STANDING COMMITTEE ON PUBLIC ADMINISTRATION

INQUIRY INTO THE PATIENT ASSISTED TRAVEL SCHEME

TRANSCRIPT OF EVIDENCE
TAKEN AT BROOME
TUESDAY, 2 SEPTEMBER 2014

SESSION TWO

Members

Hon Liz Behjat (Chairman)
Hon Darren West (Deputy Chairman)
Hon Nigel Hallett
Hon Jacqui Boydell
Hon Amber-Jade Sanderson

Hearing commenced at 1.35 pm

Ms SUE-ANN WISEMAN
PATS Regional Coordinator, Broome Hospital, sworn and examined:

Mr KIM DARBY
Operations Manager, Broome Health Campus, sworn and examined:

Mrs KERRY WINSOR
Regional Director, WA Country Health Service, Kimberley, sworn and examined:

The CHAIRMAN: I would like to call to order the public hearings for the Standing Committee on Public Administration's inquiry into the PAT scheme in Broome this afternoon, Tuesday, 2 September. Kim and Sue-Ann, we met earlier today but I will still go through some formal introductions of the committee. My name is Liz Behjat. I am a member for the North Metropolitan Region. With the committee today is Hon Jacqui Boydell, who represents the Mining and Pastoral Region; Felicity Mackie, who is the committee's advisory officer; the deputy chair of the committee, Hon Darren West, who is from the Agricultural Region; and my colleague Hon Amber-Jade Sanderson, who is from the East Metropolitan Region. Missing from the committee today is Hon Nigel Hallett from the South West Region. We are the five members of this committee. I would like to welcome you and thank you for agreeing to come in and give evidence to us today. Some of the formalities we need to do are that we are going to swear all three of you in at the moment. That will be the formal part, and then we will sit back and have a chat about the PAT scheme. Could you each take the oath or the affirmation.

[Witnesses took the oath or affirmation.]

The CHAIRMAN: You will have all signed a document entitled "Information for Witnesses". Have you read and understood that document?

The Witnesses: Yes.

The CHAIRMAN: The proceedings are being recorded by Hansard and a transcript of your evidence will be provided to you. To assist the committee and Hansard, please quote the full title of any document that you refer to during the course of this hearing for the record. Please be aware of the microphones and try to speak into them, and do not cover them with papers. I remind you that your transcript will become a matter for the public record. 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. If the committee grants your request, any public and media in attendance will be excluded from the hearing. Please note that until such time as the transcript of your public evidence is finalised, it should not be made public. I advise you that publication or disclosure of the uncorrected transcript of evidence may constitute a contempt of Parliament and may mean that the material published or disclosed is not subject to parliamentary privilege.

The formal part of the hearing is now over and done with. What we have been doing, as you know, is travelling around this very vast state of Western Australia taking evidence from a number of regions. So far we have visited Albany, Kalgoorlie, Carnarvon and Port Hedland, and now today we are in Broome. We have also done remote conferences into Newman and Kununurra. The first question that we have been asking at each of those locations is: in your own words, describe for us what you see as the efficiencies and the deficiencies of the PAT scheme.

[1.40 pm]

Mrs Winsor: The efficiencies of the PAT scheme: it is a patient assisted travel scheme. It assists patients who live a distance away from access to the specialist medical services they may need access to. From an efficiency point of view, it assists us to ensure that patients get to the specialist services that they need to access, and assists to keep people as well as possible and preventing people from deteriorating and ending up as an inpatient in our hospitals, and all the social implications that go with somebody becoming ill. I do not know how much detail you want me to go into really. We have done quite a bit of work to improve our efficiency in the administration of the system within the Kimberley and —

The CHAIRMAN: We would like you to talk to us about that because what we are finding that from region to region is that there are different ways of managing that system. That might be one of the things that this committee can look at in its recommendation, saying that this region does it that way; so as much detail as you can give us about how you administer the scheme.

Mrs Winsor: We used to have it more decentralised. It was being managed hospital by hospital. We have now centralised that with the regional coordinator, which is Sue-Ann, and Kim takes on the executive sponsor. So there are two senior people who are oversighting it, supporting and meeting with respective people who are dealing with the PAT scheme and with the other executives that have to manage the scheme, and also engaging with the community and other providers, like the Kimberley Aboriginal Medical Services et cetera. Having done that, that has allowed us to have some structure in reporting. It has enabled some standardisation of the way we manage the PATS administration and has facilitated education and training, and more compliance with that. We have had some benefit from the growth of our services in the Kimberley. That has seen a reduction in the PATS transfers or the PATS that used to go to Perth because a lot of our activity now we are actually doing locally in Broome, and the other services. From an efficiency point of view, I think we have managed to do really quite well with the budget that we have in that we are sitting under that budget at the present time in the last financial year.

The CHAIRMAN: What was your budget in the financial year?

Mrs Winsor: I do not know; I would have to take that on notice. But we saved around $900 000, from memory, last year.

The CHAIRMAN: You saved $900 000?

Mrs Winsor: Yes; that was from spend to spend.

The CHAIRMAN: If you could provide us with those figures on notice, that would be great.

[*Supplementary Information No A1*.]

Mrs Winsor: Yes. There is a reduction in spend and then there were savings, so I can do it as both. That would be primarily related to the growth of our own services. We have opened up the acute psychiatric unit, which we did not have in the past, the neonatal unit and the paediatric unit. They have been some of the main avenues for the growth of our services.

From an inefficiency point of view, the difficulties, I think, are around the services that are excluded, like dental and allied health. The people in the Kimberley who really need to access those services are quite disadvantaged socially, as you would be aware, and do not necessarily have access to those services or do not have the means to access those services. That can be quite difficult when you are faced with people who really do need to access the service and you do not have capacity to be able to support them under PATS. It is probably something that has been raised with you during the course of the inquiry, that there is certain access that could probably be improved in order to ensure more access to services for people when currently those services are excluded. The other inefficiencies are more around the spend. The program is a subsidy, so it is not supposed to cover the whole cost, but in reality we find with our clients in the Kimberley, most

people cannot afford to pay the whole cost, and so we do end up assuming that cost in order for them to access the service because if we did not, they would not go.

The CHAIRMAN: Under what means do you assume the cost—just from your general budget?

Mrs Winsor: If someone is coming from a remote community—this is just coming to Broome—and they do not have any family in Broome and they do not have anywhere to live, there will be a discussion with those people at some point regarding whether they need the PATS or not. Unless Sue-Ann or Kim want to add, those people would be housed probably in the Broome-Time Lodge if they were here in the Kimberley. That costs more than what the PATS subsidy is, but we know people are safe and they are in an environment where there is a little bit of support around them. If they go into Perth, they can stay in some of the hostels in Perth, but those places are quite limited. They sit at around $60 or so a night, so that is much more manageable. If there is a gap, it is not as much.

The CHAIRMAN: So there is no commonwealth or state government–provided hostel in Broome where the PATS patients can go?

Mrs Winsor: No, we have got one hostel, an old backpackers that has been used for the dialysis patients and they are usually living there long term unless they get a transplant.

The CHAIRMAN: So that is almost like an off-site dialysis unit really?

Mrs Winsor: No, they do not have dialysis there, but they are living there while they access the dialysis services. They might come from all over the Kimberley, not just Broome. We do have funding to build a purpose-built dialysis hostel, and the hope is that once we build that, the dialysis patients will move into it and that may free up the old hostel so that that could be used for the PATS patients, and that would enable us to do it within the PATS subsidy, most likely.

The CHAIRMAN: With the arrangement that you have with the Broome-Time Lodge, do you come under criticism for that from WA Country Health Service because it is outside guidelines and you have not gone through the general competitive tender processes and things like that?

Mrs Winsor: We have not that I am aware of. It is probably cheaper than what we were paying hotels, which was much more expensive. The other option we had was the caravan parks, and we had a lot of complaint coming from, particularly, the pregnant mums who were in the caravan parks having to go across the grounds to access the toilets after hours. The other issue was with the weather, either the heat during summer, when the caravans are frightfully hot, but also during the cyclone season we would then have to move everyone out of the caravan parks and find them safe accommodation while they were waiting.

The CHAIRMAN: Yes, obviously, when people are unwell they need to be kept in as safe an environment as possible.

Mrs Winsor: So other than the Broome-Time Lodge and other than if people have their own family to stay with, we do not have an option in Broome that is equivalent. Derby, on the other hand, has a hostel. They have a renal hostel about to be built and they have also got a 54-bed transitional hostel for people who are travelling through accessing business, health. That is just brand new; I do not think they have got any patients in it yet. They were supposed to be coming to Broome and they were unable to identify land or resolve the land issues, so it was given to Derby. So Derby is probably our best placed site for having access to accommodation that is low cost that you could do within the PATS subsidy, other than Kununurra. We built a short-stay hostel up there and that was done under the Ord River expansion stage 2 in that part of that East Kimberley development investment.

The CHAIRMAN: Is that the hostel that the Kununurra —

Mrs Winsor: Short stay, yes.

The CHAIRMAN: They use that?

Mrs Winsor: That has got 18 beds, short stay, and there are another eight beds to go onto that site, which will be a long-stay renal dialysis hostel as well. And we have got funding for a dialysis hostel, 20 beds to go into Fitzroy Crossing, and that is complementary to the four-chair satellite unit that is about to be built there. I expect that that may have some capacity to take other patients, not just the dialysis patients, depending on how far around Fitzroy Valley those people come from.

The CHAIRMAN: How many dialysis chairs do you have?

Mrs Winsor: There are 10 in Broome, so that is 40 patients; 10 in Derby, but they are not at full capacity yet; six in Kununurra, not at full capacity yet—it goes up each year over the next three years; two temporary chairs in Fitzroy Crossing, we will build four new and then those two will stop; and there is some home dialysis but not a lot. So Kalumburu clinic has got a home dialysis room and Nindilingarri in Fitzroy has a home dialysis room.

The CHAIRMAN: I am assuming that you have currently got some Kimberley residents in Perth on dialysis down there because they are not able to be looked after in the region?

Mrs Winsor: Yes.

The CHAIRMAN: As a chair becomes free, you bring someone back from Perth and you get them back to country?

Mrs Winsor: Yes.

The CHAIRMAN: Do you know roughly how many you have got down in Perth at the moment waiting to have a chair?

[1.50 pm]

Mrs Winsor: Roughly it is around 26 to 30. The patients cannot come back to the Kimberley unless they are relatively stable, so that is a limitation on them coming back. But assuming they are relatively stable, if we can bring them back and there is a chair, we try to bring them back. The investment in the dialysis services has been specifically for that reason—the reason Derby has been built, the new unit in Kununurra, and the Fitzroy Crossing unit is a fairly new one, just even the two interim chairs, and that has got eight patients home. Some of them have been away for many years.

The CHAIRMAN: One of the things we have been hearing in other areas is the cumbersomeness of the form filling out—the needing to have your yellow form and then that might or might not be filled out correctly by the referring GP and then you have got to go back to the GP. Then when you have got that form, you have got to take your blue form to the specialist and you have to bring your blue form back. Is there a better way to manage that system or do you not get that issue here in the Kimberley that we have heard about in other regions?

Mrs Winsor: I am happy to let Sue-Ann answer that.

Ms Wiseman: I cannot deny that it is not cumbersome for anyone, especially a new GP to the region who is not used to using the forms. It does create a lot of work as PATS clerks have to go back to the GPs because they are half filled in. Obviously, we spend a lot of time with patients helping them fill them in as well. There is through the state PATS working party the trial of the new one PATS form, which is currently starting —

The CHAIRMAN: We got copies of that in Port Hedland yesterday to have a look at.

Ms Wiseman: You have got copies of it? So you know the trial is happening in Port Hedland and in the wheatbelt. Ideally what I would like to see and what we have discussed within the Kimberley is an electronic form.

The CHAIRMAN: In fact, we have talked about that as well, and one of things we were wondering is if there was to be a web-based system where the patient visits the GP, the GP then starts the process, so the PATS number gets generated and they say, "You know, Mrs Behjat has come for this." Also, then the GP cannot go further in that form unless they are filling out exactly what is needed to be filled out. Presumably, because most practice managers have all of that personal information there, that the form would self-populate with relation to all the data that you need and then, bingo bango, it comes to the PATS office here in Broome and then you do what you do with it. Then the specialist accesses the same thing web based. Would that be a helpful system?

Mr Darby: Definitely, I think if we can get an electronic form brought into play. I also think we will be looking at, probably over the coming months, how much information we can glean from the initial referral letter and really questioning why we need to even have a separate PATS form. The letter of referral has probably got 90 per cent of the data that we need to make a determination on a person's eligibility. We have been talking internally around the merit of do we not even bypass the form and go straight to the actual practitioner referral letter, which probably has more information on it than we actually get on a PATS form right now. We have not quite moved to trial it yet, but we are interested to have a trial if the form goes in Hedland and the wheatbelt, but we are also very interested in pursuing perhaps simply looking at that doctor's referral letter to see the specialist and use that as a starting point.

The CHAIRMAN: One of the things you briefly mentioned in the first hearing we were talking about, Kerry, was that the system is somewhat deficient in the fact that it does not provide for dental and allied health. I think it is perhaps fair to say that one of the things that may have happened is that any system always needs to be constantly reviewed and that medical technology has advanced so much in a number of years and perhaps they have not looked at that criteria. Again, we had some evidence given to us, and the example I have been using throughout the state is a cochlear implant. When those guidelines were written, cochlear implants were not really the done thing; these days they are done daily, I would imagine, sometimes in Perth. What we were told is that the surgery for the cochlear implant is claimable under PATS; it can provide that, yet the most important part of the cochlear implant is switching on of the implant three weeks after the surgery has been done and yet that is not covered. Do you see a way around that in that the system needs to change in that regard?

Mrs Winsor: I think the system does need to change. There are some things you cannot do. Telehealth is probably one of our best technology developments that lets you get services to people who are remote without having to personally be there, and there is still scope for that to be increased and improved in the Kimberley, and we are making good roads in there. But some things you have to be there in person for and you cannot do the telehealth; you cannot use telehealth for some of those things. I think the PAT scheme itself needs to be ensuring that there is not another avenue, such as telehealth, whereby that service could be provided, and that information often comes from the clinician. We do try to educate the clinicians on "consider telehealth". But to review, the criteria probably do need to be reviewed quite quickly, because it depends on the speed at which services develop and also at which technology develops. I mean, once upon a time we used to do open-heart surgery all the time; now we do angiograms and stents and you can have that done quite quickly. I think they do need to be reviewed more regularly than currently what they are.

Mr Darby: I think too it is the move towards a very multidisciplinary approach to the way we deliver care—that the days of just simply going solely to your specialist for that whole care plan are long gone and there is now a multitude of other health professions who contribute to the identification of that diagnosis. PATS is pretty well straight down the line of the specialist, whereas I think there is some role to play in looking at the diagnosis of the patient and what is the support package around that diagnosis, in which case there may be a package of support for certain diagnoses that people have, or in that case a Cochlear implant. So rather than a straight "let us only look at the specialist component", there are a number of other components. So, if you want that to be successful, there are other components we need to look at—not just that specialist intervention.

The CHAIRMAN: I think another one mentioned to us of course was sleeve gastrectomy and those types of things where you need to see a psychologist and a dietician; you cannot only really see the specialist.

Mr Darby: The one we see quite often is the severely disabled child who may well need to see the specialist but needs to be supported through a range of allied health services as well; and, again, the allied health components may not be covered, but the specialist component will. Unless you have got the allied health component going in tandem with the specialist, then the outcome is not going to be positive. So for that allied health area, particularly for the severely disabled child in the Kimberley, there is a huge impost on families.

Hon DARREN WEST: Sue-Ann, I was just interested in your comments regarding the possible electronic way of doing the forms. I must say that we have all at different times thought it is a little bit quaint that you have got to walk around in the year 2014 with little pieces of paper, especially when you are not well and probably not at the top of your game. The risk I could see of a service like that is it may become centralised. I know that you provide two predominant areas of your service—the administration of the PAT scheme, and also the logistics of getting the person from a remote location through various modes of transport to the specialist. Can you just run us through why you think it would not be a good idea to centralise those two parts of the service, or do you think some of that could be centralised, or would it be better still administered in each region, because the reality is if there is a centralised region, it will probably go down to Perth and be run from there?

Ms Wiseman: Definitely. I think the model that we currently have in the Kimberley works exceptionally well. We still have clerks at each individual site, and those clerks are absolutely essential in ensuring that the patient gets the correct information and that the entire patient journey is planned by someone who is absolutely thorough in what transport routes are available, what community health person might be going out to a clinic for a day, and what charter company might be going in any which direction. A prime example being I can tell you what is happening around the peninsula here, but I could not exactly tell you what is happening in Kutjungka with other transport routes. So, to have a clerk in the individual sites I think for us is essential to ensure that the patient does continue to get the most efficient way to their specialist appointment, or, if they are transiting through one of our regional towns, to get to Perth. We do not have any plans of centralising it in that system. But the element that we have at the moment is that we have a regional coordinator, which is myself, and so we have a more centralised decision-making tree, if that makes sense. So, we are all communicating a lot better about transport issues and about the separate elements of PATS and things that may or may not have been approved in one region, so we are far more unified in our decision-making. So I think centralising the decision-making process is important, but I do not believe centralising all clerks in one spot for the Kimberley is the way to go.

[2.00 pm]

Hon DARREN WEST: Okay. Thanks. Just on that, another one is clearly an electronic system would need good internet access and good strong services. Can you think of anywhere where that is not the case that would be disadvantaged by—would you think that all the communities and all the clinics in the communities would have enough internet access to —

Mrs Winsor: The clinics have got relatively good internet access, but not so communities, so there are little communities like Crocodile Hole where I do not think there is any internet access there. There might be one public phone. But the patients would probably access the Warmun clinic, and if they access the Warmun clinic, then the Warmun clinic —

Hon DARREN WEST: So once they go to that clinic, they would be able to —

Mrs Winsor: Yes.

Hon DARREN WEST: Because I presume that they would have to get the forms from the Warmun clinic now?

Mrs Winsor: Most likely. The concern around the centralisation where there are practical arrangements to be made is not knowing the region, as Sue-Ann has said. For the patients coming from some of the remote communities, it is quite a frightening experience to have to go through this process, apart from the health aspect of it. A lot of people are still frightened of accessing health. There is just the worry of having to do all the travel and getting lost and not knowing where you are going and that sort of thing. So, it is really important that they have somebody who can help them through that process. I am not sure how we would do that if we just had a central body without any people on the ground out here to guide that process.

Hon DARREN WEST: Your situation certainly is unique to the others.

Mr Darby: I think the compounding issue too is that our colleagues in metropolitan Perth are not always aware of even where some of these communities are, so it is not an uncommon issue for Royal Perth or Princess Margaret to want to discharge a patient in the morning without realising that that person might live in a community out the back of Kununurra and there is not really a full understanding of, yes, the patient might be ready to discharge, but to get that patient from A to B is in some cases an overnight journey. So there are a lot of issues around just the patient returning, not just that they are ready for discharge if they are in the hospital, but the logistics of getting the patient back. We are finding that not all the time our metropolitan colleagues are across the challenge or even the location of where some of our community members are coming back to.

The CHAIRMAN: When we were touring the hospital this morning with you—thank you very much for that tour; it was really great to see the facilities you have available—you described to us your Aboriginal liaison officers scheme that you have come up with and you have put in place. Do you want to just briefly walk us through that so we have got that on the record as well?

Mr Darby: This is one of the things we were talking about where some of the efficiency gains have been made, where whilst the PATS budget itself might have made some savings, we have actually got some costs that are being borne by other parts of the business, and the Aboriginal liaison officers is one of those costs that we are bearing in other parts of our business, and it is having a very positive flow-on to PATS, and that is where we are more case-managing the patient who is coming in from a remote community into Broome, has never been to Broome before and is not too sure where the hospital is. The ALO service will meet the bus when it comes through, which undoubtedly is at six in the morning, and meet them and just make sure they find their way into the hospital, where we have got the transit lounge in the hospital where the patients can then sit in the transit lounge pending their appointment, and then the same ALO can take that patient back to the bus ready for return journeys on; or, conversely, be chatting to that patient if they have got other business to do in town that day and know exactly where that patient is at any point in time, so if they are going to meet them downtown, they can call them back for another appointment and walk them to the hospital. So we are finding that the ALO service is a critical component—it is a bit different in the Kimberley than perhaps down in the south west—of where they are connecting the patient and the service. Without that, we were finding that a lot of our patients just simply were not coming to the appointment at the time they were scheduled to do, which was a huge disadvantage for the patient because they missed the care they were getting at that point in time, and from the hospital perspective we were having highly-paid specialists sitting there idle because their appointment time was not maintained. So our very long waits, which is our key indicator for us, has decreased significantly, with patients who are now getting to the appointment when they need to get to the appointment on time, and ultimately it is a cost saving for us to get it right the first time.

The CHAIRMAN: What days and what hours does that service operate?

Mr Darby: Sue-Ann is probably in a better position to answer that.

Ms Wiseman: Seven days a week. There are four ALOs, on a rotational basis. The first ALO starts at 6.00 am. I believe from Thursday to Sunday they finish at 11.00 pm in the evening. Unfortunately, I am not sure if—I think it is a slightly earlier finish on Monday, Tuesday and Wednesday, but from Thursday through to Sunday they work to 11.00 pm in the evening. And there is often more than one on at any one time.

Mr Darby: That work is not solely related to PATS. There is a range of other patients who are coming in and out who are not PATS-related, and that has obviously provided support to them. So, we are trying to put a package of support around the patients coming through regardless of the funding source, whether it is coming from inter-hospital patient transfer, whether it is coming from a PATS service, but just trying to put that package of support around the patient, and the funding stream follows through.

Hon JACQUI BOYDELL: I have three quick questions. I will start with this as a bit of continuation of where we were. I think you have done an amazing job of supporting your patients, and also your depth of knowledge about cultural awareness and how difficult it is for some of your patients to attend health services actually is outstanding, so I congratulate you on that. I wanted to ask you under allowing an escort to either Broome or to Perth or to another area, where an Indigenous patient for cultural reasons would like to bring a family member, but it is not for clinical reasons, which is quite clear in the guidelines, are you approving that, and how are you doing it? Are you doing it under the escort guidelines as they are now or are you doing it as an exceptional circumstance?

Mr Darby: I think normally we would be finding how we can prove it within the guidelines, so we would be looking for more information —

Hon JACQUI BOYDELL: From a clinical perspective?

Mr Darby: — from a clinical perspective that might capture cultural community that we are trying to be —

Hon JACQUI BOYDELL: That you are recognising but the guideline is not giving you any scope to consider it?

Mr Darby: Not principally cultural, but there is enough leeway in the clinical component to get enough information out from the referring practitioner in many cases to make a case for an escort to go down.

Mrs Winsor: And if we cannot, we will liaise perhaps with the AMS, like KAMS or BRAMS to see whether they can assist, so if we cannot get in that guideline but the person really needs to go, we will approach the AMS to see whether there is some way that they can assist, and they have assisted on a couple of occasions.

Hon JACQUI BOYDELL: From a funding perspective?

Mrs Winsor: Yes. They will pick that bit up and pay that bit and we will pay the PATS bit. We do not just say no and leave people with no option. We try to say, “Look we can’t, but we’ll see what we can do.” To some extent, that is an inefficiency because we do not just say no and it is gone; we say no and we try to find another way, so that is I guess an inefficiency in one sense but it is an efficiency if it means the patient goes and gets treatment.

Hon JACQUI BOYDELL: Yes, I understand what you mean. Secondly, going back to Broome-Time Lodge, I was not quite clear how you were funding that extra payment you are making. Is that coming out of your PATS budget?

Mrs Winsor: Yes.

Hon JACQUI BOYDELL: My last question revolves around the forms. Is it the support that you are giving your patients that you are not finding the form issue onerous? The patient has got the

blue form. Who has got the blue form? If the patient is worried about going to the city and they have got all these other transport issues—how do they get to their appointment as well as just being frightened about engaging once they are there, who is doing the form, who is getting it back? How are you managing that?

Ms Wiseman: Ideally, the PATS office is getting the form back.

Hon JACQUI BOYDELL: The blue form?

Ms Wiseman: The blue form.

Hon JACQUI BOYDELL: But does that not go with the patient?

Ms Wiseman: That does go with the patient, so if the patient can bring it back, we obviously encourage them to bring it back. We quite often get them through the Aboriginal Hostels , so the staff down there will quite often fax them.

Hon JACQUI BOYDELL: So they get left at the hostel where they fax it.

[2.10 pm]

Ms Wiseman: They just have them and they will fax them to us. The tertiary hospitals will quite often fax them to us. Some patients—for example, a cancer patient—quite often our cancer care coordinator will help us and look up and say, "Look, the patient has attended", so there are other forms of verification. We have taken a few other options.

Hon JACQUI BOYDELL: Okay; I was wondering how logistically that was working for you?

Mr Darby: I think that is the key. The blue forms, ideally, are what would be proceeded, but at the end of the day, for the purpose of has that person attended the specialist, there are other ways of finding that out. We have access to the metropolitan outpatient system, TOPAS, and we can always look on that system and see whether the patient has actually attended the clinic. There are a number of ways outside the blue form you can get it. All you need the blue form is for verification, then there are some other ways to get that verified; the blue form ideally, but if that does not come back, there are other methods, if that is its purpose, to verify they have attended because otherwise —

Hon JACQUI BOYDELL: Is that its purpose?

Mr Darby: Principally.

Ms Wiseman: For us it is because for the majority of patients we are paying in advance. For example, in the south west where they need their blue forms to claim their reimbursements, we are already paying in advance, so for us it is purely just verification of their attendance of which there are other ways that you can get that. It is not the be-all and end-all.

Hon JACQUI BOYDELL: Good, thank you.

Hon AMBER-JADE SANDERSON: You might need to provide this on notice. Are you able to give us the number of claims you had in 2012–13 and 2013–14?

Mrs Winsor: We would have to do that on notice.

Hon AMBER-JADE SANDERSON: And the budgets?

Mrs Winsor: Yes, we would have to do that on notice.

Hon AMBER-JADE SANDERSON: And a list of the NGOs that support the access or interact with the support, the transportation of patients or support their journeys to and from?

Mr Darby: We would need to get that on notice.

[*Supplementary Information No A2.*]

Hon AMBER-JADE SANDERSON: What kind of arrangements do you have with the Darwin hospital or do you have to get them out of the Northern Territory?

Mrs Winsor: We have a contract with the Royal Darwin Hospital and we purchase six beds at a certain price, which I do not have off the top of my head. We also have access to the intensive care unit. The Darwin beds are primarily for time-critical transfers. Where it is time critical to get the patient to a specialist facility, that is how they go, so it is primarily from Kununurra. The East Kimberley is the heaviest user, although patients will come from Fitzroy and, not very often, Broome, but mostly from the East Kimberley. That has been an extremely good arrangement, not one that we would ever want to see not there.

Hon AMBER-JADE SANDERSON: I do not think there is any suggestion of that. PATS provides for them to come back too from Darwin, interstate?

Mrs Winsor: Yes, I think so.

Mr Darby: Yes, PATS provides Darwin. And there is provision in the current PATS guidelines that if the nearest specialist is Darwin, which applies to Kununurra principally, then PATS has an automatic approval to go to Darwin. It is not such an application down here because it is actually closer to Perth from here but East Kimberley we have a number of patients who we move under the PATS guidelines to Darwin. They are not large numbers but a number of people will move through the PAT setting to Darwin.

Hon DARREN WEST: Can we get a breakdown on the number of claims?

Ms Wiseman: For Darwin?

Hon DARREN WEST: Yes, the numbers to Darwin and the numbers to Perth?

[*Supplementary Information No A3.*]

The CHAIRMAN: One final thing I want to ask you about is that you mentioned on our tour today that when you have people who have a PATS application refused and you have gone through all those processes, generally you have someone who is a clinical specialist or manager delivering that news rather than a PATS administrative clerk doing that. Is that something again that you come up with in your region?

Mr Darby: Depending on why the claim is getting denied, if it is a straight administrative issue, then the administration staff will carry that but if there is an issue around the clinical eligibility, that is best delivered by, in our case, a senior medical officer who can talk both to the patient as needed and potentially the referring doctor. And that can be a two-way education street, particularly between the referring medical practitioner because in some cases they are aware that the service is available in the Kimberley and in Broome, in which case it is an education that can go forward for future referrals, but that discussion is best to be had between the clinicians. There are times where the referring doctor will provide more information than we have been given on the form and the senior medical officer will come back to Sue-Ann and say, "Look, we do need to approve this case", because they have got more information than the clinical office has been provided. Previously when the clerks were having that discussion it was not a robust discussion, so the senior medical officer now will have that discussion and nine times out of 10 it can be resolved over the phone with a clear understanding of why we have approved or why it has not been approved.

The CHAIRMAN: That, I think, brings us to the end of our questions for you but I would like to say thank you very much, on behalf of the committee, for appearing today, for showing us around the hospital and for being very fulsome in the answers you have given us. As I have been saying as we went around, there is a very large jigsaw puzzle out there called the PAT scheme and yours is a very integral part in that puzzle. Hopefully, we will get a whole picture and be able to make some recommendations. This is for the benefit of others in the room as well: this committee is not making any decisions with regard to PATS; we do not have that ability. We will merely be taking all the evidence that we have heard from around the place, deliberating and coming up with some recommendations, tabling a report in Parliament and, hopefully, then the Minister for Health and the government will have a look at that and go, "You know what, we can do a bit better", because

the Public Administration Committee said so, so we are hopeful for that. Thank you very much indeed for coming today.

Mr Darby: A quick bit of housekeeping for a moment: I did not make notes. Are we going to a request for the things we said we would do?

The CHAIRMAN: Yes, if you had listened when I was swearing you in, I said a transcript of your evidence will be provided to you. You will get a transcript and you can say "No, no; that's not quite right or that's not what I meant", and that will come back to us with those corrections and then it will go online as public evidence.

Mr Darby: Sorry, the tasks that we said we were going to get back to you on?

The CHAIRMAN: Yes, that is why I gave them A1, A2, A3, because then they will be noticed in there and you will say, "These are the things we took on notice to please provide." Thank you very much.

Hearing concluded at 2:18 pm

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