Special Commission of Inquiry into Healthcare Funding

Statement of Professor Donald MacLellan

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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. INTRODUCTION

2. My name is Professor Donald MacLellan. I am the Chair of the Central Coast Local Health District (**CCLHD**) Board. I have held that role since July 2021. I was appointed to the board of the CCLHD in January 2019.

3. In my role I have two main functions. First, as the chair of the board I am part of the group that interviews and chooses the Chief Executive of the CCLHD. Secondly, the board has a role to ensure that CCLHD delivers safe and high-quality care in a financially responsible manner and ensuring that the strategic plan of the CCLHD is implemented appropriately.

B. CORPORATE GOVERNANCE STRUCTURE

LHD governance structure

4. Local Health Districts (LHDs), including CCLHD, are established under the *Health Services Act 1997* (NSW). They are responsible for managing public hospitals and health institutions and for providing health services to defined geographical areas. 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.

5. The *Health Services Act* also sets the key functions of LHDs, and each LHD is subject to the governance, oversight and control by the Secretary, NSW Health. The Secretary can determine the role, functions and activities of any public hospital, health institution, health service or health support service under the control of a LHD and, for that purpose,

give any necessary directions to the LHD. In addition to the role described above, the Minister for Health can direct an LHD to establish any hospital, health institution, health service or health support service, close any public hospital or health institution, or cease to provide any health service or health support service, under its control, and restrict the range of health care or treatment provided by any public hospital, health institution or health service under its control, should it be in the public interest to do so.

LHD board structure

6. The board of the CCLHD currently comprises 8 members. They are appointed by the Minister for Health. The board has the following functions prescribed by section 28 of the *Health Services Act*:

   a. to ensure effective clinical and corporate governance frameworks are established to support the maintenance and improvement of standards of patient care and services;

   b. to approve systems to support the efficient and economic operation of the LHD, ensures the LHD manages its budget, and to ensure the LHD resources are applied equitably to meet the needs of the community;

   c. to ensure strategic plans to guide the delivery of services are developed for the LHD and to approve those plans;

   d. to provide strategic oversight of and monitor the LHD's financial and operational performance in accordance with the State-wide performance framework against the performance measures in the performance agreement for the LHD;

   e. to appoint, and exercise employer functions in relation to, the chief executive of the LHD;

   f. to ensure that the number of NSW Health Service senior executives employed to enable the LHD to exercise its functions, and the remuneration paid to those executives, is consistent with any direction by the Secretary, NSW Health or condition referred to in section 122(2);

   g. to confer with the chief executive of the LHD in connection with the operational performance targets and performance measures to be negotiated in the service agreement for the district under the National Health Reform Agreement (NHRA);

h. to approve the service agreement for the LHD under the NHRA, a copy of which is exhibited at (Exhibit 117 in NSW Health Tranche 4 Consolidated Exhibit List);

i. to seek the views of providers and consumers of health services, and of other members of the community served by the LHD, as to the district's policies, plans and initiatives for the provision of health services, and to confer with the chief executive of the district on how to support, encourage and facilitate community and clinician involvement in the planning of district services;

j. to advise providers and consumers of health services, and other members of the community served by the LHD, as to the district's policies, plans and initiatives for the provision of health services;

k. to endorse the LHD's annual reporting information for the purposes of the *Government Sector Finance Act 2018*;

l. to liaise with the boards of other LHDs and specialty network governed health corporations in relation to both local and State-wide initiatives for the provision of health services, and

m. such other functions as are conferred or imposed on it by the regulations.

7. The board member selection criteria are set out at section 26(3) of the *Health Services Act* and requires an appropriate mix of skills and expertise, and one member is required to have expertise, knowledge or experience in relation to Aboriginal health. Board member terms are for a maximum of five years.

8. The 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.

9. These requirements have been formalised in the *CCLHD Board Charter (the Charter)* dated September 2022. The charter:

a. notes CCLHD has implemented *Caring for the Coast Strategy 2019-2024* (the Strategy), a copy of which is exhibited at (Exhibit 107 in NSW Health Tranche 4 Consolidated Exhibit List) which contains certain strategic priorities. It sets out some further details concerning the Strategy below;

b. sets the governance framework

c. defines the board's role, goals, and objectives

d. articulates the authority and responsibilities of the board, and relationships with the Chief Executive and others, and

e. outlines the board composition, including the appointment and remuneration process.

10. The *Charter* is reviewed annually by the board.

11. To achieve its roles, the board has a number of subcommittees:

a. Finance and Performance Committee. In the context of this committee, performance includes both clinical and non-clinical performance. This committee is mainly concerned with monitoring KPI's agreed in the service agreement with the Ministry of Health (the Ministry);

b. Healthcare and Quality Committee, which is responsible for the provision of high quality and safe care within the CCLHD, and monitoring serious adverse events within its facilities;

c. People and Culture Committee. Its role includes looking at workforce issues, workplace health and safety issues, and the culture within CCLHD;

d. Consumer and Community Committee. The role of this committee is to get an understanding of the community's views on service changes within the CCLHD, and on different models of care. This committee is currently under development. It is in the process of a "reset" to ensure that it achieves that goal. That reset includes reviewing the terms of reference of the committee and its membership;

e. Audit and Risk Management Committee;

f. Aboriginal Health Partnership Advisory Council. This was previously an operation advisory committee which from time to time provided advice to the board. The board is currently in the process of making this a board subcommittee. This will occur once an Aboriginal board member is appointed, and

g. The Board Research Committee. The role of this committee oversees the CCLHD research governance policies and procedures, research risks and implementation of strategic directions approved by the board research plan.

12. I sit on the Finance and Performance committee, the Board Research Committee, the Audit and Risk Management Committee and the Healthcare and Quality committee. In my role as chair, I occasionally attend meetings of the other board committees so that I have direct information from each committee.

Relationship between CCLHD and Ministry of Health

13. The Chief Executive is responsible for negotiating the annual Service Level Agreement (**SLA**) with the Ministry. However, the Chief Executive keeps the board updated on major issues that are the subject of negotiations concerning the SLA. Over the course of each year, the board may also raise with the Chief Executive issues that it would like to be discussed with the Ministry when the next SLA is being negotiated.

14. As chair of the board, I have monthly virtual meetings with the Secretary, NSW Health, Susan Pearce along with other board chairs. The purpose of these meetings is for the Secretary to outline issues occurring at a Ministry level that are relevant to a LHD.

15. There is also a meeting between members of the board of CCLHD (including the chair), the Minister for Health, the Secretary, NSW Health(i.e. Ms Pearce), and Ministry executives. During these meetings, the Minister for Health and Ministry provide an information update of key government policies and strategic priorities, and whether there have been any changes in those areas. This meeting usually occurs annually.

16. From time to time, the Ministry executive team may also provide more information to the Chief Executive or to the Executive Leadership Team (**ELT**) members. This information is typically more granular, and may include things like changes to how KPIs in emergency departments are to be measured and reported. I also contact representatives from the Ministry who are responsible for the LHD boards concerning board appointments.

C. CORPORATE GOVERNANCE PROCESSES

LHD corporate governance processes

17. As the board's role is primarily one of oversight, it relies on sufficient information being provided to it regarding the LHD's operations and performance. That information

primarily comes from the Chief Executive, Scott McLachlan, and the **ELT**). Information flows to the board from the Chief Executive and ELT in a number of ways:

a. At each board meeting, the Chief Executive provides an update on key topics. Those topics change depending on the current issues within the CCLHD. For example, recent topics which the board have been briefed on includes the number of hospital acquired infections, workplace health and safety issues, and financial performance of CCLHD facilities. In general terms, each briefing explains what the issue is, how it relates to an aspect of CCLHD's strategic plan, what the current response is, any risk management and safety and quality implications of that response;

b. In addition to the formal board meetings, I meet with the Chief Executive on a weekly basis. Each month, three of the meetings are online, and the other meeting is in-person. This in-person meeting can last for a couple of hours. During these briefings, Mr McLachlan keeps me up to date on issues that the board has previously been briefed on, or brief me on new issues which have arisen since the previous board meeting. In addition to these scheduled meetings, I frequently speak to Mr McLachlan on other occasions during the week and would be briefed on other emergent issues relevant to the board;

c. I am also aware that the chairs of the various board committees regularly speak to the appropriate member of the ELT, and

d. The board committees also provide information to the board as a whole. The minutes of the committee meetings are provided to the board, and key messages arising out of each committee meeting are specifically relayed to the board. In addition, at each board meeting a "Deep Dive" is undertaken. During a Deep Dive, a board committee provides an in-depth update on what has been discussed within the committee, its plans, and how it is enacting the CCLHD strategic plan. Each Deep Dive usually lasts for around an hour. In addition, some Deep Dives are focused on specific topics (rather than based on a board committee's work). The topics selected for the Deep Dives include mental health, Aboriginal and Torres Strait Islander health, and patient flow. In my view, the Deep Dives are a useful way to give the whole of the board an insight into the detailed work of each committee and selected topics.

18. Through these processes the board continually monitors and oversees the performance of the CCLHD in relation to the strategic plan. On occasions where the CCLHD is not performing well, it would work with the Chief Executive and ELT to rectify that issue.

19. An example of this occurring was shortly after I first joined the board in 2019. CCLHD had been given a performance level three rating under the *NSW Health Performance Framework* (Exhibit 19 NSW Health Tranche 4 Consolidated Exhibit List) which meant that it was considered to be a serious under-performance risk. Part of the issue was that the CCLHD had slipped to a $30m budget deficit. In response to these financial issues, the board and CCLHD held a series of strategy planning days to rectify this issue. One of the initiatives that was implemented was the formation of an *CCLHD Organisational Sustainability Plan 2020-2023* (Exhibit 108 in NSW Health Tranche 4 Consolidated Exhibit List) which had the immediate function of finding efficiencies and cost savings to recover the $30m deficit over the next few years. That plan was able to make significant improvements to CCLHD's financial position. The CCLHD is currently at performance level 1, which is a significant improvement on its previous position.

Key Performance Indicators

20. The performance of the LHD is generally monitored through its KPIs, which come from two sources. The first source are KPIs which the LHD must achieve to meet its requirements under the SLA. The second source are internal KPIs which the various board subcommittees may adopt as part of their work to implement parts of the strategic plan. These KPIs then have to be translated down to a level where they are understandable and applicable at a ward and directorate level. Managers from senior levels to ward level are responsible for ensuring the strategic plans are implemented.

21. Each facility/ward has different challenges (e.g. a paediatric ward versus a geriatric ward). The responsibility of the manager in implementing the strategy is to consider the particular characteristics of the ward. In patient care strategy, the geriatric ward may have an emphasis on preventing falls which would not necessarily be the main focus in a paediatric ward. It is important that the ward staff are able to translate what their ward needs to do in order to implement a strategic focus. This is being assisted with the roll out of "Our Path to Excellence" program (see paragraph 35b).

22. If the LHD is underperforming relative to a KPI, then the board is briefed on that topic by management. However, the board's role is not solely supervisorial, and on some occasions the board may make suggestions about how poor performance can be rectified. Management may then investigate whether those suggestions are feasible, and

if appropriate implement them. In my opinion, that process of the board making suggestions and recommendations works especially well because board members come from a diverse range of backgrounds and can provide fresh insights in how to address these problems.

LHD financial governance processes

23. The CCLHD's overall budget is set in the annual SLA. Once that budget is set, the finance officer is responsible for distributing the budget to each directorate. The board is not involved in that process of allocating funds to individual facilities or services.
24. However, the board does have a role in overseeing that the budget is adhered to. If a particular hospital or service is overrunning its allocated budget, the board is briefed by management on that issue. As part of that briefing, the board may ask the ELT for information as to why the budget overrun is occurring, what is being done to resolve it, and how effective those steps are.

25. Although the Finance and Performance committee is primarily responsible for overseeing the CCLHD's adherence to its budget, like with the other committees, the minutes and key messages from its meeting are also provided to the board as a whole.

D. CLINICAL GOVERNANCE

Clinical governance framework

26. The CCLHD is responsible for approving an annual Clinical Governance Framework. The purpose of that framework is to support the delivery of safe and quality health care services within the CCLHD.

27. An important part of the CCLHD's clinical governance structure is the Healthcare and Quality Committee, which is responsible for ensuring that strong clinical governance is maintained, and monitors the safety and quality of healthcare services within the LHD.

Clinical governance processes

28. The Healthcare and Quality Committee receives monthly reports on how the LHD is performing in the areas of safety and quality. That data is reported at both an LHD level, and also broken down to each of the four hospitals in the district (Wyong, Gosford, Woy Woy and Long Jetty). Those reports also include information about safety and quality KPIs, how the CCLHD is performing relative to those KPIs, and trends in safety and quality performance. While the Healthcare and Quality Committee is particularly

responsible for overseeing and managing this subject, this information is also provided to the board as a whole as part of the board papers.

29. If the data provided to the committee indicates that the LHD is performing below the standard expected, or there is a downward trend in performance, then it would ask the ELT questions as to why that is occurring, and what is being done to rectify that issue.

30. The ELT and board also visit facilities within the LHD and conducts walkarounds. Each visit has the Chief Executive or one of his ELT members and a board member. The visits are approximately every 1-2 weeks. Between Feb-Dec 2024, there are 45 scheduled visits. All hospital wards and facilities and community facilities are included in the visit schedule.

31. During these visits, we speak to nursing unit managers and staff, ask about safety and quality data and performance of each facility (for example, fall data), and generally observe the operation of the facility. If a health and safety issue is raised during the visit, we ask staff to provide their view as to the cause of the issue or possible solutions. We also seek the name(s) of any outstanding staff so that they may be recognised and thanked for their great work.

Engagement with Pillars and the other organisations

32. From the board's perspective, the CCLHD's interaction with pillar organisations is mainly with the Agency for Clinical Innovation (**ACI**) and the Clinical Excellence Commission (**CEC**). The CCLHD may reach out to these organisations if it feels their expertise may be useful in relation to a particular matter. Generally, while the Chief Executive and ELT may reach out to ACI & CEC independently, there is often a discussion between Mr McLachlan, the ELT and the board when approaching ACI and CEC. CCLHD also has contact with the Health Education and Training Institute (**HETI**) concerning mandatory training requirements and training process for nurses and junior doctors within the CCLHD.

33. In some occasions, I may also have an informal discussion with a health pillar organisation to obtain further information or advice. For example, a few weeks ago I reached out the ACI to get some further information about low value care and what can be done to avoid it. If I have these informal discussions with any health pillar organisation, I will also inform the board and ELT that I am doing so.

34. The CCLHD also has a strong partnership with the primary health network. Although engagement within that partnership is carried out by Mr McLachlan and the ELT, the board receives reports about that relationship and any collaboration that arises from it.

E. WASTE MINIMISATION AND EFFICIENCY

35. Although the Organisational Sustainability Plan was established as a response to the CCLHD being given a level 3 performance rating, it is an ongoing program. That plan has identified and implemented total cost savings of roughly $70m over the last 3 years.

36. The CCLHD is also engaged in two other areas of focus which will have the effect of reducing waste and inefficiency:

    a. The incidence of low-value care within the CCLHD, and how that can be reduced, and

    b. Environmental sustainability, and minimising its carbon footprint. For example, in a recent project it was identified that gloves were being used and changed excessively in some clinical contexts. Addressing that issue resulted in a reduction of CCLHD's carbon footprint, and cost savings of roughly $20,000.

F. OPPORTUNITIES

37. In my view, there are some opportunities which the CCLHD may pursue to improve governance and accountability:

    a. Although I consider that the board and ELT do a good job at ensuring the CCLHD's strategic plan is implemented, ultimately middle management and frontline staff have to implement those requirements. This requires middle management to be committed to achieving those goals. There are some areas within the CCLHD where that has been more challenging.

    b. A number of directorates within the CCLHD have engaged in a culture change program, whereby staff have the opportunity to innovate and are given some freedom in achieving the strategic goals. In those units, we have seen an increase in patient care and finance performance and outcomes. The program is called *"Our Path to Excellence"* and is being gradually rolled out across the LHD. It was a recognised program that CCLHD adopted. It commenced with our staff volunteering to be trainers and facilitated its spread across directorates and units.

c. While the Ministry is supportive of new models of care, the CCLHD may occasionally consider trialling new models of care even where they are not specifically funded. These new models of care may improve the CCLHD's financial or care outcomes. Where they are seen to be successful and potentially scalable, funding can be sought for these models of care from the Ministry. For example, in FY 2023 the CCLHD implemented an Elderly and Frail model of care. CCLHD has a high proportion of elderly people, and statistically once a person in that demographic is admitted to hospital, they are likely to have an extended stay in hospital. The purpose of this model of care was to prevent elderly and frail patients from being admitted to hospital, by prioritising a fast response in emergency departments and appropriate community, home and residential aged care. The program is successful, and is currently unfunded. Although the program costs the CCLHD about $6 million or $7 million this year, CCLHD has recognised its value and has taken steps to retain it (with some modifications) by redistributing parts of its budget. Its funding may be part of the SLA discussions for FY 2024.

Donald MacLellan	Witness: [insert name of witness]
Date	Date