Special Commission of Inquiry into Healthcare Funding

Statement of Scott McLachlan

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Occupation:	Chief Executive, Central Coast 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 as a witness. The statement is true to the best of my knowledge and belief.

A. BACKGROUND

2. My name is Scott McLachlan. I am the Chief Executive of Central Coast Local Health District (**CCLHD**) a role which I have held since November 2021. My role is to ensure the proper running of CCLHD to deliver high quality clinical care the local community, and I am responsible to the Board for this. Before being appointed as the Chief Executive of CCLHD, I was the Chief Executive of Western NSW LHD for eight years, prior to which I was the Director of Operations at Hunter New England LHD. A copy of my CV is exhibited to this statement (Exhibit 4 NSW Health Tranche 4 Consolidated Exhibit List).

3. CCLHD has two acute hospitals, Gosford and Wyong. Gosford Hospital is the principal referral hospital and regional trauma centre for the Central Coast, Wyong Hospital is a major metropolitan hospital while Woy Woy Hospital and Long Jetty Healthcare Centre provide sub-acute care. Additionally, there are eight community health centres and other community-based services.

4. An organisational chart, showing the structure of CCLHD's leadership team is Exhibit 201 NSW Health Tranche 4 Consolidated Exhibit List. A committee map, showing all relevant committees currently operating in CCLHD, is Exhibit 202 NSW Health Tranche 4 Consolidated Exhibit List.

5. This statement addresses Terms of Reference B (governance) and D (waste minimisation and efficiency) of the Inquiry, but on direction from the Inquiry does not address workforce governance, which I understand will be the subject of later tranches of hearing. Specifically, this statement addresses the following:

    a. Section B Corporate Governance (including the legal framework, regional governance, and community engagement);

b. Section C System Planning;

c. Section D Financial Governance (including risk and audit, delegations, asset management and environmental sustainability);

d. Section E Clinical Governance;

e. Section F Waste Minimisation and Efficiency, and

f. Section G Opportunities.

B. CORPORATE GOVERNANCE

Legal Framework

CCLHD establishment

6. Section 17 and Schedule 1 of the *Health Services Act* 1997 (***Health Services Act***) establishes CCLHD as a statutory corporation. It is responsible for managing public hospitals and health institutions and for providing health services to a defined geographical area. Their primary purposes under section 9 of the *Health Services Act* are to:

    a. provide relief to sick and injured people through the provision of care and treatment, and

    b. promote, protect and maintain the health of the community.

7. Part 3 of Chapter 3 of the *Health Services Act* also sets the key functions of CCLHD and provide that the Secretary can determine the role, functions and activities of services under the control of a LHD and, for that purpose, give any necessary directions to the LHD. In addition, the Minister can direct an LHD to establish or close any service or restrict any treatment provided by a service under its control, should it be in the public interest to do so. There is an additional mechanism for oversight by the Secretary, discussed under the Ministry of Health heading below.

CCLHD Board

8. I am responsible and accountable to the CCLHD Board. The Board oversees the strategy, financial and operational performance, governance, reporting and other functions.

9. The specific functions of boards are set out in section 28 of the *Health Services Act* and include that they are to ensure effective clinical and corporate governance frameworks are established to support the maintenance and improvement of standards of patient care and services by the LHD and to approve those frameworks.

10. A chief executive is not a board member but is required to be invited to board meetings as is the chair of the Medical Staff Executive Council and executive staff members. In CCLHD, as there is no chair of the Medical Staff Executive Council, the chair of the Medical Staff Councils of Gosford and Wyong Hospitals attend board meetings.

11. As Chief Executive, I sit on the following Board sub-committees:

    a. Research Committee;

    b. Aboriginal Health Partnership and Advisory Council

    c. Healthcare Quality Committee;

    d. Audit and Risk Committee;

    e. Consumer and Community Committee;

    f. People and Culture Committee, and

    g. Finance and Performance Committee.

Ministry of Health

12. In the exercise of power conferred under s. 127(4) of the *Health Services Act*, the Secretary, as delegate of the Minister, has determined Conditions of Subsidy which requires CCLHD to comply with:

    a. The Accounts and Audit Determination for Public Health Entities in NSW (Exhibit B.23.035 MOH.0001.0278.0001),

    a. The *Accounting Manual for Public Health Organisations* (Exhibit 49 NSW Health Tranche 4 Consolidated Exhibit List) and

b. Any directions, Policy Directives, Information Bulletins, Guidelines, Manuals and any other policies or procedures issued or approved by the Health Secretary or the Minister.

13. The annual Service Agreement is the principal vehicle through which the service and performance expectations of the Secretary are set out. A copy of CCLHD's *2023-24 Service Agreement* is exhibited to this statement (Exhibit 100 NSW Health Tranche 4 Consolidated Exhibit List).

14. The purpose of the Service Agreement is to ensure the provision of equitable, safe, high quality and human-centred healthcare services. It facilitates accountability to government and the community for service delivery and funding. The agreement articulates direction, responsibility and accountability across the NSW Health system for the delivery of high quality, effective healthcare services that promote, protect and maintain the health of the community, in keeping with NSW Government and NSW Health priorities. Additionally, it specifies the service delivery and performance requirements expected of CCLHD that will be monitored in line with the *NSW Health Performance Framework*. These functions, particularly any monitoring of service delivery and performance requirements, are often delegated by the Secretary to the Ministry of Health.

NSW Health Policies and Procedures

The Service Agreement

15. Section 1.5 of the *2023-24 Service Agreement* sets out CCLHD's governance requirements, and requires that all applicable duties, obligations and accountabilities are understood and complied with, and that services are provided in a manner consistent with all NSW Health policies, procedures, plans, circulars, inter-agency agreements, Ministerial directives and other instruments and statutory obligations. It sets out various governance requirements with respect to the following areas:

    a. **Clinical governance**: NSW public health services must be accredited against the *National Safety and Quality Health Service Standards*, a copy of which is exhibited with this statement (Exhibit 22 NSW Health Tranche 4 Consolidated Exhibit List). CCLHD are required to complete a *Safety and Quality Account* inclusive of an annual attestation statement as outlined in the Standards by the 31 October each year. A copy of CCLHD's most recent *Safety and Quality Account* is exhibited with this statement (Exhibit 101 NSW Health Tranche 4 Consolidated Exhibit List).

Further, the *Australian Safety and Quality Framework for Health Care* provides a set of guiding principles that assist health services with their clinical governance obligations a copy of which is exhibited with this statement (Exhibit 102 NSW Health Tranche 4 Consolidated Exhibit List). Finally, *PD2024_010 Clinical Governance in NSW* provides an important5 framework for improvements to clinical quality, a copy of which is exhibited with this statement (Exhibit 76 NSW Health Tranche 4 Consolidated Exhibit List).

b. **Corporate governance**: CCLHD must ensure services are delivered in a manner consistent with the *NSW Health Corporate Governance and Accountability Compendium* (the ***Governance Compendium***), a copy of which is exhibited with this statement (Exhibit A.12 SCI.0001.0008.0001). The *Governance Compendium* is discussed further below.

c. **Procurement governance**: NSW Government agencies including CCLHD must apply the *Aboriginal Procurement Policy* to all relevant procurement activities, a copy of which is exhibited with this statement (Exhibit 103 NSW Health Tranche 4 Consolidated Exhibit List).

d. **Public health emergency preparedness and response**: CCLHD must comply with standards set out in *PD2024_002 Public Health Emergency Response Preparedness Minimum Standards* and adhere to the roles and responsibilities set out in *PD2024_005 Early Response to High Consequence Infectious Disease*. Copies of these are exhibited with this statement (Exhibits 24 and 25 respectively NSW Health Tranche 4 Consolidated Exhibit List).

e. **Performance framework**: Service Agreements are a central component of the *NSW Health Performance Framework (**Performance Framework**)*, a copy of which is exhibited with this statement (Exhibit A.11 SCI.0001.0007.0001), which documents how the Ministry of Health monitors and assesses the performance of public sector health services to achieve expected service levels, financial performance, governance and other requirements (as described above).

16. Section 6 of the *2023-24 Service Agreement* sets out CCLHD's performance requirements against set strategies and objectives. Section 6.1 sets out various key performance indicators (**KPIs**) across various key objectives:

a. patients and carers have positive experiences and outcomes that matter;

b. safe care is delivered across all settings;

c. people are well and health;

d. our staff are engaged and well supported;

e. research and innovation, and digital advances inform service delivery, and

f. the health system is managed sustainably.

17. Each of those categories contains various measures to assess CCLHD's performance. Section 6.2 of the *2023-24 Service Agreement* sets regular delivery and reporting obligations to the Ministry of Health (either quarterly, six monthly, or by a particular date) on the key objectives set out above.

18. CCLHD monitors all Service Agreement KPIs on a regular basis and meets with MOH on a quarterly basis in performance review to assess performance against these KPIs. We have developed a performance scorecard within the Board's governance requirements and report on these to the Board and its sub-committees on a monthly basis.

The *Governance Compendium*

19. The *Governance Compendium*, at section 2, includes seven corporate governance standards:

a. Standard 1: Establish robust governance and oversight frameworks;

b. Standard 2: Ensure clinical responsibilities are clearly allocated and understood;

c. Standard 3: Set the strategic direction for the organisation and its services;

d. Standard 4: Monitor financial and service delivery performance;

e. Standard 5: Maintain high standards of professional and ethical conduct;

f. Standard 6: Involve stakeholders in decisions that affect them, and

g. Standard 7: Establish sound audit and risk management practices.

20. The *Governance Compendium* requires that CCLHD publish an annual *Corporate Governance Attestation Statement* that outlines their governance arrangements,

compliance with the Standards and includes key information on their operations. A copy of CCLHD's *2021-22 Corporate Governance Attestation Statement* is exhibited with this statement (Exhibit 203 NSW Health Tranche 4 Consolidated Exhibit List). The *Corporate Governance Attestation Statement* must be prepared by myself, tabled at an Audit and Risk Management Committee meeting, and endorsed by the Board and signed by the Board Chairperson. A model Statement is provided by the Ministry of Health, which identifies the minimum information to be included.

Performance Framework

21. The *Performance Framework* incorporates the strategic priorities for the NSW Health system which flow from Commonwealth/State agreements, including implementation of NSW Health Funding Reform.

22. The *Performance Framework* includes the performance expected of affected organisations to achieve the required levels of health improvement, service delivery and financial performance. It comprises:

    a. Service Agreements with health services, and Service Compacts with support organisations, include clearly stated performance requirements including Strategic Priorities and governance requirements

    b. the roles and responsibilities of health services, the NSW Ministry of Health, the Clinical Excellence Commission and the Agency for Clinical Innovation

    c. KPIs and their performance thresholds that, if not met, may raise a performance concern and the process through which these concerns are identified and raised.

    d. transparent monitoring and reporting processes both internally to boards and externally to government

    e. expectations of responses to unsatisfactory performance or significant clinical issues or sentinel events, and

    f. robust governance processes through which escalation or de-escalation of responses is determined.

23. The *Performance Framework* applies to:

a. the 15 geographical NSW local health districts and other NSW health services: NSW Ambulance; Sydney Children's Hospitals Network; St Vincent's Health Network; Justice Health and Forensic Mental Health Network; Affiliated Health Organisations

b. NSW Health support organisations: Agency for Clinical Innovation, Bureau of Health Information, Cancer Institute NSW, Clinical Excellence Commission, Health Education and Training Institute, HealthShare NSW and NSW Health Pathology, and

c. Each health service is to have in place an effective internal performance framework that extends to facility and clinical network/stream levels for monitoring performance and identifying and managing emerging performance issues.

24. CCLHD has developed its own specific performance framework consistent with the *Performance Framework*, which is discussed in the next section.

CCLHD's Governance Policies and Guidelines

25. CCLHD develops its own policies, guidelines, which sit under and incorporate the requirements of MOH policies and guidelines and also include CCLHD standard operating practices and procedures. To set a uniform development process, CCLHD has implemented a *Policy Development Framework*, a copy of which is exhibited with this statement (Exhibit 104 NSW Health Tranche 4 Consolidated Exhibit List). Newly developed policies, guidelines, and standard operating practices and procedures are required to be developed in accordance with that Framework and submitted to the CCLHD Policy & Procedure Implementation Committee which oversees policy development. The Framework must be read in conjunction with CCLHD's *Policy, Procedure and Guideline – Development, Approval and Implementation System*, a copy of which is exhibited to statement (Exhibit 106 NSW Health Tranche 4 Consolidated Exhibit List).

CCLHD's Organisational Performance Framework

26. The CCLHD *Organisational Performance Framework* (***OPF***), a copy of which is exhibited with this statement (Exhibit 106 NSW Health Tranche 4 Consolidated Exhibit List) is reviewed on an annual basis. It sets out our arrangements for the monitoring of

organisational performance and identifying and managing emerging performance issues. It includes processes and tools to articular and monitor:

a. Service Agreement and KPI reporting

b. budget allocation letters and reporting

c. organisational sustainability initiatives and reporting

d. operational plan action setting and reporting

e. annual My Contribution & Development conversations

f. monthly accountability meetings

g. safety huddles and rounding

h. workplace induction, and

i. leader toolkits.

27. Generally local KPIs are more specific, relevant to a particular service, than Service Agreement KPIs. The OPF identifies the relevant Service Agreement and local KPIs for each service and allows the service to have visibility of both Service Agreement and local KPIs so that they may monitor their own performance. The two sets of KPIs in the OPF informs the quarterly review process and enables the LHD to support the service in the delivery of KPIs.

Partnership governance

Central Coast Health Alliance

28. CCLHD works with a range of organisations across community health, research and innovation, aged care, and Aboriginal health.

29. In 2014, CCLHD developed a demonstrator site to test new ways of providing health care with the aim of better service integration and improved outcomes for residents, titled the *Central Coast Local Health District Integrated Care Program* (**Integrated Care Program**). It was a collaboration between the LHD and The Hunter New England and Central Coast Primary Health Network to move three target groups – vulnerable young people, vulnerable older people and people with chronic and complex conditions – to a more anticipatory model of care.

30. In 2019, CCLHD staff, together with academics from the University of Newcastle and the University of West Scotland, published an evaluation of the Integrated Care Program in the *International Journal of Integrated Care*. A copy of that article is exhibited to this statement (Exhibit 204 NSW Health Tranche 4 Consolidated Exhibit List). The article sought to evaluate the Integrated Care Program, finding seven lessons centred around aligning partner objectives, developing strong relationships, having leadership at multiple levels, and the building of a common language.

31. The CCLHD continues to be a leader in integrated care, working closely with the Hunter New England and Central Coast Primary Health Network (**PHN**). In 2017 the Integrated Care Program was expanded by the establishment of the Central Coast Health Alliance (**the Alliance**). The Alliance between CCLHD and the PHN has a formal governance structure of a steering committee made up of clinicians and senior leaders from both CCLHD and the PHN and jointly chaired by me and the CEO of the PHN. The Alliance was established to develop and implement collaborative healthcare solutions to improve patient outcomes. Part of the Alliance program requires that consideration be given the whole system impact, patient outcomes and experience and the best value per resource. The Alliance is focussed on four areas: aged care, chronic pain, diabetes, and mental health, urgent care models. Some examples of programs developed by the Alliance include a model of enablement and care coordination for the older population of the Central Coast titled ALICE (All Inclusive Care for the Elderly).

GP Collaboration Panel

32. The Central Coast GP Collaboration Panel is funded by CCLHD and the PHN and sits within the Alliance. There are a number of senior CCLHD clinicians and leaders who attend the Panel, which has been established to oversee the development and implementation of an annual program of priorities aimed at improving the operation the healthcare system for patients and community on the Central Coast by facilitating effective partnerships between hospital, general practice and the PHN that enables

provision of high quality care that is comprehensive, person centred, population oriented, coordinated, accessible, safe and high quality.

33. The GP Panel was an initiative of the Central Coast Health Alliance to engage with Primary Care Practitioners across the coast and progress Integration opportunities with the Secondary and Tertiary Care Sectors in 2019.

Inter-agency partnership

34. I am a member of the Inter-agency NSW Government Regional Leadership Executive, which is made up of the Heads of NSW Government agencies for the Hunter and Central Coast region. I chair the Central Coast Human Services sub-committee which co-ordinates priorities across agencies for the Central Coast region.

C. SYSTEM PLANNING

35. CCLHD's system planning is guided by *Future Health*, a copy the *Future Health* report is exhibited to this statement (Exhibit A.14 SCI.0001.0010.0001). The *Future Health* strategy provides a 10 year strategic plan for NSW Health and sets six strategic goals:

    a. Patients and carers have positive experiences and outcomes that matter

    b. Safe care is delivered across all settings

    c. People are healthy and well

    d. Our staff are engaged and well supported

    e. Research and innovation, and digital advances inform service delivery, and

    f. The health system is managed sustainably.

General LHD and Governance Planning

Caring for the Coast Strategy

36. In 2019, CCLHD implemented a *Caring for the Coast Strategy*, a copy of which is exhibited to this statement (Exhibit 107 NSW Health Tranche 4 Consolidated Exhibit List). The *Strategy* is a five-year plan that sets out CLHD's plan for our populations changing health, providing better value care, building workforce requirements, and ensuring CCLHD acts in accordance with applicable national and State policies, for example the *Future Health* strategy. Of particular relevance, the *Strategy* identified that

inclusive leadership is evident across all levels of the organisation and encourages and supports people to perform at their best and clear governance structures support frontline decision-making and ensure all staff are aware of their responsibilities and accountabilities. The *Strategy* determined that CCLHD would:

a. ensure that our governance and management structures and processes are aligned to support and enhance service delivery;

b. improve staff awareness of their responsibilities, performance standards and expectations, and accountabilities;

c. foster positive leadership skills and qualities across all levels and roles, and

d. staff are able to access leadership opportunities and development programs.

37. The Caring for the Coast strategy was interrupted by the COVID-19 pandemic, however this coincided with the re-focussing of the strategy to particular areas needing additional attention to address performance challenges. These challenges arose in the areas of financial sustainability, quality and safety of care in hospital acquired complications and in timely access to care for particular patient groups. In addressing performance concerns, the Executive developed an improvement plan across these three areas and in particular an organisational sustainability strategy (the OPF) was developed to address the underlying financial challenges.

Caring for Our Community Plan

38. In 2021, CCLHD finalised our *Caring for Our Community Plan 2021-2031* (***the Plan***), a copy which is exhibited to this statement (Exhibit 109 NSW Health Tranche 4 Consolidated Exhibit List). The *Plan* outlines the priorities and future direction for CCLHD community health services over the next 10 years. This plan focuses on the future CCLHD community health services, models of care and how best to deliver these services. The emphasis is on future community health services that are innovative, contemporary, efficient and effective. These concepts are reflected in the vision for community health services on the Central Coast and fundamental principles underpinning these services.

39. *The Plan* was developed with input from the community of the Central Coast and a range of local health and related service providers within CCLHD as well as from partner agencies at the local level, from across NSW, Australia and internationally. *The Plan* was

also informed by a review of key local and state plans, frameworks and seminal documents and relevant literature searches and reviews. It defined four focus areas as follows:

a. community, patients, family and carers;

b. staff;

c. services, and

d. facilities

40. For each focus area, desired outcomes were set, along with actions needed to reach those outcomes. For example, in relation to our facilities, *the Plan* seeks to support a shift to a hub and spoke community health service delivery model. A hub and spoke model involves larger centres in the North and South of the Central Coast supporting smaller community health centres in a network arrangement.

Clinical Services Planning

41. CCLHD's *Clinical Services Plan 2023-2028*, a copy of which is exhibited to this statement (Exhibit 110 NSW Health Tranche 4 Consolidated Exhibit List), sets out our plan to develop services and increase capacity to meet the health needs of the community as our population ages and levels of chronic disease increase and the cost and demand for health care continues to rise. People in our community are facing challenges accessing primary care, getting placements in residential aged care facilities or accessing disability care packages. The *Services Plan* identifies four key strategic directions for CCLHD:

a. implement timely emergency care alternatives through the provision of timely, urgent and emergency health care services;

b. maximise the efficiency of acute service capacity by determining service profiles and networking to optimise activity;

c. enhance out of hospital services through the provision of services delivered outside of acute hospital settings, expanding out-reach, community and home-based services, and

d. Promote prevention, education and self-management by improving population health and education to support improved health and wellbeing outcomes, and opportunities for self-management of care.

42. Further, the *Services Plan* also identifies three action areas to implement those key strategic directions:

a. continue to drive improvements in service delivery and service access across CCLHD through existing programs and initiatives;

b. complete detailed analysis of the service models identified to inform prioritisation with the clinical teams. Undertaking data analytics and planning initiatives will provide the right level of data and evidence to determine where and how new service models should be implemented to best meet the health needs of the community, deliver optimal patient outcomes and experience, and maximise service efficiency, and

c. implement a dynamic service modelling approach to evaluate the impact of service models on patient and service outcomes, and promptly respond to new and emerging community health and service needs.

D. FINANCIAL GOVERNANCE

The Service Agreement

43. The *2023-24 Service Agreement* require that CCLHD must comply with the conditions of subsidy set out in the *Financial Requirements and Conditions of Subsidy (Government Grants)*, a copy of which is exhibited to this statement (Exhibit 28 NSW Health Tranche 4 Consolidated Exhibit List). The *Financial Requirements and Conditions of Subsidy (Government Grants)* provides that LHDs must comply with the standards regarding financial accountability, budget management, and compliance with accounting standards and government policies. Myself, my Director of Finance and our direct reports are required to understand and comply with its requirements. As a Chief Executive, I am responsible for ensuring that there are appropriate measures in place to ensure sound financial management and compliance with Ministry of Health and Government policies with regards to financial and budgeting practices.

The Financial Requirements and Conditions of Subsidy (government grants)

44. The *Financial Requirements and Conditions of Subsidy (Government Grants)* also provides that LHDs must comply with the following:

    a. the *NSW Health Accounts and Audit Determination,*

    b. the *Australian Accounting Standards Pronouncements* (where it is applicable to the public sector),

    c. the *Accounting Manual for Public Health Organisations*, a copy of which is exhibited to this statement (Exhibit 49 NSW Health Tranche 4 Consolidated Exhibit List), and

    d. any directions, Policy Directives, Information Bulletins, Guidelines, Manuals and any other policies or procedures issued or approved by the Health Secretary or the Minister.

Accounts and Audit Determination

45. The *Accounts and Audit Determination for Public Health Entities in NSW* document requires myself and the Board to ensure that:

    a. the proper performance of accounting procedures including the adequacy of internal controls the accuracy of our accounting, financial and other records;

    b. the proper compilation and accuracy of our statistical records, and

    c. observance of the directions and requirements of the Secretary and the Ministry of Health set out in policy directives and procedure manuals issued by the Minister, the Secretary, and the Ministry of Health.

Audit and Risk

46. *PD2022_022 Internal Audit* describes the internal audit procedures and governance practices that NSW Health organisations must implement and maintain to ensure objective oversight of the organisation's activities. A copy of the policy is exhibited to this statement (Exhibit B.23.158 MOH.0001.0265.0001). The *Internal Audit* policy requires All NSW Health organisations must have an effective and adequately resourced Internal Audit function, with clear separation from operational management. The Internal Audit function must be operationally independent from the activities it audits. The Internal Audit function must be appropriately positioned within the Organisation's governance

framework to work with external audit and internal business units, and a Chief Audit Executive must be appointed. The Chief Audit Executive must ensure an Audit Charter is in place and consistent with the content of the Health Model Charter, and the Charter must be endorsed by the LHD Chief Executive.

47. The Chief Executive must appoint an Audit and Risk Committee. All Members (including the Chair) must be independent and sourced from NSW Treasury's Prequalification Scheme: Audit and Risk Committee Independent Chairs and Members, on the NSW Procurement website.

48. The *Policy* also requires:

    a. ongoing monitoring, periodic assessment, and at least annual self-assessments against International Professional Practices Framework mandatory requirements, and

    b. an annual Internal Audit and Risk Management Attestation Statement to be completed which confirms compliance with the Policy and *PD2022_023 Enterprise-wide Risk Management*, which is submitted to the Ministry of Health, the LHD's Audit and Risk Committee and the Board.

49. *PD2022-023 NSW Health Enterprise-Wide Risk Management*, a copy of which is exhibited to this statement (Exhibit B.23.165 MOH.0001.0272.0001), describes the requirements for NSW Health organisations to establish, maintain and monitor risk management practices.

50. The Board is responsible for approving the LHD's risk management framework, including levels of risk appetite and tolerance, and for seeking appropriate assurance on the effectiveness of the framework.

51. The Audit and Risk Committee provide independent advice to the Board and myself. I have the ultimate responsibility and accountability for risk management and I receive assurance from and internal audit every five years.

52. The Chief Risk Officer supports me and is responsible for:

    a. the oversight and promotion of risk management within the organisation;

    b. designing the organisation's enterprise-wide risk management framework;

c. the oversight of activities associated with coordinating, maintaining and embedding the framework in the organisation.

53. Senior executives are responsible for managing specific strategic risks, managers and decision makers at all levels are accountable for managing risk in relation to the decisions they take and all staff are accountable for managing risk in their day-to-day roles including carrying out their roles in accordance with policies and procedures, identifying risks and inefficient or ineffective controls and reporting these to the appropriate level of management.

Asset Management and Environmental Sustainability

54. LDH are required to comply with *PD2022_044 Asset Management*, a copy of which is exhibited to this statement (Exhibit 31 NSW Health Tranche 4 Consolidated Exhibit List). The *Policy* promotes a consistent and improved approach to asset planning and delivery that is underpinned by the consideration of asset lifecycle costs, performance, risk and economic modelling to support the strategic priorities of NSW Health and requires that asset-related decisions:

a. represent a balance of cost, risk and performance, including environmental performance;

b. based on current and future contribution of the asset to service provision, and

c. use a whole-of-lifecycle approach.

55. The *Policy*:

a. extends to the management of all non-financial assets under the care and control of NSW Ministry of Health and NSW Health organisations, regardless of their financial value;

b. requires LHD to ensure governance systems are in place in line with the NSW Heath Asset Management Framework, Strategic Asset Management Plan and Asset Management Plan to improve asset management practice;

c. use and maintain Asset and Facilities Management Online as a single asset management asset register to meet the requirements of the Asset Management Framework;

d. requires LHDs to report on asset portfolio performance and compliance, and annually complete and submit to the Ministry of Health:

i. a Strategic Asset Management Plan. This Plan requires compliance with the *NSW Government Resource Efficiency Policy* and *NSW Net Zero Plan Stage 1: 2020 - 2030*, copies of which are exhibited to this statement (Exhibit B.23.022 MOH.0001.0324.0001 and Exhibit 206 in NSW Health Tranche 4 Consolidated Exhibit List). Annual delivery of energy and water saving, and waste minimalization projects are required as is the integration of environmental performance considerations into asset management operations. Reporting is required annually to track progress on policy objectives.

ii. an Asset Management Plan, which includes requires regarding potential environmental impacts.

iii. an Attestation Statement for Asset Management.

56. The Policy requires that LHDs to comply with *PD2012_039 Real Property Disposal Framework*, a copy of which is exhibited to this statement (Exhibit 111 NSW Health Tranche 4 Consolidated Exhibit List which sets out the identification, declaration, disposal and application of sale revenue relating to under-utilised or obsolete property assets considered surplus over a 10-year period. It requires LHDs to apply the Framework's provisions in the review of the Asset Strategic Plans and Property Disposal Plans on an annual basis.

Delegation Manual

57. In accordance with Section 40 Clause 1 of the *Health Services Act*, it was resolved to delegate some functions to approved positions and for approved purposes as outlined CCLHD's Delegation Manual, a copy of which is exhibited to this statement (Exhibit 112 NSW Health Tranche 4 Consolidated Exhibit List). All operations of CCLHD are covered by this Delegation Manual including any hospital, community health service, unit, group service, or other service that forms part of the responsibility of the Chief Executive of CCLHD. The Manual assigns levels of delegations to particular positions within CCLHD and various goods, services, approvals and powers are assigned to various delegations levels.

E. CLINICAL GOVERNANCE

Clinical Governance Structure

The Clinical Governance Framework

58. The *National Model Clinical Governance Framework* (***Clinical Governance Framework***) was developed by the Australian Commission on Safety and Quality in Health Care to support the delivery of safe and high-quality health care and best possible outcomes for patients in public and private healthcare organisations in the acute sector. A copy of the *Clinical Governance Framework* is exhibited to this statement (Exhibit 75 NSW Health Tranche 4 Consolidated Exhibit List).

59. The *Clinical Governance Framework* is based on 8 National Safety and Quality Health Service (**NSQHS**) Standards. These are incorporated in the NSW Health Safety System Model.

60. It is mandatory for all Australian hospitals and day procedure services to be assessed through an independent accreditation process to determine whether they have implemented the NSQHS Standards.

61. Under *PD2023_011 Australian Health Services Safety and Quality Accreditation Scheme in NSW Health facilities*, NSW Health services must be assessed against the NSQHS Standards over a three- or four-year cycle and are required, at each assessment, to provide evidence to demonstrate implementation of the NSQHS Standards. A copy of that policy is exhibited to this statement (Exhibit 35 NSW Health Tranche 4 Consolidated Exhibit List).

    a. PD2024_010 *Clinical Governance in NSW* (Exhibit 76 in NSW Health Tranche 4 Consolidated Exhibit List) requires that CCLHD have in place: Defined governance structures including a Health Care Quality Committee reporting to the Governing Board,

    b. A Director of Clinical Governance position reporting to the Chief Executive and a Clinical Governance Unit to facilitate the implementation of a clinical governance program,

    c. The requirements of the NSW Health Safety System Model,

    d. Processes to ensure all staff are informed and aware of their responsibilities in safety and quality,

e. Safety and quality intelligence with documented requirements for safety and quality data surveillance strategy,

f. Safety and improvement capability building, to ensure staff are skilled in safety assessment and improvement methodologies and

g. Legislative and regulatory requirements in relation to safety and quality.

The Governance Compendium

62. The *Governance Compendium* outlines clinical governance standards required of LHDs with section 2.3.2 providing that public health organisations that deliver clinical services must ensure that clinical management and consultative structures within the organisation are appropriate to the needs of the organisation and its client. It provides that LHDs should ensure that:

a. clear lines of accountability for clinical care are established and are communicated to clinical staff and staff who provide direct support to them;

b. the authority of facility/network general managers is clearly understood;

c. a Medical and Dental Appointments Advisory Committee is established to review and make recommendations about the appointment of medical staff and visiting practitioners;

d. a Credentials Subcommittee is established to make recommendations to the Medical and Dental Appointment Advisory Committee on all matters concerning the scope of practice and clinical privileges of visiting practitioners or staff specialists; and to advise on changes to a practitioner's scope of practice;

e. an Aboriginal Health Advisory Committee is established with representation from Aboriginal Community Controlled Organisations and/or other Aboriginal community organisations, and with clear lines of accountability for clinical services delivered to Aboriginal people;

f. a systematic process for the identification, and management of clinical incidents and minimisation of risks to the organisation is established;

g. an effective complaint management system for the organisation is developed and in place;

h. effective forums are in place to facilitate the involvement of clinicians and other health staff in decision making at all levels of the organisation;

i. appropriate accreditation of healthcare facilities and their services is achieved;

j. licensing and registration requirements are checked and maintained, and

k. the *Decision Making Framework for NSW Health Aboriginal Health Practitioners: undertaking clinical activities* (Exhibit 180 NSW Health Tranche 4 Consolidated Exhibit List) is adopted to ensure that Aboriginal Health Workers are trained, competent, ready and supported to undertake clinical activities.

63. Section 5 of the *Compendium* deals with clinical governance and is divided into Clinical Governance Entities, Health District/Service Clinical Management and Advisory Structures, and Quality Assurance Processes.

64. CCLHD has developed a *Corporate Governance Plan* in response to the Compendium, a copy of which is exhibited to this statement (Exhibit 113 NSW Health Tranche 4 Consolidated Exhibit List). It sets out activities, requirements and evidence of meeting each governance standard, and the monitoring and review processes in place.

Pillar Support

65. Two pillar organisations, the Clinical Excellence Commission and the Agency for Clinical Innovation, in particular provide CCLHD support.

66. The Clinical Excellence Commission provides clinical governance leadership, as well as incident management policy and reports.

67. The Agency for Clinical Innovation develops clinical guidelines and models of care, generates clinical evidence, research and innovation, implementation support and patient engagement.

Clinical Governance Processes

68. The *NSW Patient Safety and Clinical Quality Program* was established in 2005 to establish a framework to ensure patient safety and excellence in healthcare in NSW. A copy of the Program is exhibited to this statement (Exhibit 33 NSW Health Tranche 4 Consolidated Exhibit List). Its key components are:

a. Systematic management of incidents and risks to identify remedial action and systemic reforms;

b. The Incident Information Management System;

c. The establishment of Clinical Governance Units;

d. The development of a Quality Systems Assessment;

e. The Clinical Excellence Commission to promote and support better clinical quality.

Incident Management

69. It is an underlying principle of the *NSW Patient Safety and Clinical Quality Program* that the public health system must operate in an environment of openness about failure, where errors are reported and acknowledged without fear or inappropriate blame and where patients and their families are told what went wrong and why.

70. *PD2020_047 Incident Management*, a copy of which is exhibited to this statement (Exhibit 34 NSW Health Tranche 4 Consolidated Exhibit List), outlines the roles and responsibilities across the NSW Health system with respect to the management of both clinical and corporate incidents.

71. To support the implementation of the policy and program, the electronic Incident Information Management System has been developed and implemented throughout the NSW Health system. The Incident Information Management System has been established to provide a system for notification of all incidents, including those with corporate consequences.

72. The *Health Administration Act 1982* requires chief executives to appoint a team to undertake a Root Cause Analysis of serious clinical incidents allocated a Severity Assessment Code of 1. The chief executive may also conduct a Root Cause Analysis on Severity Assessment Code 2, 3 or 4 events if this is considered justified.

Accreditation

73. Under *PD2023_011 Australian Health Services Safety and Quality Accreditation Scheme in NSW Health facilities*, a copy of which is exhibited to this statement (Exhibit 35 NSW Health Tranche 4 Consolidated Exhibit List), NSW Health services must be assessed against the NSQHS Standards over a three- or four-year cycle and are required, at each assessment, to provide evidence to demonstrate implementation of the NSQHS Standards.

F. WASTE MINIMISATION AND EFFICIENCY

Organisational Sustainability Plan

74. In 2020 CCLHD developed an *Organisational Sustainability Plan*, a copy of which is exhibited to this statement (Exhibit 108 NSW Health Tranche 4 Consolidated Exhibit List). Whilst not limited to corporate governance, the *Plan* set objectives, including that:

    a. the culture, systems and processes support the provision of high quality, safe, person centred care;

    b. CCLHD's financial sustainability to enable service provision to meet community need and support investment and innovation, and

    c. CCLHD has governance and performance management systems that support the delivery of health services.

75. The *Plan* established a Steering Committee, who are tasked with:

    a. ensure that there are plans in place to enable CCLHD to stay within its allocated budget;

    b. ensure establishment of an effective program, targets and monitoring framework for sustainability plans that will position the organisation as a leader and achieve service agreement targets;

    c. provide advice and make recommendations on operational decisions with regard to sustainability, cost and safety;

    d. identify and facilitate opportunities to create greater value and deliver safe, reliable care, and

    e. ensure risks and opportunities associated with quality, safety and finances are being identified, assessed and treated to an acceptable level.

76. As the Chief Executive, I oversee the program and is responsible to ensure sound governance, management and communication.

77. The *Plan* requires that regular performance review meetings are held with the District Executive and each of their Operations Directorates and services. To ensure the integration of the *Plan* within CCLHD, opportunities and performance against the strategy

will be included as a standard item in these meetings. If performance against allocated *Plan* initiatives is unsatisfactory, frequency of these meetings will be increased. If Directorates or services are well-performing against the allocated initiatives, these meetings may become less frequent.

G. OPPORTUNITIES

78. As the Governance model across NSW Health has adapted over the recent years, the role of the Ministry, Pillars and Boards have changed to reflect the new environments, particularly through COVID in the pandemic response. The system is settling into a new model with a strengthened role for the Ministry.

79. The role of the LHD Boards has broadened over the years and being clarified at the moment with a smaller Board membership which will need a revision to the structures that support the Board and Sub Committee's. There is at times overlap between the performance management from the Ministry and the role of the Board in oversight and governance.

80. Generally, the Pillars and LHD's work well together, although there is opportunity for an increased sharing of innovation and new developments both between the LHD's and from the Pillars, in particular ACI and CEC.

	Nicole Briggs
Scott McLachlan	Witness: [insert name of witness]
9 April 2024	9 April 2024
Date	Date