from the system manager or some…it always comes from them, saying we need 15 people to sit on this group to deliver this other initiative, and it's the same people. I can set the priority, the Board can set the priority but in fact tomorrow something else will come down the email that we need to do and nobody at a high—I mean, this is way bigger than climate change.

It's just a symptom of how much pressures Government systems are under to deliver multiple priorities, some of which are political, some of which for us are patient safety, some of which are going to be environmental, they can all come together. That's brilliant. But people forget that today we said this was really important and we've taken all our people and we've put them on to this program to make sure we do it properly, because it's not just going to happen by osmosis. You're going to have to put a program around them, and they want those people tomorrow to do something different. We have got 10,000 people but most of them are directly delivering their care. They don't have the capacity to come and help over here.

It is challenging. You're right, we do prioritise every single day, but every single day I don't know what I'm meant to prioritise today because three new things have come through that are important. Now I just say "no" to some of them, but eventually that's not going to be acceptable.

MR McGINTY: The key to that prioritisation is demonstrable outcomes rather than ticking a box, to put it bluntly.

PROF WEERAMANTHRI: That's helpful in terms of thinking about our Inquiry Report and recommendations. Thank you.

Just to go to the issue of North Metro Health Services more than hospitals. You're a service provider for the community. Have you had any feedback around either patient expectations or consumer or public expectations in this area? The second question is have you had any feedback from staff about their expectations of working in North Metropolitan Health Service and what they would see as important?

DR LAWRENCE: Probably, to me, not spontaneously. I mean, it's pretty clear when you go out and you ask staff that we've got some incredibly passionate and knowledgeable people in this space and they have a very different perspective of what the community might think. But I think we can say generally the community's awareness and expectations are changing which is good.

From within the staff probably the best feeler we've got at the minute, we've got a group that sits under the Board called "People, Engagement and Culture Advisory Committee". That's made up of staff members from right across

North Metro and we have a large group of ambassadors which were people who expressed an interest in joining the committee that form a broader group. Certainly, after discussing it with them they are interested in engaging with the initiatives and what they might see for the future. In particular, we're interested in waste and how we can improve the reduction of waste and just basic simple recycling, making water available, all of those sorts of really simple things which we can do.

I think at a high level, yes, there is enough information to suggest staff are probably more interested in this area than they have been in the past, but I wouldn't describe it as a growing movement just yet.

PROF WEERAMANTHRI: We conducted a number of public forums across the metropolitan and all of the regional areas and we had staff members come to those, and certainly some people expressed this kind of dissonance between what they were trying to do in their personal and family lives then coming to work and seeing a system that's generated for 24/7 to generate good patient outcomes, but also waste and environmental impacts. It's quite difficult in that to see a bit of a throwaway culture at times in some places.

Our feeling is that staff, some staff, would like to get the permission to do a bit of kind of innovation in their immediate work unit and perhaps my reflection is the job of management here is to allow people a bit of scope to get on and try things as long as it's within budget and within broadly their authority and that sometimes management is a little too "shutting down" of those activities. Is that fair or not fair?

DR LAWRENCE: I talk about the problem pipeline in management. So certainly staff have good ideas, whether they get blocked or they don't get facilitated is pretty hard to know because I walk around saying: "why don't you just do it", and I don't get why that doesn't happen. Anyway, we've decided… we've just launched our Innovative Futures Program and that's very much designed around bottom up staff submissions. There's no requirement for them to take them to their head of department or their line manager, they can just submit them and those submissions are going to start next week. They're open for anything. They're focused around high-quality care, people and culture, and innovation and partnership. They're pretty much open, they're open to any staff member anywhere across the organisation.

There are millions of ideas coming up currently saying: can we do this, can we do that? This now will be the perfect opportunity to try and relay some of those ideas. We've put no constraints on it at all. In fact, it's a program which we're kind of adapting as we go along based on some of the stuff we learnt when we went to Israel with the Minister, around innovation. I think we've created an opportunity to try and get around some of those things.

As we've been discussing this environmental sustainability, clearly we've had really simple discussions saying: why haven't got green waste gardens? There's bucket loads of space on the QE II campus to have fruit and vegetable gardens run by staff. One of the ideas that's just been floated last week was why don't we get each ward to adopt a green area and to create their own garden and to manage it and run it. Whether it ever gets off the ground, I don't know. But those sorts of ideas are now are bubbling through. Lots of our areas, even in my own executive kitchen, don't have recycling bins. They did and they got taken out because no one paid any attention to what went into them. We're starting to bring some of those things back now that people are becoming more aware. We all hopefully separate our waste at home so why can't we do it in the kitchen at work.

PROF WEERAMANTHRI: I think that point about innovation is a fantastic one to end on.

MR McGINTY: Can I just add to that. The North Metro Health was preoccupied in the first nine months or so of the new Board being there dealing with day-to-day problems including excellence in patient care, finances, integrity, the nature of the executive and so on. I just think it's brilliant now that, having substantively dealt with those issues, we're now able to move on to innovation. It's got so many dimensions to it including in this area, and this is an area which I think a lot of staff will respond very well to, and that is the whole impact of climate change and what it is that can be done at a very micro level within a very energy or greenhouse gas production heavy environment.

I'm expecting there will be a lot that will come forward from this area and am quite delighted the Chief Executive is pushing in that direction.

PROF WEERAMANTHRI: Honourable Mr McGinty, Dr Lawrence, thank you both for your attendance at today's hearing. 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 transcripts 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 attendance.

MR McGINTY: Thank you.

DR LAWRENCE: Thank you.

HEARING CONCLUDED