Special Commission of Inquiry

into Healthcare Funding

Before: The Commissioner,
Mr Richard Beasley SC

At Level 2, 121 Macquarie Street,
Sydney, New South Wales

Monday, 15 April 2024 at 10.00am

(Day 016)

Mr Ed Muston SC	**(Senior Counsel Assisting)**
Mr Ross Glover	**(Counsel Assisting)**
Dr Tamsin Waterhouse	**(Counsel Assisting)**

Also present:

Mr Richard Cheney with Mr Hilbert Chiu for NSW Health

THE COMMISSIONER: Good morning. Mr Muston?

MR MUSTON: Do you need to receive appearances from everyone who is here?

THE COMMISSIONER: No, I don't think so. We've already done that.

MR MUSTON: Commissioner, opening the inquiry late last year we spoke of the resilience of the New South Wales health system and the high standard of care that it is able to deliver under what are often very challenging circumstances. We think it is worth pausing to note that that is something which it has again demonstrated in spades in its response to the tragic events in Bondi over the weekend.

THE COMMISSIONER: Yes.

MR MUSTON: We're embarking upon a hearing block which has as its focus terms of reference B and D. In practical terms, we will be examining the governance and decision-making structures within the public health system and exploring the way in which they impact on the system's ability to identify and meet the health needs of the population it serves.

Like the earlier hearing blocks, these areas of focus will obviously have significant interaction and overlap with other terms of reference. It is impossible, really, to confine the evidence or the hearing, the hearing block that we have, strictly to one term of reference or another but, in any event, it is our idea that we will try, as best as we can, to confine this hearing block to those issues.

Obviously, this won't be the last time we see these issues either. We're going to have to look at decision-making and governance structures, for example, in future regional hearings as we look at the way in which health is delivered by the health system in those areas. Nevertheless, those are the issues that we're focusing on principally for the next two weeks.

Governance can probably be divided into two broad areas, corporate governance and clinical governance. It also operates differently at different levels within each of the various components of the health system and at its

heart, it is all about decision-making and direction.

Our particular focus over the next two weeks will be examining how that decision-making operates at those different levels, so within the ministry, within the pillar organisations, within LHDs, and within affiliated health organisations.

You will have seen, hopefully, the witness list that we have set out for this hearing block.

THE COMMISSIONER: Yes.

MR MUSTON: There is a lot of evidence to get through in a relatively limited period of time, unless there is any particular questions at this stage that we can assist you with, Commissioner, we will move immediately to our first witness, who is Fiona Wilkinson, the director of clinical governance at the Central Coast LHD.

THE COMMISSIONER: Go ahead, thank you.

MR MUSTON: Dr Waterhouse will take that witness.

DR WATERHOUSE: I call Fiona Wilkinson.

<FIONA WILKINSON, affirmed: [10.04am]

<EXAMINATION BY DR WATERHOUSE:

DR WATERHOUSE: Q. Can you please state your full name and your position?
A. My name is Fiona Wilkinson and I am the district director of quality, strategy and improvement at Central Coast Local Health District.

Q. Can you briefly outline your qualifications and experience that have led to this role?
A. Yes. So my background, I was initially a registered nurse and worked for many years in an emergency department. I then have moved into improvement science and I have a masters degree in MBT - masters of business and technology.

Q. You have, as I understand it, quite a large and diverse portfolio, and under that you manage a number of teams?

A. Correct.

Q. I would like to start with the clinical governance team that is under you. Now, clinical governance in the Central Coast Local Health District, as I understand it, also includes oversight of volunteers, consumers, and libraries?
A. That's correct.

Q. Can you explain the connection between those, how it has come to be formed like that?
A. Yes. They all interrelate with delivering safe quality care. The input of consumers in advising an organisation in design and input into care delivery, and volunteers play a very important role in assisting our clinical teams in supporting to deliver care.

Libraries - libraries add a research value, an evidence-based value and also tie in for that reason.

Q. Now, I understand that there is a separate director of safety, quality and governance; is that the correct title?
A. That's correct.

Q. And does that person report to you?
A. Correct.

Q. Is there any other person to whom they report?
A. They also have a dual line of reporting for the chief executive and that line is for serious adverse events, serious complaints, major clinical governance issues.

Q. So is it correct to say that for the bulk of their role day to day, they report to you and there are just particular aspects to which they report to the chief executive?
A. Correct.

Q. How does that work, operationally, from your point of view - the dual reporting, that is?
A. Operationally, we work at Central Coast with an accountability matrix and a delegation matrix, and that works efficiently following that matrix. Operationally, that director reports to me on a daily basis. We manage our work flows with huddles, so we will have a huddle twice a week and also monthly accountability meetings that that director and I discuss key accountabilities and activities

in her work role.

Q. So you find it is an effective way to manage it.
A. It is effective.

Q. How would you define "clinical governance"?
A. Clinical governance is delivering safe, high quality, effective care.

Q. And what are your personal responsibilities for clinical governance?
A. So I'm accountable for ensuring that systems and processes are in place to deliver safe, high quality, effective care.

Q. And how does that compare with the director that reports to you?
A. The director that reports to me is actually running those systems and processes, so ensuring that they are in place, actively participating at varying levels. That director has a team underneath that role of patient safety and quality roles, as well as what we term "consumer feedback" roles, which manage complaints and concerns directly with customers.

Q. How many people would be reporting in that team to the director?
A. A total of I think it's 38 FTE.

Q. 38 FTE. And that's across the district?
A. Across the district, correct.

Q. Are they all based in the same unit or are they dispersed across different sites?
A. They are dispersed across. So we have two main sites, so they are primarily dispersed across those two sites, but their work takes them across all areas and they are representative in key safety and quality meetings on those sites.

Q. Does the director of clinical safety, quality and governance travel around the district to different sites overseeing those systems?
A. Correct. So that director sits primarily at Gosford Hospital, our tertiary site, but also sits at Wyong Hospital one day a week.

Q. And you yourself, do you travel because of the clinical governance responsibilities you have?
A. Because of all of my responsibilities, it takes me to all of the sites.

Q. And when you visit those sites, are you looking at clinical governance?
A. I think when you have worked in the area of safety and quality for a long time, you always have a safety and quality hat on and strive to improve, so whilst I might be there for specific purposes, you always are wearing that hat and looking at safety and quality.

Q. Given the range of responsibilities that you have, how do you ensure that the right systems are in place at the right places for the needs of different services?
A. So there is various checks and balances that assist in identifying if those systems are in place. One of those is the accreditation system, so that's one tool in the tool kit. We have audits of which the sites are responsible, for managing audits, we have a series of indicators that we monitor and manage for each of those sites. Whilst on those sites, we, both the leaders on the sites, the executive and also the board, conduct safety rounds which provides an opportunity to check directly in with staff and teams, and we have a series of governance meetings which cascade from an executive level down to a team level.

Q. I might go through some of those in a little bit more detail, if that's okay. First of all, can you just briefly tell us about the accreditation process that's in place?
A. Okay. So all organisations are required to be accredited. Accreditation occurs every three to five years and we're accredited against the national safety and quality standards, of which there are eight standards. Our accreditation is actually due this year. Accreditation is run on a short notice survey, so we will receive notice on a Thursday that the surveyors will be on site the following week and will attend our sites the following week and actually review our accreditation processes.

In our previous accreditation we were commended on the strength of our clinical governance processes, and that was in 2021.

Q. And you mentioned that there are audits done. Can you describe what those are?

A. Yes. So we have routine audits through what we call a CEWA system, which is run by the Clinical Excellence Commission, and they are routine against the national standards and any other areas that have been defined for audit, and they are conducted by our clinicians and our clinical teams.

Q. Now, you mentioned indicators. Can you just describe what those are?
A. So key performance indicators. So we have --

Q. I might come back to those. I just wanted to check that's what you meant by those. I will come back to those in a moment. Safety rounds, what do they involve?
A. Safety rounds involve a leader, so a leader from the clinical services or from the site. So you might have a director of nursing and an operational nurse manager walking around and talking to staff, asking them what's working well, opportunities to improve, any challenges. We undertake the same process with our executive, so we have a rotating roster for an individual executive and a board member to conduct what we title our executive walk-arounds, and undertake that same process and seek feedback from the clinical teams.

Q. Can you think of any examples where that has led to a system improvement?
A. Yes, I can. In doing that, you are able to identify if there are any consistent themes, so whilst they are rotated, and there is an example on one of the sites where there was difficulty in accessing bariatric beds, so a specific type of equipment to manage larger patients, and that theme was coming up consistently across that site, so there was then a process review as a result of that and an ordering - a review of the procurement process around those beds, the number we had on site and the accessibility, the ability to be able to locate those beds when needed, and a process change as a result.

Q. Now, you mentioned the Clinical Excellence Commission briefly.
A. Yes.

Q. I will just refer to that for simplicity as the CEC, which it is to be known as.
A. Thank you.

Q. Is the CEC involved in leading or supporting clinical governance within the LHD?
A. Yes.

Q. Can you explain how it plays that role? What does it do?
A. Okay. So there is a couple of mechanisms. Capability is one, where we work very closely with the CEC on the implementation of safety and quality capability improvement programs. We have those embedded within the organisation, tying in with our improvement programs, and that plays a very important role in that.

Q. What do you mean by "capability" there?
A. Building staff knowledge in safety and quality and awareness.

Q. And do you find that the initiatives brought in by the CEC or required by the CEC - do they come with additional resources to be able to embed them in the LHD?
A. The CEC does support those initiatives with a small amount of funds for us to be able to apply, which we apply centrally to one of my other teams, the improvement team, and combine that with our other improvement programs.

Q. Is that enough to be able to implement and embed those things?
A. I think there's always opportunity to enhance those resources.

Q. If you go on, you were going to say there is another role the CEC plays?
A. The CEC provides a key role in sharing learnings across the state, so any serious adverse events are reviewed by the CEC and learnings are fed back to organisations; a key role in any recalls in products and notification and management of that; guidance, education to our safety and quality program; a key support for the role that reports directly to me.

Q. You mentioned recalls. Can you just explain for the Inquiry what that might involve?
A. If there is a product recall that needs to be removed from circulation that could place a risk to harm, the CEC manages that notification, of which we then act upon in the district.

Q. How often would that happen in health?
A. Every couple of weeks.

Q. So it would have to be - everything would have to be removed. Say it was a product on the ward or in theatres, they would just have to pull those all off the shelf, effectively?
A. The LHDs need to enact - it would - it happens more frequently, but with smaller consequences. Ones that have a major impact could be every couple of weeks. So you might be removing an item off the shelf, it might be, for example, an ampoule of normal saline of a certain batch number, that we then put a process in place to remove those items from circulation.

Q. How resource intensive is that process?
A. It is resource intensive. It involves a wide range of staff from pharmacy to nursing unit managers, to staff on the floor.

Q. Does it ever result in delays, if you have to remove all of something that was being used for patient care and have to get a new replacement in?
A. There is normally a substitute item.

Q. Now, you mentioned governing committees before and I understand that you are the executive sponsor of the health care quality committee; is that correct?
A. Correct.

Q. Can you just explain what is meant by the term "executive sponsor", what that involves you having to do?
A. Okay. I coordinate items to come to the committee; coordinate evidence. That committee makes a selection annually on the priorities that that committee is going to focus on, so coordinating any literature or evidence to allow decisions to be informed.

Q. Who chairs the committee?
A. The committee is chaired by a board member.

Q. And does this mean that you, in your role as executive sponsor, effectively guide the work of the committee and decide what they will review?
A. In partnership with the executive sponsor.

Q. Sorry --

A. Sorry, with the chair, apologies. Thank you.

Q. Who are the members of the health care quality committee?
A. We have three board members on that committee and members of the executive.

Q. And are there any other external people such as consumers?
A. There is one consumer and also the director of clinical safety, quality and governance.

Q. Any GPs or other --
A. No, not on that one.

Q. Are there clinicians that are active in the hospitals that you --
A. No, we have the district director of medical services as one of our executive.

Q. So with that sort of make-up, are there people with particular expertise, either from the board or the executive, apart from yourself, in clinical governance?
A. Yes, there is.

Q. And who would they be?
A. So the director that reports to me is on there; the board chair - the committee chair; the district director of nursing; and then the other two representatives are from the operations teams and the chief executive as well.

Q. Do you find that there ever develops a disconnect, if there are no clinicians on that committee, with trying to sort of communicate with them about what is important to them?
A. The connection actually comes from the committee that sits below that committee, which has clinicians, operational managers, general managers on it, which is quite a large subcommittee and really collates other subcommittees, reviews items before they come up to health care quality committee. So there is a process of systematic review before it gets - and feedback into items, before they actually get to health care quality committee.

Q. So what's that subordinate committee called?
A. It is clinical safety, quality and governance committee.

Q. So the clinical safety, quality and governance committee reports to the health care quality committee?
A. Correct.

Q. And then what does the health care quality committee report to?
A. The board, directly to the board.

Q. How often does the health care quality committee meet?
A. Monthly.

Q. And what about the --
A. The subcommittee.

Q. I'm getting mixed up with the names. The subcommittee.
A. The subcommittee also meets monthly.

Q. And is that coordinated in such a way that concerns being raised by the clinicians will be fed through to the HCQC, if I can abbreviate it to that --
A. Yes, that's exactly right.

Q. -- in a timely manner?
A. Exactly. So the committees are offset in their timing in the month to allow something to be tabled at the subcommittee, reviewed, input, and then to be tabled at the next level, if it is required - if a decision is required to be made at a sub-board committee level, it is then tabled at HCQC.

Q. And what about sort of communication in the opposite direction, so either from the board or from the HCQC down through to that subcommittee and, more broadly, to clinicians?
A. Yes, so that mechanism happens in two ways, and that's shared membership on each committee, but also, importantly, in all of our committees we - at the end of the meeting the last item in the agenda is key messages, and so we actually record, usually three, key messages and those key messages are from that meeting and those messages flow both up and flow down back to the subcommittee or up to the board and outline key important matters that occurred in that meeting.

Q. And when you say they flow back up and back down, how

does a physiotherapist in a community health service come to know about those key messages?
A. Okay. That would go through that role, the director of those services, so it would flow back. Sitting on the subcommittee is the director of allied health and so any important messages would go back through that director of allied health.

Q. Are the minutes from the HCQC meetings and the subcommittee meetings available on the website?
A. On the intranet, the intranet.

Q. Can you outline for me what the purpose of the HCQC is from your perspective?
A. The HCQC is the peak governing body for safety and quality, so they have several functions. So they are accountable for signing off the attestation statement that the LHD is meeting the requirements of accreditation and safety and quality, which goes to the board; they have responsibility --

Q. Sorry, I am just going to stop you there. It goes to the board. Does it go anywhere else, that attestation statement?
A. No, final sign-off is by the board.

Q. Is there any feedback of the information on that attestation to the ministry or the CEC or --
A. Yes, it goes to the - from the board to the CEC and the ministry. That's a requirement of LHDs.

Q. Sorry, please go on. You were saying about the functions of the committee.
A. That committee reviews key performance indicators and looks at the level of performance at an LHD level. It identifies key safety and quality priorities and sets those for the district, and ensures that all of those safety and quality systems and processes are in place.

Q. And how as a committee does it ensure those systems are in place?
A. By reviewing the information that comes to the committee that provides evidence of that. So the papers, essentially.

Q. How does it determine the priorities - annual priorities?

A. So the starting point is usually the KPIs. The committee below provides recommendations on priorities, so through a combination of things, looking at the KPIs, feedback from the subcommittees, feedback from clinical council. We engage with clinical council to seek information as well. We align to ensure alignment of those priorities to the district strategic plan, and any evidence and literature support.

Q. You just mentioned clinical council. Can you explain where that fits into the mix of committees that we've been talking about?
A. The clinical council occurs monthly and is a requirement of the Health Services Act and has a variety of clinicians on that council and it provides a very useful environment to take anything that you would like to feed back, to have that discussion in clinical council.

Q. So would there be some opportunity for a combination of some of those things? I'm just wondering why you need - the clinical council is maybe a requirement, but why do you need two other committees in addition to that? Would it be possible to combine some of those functions?
A. I would think not. All of those functions have quite large agendas and I think our committee structure has been tabled, I think time wise, you wouldn't - it wouldn't be an effective way to run a meeting.

Q. And when you say they have large agendas, what proportion of those agendas would be noting things that are happening as opposed to making active decisions that will result in changes?
A. Maybe 50 per cent.

Q. So 50 per cent they are noting things, progress with things or events that have occurred, and 50 per cent they are making decisions that will lead to changes for patient safety and quality?
A. Correct.

Q. I'd like to talk a bit more about the KPIs, if I may. So what is the role of the HCQC, first, in relation to KPIs?
A. Provides oversight, and so the KPIs indicate performance against key criteria, and so the HCQC monitors that performance and looks at the performance levels across those various indicators.

Q. And are they looking at it by facility, by service, by clinical unit? How does it work?
A. So, at that level, we report at a district level, but each indicator is broken down on that report by facility. So if something is not performing, you can then see which facility is not performing against that particular KPI.

Q. What happens if a unit or a facility is not performing or that there is perhaps a worrying trend, if I can put it that way? What does the HCQC do?
A. So the HCQC would initially monitor, but then the way we report, we provide a brief analysis of what is occurring, so if there are any special calls or circumstances, so there may be a known event that has pushed that KPI outside its parameters, so that would be noted and reported in the report. If there is continuing non-performance or you were seeing a trend, a decline in performance, the various executive would then engage and work with their teams, so the general managers or the directors of nursing, to look at opportunities for improvement. That would then be reported in that report as well, what those improvement activities are.

Q. So the - they would monitor it, they would - changes would occur. Would there be any feedback to continue looking at whether those changes have been effective?
A. And that occurs through the subcommittee. So those - the person that is accountable for delivering those changes will report through the subcommittee. That is then recorded in that report that comes to that - to the HCQC. So it is continually monitored.

Q. Can you give me an example of where that's happened - like where there has been an adverse trend, say, and works that needed to be done?
A. I could give you multiple examples. I will draw on one, which would be unplanned readmissions within 28 days. So probably close to 18 months ago we were seeing a trend of increasing unplanned readmissions. An improvement program was put in place as a result of that. That trend was on both sites, the two acute sites, and we saw a significant improvement. A large piece of diagnostic work was undertaken to see what the cause was. And then, recently - and there was considerable improvement and it was monitoring as performing, but recently, we have seen an upward trend again in the unplanned readmissions, so the

executive accountable for that area on health care quality committee have put further actions in place to again review the cause and put improvement processes in place.

Q. In determining what actions are required, what the causes are, is there - who do they consult with?
A. So they consult with their teams, so that's - because that's the facilities, that's commencing with the general managers on the site and then working directly with clinicians, drilling down on data and information to see, looking at cohorts of patients and then working with those clinical teams to look for opportunities to improve.

Q. Now, I understand that the HCQC has also given some direction in relation to hospital-acquired complications. Can you outline a bit of the work that's been involved with that?
A. Correct. So we were seeing a trend of non-performing hospital-acquired complications and initiated a large improvement program, of which we stood up dedicated governance around that to guide that improvement program, and --

THE COMMISSIONER: Q. What is a non-performing hospital-acquired complication?
A. The complications, each have indicators. There are 14 hospital-acquired complications and so their level of performance was outside the tolerance band.

Q. I see.
A. So they were not performing within the tolerance band for our LHD within our service agreement.

Q. And for the unplanned readmissions within 28 days, you said a large piece of diagnostic work was undertaken to see what the cause was. What is the detail of a large piece of diagnostic work - what does that mean?
A. So that commences with reviewing our data to understand the cohorts of the patients that are actually returning to the organisation. So starting with the data and then actually interviewing staff and understanding processes, and it's often a step-by-step process review.

Q. And was there a sole cause found for the unplanned readmissions, or was it more complex than that?
A. It is complex and multiple causes.

Q. With multiple causes, then, how was it improved?
A. Really taking each problem at a time and putting an improvement process around that. So an example would be discharge summaries. So there is evidence that if a patient on discharge visits a GP within seven days, then there are reduced unplanned --

Q. Chances of coming back to hospital?
A. Are minimised.

Q. Sorry, did that involve - sorry, you continue.
A. So that involved ensuring that there is timely discharge summaries, that our patient had a copy of the discharge summaries, and that our GPs are receiving discharge summaries.

Q. So an improvement in at least the timeliness of discharge summaries saw an improvement in unplanned readmissions within 28 days?
A. Correct. Correct. And then another example is a process change. So there are some patients that we actually ask to come back, and if that's not recorded as being requested to return to the hospital for a review - it might be a wound, it might be an injury, a fracture - then, on return, it's then recorded as an unplanned readmission, so the result of that is a process change, an administrative process change.

Q. And with the discharge summaries and - I assume one is an issue of timeliness, two is an issue of I suppose the adequacy of the discharge summary?
A. Correct.

Q. How accurate it is and that the information in it is the most pertinent for the patient's condition?
A. Correct.

Q. What steps, if you recall, were put in place to make sure that there was an improvement in both of those things in relation to discharge summaries?
A. The greatest step is timeliness and ensuring access by the GPs and, unfortunately, our systems don't always connect.

Q. Just explain what you mean by that.
A. So the discharge summary automatically goes into My Health Record but the GPs may not always access My Health

Record. So providing a patient a copy to actually have in their hand was an important step.

Q. And that was a reform, if you like, was it?
A. Correct.

Q. And who, in the main, creates the discharge summaries? Is it the junior doctors, is it the treating clinician? Who is it?
A. The junior doctors.

Q. And were there any steps taken in relation to the junior doctors to ensure that the discharge summaries had the most pertinent information and were timely as well?
A. There is. Clinical documentation in most of these improvement programs is a very important matter, particularly in hospital-acquired complications, and so working with the JMO teams to improve documentation.

Q. And when you say "working with the JMO teams", what does that involve? Does that involve the more senior clinicians providing some better training, if you like, or - you tell me?
A. Yes, as leaders, so the SMOs, the senior medical officers and the senior registrars, as leaders, coaching the junior medical officers. But the - they don't sit within my teams but in the medical services, they have training, education programs.

THE COMMISSIONER: Thank you.

DR WATERHOUSE: Q. Just one further question in relation to the unplanned readmission. You said that there had been a significant improvement but then it started to --
A. Decline.

Q. -- go outside the trend again. When you went back and looked, when the team did, did they find that that was because some of the steps that had been taken had not been embedded effectively, perhaps there had been a changeover in junior doctors or whatever, or were there new issues that were identified?
A. They are still working through that, but what my knowledge is, they are finding some very complex patients with multiple comorbidities returning, and they are focusing with the community teams how they can better manage those patients.

Q. So it's more about a subset of patients that need additional attention --
A. Correct.

Q. Than a general deterioration in that program?
A. Correct.

Q. Just with the hospital-acquired complications, can you give us examples of a few of those? I understand you said there are 14, but just to give us an idea of the sorts of things we're talking about.
A. The type of complications?

Q. Yes.
A. Falls is a complication; health care associated infections, which has multiple subsets underneath it; pressure injuries is a complication. There are respiratory complications, medication complications, birth trauma.

Q. What is the relationship between those examples that you give and the accreditation system? Does it look at those particular types of complications?
A. The accreditation system will view those as well.

Q. Can you go into any more detail about how that occurs?
A. Those complications will relate to the various standards, into the eight standards, and they will be reviewed as part of that.

Q. And are there any implications from a financial point of view in relation to meeting the health care - sorry, hospital-acquired complications KPIs?
A. There is. So the hospital-acquired complications form part of our service agreement. In the financial part of that agreement, there are adjusters applied to the complications, and that is a negative adjuster for non-performing complications.

Q. Can you explain in a bit more detail what that means exactly?
A. Basically, we have a negative budget applied as a result of not performing against those complications.

Q. And is there a certain degree of tolerance beyond which those negative adjusters apply, or are there negative adjusters for any hospital-acquired complications?

A. I don't know the detail of how that is managed. There is a complex algorithm, but it applies to each of those complications.

Q. Now, you mentioned that KPIs are in the service agreement, and for clarity, that's the service agreement between the district and the ministry; is that correct?
A. Correct.

Q. Are there other sources of KPIs?
A. There is. So, then, as a local health district, we then can set our own KPIs, and that occurs at different levels in the organisation.

Q. Can you give us some examples of the sorts of KPIs that would be set by the district?
A. We will look at a series of indicators if we're managing improvement programs, so we will wrap KPIs around those improvement programs; and also in health care quality committee at the moment, we're looking at some lead indicators rather than lag indicators, and the aim of that is to help identify what good practices are in place to prevent leading to complications.

Q. So those are not KPIs that are actually factored in to the service agreement?
A. Correct.

Q. Those are just done locally?
A. Correct.

Q. Are you aware if those types of KPIs are picked up by other districts? Do you share KPIs that you might be doing with your counterparts in other districts?
A. We are a member of Health Roundtable, which benchmarks KPIs. So there is a sharing through that process and also a learning through that process. Often things get shared just through collaborative effort and improvement programs. It's not a deliberate sharing.

Q. But to be clear, this is happening at one level between local health districts or facilities, perhaps, but it's separate from the KPIs that are being included in the service agreements?
A. Correct.

Q. Now, with those KPIs in the service agreements, given

your senior role involved in clinical governance, do you have any involvement in setting those KPIs?
A. Not directly.

Q. When you say "not directly", can you expand on that?
A. The chief executives take feedback to the ministry. We have involvement in performance - finance negotiation in the service agreement, but not with the KPIs.

Q. So the chief executive can take feedback about a KPI. Does that translate to changes in the KPI?
A. It can - and actually I might just correct myself. My performance team also provide feedback to the performance unit as well, which - that branch in the ministry assess the KPIs and performance and improvement.

Q. And you are aware that that has led to changes in the KPI based on the feedback?
A. I'm just trying to think of an example. I am aware but I just can't think of an example at this point.

Q. Are the KPIs tailored to your local health district?
A. Yes, they are.

Q. So they won't be the same as in the Sydney Local Health District?
A. No. They will be the same KPIs but they will have different target rates. So the ministry will review the local demographics and the impact which adjust the target rates.

Q. And how do you then translate that through to your facilities and community health services, et cetera?
A. So they are reported through a series of reports and dashboards, but as you can imagine, if you are a nursing unit manager on a ward, and you are looking at a rate at an LHD level, it has very little meaning. We have improvement programs throughout the district where the wards can set their own KPIs. The facilities have a KPI and then - that all feed up to delivering that KPI in the service agreement. So the NUM on the ward might simply be recording the number of, for example, falls that have occurred on that ward, rather than looking at the total rate as a district.

Q. In the years that you have been in this role, or clinical governance roles more broadly, how much change has

there been in the KPIs?
A. The KPIs themselves have been fairly consistent. There's been some variation in the HACs, some variation in the access indicators. The access indicators are under review at the moment, bringing learnings in what adds value, so there will be continued change in those. So there is always a small percentage of change that occurs annually through learnings.

Q. So it is a small percentage of change annually but they tend to be consistent year to year, is that what I'm hearing?
A. Fairly consistent.

Q. Have they tended to grow in number significantly over the years? Do they keep adding to them, or do they take some away that are no longer apparently relevant?
A. It is probably on balance, if something comes off, it's replaced with something else. I would not say that they grow.

Q. I wouldn't say, sorry?
A. I wouldn't say they grow.

Q. So they maintain a relatively stable number?
A. Mmm.

Q. From your perspective, with your experience, how effective would you say that the KPIs in the service agreement are for measuring safety and quality of patient care?
A. On the whole, I would say they are effective.

Q. They are effective?
A. Yes.

Q. Would you make any changes to them if you had more involvement in setting the KPIs?

THE COMMISSIONER: Q. It might be changes or it might be additions, there might be --

DR WATERHOUSE: Q. It could be additions, there may be some that are not as useful as others or may be reworded?
A. I think the additions are what we see at the LHD level and it's adding in the lead indicators so that we're not always looking at lag indicators, so that we have a better

indication of our safety processes.

Q. Just going back to the role of the HCQC, I understand that they also sign off on the safety and quality account?
A. Correct.

Q. Can you explain what that is, please?
A. The safety and quality account is a requirement that we have in our service agreement to produce annually a document that provides a summary of key activities across the district towards safety and quality, and that document we aim to write so that it can be published.

Q. When you say "published", do you mean for the community?
A. Published on the internet for the community.

Q. So that contains examples of what has happened, or is it more statistics? How would you describe it?
A. It is a mixture. It provides an outline of the demographics on the Central Coast; it then outlines the achievements towards the agreed priorities. It demonstrates what we have celebrated. It provides an outline of the awards that we provide annually and it is very much a document that celebrates the work that has been undertaken, and demonstrates.

Q. And just one other question about the HCQC. Is there any relationship between that, that committee, and the CEC, directly?
A. No.

Q. So it is all through the board?
A. Correct.

Q. How do you think that clinical governance could be improved in your local health district?
A. There is opportunity to improve the incident management process, and that is being undertaken by the CEC now, with engagement with key staff and the design of that policy. That policy had significant improvements in 2020 and improvements in the way we constitute a team to design recommendations, and that has been a considerable benefit. And there is opportunity for further refinement in that policy to ensure that investigations add value.

Q. That would be a statewide change, would it, or is that

specific to your district?
A. That will be a statewide change.

Q. Are there particular issues that the incident management policy currently in place present for your district which is leading to your involvement in that change?
A. An immediate example on that would be investigations into deaths relating to COVID-19 and there is - these investigations take significant time and effort and there is a point reached where the system is unable to be improved further.

Q. Are there other local changes that you would seek to make in the coming year or so in terms of clinical governance?
A. I think the most important thing for me in clinical governance is the culture that you have at an organisation and the learning environment, and we seek to continually improve that learning, embed training in safety and quality, and ensuring that staff are comfortable and safe, that level of psychological safety, to raise issues. We have focused a lot on our morbidity and mortality committees, allowing them to be broadened to multidisciplinary teams, and a safe and secure environment to raise issues and concerns.

Q. Now, do you think that the CEC should have a role in surveillance monitoring of health services to identify outliers and predict where there might be poor outcomes?
A. The CEC does have a role in that. An example of that is hand hygiene. So there is a requirement for each LHD to perform above a benchmark in hand hygiene, and we had - I'm just trying to think what year - probably in 2022 we had one of our sites were performing below that benchmark and the CEC's surveillance and role in that was to identify - number one, identify, we were aware of it, and then undertake an external audit and work with us on improvement - efforts to improve that hand hygiene.

Q. How did that - how well did that work, liaising with the CEC in that relationship?
A. Very well, and it helped us a lot to bring in fresh eyes. There is a process around monitoring hand hygiene, but bringing in fresh eyes, fresh auditors, identifying opportunity for improvement, it adds value into the system, that level of independence.

Q. And what if the CEC were to take more of a role in that regard, for example, using predictive modelling to determine where there might be potentially poorer outcomes, before those outcomes are actually evident --
A. Yes.

Q. -- would you see that as being a role the CEC should take?
A. It would probably be an opportunity.

Q. I would like to move on to some of your other areas of your portfolio, if I might. You mentioned just briefly that you have a health care improvement team. What is that team responsible for?
A. That team is responsible for managing any significant projects, improvement projects; a responsibility for building capability in the organisation, so they run several improvement programs. The team is also responsible for health planning, so we have two health planners in that team, which is - the accountability there is for the delivery of the strategic plan, the clinical services plan, any key planning documents.

Q. Does this team have a role in improving efficiency within the district?
A. Yes, they do.

Q. How does it go about doing that?
A. So that's working with the various general managers and clinicians to implement individual projects using a methodology. We use Lean Six Sigma, which is looking at - exactly looking at efficiency and defects and working with clinicians on the floor to implement those improvement projects.

Q. Can you give us an example of where that has been implemented using Lean Six Sigma?
A. Yes, there is multiple improvement projects with Lean Six Sigma. As part of the training, the attendees' requirement is to run an improvement project. So there are several per year. On a large scale, access improvement has been the biggest areas where they have run those projects. So looking at length of stay in the inpatient units, running a project to reduce length of stay, to identify barriers to discharge, and planning.

Q. And so that has been done in multiple different services within the district?
A. Correct.

Q. Are you able to explain the sort of degree of reduction that there has been in terms of length of stay?
A. If you - if I take our KPIs as an example, length of stay, there has been a reduction, I can't think what we are now, around 3.6 days, but there has been significant reductions in specialty areas. But overall, our KPIs for access performance have improved significantly over the last two years, with focus and improvement programs.

Q. And when you say "access", does that extend to sort of waits in ED and --
A. Correct. Transfer of care, so time off the ambulance stretcher, waits in ED, length of time in ED.

Q. Does the team undertake initiatives to identify and reduce waste?
A. So it's around efficiency and effectiveness, which absolutely is waste, and even if you take the HACs as an example - hospital complications - there is waste if we're - if there are areas where patients are ending up with a complication. So most of our programs are removing waste.

Q. So that might be waste of time, effectively?
A. Yes.

Q. What about waste of resources?
A. That includes waste of resources.

Q. Have there been challenges embedding and sustaining the changes that the team identifies?
A. I think in improvement there are always challenges embedding things. You've got a constant turnover of staff with your junior medical workforce, a constant turnover, so it is often that you're going back, you are reinforcing that change, you are putting systems and processes in for relevant managers to reinforce that change.

Q. Now, I understand you are engaged with the local primary health network. Can you outline what that involves?
A. We have a partnership with the PHN and we call - it is an alliance between the LHD and the PHN. We have a charter

where we agree on priorities that we can align those priorities and work together to deliver outcomes to improve, really, the health care on the Central Coast.

Q. So those priorities translate to projects?
A. They do.

Q. What sorts of projects do you get involved with with the PHN?
A. An example, we've run a diabetes project, where at the moment we're running a chronic pain project. There are various projects sitting within the mental health teams. We have a GP panel that reports up to the alliance steering committee. We look at projects in the GP panel as well, all of which align to the LHD's priorities but also the PHN's priorities.

Q. Taking that example of diabetes, what would that project look like in terms of who would be involved, what would they be doing?
A. So involvement comes from both services, so both the LHD, the PHN teams, but also the general practitioners on the coast, and so that project was using a support mechanism for GPs with the expertise of the specialist staff in the LHD.

Q. And you mentioned a GP panel. Is that a way of consulting with GPs?
A. Correct, it is. It is a panel of seven GPs that we meet every six weeks and we work to have a consulting process so that if the LHD is implementing a change in your model of care, a new process, we actually use that consultative panel work with them to provide feedback into the design.

Q. How are those seven GPs identified?
A. It's an expression of interest that is run by the PHN, and they apply for that role.

Q. And are there ways to engage with other GPs beyond those seven?
A. Yeah. So through the PHN and the LHD we run several connecting sessions, education sessions, for the broader GP network.

Q. What arrangements are there in place for consumer consultation?

A. Consumer consultation, we have various mechanisms. We often use survey, as an example, to get to the community of the coast. An example of that is we're undertaking master planning at the moment on the Wyong Hospital site and a survey that went out via social media, we had 600 responses in that. Or we will use expressions of interest out to dedicated groups to provide feedback into design, design of facilities, design of a model; or we have consumers as a member of key committees.

Q. Now, say you are developing a new model of care for diabetes or maybe chronic pain.
A. Mmm-hmm.

Q. How would you bring the relevant groups together to develop that?
A. So normally, we would start some form of design group, identify the various stakeholders in that model of care, and that will often be broader than the LHD. It might be NSW Ambulance; it would definitely be somebody in PHN; it might require a GP representative; we would most likely want a consumer representative and the various representatives within the LHD.

Q. So you've designed the model of care with those people giving input. What happens next?
A. You would probably be writing a business case to actually get - establish the costs, the outcomes, the benefits that are expected in that model of care. That would go through an approval process, determined where the funding mechanism comes from, and then, once approved, that would then move into an implementation model.

Q. Would it be piloted somewhere first generally or --
A. It possibly would. It's difficult when you pilot things if you need to recruit. So it depends if you are changing the way existing people are working or you are commencing something new.

Q. You are responsible for major capital works worth over $10 million?
A. Correct.

Q. I gather you sit on the executive steering committee for each project?
A. Correct.

Q. What does that involve?
A. The process facility planning in major capital works is probably, in my view, one of the best governance structures, and so it has a series of committees from engaging with clinicians in design, up through project control groups, and the final committee, being the executive steering committee, where you have oversight of the entire project.

Q. Is this a decision-making committee?
A. Yes, it is.

Q. If you are developing a new project that you build, a capital work, how do you ensure that there is accurate forecasting of what it is going to cost to run that facility so that it can be fully operational when it is finally opened?
A. Okay. So the major capital works above 10 million fall under the responsibility of health infrastructure. The LHDs have key responsibilities within that. As part of those business cases, the LHD working with the ministry and health infrastructure, complete a financial impact statement, and the FIS determines the - it projects the activity against our population data and also the staffing models required to deliver that activity.

Q. Now, if that financial impact statement predicts that there will be, say, an increase in demand, but also a significant increase in staffing requirement due to the footprint or whatever, aspects of the capital works, is that - is approval of that significant increase required before the work will go ahead?
A. It's - I think I would say it's concurrent. So it's part of the process in the build-up of that business case.

Q. Is it possible that capital works could actually be progressed despite the fact that the financial impact hasn't necessarily been acknowledged and resourced?
A. No.

Q. So there will always be the full amount of funding that the LHD says it needs to operate the capital works before the capital works are built?
A. The FIS doesn't necessarily mean that the funding will be there. It's the LHD and the ministry committing to those requirements, which can be some years before that building has opened.

Q. So it's a commitment that a certain level of resources will be needed, but not a commitment that they will be funded?
A. It's an agreement that they are required. But the budgets are negotiated in the years that those services are being delivered.

Q. One other team that you are responsible for is the health information and business support team. What does that team do?
A. So that team has three key functions. It has the medical record services, so the health information services which are responsible for collating the medical record, coding the medical record, and also a clinical documentation team. They have a performance and analytics team, which produce all of our local performance reporting. Then they also have a team, a design and architecture team that develop the systems and the dashboards to make that information available to our staff.

Q. How does that intersect with the role of the chief digital officer?
A. Work quite closely with the chief digital officer, particularly in the team that develops the dashboards, the systems and the processes.

Q. Is there ever a sense that there is a potential for duplication?
A. No, they have different roles.

Q. Finally, your research governance responsibility, can you explain what research governance involves?
A. Okay. Research governance involves the processing of research at the LHD. We don't have an ethics committee, but we have to approve the research that occurs, so the site-specific assessments. So the team monitors clinical trials to ensure that they are compliant clinical trial activity, and the approvals for research.

Q. When you say you don't have an ethics committee, I'm sure that doesn't mean you are doing unethical research, so how does that --
A. That means our ethics either go north or south, so they either go to Hunter for approval or to Royal North Shore for approval.

Q. So they are approved by ethics committee first?
A. Correct.

Q. Then there is a research governance approval process?
A. Yes, correct.

Q. How long does that take?
A. There are KPIs on research processing and so there are completion times, and that's monitored by that research team.

Q. And I gather there is a research institute in the district?
A. There is.

Q. What does that do?
A. So the Central Coast Research Institute is a joint institute between the University of Newcastle and the LHD. That institute's focus is on integrated care and translational research, translational research being it is translated into active changes or policy changes or process changes.

Q. So it's not a laboratory-based research entity?
A. No.

Q. Is there any intersection between research governance and clinical governance?
A. There is.

Q. Can you explain that in a bit of detail?
A. Particularly around quality projects, so quality is a key part of clinical governance - quality improvement. And so there are areas of quality improvement that require review by the research team to determine level of risk and what process that needs to go through.

Q. So if a clinician wanted to do some sort of quality improvement project, would they have to get approval from the research governance team and also the clinical governance team? How would that work?
A. No, there is a pathway where they initially receive approval from their direct line managers and their services, and that's to ensure that that improvement activity or research is aligned to priorities, and then that then goes through a process where the research team reviews to see the level of risk and what process that will

go through, and that's quite a clear pathway for clinicians to follow.

Q. So the clinicians can easily work out how to traverse that pathway?
A. Correct.

Q. Does the research governance also look at the financial impact of doing the research - how much it will cost in staff time, that sort of thing?
A. No, that is in the approval process before it gets - the research governance is purely responsible for the governance and the level of risk, and the process that needs to go through, that approval process happens with the line manager. So if you needed somebody released to undertake the project, released from delivering care to a different role, then that is part of that initial approval.

DR WATERHOUSE: Commissioner, I have no further questions.

THE COMMISSIONER: Do you have anything Mr Cheney?

MR CHENEY: No, thank you.

THE COMMISSIONER: Thank you very much for your time. We are very grateful. You are excused.

<THE WITNESS WITHDREW

MR GLOVER: Commissioner, the next witness is Mark Zacka.

<MARK GERARD ZACKA, affirmed: [11.11am]

<EXAMINATION BY MR GLOVER:

MR GLOVER: Q. Would you state your full name for the record, please?
A. Mark Gerard Zacka.

Q. You are the executive director, clinical governance and patient experience, at the Northern Sydney Local Health District; correct?
A. That's correct.

Q. You have been in that role since about 2019?
A. That's right.

Q. And prior to that, you have held various roles in clinical governance in the health sector, if I can put it that way?
A. Yes.

Q. Including at St Vincent's, South West Sydney LHD?
A. Yes, and justice health.

Q. Can you just tell us a little bit about what your role involves on a day-to-day basis?
A. So my primary responsibility is to assure patient safety. That's probably the overriding responsibility. That involves management of incidents that have happened to patients whilst they have been in our care. Broader than that, it also includes the management of complaints that have been raised by patients or families, and then there is a whole range of other activities that we are - myself and my team - involved with, to assure the safety and the quality of the care that we're providing. Things include medication safety, they include a strong focus around consumer-centred care, and we are also responsible to assure the accreditation of the health service against the national standards, health care standards, that are prescribed by the Australian Commission. That's probably the key things. I also have some other responsibilities beyond clinical governance that are tethered to my role as well.

Q. We'll break that up a little. Do you have a team that reports to you?
A. It's the clinical governance team, or clinical governance unit. It's a group of about - head count is about 20 people, maybe 15 FTEs.

Q. In that earlier answer you referred to "consumer-centred care". What's in the definition of a "consumer" for that purpose?
A. So the terminology can move around a bit, but "consumer" is considered a broader term that includes patients of the health service, that can be inpatients or outpatients as well; and "consumer" is a preferred term for mental health patients as well. So the terminology jumps around a bit, so sometimes we're using "consumer", sometimes we're using "patient", but it is essentially somebody who is receiving care or is engaged with our health service in some way, shape or form.

Q. Who do you report to?
A. The chief executive.

Q. Is that a standard position of people in your roles across the state, to report to chief executives, to your knowledge?
A. It is. It is a requirement that is expressed - it was initially expressed in the patient safety and clinical quality program, but it has been restated in the clinical governance policy more recently that was released literally in March this year.

Q. Are you aware of the rationale for the statement of that policy in March this year?
A. I believe and understand that the rationale is that the chief executive has an unfiltered input from the director of clinical governance in relation to any issue about patient safety or the care of patients or consumers within the health service.

Q. Is that a good idea, in your view?
A. I think it's fundamental to --

Q. Why?
A. I think that it puts the importance of the safety and the care of patients to the chief executive consistent with other important issues that the chief executive needs to be aware of, such as financial matters, people and culture, and the operational efficiency of the organisation. It puts it in that same sort of level of importance.

Q. In a couple of answers you have mentioned the concept of clinical governance. Is that a concept that has an understood definition within the sector, or is it something that might mean different things to different people?
A. It's a broad term, and there is probably a dozen different definitions for it. The recent policy that was released has a definition, and I think broadly people understand that it represents the systems and processes that assure the safety - the systems, processes and responsibilities of individuals to assure the safety and quality of health care. That's sort of an abbreviated version, but there are many different definitions of it. Essentially saying that, though.

Q. The district has a clinical governance framework; is

that right?
A. That's right.

Q. And we might bring it up on the screen, please. This is [MOH.999.825.0001]. Were you involved in the preparation of this document?
A. Yes, I was.

THE COMMISSIONER: This is exhibit 64, is it?

MR GLOVER: It has notionally been marked exhibit D.1.64.

Q. What is the purpose of this document?
A. The purpose is to articulate pretty much the requirements of clinical governance within the Northern Sydney Local Health District. It is underpinned and expresses - sorry, it is built on the national clinical governance framework that the Australian Commission issued in 2017, but it's specific to Northern Sydney, so it identifies all those systems, processes, policies and procedures and responsibilities that are required for clinical governance, but are specific to Northern Sydney Local Health District.

Q. What was the process for the development of this framework in general terms?
A. There were various stakeholders involved in the development. Mostly my team - me and my team were responsible for the drafting, and then it went through sort of a consultative process to ensure that it reflected the - what we have in place, and there was an agreed - an agreement about the document and it went through a process of sign-off by the executive and the board.

Q. I won't take you through the whole thing but I would like to take you to page 12 of the document, if you just look to your left or in front, whichever one is more convenient for you, to view it. Here is a summary of some expected outcomes. Are you familiar with this page?
A. I am.

Q. I just want to ask you about a few of them. In the first column on the left, fourth from the bottom:

> *Consumer feedback is used for quality improvement and service planning.*

Do you see that?
A. Yes.

Q. Firstly, how is consumer feedback in this context obtained?
A. We obtain consumer feedback in a range of ways, both informal and formal. Some of the ways that it is formally obtained is - well, negative feedback often is through complaints process. We have a very structured way of managing that and responding to it. We have various surveys, some of them very local, at a unit level, but we also have a survey system that we have in place internally within Northern Sydney called the real time patient experience survey, which gathers feedback from patients when they are discharged from hospital.

The Bureau of Health Information is one of the NSW Health pillar agencies. It has a very structured survey that it sends to consumers and provides very detailed feedback from consumers at sort of a regular - regularly. We then also have structures within our health service that allow consumers to engage with our governance and be involved not just in their own health care, that happens at an individual basis, but also we have them - have consumer advisers sitting on our various peak committees, health care quality committee, board consumer committee, but we also have local consumer participation committees or CPCs, at every facility and service, which has a range of consumer representatives.

Q. We will come back to some of those committees a little later, but in that answer you have described a lot of sources of feedback or information. Would you agree?
A. Yes.

Q. Is it the responsibility of your team to collate all of that and gather it and analyse it?
A. Well, we have a role at the sort of top level, at the district level, but there are local quality and safety teams across our facilities and services who also have a role in reviewing that feedback and synthesising it, analysing it and providing a response and/or looking at trends and issues that also may require a more systematic response.

Q. So once the feedback is gathered, analysed, synthesised, I think you said, how is it then used for

quality improvement and service planning at the district level?
Q. Sometimes - well, the main way is to identify themes or issues that are coming through the feedback. It doesn't necessarily require, you know, a cohort of people to have the same issue. Sometimes important issues come from a single piece of feedback from a complainant, for example, that identify an important safety or quality issue that requires us to respond. So it is important that we look carefully at the detail of individual feedback but also then at the broader level at the sorts of themes that are coming through more generally. So an example - would you like an example?

Q. Yes, please.
A. So an example would be from our real time patient experience survey, you will be surprised to know that the food is not particularly always the best, so that has come through very strongly through our real time patient experience survey. So rather than do nothing about it, that issue has been brought before our health care quality committee and we're looking at that issue, we've brought the - HealthShare, who are responsible for the food, we've brought them to talk about that issue at our committee, and our chief executive is one of the chief executive representatives on the statewide committee about food. It is a really important issue. It is a tough one to resolve. But rather than do nothing, we're actually trying to do - see what we can do.

Q. So in that example that you just gave, a theme or a trend from feedback had been identified and then was referred to the appropriate committee or body within the system to action; is that a fair summary?
A. That's right. That's right.

Q. And is that how themes or trends that are identified through this feedback, this consumer feedback loop, are dealt with in a general sense?
A. That's right.

Q. Two boxes down in that same page, on the left-hand column:

> *Clinical safety and quality performance data is used to inform strategic decisions and to drive operational performance and*

promote practice improvement.

Do you see that?
A. Yes.

Q. Can you just describe what that means in practice, please?
A. So we have a range of what are called key performance indicators about every aspect of our business - operational, financial, people and culture, and in terms of quality and safety, so those clinical safety and quality performance data, we look at that routinely through our committees, specifically in relation to quality performance, a relevant set of KPIs would be the hospital-acquired complications.

Q. Pausing there, these are KPIs in the service agreement between the --
A. Yes, that's right.

Q. -- ministry and the district; is that right?
A. That's right. So we look at that data routinely, we set targets based on a risk adjusted methodology that the ministry applies, and any time that we're not performing, we're reviewing that data and trying to understand what are the drivers of that underperformance.

Q. So the analysis of clinical safety and quality performance data that you have referred to in that answer, and is referred to in that box, is linked to performance against the KPIs in the service agreement; is that right?
A. That's right, yes.

Q. What about general patient health outcomes, is it used for that type of analysis as well, or only those things that are measurable against the service agreement?
A. They are. That's not entirely in my portfolio, it's slightly different - related, but slightly different. But certainly --

Q. To the extent that it is slightly different, whose portfolio would that sort of analysis fall within?
A. Well, where it would fall within my portfolio is say, for example, the death rate associated with particular health conditions. Again, the Bureau of Health Information releases information about that routinely around specific health conditions, and we can get a sense from that how

well or otherwise our facilities are performing around specific health conditions, for example, stroke. So that would fall within my purview, but then perhaps more from a health promotion point of view, other directors within our health service would look at that.

MR GLOVER: Is that a convenient time, Commissioner, for a short break?

THE COMMISSIONER: Yes. We will have an adjournment, then, until 11.45. We will break until then, thanks.

SHORT ADJOURNMENT

THE COMMISSIONER: Yes, Mr Glover.

MR GLOVER: Q. Just before we broke, I was asking you about the outcomes page, and we'll get that back up, if we can, [MOH.999.0825.0012] was the page we were at. I just want to ask you about one more box on this page. It is the top box in the right-hand column:

> *Evidence based care pathways and guidelines are utilised and unwarranted clinical variation is systemically identified and addressed.*

What's encompassed in the concept "unwarranted clinical variation"?
A. Sorry, I just missed that.

Q. What is within the concept of "unwarranted clinical variation" in this concept?
A. Unwarranted clinical variation?

Q. Yes.
A. So it is a broad term, but essentially it relates to where clinical care varies from an expected norm or an expected average, and that that variation isn't justified by the particular individual characteristics of the patient or the patient cohort. That's sort of a - my interpretation of that.

Q. How is it monitored?
A. It is - if you appreciate that fairly general definition, it is not something that's simply monitored by one set of, for example, performance indicators. Because

it is so broad, it can manifest in a variety of ways, but I can give you some examples where we have - where the system aims to provide clarity around an expected norm and then we can monitor around that. So we have at a statewide level a program called leading better value care. I'm not sure whether that's been brought up before now.

Q. Just describe it for us?
A. So it is overarchingly governed by the ACI, the Agency for Clinical Innovation, another one of the pillars. It is particular care - models of care that have been demonstrated at least in one place to have good value and good outcomes for patients, and has described - that model of care has been well described and that is then deployed across the system and implemented across the system at the local level.

There are probably about 14 or so that are quite visible to - at the system level at this stage, and we have implemented most of those models within our health service, and it allows us, because they've got particular explicit features that we can identify to see that they are in place and then are able to monitor how well that is being performed in terms of the number of patients that are receiving that particular type of care.

Q. And those models of care become the expected norm that you referred to in your earlier answer, do they?
A. That's right.

Q. And then how are variations from that norm identified?
A. Well, usually it is attendant - the model of care is attendant to a particular specialty, maybe orthopaedic surgery, for example, so the people delivering the care themselves will monitor it in an operational sense, then usually at a facility level, sometimes at the district level, we'll also look at data to indicate how well that has been deployed - you know, the number of patients, for example, who are getting that particular prescribed model of care. So the governance and oversight of it is where the care has been delivered, but then also more broadly at the facility level and then overarchingly at the district level.

Q. So where the instances of unwarranted clinical variation are identified, what steps are taken in response?
A. Again, it is hard to be general about that. It is

particularly - it is specific to the particular type of clinical variation that we're talking about. With those models of care that I have just mentioned, they are quite visible, quite measurable, and that can have a more systematic response.

If you are talking about, say, unwarranted clinical variation at, say - within a surgical team or teams, where, say, one doctor takes longer - one surgeon takes longer than another doctor, for example, could be considered unwarranted clinical variation, but how you respond to that is far more difficult and usually that would be about engaging with the team themselves, providing them with the data and they work through how - what might be driving that variation.

Sometimes things are designated unwarranted clinical variation when, in fact, there may be reasonable justification for that variation.

Q. Does the concept of unwarranted clinical variation include the delivery of what might be described as low value care?
A. I think low value care is, whilst in the same neck of the woods, probably slightly different.

Q. In what way?
A. Well, you could have low value care delivered very efficiently and effectively and with little variation to a particular standard. So it's not - there is no unwarranted variation within the care delivery, but that doesn't mean necessarily that the care is high value, because it may still not make much difference to the health of the individual, for example.

Q. By that do you mean that the particular instance of care could be delivered entirely in accordance with an efficient model of care for that particular instance but it would not overall be high value; is that what you mean?
A. It may - when we say "value", it may not. Actually, probably the thing that that's referring to is the health outcome for the individual.

Q. Yes.
A. So it could be delivered very efficiently and with little variation, but in terms of individual health outcomes and possibly more broadly health outcomes for the

community, it may have little impact.

Q. Is any part of the work of your team directed to identifying and analysing potential instances of low value care?
A. It certainly comes up, has come up, over the years efforts to delve into low value care. It is difficult, because it is that intersection between, I guess, the administration of the organisation and the governance of the organisation, and then it's starting to intersect with clinical decision-making and individual clinician performance, and that's a very difficult area to get real clarity around, because there are so many variables, not the least of which are patient variation, that may - you can't just say one particular procedure is low value, because it may be extremely high value for an individual; maybe across the community, though, you might see that it doesn't deliver - across a cohort of people it doesn't deliver high value.

Q. Recognising that challenge, though, is there any work currently under way within your district that you are aware of at least considering the concept of low value care?
A. The issue is never off the table. I can give you an example where I have worked previously, just to - would you like me to give you that?

Q. Yes, please.
A. That I think underscores the difficulty of the issue. It was in relation to knee arthroscopies for patients over 50 years of age. The health literature is quite clear that it isn't a procedure that delivers much value in terms of symptom relief and improvement in function, yet it was being, across the system, conducted by proceduralists at quite a high rate. One of the orthopaedic experts and leaders, Professor Ian Harris, he locked on to this idea and worked to, I guess, spread the information and talk to his colleagues about that particular issue, and through a process of working at that level, the senior clinician working with colleagues, the system was able to turn that around, and if you look at the data now as compared to, say, more than five years, probably 10 years ago, there has been a demonstrable change in practice.

Q. So that's an example where change was able to be effected in a model of care that was seen to be low value. Is there any current work that you are aware of of

a similar kind?
A. I just can't think off the top of my head of other examples. I know there are some but I wouldn't say there are a lot.

It might be worth just mentioning, if you like, the Australian Commission's work. They have produced an atlas of variation which they have updated about I think 12 months ago, and it identifies across the system where there is variation in relation to a whole range of different procedures and conditions.

Q. The Commission you refer to, is that the Australian Commission on Safety and Quality in Health Care?
A. That's right.

Q. In some earlier answers you referenced some of the committees that are in place across the district. I just wanted to ask you some questions about those. We might bring up on the screen, please, document [MOH.9999.0822.0001]. These are the Northern Sydney Local Health District By-laws, and I will refer to some of those as we go. Can you just briefly identify the various committees that are stood up in the district that intersect with your work?
A. So at the district level, or board and district level, there is the health care quality committee, which is really the peak quality and safety committee for the district. There is the board consumer committee. Then, sitting under those at the operational level, there is the clinical and quality council, the district's clinical quality council. That committee then relates to local clinical councils at each of the facilities and services, so that would be their peak sort of quality and safety committee at the facility and service level. So they're probably the standout committees - not the only ones, but certainly the main committees responsible for oversighting quality and safety and driving it in terms of a strategic and operational sense.

Q. If we go ahead to page 6 in the by-laws, which will just be on the screen there for you, there we can see that the organisation, that is the district, is required to establish structures and forums to provide input for medical nursing and allied health staff - do you see that? The first is medical staff councils, a mental health medical staff council, and a medical staff executive

council - do you see that?
A. Yes.

Q. Are you familiar with the work of those councils?
A. It's probably an area - I'm familiar that they exist and it's probably an area that I don't have direct involvement with. From a clinical governance point of view, understanding that they are in place and are working, that's my prime concern.

The executive director for medical services has much more direct relationship with those committees than I do.

Q. To the extent that these committees are set up to provide opportunities for clinician input, and that input relates to clinical safety and governance issues, how does it feed in to the work of you and your team?
A. So as I said, the most direct relationship with these committees is through the executive director of medical services, and that position is a member of the executive, so we work collaboratively across portfolios as an executive, and so any issues relevant to my area of work that emerge from these committees would come to my attention most likely through that collaboration with the executive director of medical services.

Q. Tell me if you don't know, but how many of these committees are there in place across the district?
A. I don't know exactly, but there - there are committees at a district level and then at a facility level as well.

Q. The other committee you mentioned was the clinical and quality council; correct?
A. Yes.

Q. Are you familiar with the work of that council?
A. Yes.

Q. If we go ahead in the by-laws, bring up page 15, please, you can see there on the screen, this is the section of the by-laws which deals with that council, and then down to page 16, there should be a heading "44. Functions"; do you see that?
A. Yes.

Q. And it says the council is to provide advice to the board and the chief executive with regard to the various

matters set out in that first paragraph. Do you see that?
A. Yes.

Q. How, in practical terms, does it achieve that aim?
A. So the committee meets routinely. I think you may have the terms of reference for that committee, and we have, in the first instance, broad representation on that committee. Most particularly, we have the clinical network directors and what are called service development managers.

Q. I might just be able to assist you by showing you the terms of reference. It is [MOH.9999.0951.0001]. I will have that brought up. Is that the document you are referring to?
A. That's right.

Q. Then, towards the bottom of the page, and then over the page, we see a long list of the members?
A. That's right.

Q. Quite a large committee?
A. It is quite a large committee. The intention there is to ensure broad representation, particularly around different specialties, so that, you know, there is - it being an advisory committee for the chief executive and to, you know, drive particular directions, we want to make sure that there is sufficient representation at that committee and that decisions made or advice given to the chief executive at that committee is sufficiently representative.

Q. So this is a body that gives advice?
A. It technically gives advice to the chief executive about direction on a range of issues, clinical and otherwise - issues affecting particularly the health workforce in different specialties.

Q. Before I cut you off to bring up the document, you were saying that it meets regularly. Other than having meetings, how does it function, in practice?
A. So it meets on a monthly basis, but we also have a clinical network sort of stream system, so these clinical network directors, they represent particular specialty areas and they are - the model is that they will work with their colleagues to understand issues that are coming up from the area of responsibility that they have. So that work goes on separate to the committee, but it is brought together - that network is brought together in terms of its

representation at this committee.

Q. So the members are to obtain feedback from their respective areas and colleagues and bring it to the committee?
A. That's right. There is a two-way --

Q. And what about the other way down?
A. Yes, there is an expectation that there is a two-way flow of information and potentially action as well.

Q. Given its large and diverse membership, do you have a view about how effective it is in achieving its aim?
A. We've recently, with the arrival of our new chief executive in the middle of last year, one of his first priorities was to look at the effectiveness of this committee and to reform it, so we've gone through a process of reforming this committee to ensure that it is effective. So every second meeting now has a particular theme, and the intention there is to ensure that there is actual meaningful actions that come from the - from the work of this committee around important issues that the membership feel are important for everyone.

So I think it is a difficult one to assess its performance, but certainly a key area of - an important area is that it has that representation and it's bringing the disparate parts of the business to the table collectively, and certainly in that regard it is very effective.

Q. Aside from having a theme for meetings, were there any other reforms to this committee introduced by the recently appointed chief executive?
A. I think, for this committee, that was the main reform, but it is an important one because it starts to focus. Sometimes with big committees like this, it's - it can just be information exchange, which is not always that productive. It's important that people are informed and have an opportunity to inform the committee, but the committee needs to do more than that; it needs to actually take action on important issues, and I think by having a specific theme agreed to by the membership for some of those meetings allows a meaningful action to take place.

Q. In an earlier answer you mentioned the BHI. What interaction do you have with the pillars generally in your

role?
A. Variable interaction. The BHI - we don't have a lot of direct interaction, but we do utilise the information that stems from the BHI quite extensively. The main pillar that I have interaction with is the Clinical Excellence Commission and possibly secondarily the Agency for Clinical Innovation.

Q. In relation to your interactions with the Clinical Excellence Commission, what do they relate to primarily?
A. The Clinical Excellence Commission was established at the same time that the directors of clinical governance and clinical governance units were established, back in the mid noughties, and it therefore reflects very closely - its business reflects very closely the business of clinical governance directors at our local level; it reflects that work at a statewide level. So we have a lot of connection with the CEC. It has a statewide directors of clinical governance meeting it hosts on a monthly basis, but then its programs of work are, by and large, implemented at the local level by us. So it's seen as a - as the expert centre, as its name suggests, and it provides a lot of guidance, a lot of tools, a lot of training, expertise for directors of clinical governance and for local health districts in implementing its programs of work and for us implementing our work locally.

Q. So the CEC will provide some guidance or some direction on a particular issue, and that will be implemented, obviously enough, at the local level. What about input from the district to the work of the CEC? Is that confined to the meeting of you and your colleagues that you referred to earlier in your answer, or are there other opportunities for the district to --
A. Many other opportunities, so around specific programs of work, we're - either myself or quite often my team will be directly relating to the CEC around specific areas of work, and the staff that are assigned at the CEC around those programs of work. So we have daily interaction with the CEC, maybe not at my level but at different levels in relation to quality and safety.

Q. What about the interaction of you and your team with the ACI, what issues does that relate to?
A. Similarly a lot of interaction - ACI is focused more around models of care, so it sort of sits in an interesting place, somewhere more operationally focused, but programs -

there are programs of work that I'm responsible for that sit with the ACI. One of those is the patient reported outcome measures program, which sits with me, so they're not always perfectly split along certain directorates.

THE COMMISSIONER: Q. You said in response to Mr Glover that you have a lot of connection, as you were explaining, with the CEC, and it is an expert centre and it provides a lot of guidance, a lot of tools, et cetera. What about the Australian Commission on Safety and Quality in Health Care, do you have much interaction with that federal body? I know you have said that the - I'm holding it up - National Model Clinical Governance Framework was some sort of guideline that you adapted for your own clinical governance framework, but do you have any other interaction with that federal body?
A. We do on occasion. Being a federal body, it's less direct, but around specific issues, and one issue that I'm thinking of, we did a - we conducted a patient safety culture survey and we utilised a survey tool that the commission had been looking at and testing itself, so we, in that instance, worked directly with some of the staff at the commission. The most usual, if we were going to - so it's usually around a particular issue.

Q. "The commission" being the federal commission?
A. Yes, but they are incredibly approachable and helpful, and the other thing that most likely we would deal with them directly with would be around accreditation and national standards.

THE COMMISSIONER: Thank you.

MR GLOVER: Q. I might go to that now, could we bring up [MOH.9999.0834.0001], I think this might be the document that the Commissioner just held up.
A. It is, yes.

Q. And if we can go to page 25 within that document. These are the standards, but before we get to these, can you - we've heard a little bit about the accreditation process this morning, but can you just generally describe how it operates within your district?
A. So the national standards are mandatory and therefore implemented across all of our system. In Northern Sydney Local Health District, I'm the executive who has overall responsibility for ensuring that we are currently

accredited.

The accreditation models that - the way we run it in our district is that it is the facilities and services that are actually accredited to the standards, not the district itself, although there are variations on models of how it works, but at ours, that's how it works.

Q. When you say there is variation on models, other districts might do it differently; is that what you mean?
A. Well, that's right. Other districts, they accredit as a district. Technically still the facilities are the ones that are accredited, or the services, but their approach to the - there is a survey that's part of the process, and they do that as sort of a job lot, if you like, whereas we do it facility by facility and service by service. But overall I hold the responsibility to ensure that we approach accreditation and that we're sufficiently prepared to meet the standards.

Q. And the standards that you referred to a couple of times in that answer, are they the eight standards that we see there on the top left of the page?
A. That's right.

Q. What work does you and your team do, if any, to ensure that the facilities across the district are meeting those eight standards at any one time?
A. So one of my team members is our district accreditation manager, and she works closely with the relevant staff at the facility and service level. The real work at a facility/service level occurs at that level and is led notionally by the general manager of that, or the service director of that facility or service, but what my staff member, her role is to ensure that they are managing the issues, managing to address the standards appropriately at the local level, even though most of the work will be occurring at the local level. She works with them and supports them, and we have a district-wide accreditation committee that supports that process as well, and we've also got policies and procedures that also support the process.

Q. Those policies and procedures that you just referred to take into account the requirements of the standards, do they?
A. That's right.

Q. Do you and your team have any involvement with or engagement with the affiliated health organisations that are attached to the district?
A. We do. There is only a couple. It is a - probably a very loose connection, and where it, for my part, mostly comes into play might be around a serious adverse event that requires an investigation. We may support the AHO, if that was necessary. I guess to - perhaps around the definition as well, so in our district, we've got two AHOs that I'm thinking of, HammondCare and Royal Rehab. There is a public-private partnership which governs the --

Q. I will deal with that separately.
A. Yes, I just want to make that distinction.

Q. You are quite right to do so. Let's just deal with HammondCare and Royal Rehab and then we'll come to Northern Beaches.
A. So our connection is not - not that often, and typically might be around a particular issue, a quality and safety issue, that they might be struggling with or that may have a relationship to the broader system, or it could be a serious adverse event, for example, where they - not having the resources that we do, we would quite often support them in that investigation.

Q. So what, if any, requirements or obligations do the AHOs have in relation to clinical governance for the services that they deliver?
A. They have their own policies and procedures and their own governance processes to assure quality and safety. I, in the absence of looking at their contract, can't tell you confidently what it says in relation to that, but I can tell you it would usually be quite light in terms of the requirements expressed. It might be something like if there was a serious adverse event, that the requirement would be that they conduct an appropriate investigation. It would be those sorts of - that sort of detail but not a lot of detail. It is usually quite a high level.

Q. So to your understanding, is it the case that the AHOs aren't, for example, required to comply with policies in relation to clinical governance that would apply in the district?
A. No, I wouldn't say that. I think again it would be specific to the contract and in the absence of seeing those

I can't tell the - can't tell you confidently, but it might be that they would observe our policies and procedures, but certainly without referring to the Northern Beaches - that is the case with Northern Beaches, the others I just can't tell you confidently.

Q. Is there any particular reason that you are aware of as to why this would vary from contract to contract, the requirements or otherwise to comply with policies written in relation to clinical governance?
A. I'm not sure what's in the contract, so therefore I can't really answer that. It may not vary. It might be a standard requirement expressed in there.

Q. Let's turn to Northern Beaches Hospital. What's the engagement of you and your team with the Northern Beaches Hospital?
A. So we have quite a bit more involvement with Northern Beaches Hospital than the Royal Rehab and HammondCare and, for example, we meet monthly - I meet monthly with my chief executive and my executive colleagues, and there is a director who is the liaison and the partnership - is responsible for the liaison and the partnership agreement with Northern Beaches. That person is there as well. So our executive team meets with their executive, chief executive and their executive team on a monthly basis. It is ostensibly to look at all the performance elements, be they operational, financial, people and culture and quality and safety.

Q. So you attend those executive meetings?
A. Yes.

Q. And to the extent it intersects with your role, what are the matters that you may engage on?
A. Around - we tend to conduct the meetings similar to how we do our own facilities and services, so it's quite a structured process, working through those four elements that I've just indicated, in terms of their performance and having that discussion. For my part, it's particularly around the quality and safety indicators and performance in regard to that.

Q. So is the Northern Beaches Hospital required to provide reporting on those matters to you --
A. Yes.

Q. -- and your team?
A. Well, yes, I mean, to the - to Northern Sydney and certainly me and my team work with them around their performance.

Q. So would it be the case that you and your team get involved when there's been a report of an adverse incident or a lack of performance on those measures?
A. Depends on the issue. Like all our facilities, there is a devolved responsibility and things go wrong, sadly, all the time, varying in the severity of them, so a lot of their business in managing when things go wrong happens locally.

When things have - you know, when we've really harmed somebody or they've really harmed somebody, that would be more the instance where I might get involved. Sometimes the patient may have been managed, as an example, by both Northern Beaches and somewhere else within our health service, so it might require a joint investigation in that circumstance.

MR GLOVER: Just pardon me a moment, Commissioner. I have no further questions, thank you.

THE COMMISSIONER: Do you have anything?

MR CHENEY: No, thank you.

THE COMMISSIONER: Thank you very much for your time, sir, we are grateful for it. You are excused.

THE WITNESS: Thanks, Commissioner.

<THE WITNESS WITHDREW

MR GLOVER: We're just seeing if the next witness is here.

THE COMMISSIONER: Yes, I notice it is listed at 2 o'clock. If he is here, he is here; if he is not, he is not.

MR GLOVER: He's here.

THE COMMISSIONER: Okay.

DR WATERHOUSE: I call Michael Wood.

THE COMMISSIONER: I don't know if he knows he is being called yet. Someone will get him.

<MICHAEL WOOD, sworn: [12.32pm]

<EXAMINATION BY DR WATERHOUSE:

DR WATERHOUSE: Q. Can you please state your full name and your position?
A. Michael Wood, I'm the director of clinical governance at Nepean Blue Mountains Local Health District.

Q. Can you outline your background that has led to you having this position?
A. So I worked in the clinical governance unit for the last 12 years, with my substantive position being the manager of quality and process improvement, and prior to that, I held nursing executive positions in other districts, with a clinical background in nursing, yes.

Q. How would you define your role now compared to the role you had previously as the manager of quality and process improvement?
A. So as the director of clinical governance, I have the principal role of ensuring that across our district, that we have the appropriate clinical governance systems, meaning processes in place to understand the quality and safety of care that is being provided across the district.

Q. How do you define "clinical governance"?
A. So "clinical governance" is the systems and the processes within a district that flow through to or across the health service and into each and every person's role to ensure that the work that we do provides the best outcomes for patients as possible.

Q. Are you familiar with the Clinical Excellence Commission?
A. Yes.

Q. The CEC, as it is often abbreviated to?
A. Yes.

Q. So what role does the CEC play in your experience in leading and supporting clinical governance within the district?

A. So the CEC, from a clinical governance directorate perspective, is the principal pillar within NSW Health to provide, again, the processes and the base systems for us as a unit to roll out those broader systems, in the forms of guidance from policy directives, across our service. So the CEC is a very key component of that, with both an operational connection through clinical systems and then the governance side for support for our unit.

Q. So what sorts of interactions do you have with the CEC in your role as the DCG?
A. So the - I mean, on one level the CEC is available to all of us all the time, but the regular connection comes through - sorry, the regular and scheduled connection comes through the directors of clinical governance forum that the CEC hosts, and that provides a forum, as it suggests, for all of the DCGs to come together each month at a dedicated time. But there is a multitude of connections for the - for my directorate to make contact with and receive information and guidance from the CEC.

Q. How effective do you find the relationship to be?
A. Very effective.

Q. I want to look at some of your particular responsibilities for clinical governance, so can you maybe just give me a brief overview and then I will go into detail with some of those. So what are your specific responsibilities in the role?
A. So I probably just need to step back, sort of out of my directorate, in a sense, to see how the connection comes in. So that's through the national clinical governance framework, which then links with the NSW Health version, which has recently been updated as clinical governance in New South Wales, and then it's my role where I pick that guidance document up and then convert that into an operational model across our district so that all facilities and services within the district can follow and adhere to those frameworks.

Q. The district that you are from has some different types of hospitals, community health services, et cetera. How do you ensure that the systems that are in place are appropriate for the different types of health services being delivered?
A. So the principal mechanism of the district from a governance perspective for patient safety and quality is

through our district's health care quality committee, which we call the safe care committee.

Q. I will come back to that, if that's okay. But just more in terms of at an operational level, what are you doing to make sure that the system works at a hospital compared to a community health service, et cetera?
A. So our directorate or my directorate employs patient safety and quality managers that we place within each of those facilities and services, and they are our - the directorate's operational eyes and ears, as well as playing an absolutely key role in connecting with the services directly.

Q. Now, I understand that one of the hospitals in your district is run by a private provider, St John of God.
A. Yes.

Q. So what role do you have in relation to that hospital, Hawkesbury hospital, when it comes to clinical governance?
A. So on the surface, we request the same information from that site as we do from our other similar sites. There are some limitations in some of the influence that we can have, but in terms of reporting, the standard applies to both, and we don't and haven't had issue of receiving that information.

Q. Do the same principles from the clinical governance framework apply?
A. In - the principles, yes. The execution is up to that site to manage.

Q. Does your role include any sort of aspect of system improvement in response to complaints or incidents?
A. Yes, it does.

Q. Can you explain that with a bit of detail?
A. So the - one of our positions is the district's feedback and complaints manager, and that person has a small team that manages complaints at one site, and the patient safety and quality managers that I have mentioned earlier have the complaints management portfolios at their respective sites or services.

Q. Who are these complaints made by that are followed up with this team?
A. Consumers.

Q. In terms of the incident management process, I'd like to you take us through and describe what the process is that is used for assessing and responding to or investigating an incident. Can you maybe clarify or explain that to us?
A. Would you like me to start at the incident entry component or at the reviewer?

Q. So say there has been a serious adverse event in a hospital. What happens from that point?
A. So if we use the most serious of incident types, we've got, I guess, our formal system and our informal system. The informal system I can simply describe as people being aware of their reporting requirements and actually just make phone contact as a mechanism of notification. Whether they do or don't, our other process side alerts us to an incident that has been classified as being our most serious, and so that comes as an email notification and key people within the team immediately review those notifications.

Q. What happens next?
A. So a clinical review, a preliminary clinical review is conducted in consultation with the medical or nursing or allied health staff that are involved or available to confirm that the reported incident is in fact of its most serious type, and then a preliminary risk assessment, which is a formal mechanism, is conducted as soon as practical with the executive from that site or service. And, from that, a reportable incident brief is developed, which comes with my endorsement to our chief executive, and then to the Ministry of Health.

Q. So it doesn't go to the CEC, it goes to the ministry?
A. It does.

Q. What steps are put in place to support the patient or family that has been the subject of the incident?
A. So unfortunately most often in the patient side of most serious events, they are deceased, so the support is directly with the family. So immediate contact is made with family through the mechanisms described in open disclosure, which includes acknowledgment and apology for the outcome.

From a staff perspective, as part of that preliminary

risk assessment, there is discussion about the need for action, if it's warranted, that further support is required by staff. So there are some standard responses in terms of - which aren't - I don't mean "standard" as in there's anything wrong with them, but making contact with the staff, offering support, offering our EAP support and then making a determination if further supports are required, immediately and then ongoing.

Q. Are the processes that you have just outlined applicable whether this occurs in a hospital or another type of health service within the district?
A. It is all the same.

Q. What about for a less serious incident? How does the process differ for that?
A. So the notifications process goes to the manager of the unit where - or ward or clinic that the incident has been reported. We have a position within clinical governance that does screen all incidents just as a checking mechanism, as a first pass, to ensure that the incident that has fallen into the lower categories isn't one that actually requires a reclassification.

There is then a number of mechanisms of review that we can institute depending on what we understand to be the situation of that first instance.

Q. So what might a review like that look like? What would be involved?
A. So within our district, we have a review process called a harm score 2 to 4 review, so that's indicating it's a higher level of investigation that is not solely based on the prescribed harm for that particular patient, but it may be triggered because that particular incident may have the potential to be repeated, and we initiate that harm score 2 to 4 review process.

Q. And is my understanding correct that - so that's for harm score 2 to 4. The harm score 1 is what you were describing previously?
A. To begin with, yes.

Q. And what is the name of the review process for a harm score 1?
A. It is a serious adverse event review.

Q. Now, if an investigation is done, whether it is for a serious adverse event review or for one of the other investigations that you just mentioned, are system changes implemented to prevent recurrence, or does the focus tend to be on staff education and reiterating the requirement to comply with policy and that sort of thing?
A. It could be either or both.

Q. Can you give me an example of where there have been system improvements made as a result of an investigation?
A. So there is - a lot of investigations result in recommendations. In the most serious of event types, they are classified into three categories: a review that has identified a root cause; a review that has identified contributing factors; and then the third being issues that have been identified that didn't directly relate to the incident but are opportunities for improvement. So to your question of the scale of those recommendations, we can often have education-based recommendations or policy compliance. They are regarded as the weaker type of recommendation, whereas others are far more direct in implementing or changing the system.

Q. So from your 12 years in this field, can you give me an example of where you have introduced a system change as a result of an incident?
A. It's not uncommon for models of care to be reviewed as a result of the incident investigation. So the review has identified that the way in which work has been carried out could or should be improved and then that work follows the recommendation.

Q. Where there has been a change or recommendations implemented, is there a process for going back to confirm whether or not they are preventing recurrence?
A. Often the review process itself forms - of a future incident then goes back to prior incidences to assess the ongoing compliance with that prior recommendation, although because of the changing environment it is not always unreasonable that a prior recommendation, although completed at the time, you know, no longer serves a purpose because of an environmental or model of care change following the initial implementation.

Q. Are you able to give an actual example of when that has happened?
A. Am I able to come back to that?

Q. That's okay. So you mentioned before the health care quality committee and that that has been renamed; is that correct?
A. Yes, that's correct.

Q. So what is the new name for that?
A. The safe care committee.

Q. And why the name change?
A. So the district undertook a review of its governance structure and took guidance from the future health framework from NSW Health that articulates six key objectives, and the district had then aligned its own operational and governance structure in line with that document.

Q. Has that required any change to the by-laws for the district?
A. No. So the safe care committee is still described as the district's health care quality committee, consistent with the by-laws.

Q. I understand that you are the executive sponsor of that committee; is that correct?
A. Yes, that's correct.

Q. What do you do in that role as executive sponsor?
A. So as the executive sponsor, it's my role to ensure that we have a structure to ensure that the committee itself is provided with the correct information in order to carry out its function, through committee papers and the reporting templates and information that make up those papers.

Q. So do you guide what the committee will consider?
A. We guide the base structure of the reporting requirements from each facility or service in partnership with them, and devise the structure, yes, of the safe care committee, together with the board member that chairs it.

Q. So it is chaired by a board member?
A. Yes.

Q. Who else sits on this committee?
A. So there are two board members; there is also the chief executive; the directors of - the director of

hospital services and the director of community and integration, so that covers all our hospital and our community mental health and drug and alcohol, oral health services; the directors of nursing, medicine and allied health; we have two consumers that play an important role in that committee; and some additional members from the clinical governance unit.

Q. Now, it is chaired by a member of the board. Does this committee report to the board?
A. Yes.

Q. And are there other committees reporting through to this committee?
A. Yes.

Q. What are their names?
A. So the district's reporting structure into safe care aligns with the national standards, and in order for the governance of those standards to be carried out across the district, we have the committees reporting in for partnering with consumers, the infection prevention and control governance committee, the medication safety governance committee. For the fifth national standard we, as a district, break that up into a number of components, covering pressure injury, falls, delirium and dementia, nutrition and hydration, unpredictable behaviours and advanced care planning and end-of-life care.

Q. So these governing committees are based on the accreditation standards --
A. That's correct.

Q. -- in terms of the way they take their name?
A. That's correct. Sorry, there are still three more.

Q. So you wanted to say the others?
A. So the remaining three are communicating for safety, blood management and responding to the deteriorating patient. Sorry to cut you off.

Q. No, that's okay, very good memory remembering them all. So they feed through to this safe care committee?
A. That's right.

Q. Is there a clinical council?
A. There is, but the clinical council doesn't report to

the safe care committee.

Q. Does it have any relationship with the safe care committee?
A. So we have medical membership from the council on safe care.

Q. So how does the safe care committee gain evidence directly from clinicians to know the things that are important to them in terms of clinical governance, perhaps?
A. So there is two more groups that are largely medically led that I can include, one being the clinical advisory group, and then the clinical ethics group. So they, together with the other governing committees, of which there is some medical involvement with those, report directly through the structured reporting mechanism.

Q. Now, in your role as the executive sponsor for the safe care committee, I understand that you prepare a report after each of those meetings. What is the content of that report?
A. The reporting format for this changed with the introduction of the broader governance change. So the template now consists of identifying achievements from - through the safe care committee; the areas of greatest risk or concern; and the areas of future focus; and then there is a fourth, which is items for direct escalation to the board. That can be for advice or for information. And then there is - the remaining components of the report are the performance against our KPIs that map through safe care to the board.

Q. Where does that report go? You prepare a report. Who does it go to?
A. So it goes to the board member that is the chair, and after their approval, it goes to the office of the chief executive for inclusion in the board papers.

Q. What happens with that report?
A. So at a board meeting, that report is always tabled and it is the board member that speaks to that report to the remaining board members.

Q. Is it mainly for noting or are there actions taken by the board in response to that report?
A. It depends on the elements that have been either identified as being of risk or for escalation, or at times,

it would just be for noting.

Q. Can you give us an example of when action has been taken in response to one of those reports?
A. We did have an area of poor performance that was reported to the board where it was requested of the safe care committee to investigate further. The safe care committee had in fact already requested additional information pertaining to that KPI and its impact on patients, but through that reporting mechanism, it alerted the board to ask for updates.

Q. So what is the role of the SCC, the safe care committee - what does it do primarily?
A. So as the key governing committee, it is there to, on behalf of the board, be reassured that the services that we're providing as a district are meeting not only KPIs but expectation from all - the patients and carers and families that operate through our system.

Q. So what sort of role does it take in relation to the KPIs?
A. So there is a strategic component where members of the safe care committee identify through the reported data that there is potentially an area of concern, and request action of various types, back to the site or the facility or the service where that poor performance relates to.

Q. What sort of KPIs are we talking about? Are these from the service agreement?
A. Yes, they are.

Q. Are there other KPIs?
A. Our current focus is primarily on those from the service agreement.

Q. So they are monitoring the KPIs. Are they looking at trends? What are they looking at about the KPIs?
A. So the data that is provided at safe care is both trended data and additionally the data on a patient number level, so we're not just dealing in rates, we also deliberately people-ise the figures to be very clear with the members of safe care about the volume impact, not just the rate. Then we look at the areas within a facility that that might be impacting on as part of that suite of reports.

Q. And are these data across the entire district, not just hospitals but other services?
A. So at each meeting, the district-wide data for those elements are reported and, then, through the sequence that applies to each facility or service, that site or service then reports its own data, the analysis and the actions that are being taken.

Q. Now, if it sees a concerning trend or concerning impact on a number of patients, what does the SCC do?
A. So if I use an example?

Q. Yes.
A. Yes, so even at our last safe care committee meeting, there was a particular KPI for a site. Sorry, it was - the KPI was a pressure injury, and this is an area where we had usually been performing very well, and there was an increase toward the end of last year, and the committee requested of that site to present at the next safe care committee meeting about its analysis and understanding of that increase, and then the actions that they've taken since, and will continue to take.

Q. In terms of the content of the KPIs that are in the service agreement, do you have any sort of influence in determining those, the KPIs?
A. Not directly. They are provided to the chief executive and the chief executive then opens those up to the exec for comment. But the agreement comes from the chief executive.

Q. But these are KPIs from a service agreement --
A. Yes.

Q. -- between the district and the ministry; is that correct?
A. That's correct.

Q. So is there any amendment to the KPIs in response to the feedback that you and your teams are giving to the chief executive?
A. I would have only had exposure to that in the director of clinical governance role, and I haven't seen that in the 12 months that I've been there.

Q. What happens with the KPIs in the service agreement that are at a district level, how do you diffuse those down

to be meaningful at an operational service level?
A. So that goes back to the templates for the reporting structure for safe care, so there is obviously KPIs that are directed at community oriented services, so they are included in those templated reports, and then the inpatient oriented ones go to, obviously, the hospital services.

Q. As the DCG for the district, which is quite a disparate district in terms of different types of services, how effective do you find the KPIs as a measure of safety and quality?
A. Well, the KPI is just that, it is simply an indicator. It is not an absolute. But we have found that where our performance has not been meeting KPI, and we've delved into the detail, we have found reason to be concerned and to act. So I see there is great value in the KPIs, and they have resulted in us, you know, making improvements.

DR WATERHOUSE: Commissioner, it might be better if we take a break at this point, if that suits.

THE COMMISSIONER: We can.

DR WATERHOUSE: I've got quite a bit to go still.

THE COMMISSIONER: All right. We'll take the luncheon adjournment now, then. We will come back at 2 o'clock.

LUNCHEON ADJOURNMENT

THE COMMISSIONER: Go ahead.

DR WATERHOUSE: Q. Mr Wood, earlier you listed all of the governing committees that you have under clinical governance and you said that these are aligned to the national standards. Is their primary role to facilitate the accreditation process in each of your different facilities? Is that mainly why they've been set up?
A. They've been set up that way to be more - for it to be easier for sites to understand the requirements and to provide the change to services that are required in order to meet those standards.

Q. Do they get involved in other types of work as well, so, for example, where there are KPIs that are trending outside what is expected?
A. Related to that topic, definitely. The governing

committees do have oversight for the site's performance against the respective KPIs and do request action or investigation or assist with resourcing or information or connection to meet those targets.

Q. And what are the - so would they have any role, for example, in developing recommendations or implementing recommendations that came out of an incident review?
A. So in the serious adverse event review process, at the recommendation stage, we bring in expert advice, which may come from a governing committee or maybe a head of department. So it is not an automatic connection, it does depend on the topic, and members from that governing committee in the clinical capacity were mostly involved in the investigation side of that.

Q. So when you say in their clinical capacity and you refer to their expertise, who makes up the membership of these governing committees generally?
A. So the terms of reference for each of those stipulates a requirement for membership across each of the sites and services where that topic is relevant, and then there is medical, allied health and nursing representation, as well as particular roles that have a direct connection to that governing committee.

Q. So would there be a combination of clinicians who are actively working as clinicians and also managers who are --
A. Yes.

Q. -- perhaps implementing?
A. Yes.

Q. What determines the program of work for each of these governing committees? Who decides what they will do, what activities they will be involved in?
A. So that is largely prescribed by the national standard itself, so the - if I use an example of the infection prevention and control governance committee, it gets a lot of its guidance from the requirements of the national standard, but then there are other elements, like the Australian Standard, for example, that also sits under the governance of that committee.

Q. And how often do the committees meet?
A. It's varied, again depending on need, but monthly or up to quarterly.

Q. Can you give us some examples of the types of activities, say, the infection prevention control committee does? What sort of things would it be involved with?
A. So that - the infection prevention and control governance committee oversees programs like hand hygiene, vascular access and sterilisation, those types of topics.

Q. What about the partnering with consumers committee, what sort of activities does that one have?
A. So that is a committee that looks to ensure that we do have consumers involved in our respective services and - so it is a combination, because it has consumer membership, as do all of our governing committees. So it's a combination of ensuring, like the other standards, that they are meeting the requirements, and then looking for opportunities for expanding how we address to exceed that minimum requirement.

Q. I understand that you are the executive sponsor for a committee called the PACE committee; is that correct?
A. Yes, that's correct.

Q. Can you please just clarify what PACE stands for?
A. So it is the patient and carer experience subcommittee of the board. That committee was developed with the restructure, but is yet to commence within the district.

Q. And what is the relationship, say, between the PACE committee involving patient and carer experience, and the partnering with consumers committee? Is there any relationship between those?
A. Yes. So under the restructure, the partnering with consumers committee will have essentially a dotted line relationship to the safe care committee and a reporting line to the patient and carer experience committee, and the chair of that committee will have membership in the patient and carer experience committee.

Q. When you say a "dotted line", what do you mean by that?
A. So because of the safe care committee's oversight of the national standards, and with partnering with consumers being the second standard, there's still a requirement for safe care to understand the work that's being done and its relationship to the remaining seven standards, but the reporting line, because of the broader connection to

patient and carer experience, will be to the other board subcommittee.

Q. In a practical sense, does that create a risk of duplication of some of the things that they are working on or talking about?
A. The nature of consumer engagement overlaps with all of our work, so the fact that the safe care committee has oversight or information, sorry, to do with that committee only guides the requirements for the other standards. So I don't see that it's necessarily an overlap in the sense that it must connect with all of our work anyway.

Q. So as the director of clinical governance, how do you ensure that these conversations are progressing towards improvements as opposed to just talking about issues?
A. So it's important, obviously, as the executive sponsor, to - and being a member of both of those committees - that where action needs to be taken, that it is identified and recorded in the meeting. It then obviously moves to being recorded as an action where that work is followed up. But - so that the chair of that committee performs that function very well, so it's not one that I need to really step into.

Q. As a director of clinical governance, do you have a role at all in identifying and reducing waste?
A. Indirectly, yes.

Q. Can you expand on that?
A. So our - the directorate doesn't have a direct function in waste - I will say waste management, but the efficiency side, but often in the provision of effective care, it becomes more efficient. So part of our role as a directorate is to have an awareness of the costs associated with what's being prescribed and, if it can be addressed more efficiently, that we would make that recommendation.

Q. Are you able to point to any examples of where you have introduced efficiencies through some of these clinical innovations?
A. Often with an investigation, on the surface the solution could be a staffing-based solution, but with further investigation, you identify that there are opportunities with the way in which the work is being conducted, that if you spend the time investing in how the

work is done, it's then not always just a matter of, you know, adding another person. So that's not always about avoiding employing more staff, it's also done with the awareness that certain staff groups are incredibly difficult to recruit to, so we equally don't want to waste time, and therefore be inefficient, progressing a recommendation that actually can't be met.

Q. How do you think that clinical governance could be improved in your district?
A. One of the items - well, actually two things I'm hoping can be addressed with the introduction of the single digital patient record, and what I'm hoping that can address is some of the availability of clinical outcomes through our own systems, meaning that we have access to that information and --

Q. Sorry, can I just stop you there. You said the "access to clinical outcomes", I think, so do you mean information about clinical outcomes?
A. Yes, yes. So within the medical record, currently the really only effective way to draw information is through actual clinical review, simply by reading, whereas if we have better ability or improved ability to extract clinical outcomes and indicators of performance from the record itself, then we can be more proactive in responding to what's going on in the clinical setting.

Q. What do you mean exactly by "extracting clinical outcomes"?
A. Probably best to describe the clinical quality registers, which are a recognised data source, which are specialty specific, that services subscribe to and submit data about a whole range of clinical elements relating to their specialty, and that - so they are managed externally from us, and then that information is returned to the specialty group.

If that same ability to access information is made available through the single digital patient record, then we will have a much better understanding of the quality of care that we're providing.

Q. So is your understanding that the single digital patient record will actually include clinical quality registers?
A. I have some advice that it will include elements,

I don't know to what extent. That would be definitely --

THE COMMISSIONER: Q. Who was that advice from?
A. Our chief information nurse manager, who is part of the SDPR - sorry, the single digital patient record group.

Q. The topic you are addressing now or the issue you are addressing now I assume is paragraph 25 of your outline. Do you have a copy of that in front of you?
A. Yes, I do. Yes, that is.

Q. Where it says the data which is reported by various sites to the safe care committee is tied to the LHD's KPIs, and then you make a reference to the KPIs being in the agreement. Then you say:

> *There are difficulties with reporting on information that [are or is] outside the KPIs and are relevant to whether safe and quality health care is provided.*

Can you give me an example of the information specifically that you're talking about?
A. So if we were looking at a surgical specialty, our current KPIs would be focused on access, where I'm looking more about that particular surgical sub-specialty and the performance around the selection of a prosthetic and the outcomes that would come from that prosthetic versus another.

Q. The health outcomes?
A. Yes.

THE COMMISSIONER: Thank you.

DR WATERHOUSE: Q. Just building on from that, you mentioned earlier that you focus within the SCC on the KPIs that are in the service agreement rather than other KPIs that you might consider. Is that because of difficulty accessing information in relation to non-service agreement KPIs?
A. Primarily, yes. Yes, it's a very timely - time-consuming exercise currently.

Q. So what impact does it have that you can't easily access this information, currently, without the single digital patient record?

A. It just means that we need to be very selective in where we invest our time, reviewing individual cases or specialties, where if we had a data feed, we would be able to be directed more reliably to areas where clinical review would still be required, but would be more easily identified.

Q. Do you find that there are gaps that affect the way that care can be delivered based on the information you can't access easily?
A. Sorry, would you mind just repeating --

THE COMMISSIONER: Yes, I'm not sure I understood the question either.

DR WATERHOUSE: Q. Do you find gaps in the way that you are delivering services because you can't get the information you need to drive those - the way services are planned and delivered?
A. I wouldn't describe it as a gap in terms of service provision. It would be a gap in our understanding as to the clinical effectiveness and the outcome as a result of that care.

Q. So by that do you mean that you can't be sure whether or not it's the most effective way to provide the care?
A. Yes, so we - without the individual patient review, we can't tell.

Q. I understand that the single digital patient record will not be fully rolled out for a few more years. Are there things that you are looking at in the meantime to try and create some of these improvements you seek?
A. So our incident management system is our primary tool for identifying not only error but clinical variation, and it's through that mechanism that we can influence and make change.

Q. And you refer there to clinical variation. Do you want to elaborate a bit more on what that means and the work you are doing in that area?
A. So clinical variation just refers essentially to the differences in practice based by clinician. Some of those variances are acceptable and very reasonable, and others just represent a variance from best practice that may not be able to be justified.

Q. And when you identify one of the latter examples, what do you do about it?
A. Well, depending on the degree of variance, in its most serious form in the role of director of clinical governance we make a referral for performance management to the director of medical services to investigate that variance or poor performance. In others, it might be working with subspecialties to devise either, you know, education or checklists or standardised procedures to manage the 80:20, if I can put it that way. I'm just saying the 20 to acknowledge the acceptable variance.

Q. What do you think about the CEC playing a greater role in terms of surveillance monitoring of health services?
A. The CEC does already play a role in surveillance and certainly making information available for us to assist with our own surveillance. Enhancements to that could do nothing but help patient outcomes, I would say.

THE COMMISSIONER: You're both using, in question and answer, the term "surveillance", what do you mean? I will ask you first, Dr Waterhouse. What do you mean by "surveillance"?

DR WATERHOUSE: I'm taking it from the CEC statement, that they refer to that.

THE COMMISSIONER: Q. When you were using the term "surveillance", what were you meaning?
A. So I'm referring to people looking - looking with knowledge and information to identify things that are outside what would be expected or what would be considered normal.

DR WATERHOUSE: Commissioner, it might actually help if I read the paragraph from the CEC statement. Can I do that?

THE COMMISSIONER: Feel free, if you think that's what you want to do or need to do.

DR WATERHOUSE: Q. It's really just a suggestion that has been made that will be dealt with subsequently. This is the statement of Professor Michael Nicholl. It refers to the identification of outliers - paragraph 88 -

> *... the identification of outliers through*

surveillance monitoring as well as the development of predictive models for anticipating the potential for poorer safety and quality outcomes at a unit and LHD/SHN level.

So that is something that you would support, a greater role in that regard?
A. Yes, definitely.

Q. Can I just clarify, are you currently acting in the role of director of --
A. That's correct, yes.

Q. How long have you been acting in the role of director of clinical governance?
A. Since December 2022.

Q. So that's 17 months or so?
A. Yes.

Q. Is that because you are covering for somebody who is on leave?
A. I was originally covering for someone on leave but they have since resigned, or retired, in fact.

Q. And what was the timing of their retirement? So how long have you been acting and not covering for someone?
A. I think their notice was in May of last year.

Q. What's the normal time frame for appointment to a position such as this? Would a year be considered typical?
A. I think it's highly - highly varied. Some are recruited to very quickly and others are an extended activity.

Q. Is there a process under way at the moment to recruit to this position?
A. I believe so.

Q. Have you found that acting in the role for an extended period, for a year and a half, has presented challenges for you?
A. I - no, I don't think so, no.

Q. Does it limit what you want to accomplish at all in

the role?
A. No.

Q. Do you find it at all difficult in terms of engaging with staff to get them on board to do things, if they see that this is not a permanent role?
A. I haven't experienced that, no.

DR WATERHOUSE: Thank you. I have no further questions.

THE COMMISSIONER: Q. Can I just ask you a question about 26 of your outline, to make sure I'm not misunderstanding something. You have said - this is your second opportunity for improvement:

> *Secondly, the improvement systems adopted are generally reactive to adverse incidents and complaints. A more effective system may be one where the LHD is also able to easily recognise care that is reliably achieving great outcomes.*

I suppose we can include "good" and "appropriate" outcomes in with "great" as well, but aren't models of care - I assume - based on healthcare procedures or protocols that lead to good or appropriate or best possible outcomes - are you talking about something different?
A. It would include those elements. So I'm suggesting here that although in the presence of effective models of care, there may be pockets of performance that far exceed what either would be expected from that model of care --

Q. There might be a tweak of a model of care or there might be something that's outside it that should be incorporated in it?
A. Yes. So the reference to being reactive is unfortunately we spend a lot of time investigating error and if we had better data systems, we might be able to use the system --

Q. You could look at what is working well as well?
A. -- to identify what is working really well.

THE COMMISSIONER: I understand, thank you. Nothing arose out of that, Dr Waterhouse?

DR WATERHOUSE: No.

THE COMMISSIONER: Is there anything?

MR CHENEY: No.

THE COMMISSIONER: Thank you very much for your time, sir. We're very grateful. You are excused.

<THE WITNESS WITHDREW

MR MUSTON: I think our next witness is Matthew Russell. While Mr Russell is coming, we should probably mark the outline of evidence of Michael Wood as MFI 3. You have mentioned it a few times.

THE COMMISSIONER: You are quite right.

MR MUSTON: One other procedural matter along those lines, I think there was some reference to a statement --

THE COMMISSIONER: Is there any reason - I mean, we can mark it as MFI 3, is there any reason this just doesn't become an exhibit or would you like some time to work out the right number or --

MR MUSTON: I'm content for it to become an exhibit.

THE COMMISSIONER: I don't know where we're up to but it can go in as an exhibit. Someone can sort it out in due course.

MR MUSTON: There was some mention of a statement a few moments ago being the statement of Michael Nicholl, I think it is worth recording that that is the statement of 8 April.

<MATTHEW IAN RUSSELL, affirmed: [2.28pm]

<EXAMINATION BY MR MUSTON:

MR MUSTON: Q. Could you state your full name for the record, please?
A. Yes, it is Matthew Ian Russell.

Q. You are the director of mental health for the Nepean Blue Mountains LHD?
A. Yes, that's correct.

Q. How long have you been in that role?
A. Three years.

Q. And did you have previous roles within the public health system prior to that?
A. Yeah, I previously worked at Northern Sydney LHD, but before I went to Nepean I had a couple of years out of the public health system working for the non-government organisation.

Q. What was the role you had at North Sydney LHD?
A. I managed some of their child and youth mental health programs.

Q. So as the director of mental health within the Nepean Blue Mountains LHD, what are your responsibilities or roles as you see them?
A. Sure, so it is a fairly broad portfolio. I have kind of overall responsibility for strategic, financial, clinical and general operational issues relating to the running of the mental health service.

Q. So what are the - perhaps describe the mental health services which are delivered through the LHD.
A. Sure. So we operate across the whole of the age spectrum, from perinatal mental health services up to specialist older mental health services. It is a combination of inpatient services and community-based services. Generally, the people that we support are at the more severe end of the spectrum of those impacted by mental illness and mental ill health. However, we also run some specific early intervention programs for children.

Q. Let's take them one at the time. The inpatient services, could you just give us a brief description of what they involve?
A. Yes. So we have five different inpatient units across the district. Four of them are based on the Nepean mental health campus. In the Nepean campus we have a Psychiatric Emergency Care Centre, which is a six-bedded unit; we have a high-dependency unit, which is a 12-bedded unit; we have a general adult acute mental health unit, which is 32 beds; and we have a specialist older persons' mental health unit which is 16 beds; and the fifth unit is up at the Blue Mountains hospital and that's a 15-bedded general adult acute unit.

Q. That's the inpatient services, community based --

THE COMMISSIONER: Q. Can I just ask - sorry to interrupt. Those bedded units you have just described, are they usually at full capacity?
A. Yes.

MR MUSTON: Q. So moving to the community-based services, compared to --

THE COMMISSIONER: Sorry, I should ask a follow-up.

Q. Given you have said that they are at full capacity, does that mean you could have more beds and they would still be filled?
A. Yes, we - yes, Commissioner.

Q. Do you have any idea about numbers?
A. When we had a look at it recently, we thought that we were probably about 7 to 8 beds short in the district of what we needed.

THE COMMISSIONER: Thank you. Sorry to interrupt.

MR MUSTON: Not at all.

Q. That's the inpatient services. In terms of the community-based services, what do they comprise?
A. So the community-based services are scattered across the district. They are generally multidisciplinary teams that consist of nurses, psychologists and allied health professionals as well. There is a mixture of kind of - we have two access teams, which one is based down in Penrith and one is based up in the Blue Mountains, and they deal with all our initial referrals and initial triages that come through the mental health line and are really kind of people who first need to come into our mental health care.

We then have a number of general community teams that provide short to medium term support for people with severe and enduring mental health problems and then we have a couple of assertive care teams as well which provide more support to people who have generally found it hard to engage with traditional mental health services, generally have smaller case loads and provide a much more assertive kind of community-based outreach to engage with people who

haven't traditionally engaged with services.

Q. So following on from the question the Commissioner asked a moment ago about the beds, do you feel that the existing array of community-based services that you are able to offer are sufficient to meet the mental health needs of the population within your LHD?
A. I think there is definitely opportunity for more community mental health services, particularly for the general adult mental health community population.

Q. Who do you, in your role, report to?
A. I have a dual reporting line. So I report to the chief executive of the district and I also report to the director of community and integration.

Q. And you have a number of people who report up to you from different parts of your - from within the mental health service?
A. Yes. I have mainly six direct reports that come through.

Q. What are those roles who report directly to you?
A. So there is the medical director, which is the clinical director for the mental health service; there is a divisional manager who manages all of our corporate and administrative and general services functions; I have a manager for adult mental health stream, a manager for the child and youth mental health stream, a director of nursing, and a manager for allied health and specialty teams.

Q. So in terms of the process whereby you report up to the chief executive, what is the form of that reporting? How is information passed from you to the chief executive? Is there a formal meeting structure or is it just an as-needed? How does it work?
A. So we have a series of one-on-ones scheduled throughout the year and during those one-on-ones, we will discuss any particular issues or topics that need to be discussed.

Q. And do you find that, through those discussions, you are able - well, through those discussions do you identify what you perceive to be gaps in the availability of mental health services within the LHD?
A. Yes, we will discuss those.

Q. And through those discussions, is it your observation that those gaps are able to be filled?
A. Sometimes.

Q. In terms of when they are not able to be filled, do you have any sense of what the impediment is?
A. Generally budget constraint - well, it is probably budget constraints but also workforce constraints. There is a significant gap in mental health workforce across the whole of the state at the moment.

Q. When you talk about mental health workforce, are we talking about the medical workforce, as in for psychiatrists?
A. All mental health professionals, there seems to be a gap across New South Wales at the moment, from --

Q. Psychiatrists, mental health nurses --
A. Allied health professionals.

Q. A shortage in every area?
A. (Nods).

Q. And it is a combination, is it, of an inability to find someone to do the job in some cases, and an inability to find some money to pay someone to do the job, which, one or other or in combination, lead to --
A. Yes.

Q. -- an inability to fill the gaps as you identify them?
A. And also the impact of those staff that are doing the jobs in a tight resource where there is a lot of demand, that can lead to higher levels of stress for people working in those areas as well.

Q. So can you explain to us the governance structure within your mental health service?
A. Sure. So we have a monthly executive leadership team meeting, which is - I chair and convene that with all of my direct reports. We have a fixed agenda for that meeting where we review the main priorities that we need to review. That includes whether we have got outstanding recommendations from serious adverse event reviews, whether we have got any outstanding incident management issues that we need to review; we look at our financial performance within that meeting as well. We also cover off work health

and safety issues within the executive leadership team meeting. That's the kind of peak meeting within the mental health service where then there is a whole range of other meetings and structures that occur throughout the different streams, that they report through to that executive leadership team meeting.

Q. So do you, as a mental health service, have any particular KPIs that you are required to meet?
A. Yes.

Q. Where do they - where do you find them?
A. They come from the service agreement. So the service agreement --

Q. The service agreement between the LHD and the ministry?
A. Yes.

Q. And which KPIs in that service agreement do you perceive to be particularly relevant to the mental health services that you are delivering?
A. So we have a range of KPIs around seclusion, restraint and restrictive practices which we have to monitor and measure as well; we have KPIs around readmission rates for people who are discharged from our inpatient units; we have KPIs around seven-day follow-ups for people that are discharged from those mental health units as well to make sure that they have a seven-day contact from somebody after they have been discharged; we have KPIs around the number of peer workers that we have within our mental health services; we have over KPIs around performance in terms of ED access, in terms of making sure that people don't spend too long in emergency departments; and we have - I'm just trying to remember what other KPIs --

Q. Would it be fair to say the KPIs tend to be things that are readily measurable - relate to things that are readily measurable?
A. Yes. Sorry, I just remembered the other one --

Q. Yes.
A. -- is about patient experience of care as well. We have a KPI that monitors on patients' experience and carers' experience of care.

Q. And is that based on a data collection that you do

when patients interact with the mental health service?
A. Yes. There is a - it is called the YES survey, "Your experience of service" survey, and that's available on paper forms or e-form as well.

Q. Would it be right to assume that those KPIs relate in part to the number of people who can be persuaded to fill out the form, on a particular threshold, number of consumers who fill out the survey; is that --
A. So the actual KPI is a percentage of people who have completed the survey that report a good or excellent level of care.

THE COMMISSIONER: Q. I asked you about numbers of acute beds and Mr Muston's asked you about community services and there's been some discussion about workforce. Can I just ask you this, on that general topic: there are obviously people in equivalent positions to you as either director of mental health services or clinical director of mental health services in other LHDs. Do you get together and have meetings either formally or informally with them?
A. Yes, Commissioner, we do.

Q. Is that formal?
A. Both. There's a formal mental health directors meeting that occurs four times a year. There is also a mental health program council meeting that occurs on the same day four times a year, and that includes various different NGOs and peak bodies from mental health that come to that session in the morning. We also have an informal catch-up with the executive director for mental health probably every four to six weeks.

Q. And in general terms, either as a unanimous position or flowing from discussions with some of your colleagues, is the position in other LHDs the same, that there is - there could be more acute beds, there could be more community-based services to meet the need?
A. I would hate to put words into my colleagues' mouths but I would generally say yes.

MR MUSTON: Q. Just to finish on the KPIs, are there any KPIs that you are aware of or that you feel that your mental health service needs to respond to which measure the extent to which the services are sufficient to meet the mental health needs of the population within your LHD?
A. I am just trying to think. I don't think so, because

for that, we would have to be - I'm just trying to think about what KPI we would have to measure to be able to catch whether we had enough services.

Q. A starting point, presumably, you would have to make a reasonably detailed or careful assessment of the needs within the population?
A. Yes.

Q. And then it may well be that some KPI could get built around that on the basis of certain assumptions as to the number of clinicians or the types of services or acute beds that might be needed to meet those needs in any given period?
A. Yes.

Q. Is the first step something which is done in a formal way - that is to say, is a formal assessment made of the mental health needs or anticipated mental health needs of the population within the LHD?
A. I'm not aware of it being done by LHDs specifically. I am - I think that there was some work done across the whole of the state in terms of assessing mental health needs across the whole of the state.

Q. So the next question that may follow on from the one I just asked, but in terms of KPIs, is there any KPI that you are aware of or consider your service is required to meet which measures the extent to which the services that you provide are effective, in the sense of, say, number of occasions when someone, due to the excellent services that you have provided, has not had to present either to an acute or community-based mental health facility?
A. Most of our KPIs are kind of proactive KPIs, so it's hard to report on things that haven't happened, so it's very hard to report on someone who hasn't presented to an emergency department as opposed to someone who has presented.

Q. Whether it be emergency or some other form of mental health care, is any assessment made of the extent to which the care that is delivered through the various services that you operate is effective in managing the mental illness of the people within the population?
A. Yes, so we have some standard outcome measures that we have to do, so we have a HoNOS, which is - I'm going to trip up on the exact word of it, but it basically looks at

a broad measure of people's wellbeing, severity of symptoms and how generally distressed they are and the impact of their mental illness is. We do those assessments regularly during people's journeys of care, so we do one on admission and then there is a schedule for when we would actually redo those assessments during - whether they are an inpatient or in the community as well.

Q. So to the extent that someone as part of that journey of care might present say at an emergency department, be transferred into an acute bed, they receive some care in that acute setting and are discharged, possibly discharged with the opportunity to participate in some community-based outpatient care - would that be a typical patient journey?
A. Pretty much, yep.

Q. And in terms of the assessment as to the efficacy of the care that is provided, an assessment is made at the end of the acute phase of their care?
A. Yes.

Q. And did you say a further assessment is made at some point after that, in terms of the efficacy of the care?
A. Yes, so there should be a reassessment done at every transition of care. So at every point, someone either steps up or steps down, either from a community to an inpatient unit or an inpatient unit down to a community service. There should be a reassessment done of that person's needs at that point. When they are involved in general community services, there should be a reassessment done every 13 weeks.

Q. So to the extent that they are regularly presenting to a community-based service, it's not --
A. Every 13 weeks.

Q. Every 13 weeks an assessment should be made of the efficacy of the care that they are receiving?
A. Yes, so it would require doing that set of standard measures every 13 weeks of somebody in care.

Q. What are the standard measures - I don't need to hear about all of them, but in general terms, what sort of things are being measured?
A. So the HoNOS would be the main one, but we also do a strengths and difficulties questionnaire and some of the questionnaires are specific to age range as well. So there

is a suite of questionnaires that would be done for children and young people and that would include talking to parents and asking parents for their assessment of how that person is going and how that child is going, and then there is a different suite of documents that would be done for an older person as well. So they would be looking at people's general wellbeing, how impacted they are by their mental health symptoms, how distressed they are by their mental health symptoms, are they able to work, are they engaged in meaningful engagement, in activities. It would kind of - it is a fairly broad assessment.

Q. The results of those assessments inform the way in which services are planned and delivered by the LHD in what way?
A. They probably wouldn't go into a broader service planning, but they would be looking at the individual person's treatment and the individual's treatment goals. The idea is that the treatment goals for the 13-week period should very much be tied to the reports and the assessment that is done through those standardised measures. There should then be a set of goals and activities created with the person and their families and their carers, which should guide the support that's offered for the next period and then that would be reviewed.

Q. So the assessment is obviously important from the point of view of the care being delivered to the individual who is passing through the service?
A. Yes.

Q. But do I understand you correctly to say that the results of that data collection process are not used in a more systemic way to work out whether or not the system - the services that are being delivered and the way in which they are being delivered is, system-wide, the best way of doing it?
A. Not to my knowledge. Someone else might be able to provide more specific answers around that.

Q. I will move away from KPIs for a moment. You said there was an array of further meetings and gatherings that formed part of the governance of the mental health service. We've got the monthly executive leadership team meeting you have told us about. What are some of the other meetings that you have?
A. We have two patient safety and quality meetings, so we

have a patient safety and quality meeting for all of our inpatient services and then we have a patient safety and quality meeting for all of our community-based services as well. Those two meetings really look specifically at incidents that have occurred, they look at trends of incidents that have occurred and they look at whether there is any specific issues or actions that need to be taken. So that really kind of monitors the safety for patients and families through those two services.

We also introduced a new meeting probably about 12 months ago called the safety and strategy review meeting. We introduced that because we picked up that the patient safety and quality meetings were very focused on kind of individual incidents, things that had happened, data type things. There wasn't really a good opportunity for the service to think about broader trends and more wider kind of - how workforce is interacting with safety as well, and particularly about kind of some of the workforce challenges that we've had or cultural aspects that might impact on safety as well. So we implemented that meeting as a new meeting, as a more kind of broader discussion rather than being so focused on KPIs.

Q. So that's around ensuring that the care that you are delivering is safe for patients or consumers?
A. Yes.

Q. And safe for the workforce?
A. Yes.

Q. Do you meet - in what forum do you gather information from the senior managers who operate at each of the various services that form part of the mental health service in the Nepean?
A. Yes, so we've got structured terms of reference for all of our teams' meetings and we have kind of aligned that across the whole of the mental health service. The agendas for those are set to include work health and safety issues, clinical governance issues that need to be escalated as well, so it would be going through those fixed terms of reference and agendas for each team meeting and each stream, which would then get filtered up and escalated to the executive leadership.

Q. Do the fixed terms of reference involve any routine assessment being made of deficiencies or gaps in the mental

health services which are being provided relative to what might be perceived to be the needs of the community within the LHD?
A. Where it would relate to a work health and safety issue, that would come up through those meetings because that is a standard escalation pathway for it. I don't - we don't have a formal part of that agenda that - where teams could report on perceived gaps.

Q. So to the extent that people - that might be involved in running a community based form of care, if they perceive there to be some need for additional service of some sort to meet the requirements of the community, there is no standing item on the agenda that says "Is there anything that we could be doing or should be doing that we're not"?
A. No. We do ask people to report through the incident management system if there are ever times when a clinical service couldn't be provided due to a resource issue, we ask them to report that through the incident management system, and then we review that on a case-by-case basis.

Q. Is it right to say that the incident management system kicks in when something bad has happened?
A. Not always. We do encourage people to record near misses in there as well. The area that we're asking people to record at the moment is if there isn't a car available and they wanted to do a home visit, if there wasn't a car available they could report that in the incident management system as well.

Q. To what extent or in what way is the performance of each of the various services that you offer monitored by you as the person who sits at the apex of the mental health services?
A. Yep, so we look at a number of things which we then report through to our district performance meeting, as well, and --

Q. Just pausing there, how often does the district performance meeting happen?
A. Depends on what level we're on. So the district sets different performance levels for each part of the service and there is a clear framework around what performance level you are on as a service as to how frequently you would meet with the district to do your own performance meeting.

Q. Who attends those meetings usually?
A. So I attend them with my executive leadership team from mental health. From the district, it's generally the tier 2s of the district, which is the director of nursing, director of finance, director of community integration, director of hospital services, director of allied health and research, and director of clinical governance, and I may have missed one.

Q. So that's the means by which the information that exists within your team is being passed up to that executive level within the LHD?
A. Yes.

Q. What about the process by which information is gathered from within your team by you?
A. Yes.

Q. Is there a formal meeting structure?
A. So each of my direct reports has a formal meeting structure in place for their streams, and then I meet with my direct reports monthly as well and ask them to report to me on some specific items.

Q. Is there a standing series of items?
A. Yes.

Q. What are those items?
A. So they cover the kind of range of KPIs that we would look at, there would be a whole lot of workforce KPIs around annual leave, vacancies, recruitment, overtime, budgets as well. There is also the incidents as well, so if there is any clinical incidents that need to be reported, they are included in there as well, and mandatory training for staff is included in those reports as well. So it kind of tries to mirror as much as possible the structure that we have to report up to the district and back to the ministry as well.

Q. So the KPIs that you are looking at in those meetings are, whilst maybe slightly bespoke for your service, intended to populate the KPI performance measures for those same KPIs that are engaged at the district level?
A. Correct.

Q. Which, being the ones which we have spoken of already, exist in the service agreement?

A. Correct.

Q. In terms of the financial management, do you have a role in relation to financial management of the mental health services within the district?
A. So I receive a budget from district finance, so there is a budget allocation that goes from the service agreement from ministry to the district and then district finance allocate a budget out to me as the mental health director.

Q. Can I ask in relation to that, is there a process that you engage in with the district whereby you work out what that budget should be?
A. No.

Q. So what is the process in terms of - insofar as you are aware, at least as the person receiving the budget, how are decisions made about how big it should be?
A. I receive a budget. So the district gets a budget, finance looks at activity targets set for community and inpatient services, then some time after the district has received their budget from ministry, I get a budget that comes out to me as mental health director.

Q. So I take it that between the district getting its budget and you being allocated your budget, there is no process whereby there is a discussion that happens between you and, say, finance within the district, about what the potential needs in terms of mental health care of the community might be and how much it might cost to deliver?
A. There's been different discussions over the years about how that process occurs and what the budget setting mechanism will be.

Q. When you say "different discussions over the years", how have they differed as the years have rolled on?
A. Sometimes it's been based around FTE targets, around what is your FTE target for your service. Other times it's been based around what are your activity targets in terms of NWAU that has been set for you as a service. Sometimes it's a combination of both.

Q. So going through them each, the FTE target days, that was a "This is the number of staff, full time staff members, that you are going to have, and so here is the budget that we're going to give you for that"?
A. Yes.

Q. Was there ever a discussion at that point around how many FTE might have been required to deliver on the mental health needs of the population within Nepean?
A. Yeah, there was a discussion.

Q. How did it go?
A. It's - I would have liked to have had more - more FTE allocated.

Q. And in terms of the next discussion or the next form of assessment that you described, which is the NWAU discussion, how did that - was there a discussion around that?
A. No. So they are fixed targets that come - that are allocated to us.

Q. And is that now the way that it tends to work, as in has it - is that what happens now or is it --
A. No, it's moved more towards FTEs, more towards affordable FTE for budget.

Q. So it started with the NWAU, "This is your activity, this is what you are going to get"?
A. Yep.

Q. It has moved now more to an FTE, "This is how many people we're going to pay for".
A. Yes.

THE COMMISSIONER: Q. We should understand - "I would have liked to have had more FTE" in the context you said as there is a population health need for more FTE?
A. Yes, correct, Commissioner, yes.

MR MUSTON: Q. Whilst workforce challenges you have spoken about probably mean it's not possible to necessarily fill every post that you might like to fill, is it your sense that those workforce challenges are not the limiting factor but, rather, it's the - well, let me put it another way. If you were given one more FTE which you felt was required, do you feel confident that you would be able to fill it?
A. Yes, for some - but to clarify that answer, for some professions and areas more than others.

Q. When you say "some", which are the particularly hard

ones to fill?
A. So registered nurse positions in the community are really difficult to fill, so we have a number of registered nurse positions within our community mental health teams, and they are challenging to fill because they don't attract penalty rates and for registered nurses moving from inpatient to community teams, they pick up a lot of extra money through penalty rates from working weekends, working evenings, working nights, and then to move to a Monday to Friday community-based team, you lose all of those penalties, which can have quite a significant financial impact for those registered nurses.

Q. And that overtime, if they have been engaged in a community-based setting, is not something that they are able to pick up in an acute settings?
A. Yes, they do have the option of doing overtime if they want to do it, but if it's - they do.

Q. Well, what's the challenge? Is it less predictable or is it less easy for them to facilitate or --
A. It's less predictable. Also the shifts don't always align, so the community - community teams generally work 8.30 till 5 o'clock. There is kind of a rostering process that occurs for inpatient units which is different to that. The community teams are also kind of spread out across the whole of the district as well, so it might be hard for them to come and then pick up an overtime shift at Nepean after they've worked their community shift as well.

Q. So registered nurses in community settings is one of the challenging spots to fill. Are there others?
A. Yeah, occupational therapists, really hard to fill, and a number of other allied health professions but particularly occupational therapists are hard to fill at the moment in public mental health services.

Q. Is that because there are not many occupational therapists out there with the experience in the mental health space, or is it just because they are hard jobs to fill and there is a lot of other jobs?
A. A lot of them work for NDIS now, so again it's kind of - there is a much more - within kind of the NDIS space, there is much higher remuneration available for allied health people rather than working in the public health system.

Q. So having been given your budget, how do you go about monitoring within your - within the mental health service the extent to which the services you deliver are able to be brought in within that budget?
A. So we have monthly financial reporting, we have gone through a process of trying to re-establish a cost centre by cost centre budget as well, so that we can be really clear with each cost centre and each cost centre manager what their budgets and what their targets are for that, and then we would kind of support them to be able to look at what aspects of those budgets can they control, can't they control, what can they change, what can't they influence, and then we would report that up back to me as an overall kind of mental health performance.

Q. Each of them presumably is incentivised to deliver the services they do as efficiently as possible in a financial sense?
A. I don't - I'm not quite sure what you mean.

Q. So in terms of a budget, a budget is allocated to you?
A. Yes.

Q. You then, cost centre to cost centre --
A. Reallocate that.

Q. -- tally all your reports, this is roughly the amount that has been allocated to the services you are delivering?
A. Yes.

Q. You encourage them and they no doubt endeavour to deliver the services that they deliver as efficiently as possible?
A. Yes. Yes, and try and stay within --

Q. Is it your sense that they do?
A. I think they try really hard to, yeah. They do try to kind of stay within allocated budget. There is some - some of the aspects make it more challenging to be able to stay within it, particularly with the workforce issues we're having to increasingly use more premium labour, particularly around medical workforce costs and some overtime for back-filling nursing agency shifts - not agencies but back-filling nursing shifts, the use of premium labour sometimes makes it hard to be able to stay within budget when you still kind of have to have the same number of beds open, the same number of getting people

through the emergency departments.

Q. To the extent that things like that increase the costs of delivering the services that you deliver, do you get budgetary relief for that from the district?
A. No.

Q. So if it costs you more to deliver a particular service because you have to rely on premium labour to a greater extent than had been expected or desired --
A. Yes.

Q. -- the saving to make up for that has to be found somewhere else within the mental health service; is that right?
A. Yes.

Q. How do you go about deciding where those savings are to be made?
A. It's a really hard decision. Sometimes we just kind of accept that we're going to have to go over budget if we're going to be able to provide good quality care.

Q. But is it the case that sometimes, services or particular services within the mental health service do have to contract in order to accommodate increased costs like the use of premium labour?
A. Yes.

Q. Are discussions around that and the need to contract services something which you have with the executive or the CE within the LHD?
A. Yep. They would either be discussed through my one-on-one with the CE or they would be raised at the performance meeting that I have with the district.

Q. So, do you, in your role, have any direct interaction with the ministry in dealing with the mental health services that get delivered through Nepean?
A. Well, the - so the meeting that we - we have a really good relationship with mental health branch, which is one of the pillars in agency - in ministry, so we have a very close relationship with mental health branch.

Q. What does that relationship look like? How does it actually play out? Do you have regular meetings or do you --

A. Oh, sorry, yes, so the executive director for mental health is part of mental health branch, so he is our main kind of conduit into ministry. He chairs the regular meetings that we have as mental health directors and the informal meetings that we have as well during that.

There is a number of leads within mental health branch for specific programs that we are running in mental health as well, so we have quite close liaison/contact with them around some specific programs.

Q. So the meetings that you have with the executive director for mental health of the ministry, what do they - what sort of topics tend to be discussed at those meetings?
A. So we will generally talk about kind of issues that are facing the whole mental health system across New South Wales. We will talk about kind of common pressures that mental health directors are experiencing and feeling and we'll talk about if there is significant kind of policy development or policy work that is being led by ministry.

Q. In terms of the common pressures, are budgetary pressures one of those items that is regularly discussed at those meetings?
A. Yes.

Q. And again without inviting you to put words into the mouths of your colleagues, is the sense that you get that they share those budgetary pressures?
A. Yes.

Q. We've heard about a mental health program council. Can you explain what that organisation is?
A. Yes. So it's not an organisation, it's a combination of the mental health directors and a number of NGOs and peak bodies that work in the mental health sector, and it really - it is an evolving meeting, to be honest. So we just had a meeting last week where we were looking at reviewing the terms of reference for that meeting. So it involves BEING, it involves Mental Health Coordinating Council, it involves the carers' network as well - apologies, I'm probably getting their titles wrong and they will be upset with me, but it is a range of different NGOs and different peak bodies trying to work together, and the PHNs are involved in it as well.

Q. Do those meetings or the outcome of those meetings

inform in any way the services which you deliver through the mental health service in Nepean?
A. It's more - quite often it's more of an information sharing meeting, to be honest. So it is a good opportunity for us to look at where is there greater areas for collaboration and integration between the different kind of players in the mental health field.

Q. When you say collaboration and integration, to the extent that the NGOs are providing mental health services within your LHD's footprint --
A. Yes.

Q. -- is part of what you are doing seeking to identify what they are doing so that you can integrate what you are doing as best as possible with them and avoid any overlaps?
A. Correct.

Q. Is it a particular challenge within the delivery of mental health services that there are so many different organisations that are delivering mental health services perhaps to the same patient sometimes?
A. Yes.

Q. Yep.

Q. How is the LHD, your LHD, seeking to deal with those challenges?
A. We're trying to make sure that we coordinate services around patients and people as much as possible. We have a really strong view that people needing mental health care should experience that mental health care as seamless, regardless as to who is funding it or who is providing it, that they should experience that care as coordinated and seamless. So we're trying really hard to make sure that we have as best relationships and clear points of contact and escalations through the different NGOs and PHNs that are working to provide care often to the same person.

Q. What about information sharing about a patient and their condition?
A. So we need to do that with their consent, and we will work hard with people to explain the limits of consent, privacy and confidentiality.

Q. Assuming you have explained it to them and they have said "Yes, we consent, that would be great if we didn't

have to retell our story every time we came to a different service", how do you as a service facilitate that sharing of information that has been consensually shared?
A. There are different ways that we could do it and some of that would depend on the individual person, the service being provided and what information is relevant for that service to be able to make sure that the person is getting the best care.

Q. Are there any formal structures for that information sharing that exist between your service, or services, and the other services delivered by other organisations, including the NGOs within your LHD?
A. While not specific to individual patients, we do have a data sharing arrangement with the PHN, which is the primary health network, and we do have an agreement that we can share some broad demographic data and particularly suicide monitoring data and suicide monitoring reports that we get from ministry - we have a data sharing and confidentiality agreement that we can share that with the PHN.

Q. But in terms of a particular patient's experience or their journey to date through the mental health system, there is no formal mechanism whereby that information is, if consent given, shared with anyone else within the system who might be delivering mental health care to that person?
A. No, I would say there isn't a formal system to do it. It would probably involve kind of printing out things, sharing them that way.

Q. So the district presumably reports to the ministry. Do you have some role in the gathering of information for the purpose of the district's reporting obligations?
A. Yeah, so the ministry sends out a reporting pack before we have our meetings with ministry, so we have regular performance meetings with them. They send out a performance pack that identifies KPIs that they are concerned about for each district. We then review those KPIs when they come out and we submit what strategies we are putting in place to monitor or improve those KPIs, and then they get submitted back to ministry, which then become the meeting papers for the performance meeting.

Q. Do you have any direct engagement with the LHD board?
A. No.

Q. The next thing I would like to ask you about is the Quadrant report?
A. Yes.

Q. Could you tell us, first of all, what the Quadrant report is?
A. Yes, so that's a one-page report that we need to submit to the safe care committee and to the work health and safety committee. What it does is try to summarise some of the more detailed reporting that we need to submit to both of those committees, so that there can be a really simple kind of highlight of achievements, challenges, issues that we're working on and issues that need to be escalated to the committee.

Q. The fact that it is going to those two committees - would it be right for us to assume that the content of that Quadrant report is predominantly dealing with patient safety and workforce safety issues?
A. Yes. Depending on which committee it's going to.

Q. And not descending into detail around an assessment of the needs of the community and the extent to which they are able to be met by the services that are being delivered?
A. Correct.

Q. So you said you had no engagement with the board. Do you - is information passed down to you from the board in any instance, or are you - is there any way in which the board is involved in directing or involving itself in the services that you deliver through your mental health service?
A. So it comes down through the committees. So if there is a particular board direction around the KPIs that we're looking at, that would come back down either through the meeting I have with the chief executive or back down through one of the committees that we attend or through the performance meeting.

Q. Can I ask you some questions about the mental health strategic plan which, as we understand, is co-developed with the CCC?
A. Yes.

Q. Just explain what that strategic plan involves --
A. Yes.

Q. -- from your perspective in a practical sense?
A. Yeah, so it really just kind of identifies the key areas that we really want to try and focus on over a certain period of time. It isn't directly linked to the service agreement KPIs that come out through that. It's more an internally generated strategic plan of wanting to look at which areas, as an internal mental health service, we really want to focus on over a period of time.

Q. So how do you go about identifying them?
A. So there was a really big plan - the original plan was created before I was in the position, and that was created through a number of workshops and engagements and looking at some of the bigger strategic plans, I think, that was done, and we did a refresh of it last year.

Q. And when you did the refresh, what was the refreshment process?
A. What it was was looking at the actions that were included within the previous plan, seeing had we actually made any progress on those actions or whether, if we hadn't made progress on those actions, trying to understand why not, and did we want to carry those actions over into the second half of the strategic plan.

Q. And as part of that process, did you identify actions which you didn't persevere with?
A. Yeah, we found some actions that we hadn't made progress on and when we went through a process of saying, well, do we want to still keep these actions or do we want to refine the actions that we are really going to target over the remaining 18 months of the plan - so we ended up with yes, there were actions under every aim, but we were really going to focus on probably five actions out of each aim.

Q. How did you go about identifying what it was that you wanted to focus on?
A. So we got the whole of the mental health executive together with the consumer and carer council and we went through a voting exercise to - I think we had a whole room covered with white butcher's paper and sticky notes and things like that and we went through a process of everybody voting to say, firstly, did we want to keep the action in the strategic plan; and, secondly, did we then want to prioritise it for focused action in the remaining time that we had in that plan.

Q. And to the extent that you have identified those things to focus on, do you think progress has been made towards achieving them?
A. Yes.

Q. Can I ask you a little bit more about the consumer and carer council. How long has it been in operation?
A. So it was formally established in 2019, but there had been a significant amount of work done into the lead-up of that about how do we formalise a structure for carer and consumer engagement within the mental health service. Consumer and carer engagement has a really long history within mental health services and a lot of it has been done kind of either on volunteer bases or ad hoc bases, and we wanted to make sure that there was a really solid robust framework around how we would engage with carers and consumers, and making sure that they had ability to partner with the mental health service at a high level to make sure that they were - their voice and their views were heard at the right level.

Q. In terms of the structure of the council, is it an LHD specific thing or are you aware of equivalents existing in other LHDs?
A. So this is just in our mental health service. I know that most LHDs will have a version of a consumer and carer council but I don't know the exact specifics of what other - how other LHDs would run one.

Q. In terms of your consumer and carer council, how many people sit on it at any given time?
A. Twelve.

Q. How are they chosen?
A. They go through - it is a recruitment, selective recruitment process. We have six carers and six consumers, so we have six people who have cared for someone with a mental illness and then we have six people who've got a lived experience of a mental illness.

Q. Is there an expression of interest process?
A. Yes.

Q. So it advertises somewhere?
A. We often recruit people who have made complaints or had poor experiences of care. We will often kind of

actively try and recruit them in to be part of our consumer and carer council to make sure that we're getting a really good diverse range of views and that we're not - so it is a really good diverse range of views within that. We generally have a waiting list for our council as well. So we have - when we don't have the waiting list or we have got vacancies, we have gone out and done more promotion through the district social media channels as well or other ways of recruiting people.

Q. Do you find that it is an effective way of engaging with the consumer and carer population?
A. Absolutely.

Q. To what extent is the feedback - I know we have just been through the strategic plan but are there any other ways in which the feedback provided by the council is directly integrated into or results in changes in the service that is delivered through your service?
A. Yes, so the council develop their own work plan as well, so they have a planning day every year, and then they develop a work plan for the work that they want to do within the council. I meet with them every time they meet. I have a half-hour meeting with them as well where they will present their plan to me, we will have a look at it and see if that's kind of something that we can kind of work on and put - whether it is a certain kind of area that we want to work on together.

Q. Do you have any examples of occasions on which the outcomes of the council's meetings have resulted in changes to the services delivered through the mental health service?
A. Yes, so one of the big ones is what we called our advance statements, and it's - it was a key project that the council identified a few years ago, that they really wanted to come up with a process where people who were having mental health crises could have what is called an advance statement, which is very different to anything to do with voluntary assisted dying or advanced care directives, but it was really a document that people could come to either the emergency department or a community mental health service or any other setting, when they are in crisis, that really describes how they want to be supported in a crisis and how they don't want to be supported in a crisis. So one of the things we've learned from the CCC really strongly was that asking people to

retell their story, asking people to do lots of kind of tricky questions when they are in a crisis is probably the worst time to be doing it, so they went through a co-design approach of developing a document where it could be filled in when people aren't in crisis so that they could then present this and have that as a guide for how they want to be supported when they are in crisis.

Q. Now, do you have any particular arrangements, strategies or programs which are in place for the delivery of mental health care to First Nations people within your LHD?
A. So over the last 12 months we have just stood up an Indigenous advisory council, which very much mirrors the structure of the consumer and carer council, in that it would again be recruited to in the same way and it would sit on the same level of the organisational chart and it would work specifically in the same way as the consumer and carer council has worked to support me and my executive, but it would have a specific Indigenous and First Nations approach.

Q. So it is - has it stood up yet, or is it being stood up?
A. They've had two meetings, two or three meetings.

Q. And have you - so early days. But have you found that - have you received any output from those meetings or from that --
A. They are still working their way through how they want to work, and I don't want - I want them to find their own way through how they want to work. So they are still going through a process of how - what do they want to be called, how do they want to invite people to be part of it, how do they want to work with me and work with the service, so I'm giving them time to do that.

Q. What is it that you are hoping, if it works as well as it can, to achieve through the standing up of this committee? What input into the way in which services are delivered are they going to provide, do you hope?
A. What I'm hoping is - what we have found with the CCC is that it really gave us a kind of bottom-up approach to what we needed to be doing better, and the CCC had really good engagement with consumers and carers at lots of levels, which wasn't someone officially from the service meeting with them. We would get a lot of kind of anecdotal

feedback coming up through the committee, but also it would give them the opportunity, like, to kind of really say, "You've got to focus a bit more on this area. You've got to do a bit more around this." We're hoping that the Indigenous council has the same thing in that it's actually, as it is Indigenous led and chaired by our Aboriginal Indigenous workers, that it will be a much safer place and a cultural place for people to raise concerns.

Q. When you mentioned a minute ago the need to focus more on a particular area, is that particular areas within services that are being delivered, in the sense that you need to adjust in a slight way the way in which services are delivered, or is it - are you talking about focusing on a particular area being an unmet area of mental health need within the community?
A. Yeah, I think there's so much unmet mental health need across the community everywhere. For these two bodies, they are generally focused more on things we can do better within our existing services.

Q. You have mentioned the Primary Health Network. Do you have any formal engagement with the Primary Health Network other than through the meetings that you referred to a minute ago, which were the mental health program council meetings?
A. So we have a - there is a board subcommittee that we - that I co-chair with my equivalent over in the Primary Health Network, which is the Joint Regional Mental Health Suicide Prevention Plan Committee. We have to have a joint regional mental health and suicide prevention plan which is between our services and the PHN. We have a committee that oversees the operationalisation of that plan and the delivery of that plan. That's our formal structure around how do we work with the PHN.

Q. So is the formal structure built around programs delivered through or facilitated through the PHN which are funded in part or whole by the Commonwealth?
A. It's a bit of both. So there are some programs which are jointly funded through state funding and Commonwealth funding under the new bilateral agreements, so we oversee some of those programs. It's also a broader plan that looks at how do we work with people like Lifeline, how do we work with non-PHN funded or non-health funded services to again try and make sure that we're providing joined up and integrated care for people in our district.

Q. Insofar as you are aware, does the PHN have a pool of discretionary funds that it and you can collaborate to work out how best to spend?
A. Yes, yes.

Q. How does that process work in terms of deciding how you should collaborate to spend pooled resources?
A. Yeah, we generally kind of have a conversation between me and my equivalent at the PHN, and they will say "We've got a bit of money left over, we've got some discretionary funding. Where do you think it would be best placed, what do you think would be the best way of using it?" We will link it back to - if there is something from the joint regional plan that we can think, "Well, this needs a bit of funding, let's have a look at that", or if there is just kind of feedback that we're hearing from the clinical teams or clinicians around gaps in terms of what is being offered for people at the moment.

Q. In terms of the funding, the PHN funding which is tied to particular programs, do you have a view about whether those programs - let's start in the general - are usually or always the best way of spending the resources that have been deployed toward them, or is it your view, sometimes, that the programs are not necessarily the best way of spending money which has been earmarked for mental health? Maybe it would be easier if I asked you to sort of run through the programs. Pick a few of them.
A. So the programs that they kind of fund are the Head to Health centres. I think that that's a really good use of Commonwealth funding. I think what we're trying to look at is how to manage that difference between what's kind of primary health interventions, which are generally Commonwealth and PHN funded, and then what is the kind of more specialist or tertiary interventions which come through the district's funding, recognising that that is really complicated in the mental health space and people will often kind of need to switch between the two quite quickly. So I think the Head to Health is run really well and they do provide a really good soft entry for people who need mental health care and mental health support. That's a good one.

The other new funding that we've got, which we haven't had a look at yet, is the after care program, which is a specific program that's being stood up for people who

have experienced a suicide attempt or someone who they care for has had a suicide attempt, and that pathway will be in either through the emergency department or someone who has presented to a district service with a suicide attempt, could then be followed up and supported by the after care program. They have got a mental health nurse program as well, which has been really helpful and has been really good, and they've done more work recently around disaster recovery and disaster support, which has been really helpful as well.

Q. And "disasters" as in floods and fires?
A. Floods, bushfires, things like that.

Q. So that's the funding that the PHN potentially has. What about information or data that the PHN has. Do you find that you are able to capitalise on any data that is available to the PHN about health needs of the community within your LHD?
A. Yes, so they have done a number of attempts at sampling and trying to understand what the health needs of the area are. We share around those - we share that data and that information when we can.

Q. To the extent that you have access to it, does that data that you receive from the PHN inform in any significant way the sort of services you choose to deliver through the budget that you get allocated by the LHD?
A. The - yeah, so the services that we deliver are already fairly tight in terms of we have a fairly defined brief of supporting people generally who are most - with the most severe, enduring and chronic mental health problems, so we have a fairly clear brief already around who we need to support.

Q. So is it your view that in order to deliver on perhaps the broader mental health needs of the community, that tightness should be loosened a little bit, or would, in the perfect world, be loosened a little bit to perhaps deal with the mental health needs of people who are not in quite such a state of acute need?
A. Yes.

Q. And if you had an ability to change the system that you currently work in, in order to do that or anything else, what changes would you make?
A. I would love for mental health care to be much more

integrated. It is very fragmented at the moment, like we've talked about earlier, with the PHN, NGOs, private providers, public services. It's a really difficult, complex landscape of care for people to try and navigate. I think if there was an ability to have a broader remit, so we weren't just so focused generally on the very acute end of things, it would allow us to be able to provide much more joined-up care to people; people would have much less transitions of care between different people at different points, and I think that would - overall, my personal view would be that that would make things more efficient, if there was less kind of different people involved but a bigger and broader mental health service that could support people.

MR MUSTON: Thank you. I have no further questions for this witness, Commissioner.

THE COMMISSIONER: Thank you. Mr Cheney?

MR CHENEY: Nothing.

THE COMMISSIONER: Thank you very much for your time, sir. We're grateful. You are excused.

THE WITNESS: Thank you, Commissioner.

<THE WITNESS WITHDREW

MR MUSTON: I think that brings us to the end of our witnesses for today. I don't think we have tomorrow morning's witness waiting in the wings yet.

THE COMMISSIONER: All right. The three witnesses for tomorrow are still Gregory, Smith and Nicholl, are they?

MR MUSTON: Yes. I think we're thinking about the possibility of bringing in a reserve for the afternoon because we might finish a bit early if it's just those three.

THE COMMISSIONER: All right. Thank you for that. We'll adjourn until 10 o'clock tomorrow.

AT 3.34PM THE SPECIAL COMMISSION OF INQUIRY WAS ADJOURNED TO TUESDAY, 16 APRIL 2024 AT 10AM

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