Special Commission of Inquiry into Healthcare Funding

Statement of Peter Carter

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Occupation:	Board Chair, Northern New South Wales Local Health District

1. This statement made by me accurately sets out the evidence that I would be prepared, if necessary, to give to the Special Commission of Inquiry into Healthcare Funding (**Inquiry**) as a witness. The statement is true to the best of my knowledge and belief.

2. It is provided in response to topics identified by the Inquiry in a letter to the Crown Solicitor's Office dated 14 August 2024 (**MOH.0010.0542.0001**), to the extent that such topics are relevant to my role, and to the Inquiry's letter to the Crown Solicitor's Office dated 22 August 2024 (**MOH.0010.0541.0001**).

A. INTRODUCTION

3. I am the Board Chair of Northern New South Wales Local Health District (**NNSWLHD, LHD, District**). I became a member of NNSWLHD's Board in January 2019 and was appointed Board Chair in January 2023.

4. My professional experience is in healthcare quality and safety, strategy, innovation and management. I am a former Chief Executive Officer (**CEO**) of the Royal Australian and New Zealand College of Psychiatrists, the Royal Australasian College of Surgeons, and the International Society for Quality in Health Care (**ISQua**) and a former Board member of ISQua.

5. A copy of my curriculum vitae is exhibited (**MOH.0010.0581.0001**).

B. BOARD GOVERNANCE

6. The NNSWLHD Board has eleven members from a diverse range of backgrounds including medical, nursing, allied health, accounting, legal, healthcare research and health management. Board Deputy Chair, Mr Scott Monaghan AM, is the CEO of Bulgarr Ngaru Medical Aboriginal Corporation, providing direct integration between the NNSWLHD Board and one of NNSWLHD's Aboriginal and Torres Strait Islander partner organisations.

7. The Board meets monthly in locations across NNSWLHD including in small facilities, to increase the Board's connection beyond the larger facilities within the LHD. The Board also invites clinicians and other staff to present to and hold discussions with the Board at Board meetings in each location.

8. The NNSWLHD Board is responsible for:

    a. Improving local patient outcomes and responding to issues that arise throughout NNSWLHD,

    b. Monitoring the performance of the District against performance measures in the Service Agreement between the NNSWLHD and the Secretary, NSW Health (**Service Agreement**),

    c. Delivering services and performance standards within an agreed budget, based on annual strategic and operating plans. This forms the basis of the Service Agreement,

    d. Production of Annual Reports that are subject to State financial accountability and audit frameworks,

    e. Maintaining effective communication with local and State stakeholders, involving providers and the community in decisions that affect them,

    f. Ensuring effective engagement with our clinicians and staff,

    Establishing and overseeing an effective governance and risk management framework for the LHD,

    g. Ensuring high standards of professional and ethical conduct are upheld,

    h. Setting the LHD's strategic priorities, and

    i. Holding the LHD Chief Executive accountable for their performance.

Board and Committee Structure

9. The Chief Executive, who is accountable to the Board in the exercise of their functions as Chief Executive, regularly reports to the Board and attends Board meetings.

10. The NNSWLHD By-Laws, which reflect the Model By-Laws and are established in accordance with section 39 of the *Health Services Act 1997,* provide for the structure and procedures of the Board. In accordance with the Model By-Laws, the NNSWLHD Board has established the following Committees:

    a. Audit and Risk Committee,

    b. Finance and Performance Committee,

    c. Health Care Quality Committee, and

    d. Medical and Dental Appointments Advisory Committee (**MDAAC**) including the Credentials (Clinical Privileges) Subcommittee.

11. The NNSWLHD By-Laws provide for the following additional management committees of the NNSWLHD Board:

    a. Clinical Planning and Clinician Engagement,

    b. Community Partnership Advisory Committee,

    c. Environmental Sustainability and Healthcare,

    d. Research and Innovation, and

    e. Creating a Sustainable Future Together.

12. With the exception of the Audit and Risk Committee, each Board committee is chaired by a Board member and usually comprised of at least one member of the LHD Executive or delegate. The Board appoints clinician representation as it considers appropriate, in consultation with Medical Staff Executive Council or any relevant Medical Staff Council or the LHD Clinical Council.

13. The Audit and Risk Committee is made up of three to five members independent of the LHD and the Chair who is also independent of the LHD.

14. The Chair of each Board Committee or Management Committee presents updates to the Board on the work of their committee and also feeds back information from the Board to their respective committees.

15. In addition to the committees and management committees of the Board, the Model By-Laws provide for the establishment of a number of structures for clinician consultation and input into the LHD including:

    a. Medical Staff Councils (**MSC**) and Medical Staff Executive Council (**MSEC**), and

    b. Hospital Clinical Councils and District Clinical Council.

16. In NNSWLHD there are MSCs at X which report up to the MSEC, with the Chair of each MSC being a member of the MSEC. The Chair of the MSEC attends Board meetings from time to time and is a direct point of contact between the Board and clinicians.

17. Similarly, the Hospital Clinical Councils report up to the District Clinical Council, whose role is to advise the Board.

18. In addition, the Board reviews MDAAC minutes.

Board Chair

19. In my role as Board Chair, I am responsible for ensuring that the Board performs its functions. I do this in various ways, including:

    a. Maximising the benefit that each Board member can bring to Board processes and NNSWLHD by reviewing and understanding their skills, expertise and interests. For example, one of our Board members has a PhD in Engineering and professional experience in the energy sector, a skill which has been utilised in the development of the NNSWLHD Environmental Sustainability and Healthcare Program.

    b. Horizon scanning by one or two Board members presenting, at each Board meeting, on what they are doing in their own workplaces that may have a bearing on their Board roles, so that we can consider new ideas and ways of working.

    c. Increasing the cohesiveness of the Board and NNSWLHD, maintaining a presence amongst the NNSWLHD workforce and strengthening the bonds between the Executive and the Board. This is undertaken in a variety of ways including formal and

informal workshops and gatherings, and meetings (work and social) with staff in hospitals and other facilities.

d. Ensuring Board members participate in professional development activities, including *Respecting the Difference (*Aboriginal cultural training) and extending healthcare networking.

20. These responsibilities are reflected in the *NNSWLHD Board Development Plan: Proposed Key Performance Indicators as at October 2021*, exhibited to this statement (**MOH.0010.0582.0001**).

Board training and development

21. In 2019, when I became a member of the Board of NNSWLHD, I participated in a two-day program in Sydney with a private organisation facilitated by the Ministry of Health (**MOH**). This program assisted Board members to learn about the mechanics of Boards, how MOH operates, and the relationship between the two. I understand that the last comprehensive two-day training program for Board members was run by MOH in 2021.

22. I understand that since 2022 there have been only limited changes in Board appointments across the State and, accordingly, MOH has run a smaller 'core requirements' program for any newly appointed Board members, plus any members who may have missed a previous program.

23. I also understand that MOH is in the process of procuring a new program for Board members to commence in 2025. In addition, MOH hosts an annual Board Members' Conference and regular Council of Board Chairs' forums.

24. As Board Chair I also conduct one on one onboarding programs for new Board members focussing on local priorities, procedures, accountabilities and relationships and on the changing healthcare landscape locally and internationally.

25. In part, I have utilised the training I received in the two-day program in forming the Board Development Working Party ("**the Working Party**") and developing the *Board Development Working Party Implementation Plan*, exhibited to this statement (**MOH.0010.0583.0001**) The Board appointed the Working Party to guide the Board development planning and implementation and its ongoing oversight is the responsibility of a Board member with a particular interest and expertise and myself as Chair.

26. The Working Party has developed a series of minutes, proposals and reports from its meetings which reflect the work of and plans for Board development. These are discussed with the Chief Executive so the Executive are informed about Board member development and to enable the Chief Executive and the Executive to advise on any managerial implications of these plans and activities.

C. THE BOARD'S ROLE IN STRATEGY AND PLANNING

27. Health care quality is impacted by what occurs from the Boardroom to the bedside as the Board decisions and directions influence the quality of the services NNSWLHD delivers, particularly through its focus on outcomes and innovation.

28. The Board and Chief Executive work together in the preparation of NNSWLHD's future strategic planning and the current Chief Executive has a strong engagement with the Board in general and the Board Chair in particular.

29. The Board recognises that healthcare must change if we are to continue to be able to deliver high quality, safe and timely healthcare and to do so affordably. In particular, the Board focuses on encouraging exploration of approaches that recognise importance of innovation and change and exploring new models of care; secondly by working with the community particularly in Aboriginal and Torres Strait Islander Health; and thirdly by working to ensure the effectiveness and responsiveness of the Board. In addition, as Chair, I frequently address workforce and community groups encouraging them to understand and embrace new ways of approaching healthcare (eg. a focus on encouraging wellness to prevent illness rather than treating illness).

30. Decentralisation of health services, which is a strength of the NSW Health System, enabled the Board to support a locally tailored approach in response to the COVID 19 pandemic, specifically in the roll out of vaccinations to Aboriginal and Torres Strait Islander communities (see Board preliminary submission to the Inquiry).

Partnerships

31. The Commonwealth and State governments have an interest in the Local Health Districts (**LHDs**) and Primary Health Networks (**PHNs**) working more closely together, and NNSWLHD, Mid North Coast LHD and the Northern NSW PHN were the first in the State to sign a Memorandum of Understanding (**MoU**) to facilitate such a partnership. This MoU was signed on 6 February 2024. The MoU assists in facilitating joint projects across

the geographical region, with the first such project focused on mental health and drug and alcohol treatment. A copy of the MoU is exhibited (**MOH.0010.0585.0001**) as is the Tool for Reporting Progress on the MoU (**MOH.0010.0584.0001**).

32. There are three Aboriginal Medical Services (**AMSs**) operating in the geographical region of NNSWLHD. NNSWLHD has entered into an Aboriginal Health Partnership comprised of NNSWLHD, the PHN and the AMSs. The NNSWLHD Board participated in a meeting of the Aboriginal Health Partnership in August 2024.

33. NNSWLHD has work underway in relation to Aboriginal and Torres Strait Islander cadetships and apprenticeship programs to work towards the aims of the National Closing the Gap strategy. Our Director of Aboriginal Health, Kirsty Glanville, and Board Deputy Chair, Scott Monaghan, are best placed to discuss these cadetships and programs in detail, but NNSWLHD is improving the overall representation of Aboriginal and Torres Strait Islander people in the LHD workforce.

Community

34. Communication, consultation and management are key to listening to the community and informing the community about matters relevant to the delivery of health services in NNSWLHD. Faults in communication, whether in the way information is communicated or the way in which it is received, can cause problems in the LHD's relationship with the community. For example, in 2022 the Board spent a lot of time consulting with the community, LHD workforce and MOH about ceasing overnight surgery at Murwillumbah Hospital. The Board and MOH approved this decision in October 2022. The decision was conveyed to the community, LHD workforce and the local member however the date of implementation (approx. one year later) was not announced to the staff and the community until approx. two months before it was to occur. The problem was not the way in which we communicated about the change, but the communication concerning the implementation of that change was inadequate.

35. Communication with leaders in the community, particularly local mayors, and the provision of reasons for decision making, are an important part of the Board's role. Together with the Chief Executive, I wrote to the Mayor of the Shire in which Murwillumbah Hospital is located in response to her request that NNSWLHD retain a 'highly functioning hospital in perpetuity', following the closure of the surgical ward in question. We explained that it is not possible to give such a guarantee as models of care

are rapidly changing and the health system is constantly evolving and cannot survive without innovating. We gave examples of the sorts of models of care needed to make healthcare more sustainable. A copy of the letter to the Mayor dated 8 May 2024 is exhibited (**MOH.0010.0651.0001**).

36. I have delivered annual presentations to a key community group and our workforce on the issues of the rapidly changing nature of the health system and the need for innovation. The purpose of the presentations is to socialise these issues with our communities and staff generally, rather than just raising issues in the context of specific changes.

D. INNOVATION AS A PRIORITY TO ADDRESS WORKFORCE AND FUNDING ISSUES

37. There are workforce challenges in NSW that innovation may help to address, some of which are described in the aforementioned paragraphs and others include considering changes to the roles of various workforce groups such as nursing and allied health and placing more emphasis on integrated care (e.g. better value care, knee and hip and overnight joint surgery) The NNSWLHD Board is focused on the adoption of various programs to encourage innovation, and new models of care and technologies to enhance the delivery of healthcare to NNSWLHD's consumers. Such innovation can also help to overcome structural funding issues. This is a particular focus of mine, following my work for the ISQua which supports innovation globally. The recurring theme is that we need to do things differently and focus more on preventative health rather than pouring money into treatment that may be avoidable.

38. NNSWLHD has a research committee focused on research and innovation, however the LHD does not have the advantages of metropolitan LHDs in terms of funding and connections with large universities on their doorstep, so to be effective in research is more of a challenge. To respond to this challenge, the Board has prioritised development of local partnerships in particular the Education Hub located on the campus of the Tweed Valley Hospital.

39. The Board had a leadership summit around two months ago in NNSWLHD, where I gave a presentation on future challenges and long-term investment in health care. The Board has also focussed on communicating with senior managers, leaders and community members on these issues.

40. In my view, the issues impacting our health care system are becoming increasingly serious, and persisting with the existing system is not going to take us where we need to be in the next two decades. In NSW, the spending on healthcare is approximately $33 billion a year from a $100 billion NSW budget. LHDs are being asked by MOH, understandably, to keep costs down, but if we keep delivering healthcare the way we deliver it, it is impossible to keep costs down in the context of an aging population and having a product for which the demand continues to increase irrespective of other economic factors such as price. Through my presentations and talks as Board Chair, I try to deliver this message in more detail, as well as discuss potential new models of care, to our workforce, the community and to any other relevant forums.

41. There will never be enough resources to provide healthcare without limitation, but we know that the last 10 years of life takes up about 70% of healthcare resources and the elderly as a proportion of the total population is rapidly increasing. In the context of an aging population, I anticipate that this will lead to a worsening of budgetary pressure. There are things we can do (referred to in previous paragraphs), and need to do, to respond to these increasingly serious issues.

42. In my view, fundamental changes are required, including investing more in preventative care, improving the social determinants of health and exploring alternative models of care to be able to afford healthcare in the future. This may not provide a return on investment for many decades and, unfortunately, there may not be political will to promise plans beyond a term of office.

Peter Carter	Witness: [insert name of witness] Geoff Hilton
05 09 2024	5/9/2024
Date	Date