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, 22 April 2024 at 10.00am

(Day 021)

Mr Ed Muston SC	(Senior Counsel Assisting)
Mr Ross Glover	(Counsel Assisting)
Dr Tamsin Waterhouse	(Counsel Assisting)
Mr Ian Fraser	(Counsel Assisting)
Mr Dan Fuller	(Counsel Assisting)

Also present:

Mr Hilbert Chiu for NSW Health

1 THE COMMISSIONER: Good morning.
2
3 MR GLOVER: The first witness today is Professor Schembri.
4
5 THE COMMISSIONER: Mr Chiu definitely knows - my
6 apologies - I have to go to the dentist urgently at 2.30.
7 So there is no point sitting at 2 o'clock. Are we sitting
8 until 1.15? Is that the plan?
9
10 MR GLOVER: Subject to how the second witness goes, if we
11 can finish him today, that would be the preference, given
12 he is from the Central Coast.
13
14 THE COMMISSIONER: People have to have lunch. I don't
15 have to leave until 2.15, but --
16
17 MR GLOVER: We might take that on notice and see how we
18 are travelling, Commissioner. If we can finish the second
19 witness --
20
21 THE COMMISSIONER: I will leave it with you. Anyway, my
22 apologies for the inconvenience.
23
24 MR GLOVER: I call Professor Schembri.
25
26 **<ANTHONY MICHAEL JOSEPH SCHEMBRI, sworn: [10.02am]**
27
28 **<EXAMINATION BY MR GLOVER:**
29
30 MR GLOVER: Q. State your full name for the record,
31 please?
32 A. Yes, Anthony Michael Joseph Schembri.
33
34 Q. You are currently the chief executive of the Northern
35 Sydney Local Health District?
36 A. Yes, I am.
37
38 Q. You assumed that role in July of 2023; correct?
39 A. Yes, I did.
40
41 Q. Prior to that, were you the chief executive of the
42 St Vincent's Health Network?
43 A. I was, for nearly 10 years.
44
45 Q. And prior to that, you've held various management
46 roles in hospitals within the New South Wales public health
47 system; correct?

1 A. For 30 years.
2
3 Q. You also hold a number of academic appointments; is
4 that right?
5 A. Yes, I do.
6
7 Q. With what institutions?
8 A. With the University of Technology in Sydney, the
9 University of Sydney, Macquarie University, and the
10 Australian Catholic University.
11
12 Q. Are they teaching or research roles?
13 A. A mix of teaching, research and also curriculum
14 development.
15
16 Q. You made a statement on 12 April 2024, to assist the
17 Commission; is that right?
18 A. Yes, I did.
19
20 Q. I'll bring it up on the screen. It's
21 [MOH.9999.1086.0001] - that is not your statement. My
22 apologies, Professor Schembri. I will get the correct
23 reference. I see you have a copy there in the witness box
24 with you.
25 A. I do.
26
27 Q. Have you had a chance to read it before today?
28 A. Yes, I have.
29
30 Q. Is it true and correct to the best of your knowledge
31 and belief?
32 A. Yes, it is.
33
34 Q. If you just turn to paragraph 4 - Commissioner, do you
35 have a copy?
36
37 THE COMMISSIONER: I do, and I would help you, but
38 unfortunately the number is cut off in my photocopy and
39 I can't read it.
40
41 MR GLOVER: It is [MOH.9999.1062.0001]. It has been
42 found.
43
44 Q. Would you go to paragraph 4 for me, please?
45 A. Yes.
46
47 Q. There you tell us, in your role, you report to the

1 board and to the secretary of NSW Health. Do you see that?
2 A. Yes.
3
4 Q. In what way do you report to the secretary of
5 NSW Health?
6 A. So I report to the secretary for all matters of the
7 operation and functioning of the district, in partnership
8 with our boards, and in practical terms, that involves
9 regular performance review with the secretary, so recently
10 I passed six months in this role and I undertook
11 a performance review with the chair and also with the
12 secretary.
13
14 Q. Was that a process that was done concurrently - that
15 is, with - by "chair" you mean the chair of the board?
16 A. Yes.
17
18 Q. And the secretary at the same time, or are they
19 different processes?
20 A. So I have a process firstly with the board chairman,
21 reviewing my performance over the first six months against
22 our performance with the service agreement that we have
23 with the ministry, as well as some board-directed
24 initiatives that are set locally by the Northern Sydney
25 board, and then I meet together with the board chair and
26 with the secretary at the same time.
27
28 Q. So in relation to those meetings with the board chair
29 and the secretary, what do they relate to?
30 A. They relate to my performance as a CE, specifically
31 how the district is performing against our service
32 agreement, and other key measures like our strategic plan,
33 for example.
34
35 Q. So in those meetings with the secretary, is it right
36 to say the focus is on the performance of the LHD against
37 its KPIs that are set out in the service agreement?
38 A. Yes.
39
40 Q. We'll come to those in a moment, but having regard to
41 the structure that you have just described, if it were to
42 be suggested to you that the arrangements for reporting of
43 CEs should be adjusted such that there is a single line of
44 accountability to the secretary, what would you say?
45 A. I think a matrix model is one that senior executives
46 are used to for governance and reporting, so having the
47 local input into performance and accountability through the

1 chair and the board ensures that my performance is really
2 tied to local need. But at the same time, recognising the
3 system-wide responsibilities that the secretary has, so
4 I think a matrix model is one that I'm used to and I think
5 allows for that local input as well as the statewide input.
6
7 Q. When you use the term "matrix model", what do you mean
8 by that?
9 A. Having multiple points of accountability.
10
11 Q. So from those answers, do we understand it that you
12 would favour retention of the current structure?
13 A. For me personally, yes.
14
15 Q. When you say --
16
17 THE COMMISSIONER: Sorry, did you mean by your question,
18 no board at all or just the CE reporting?
19
20 MR GLOVER: That question comes directly from the
21 NSW Health submission so I'm testing it with this witness.
22 I take it to mean the CE reports directly to the secretary.
23 If that's wrong --
24
25 THE COMMISSIONER: But with there being no board in
26 existence or a board there but the CE still just reports
27 straight to the secretary?
28
29 MR GLOVER: My question is only directed to reporting
30 lines.
31
32 THE COMMISSIONER: All right. And you said that is
33 something that comes straight out of the NSW Health
34 submission to this Inquiry?
35
36 MR GLOVER: Paragraph 193.
37
38 THE COMMISSIONER: Thank you.
39
40 MR GLOVER: Q. When in those earlier answers you
41 described being familiar with the matrix model, as you have
42 described it, is that something that worked in a similar
43 way when you were at St Vincent's?
44 A. Yes, very much so, yes.
45
46 Q. St Vincent's network being the only network-affiliated
47 health organisation in the state system; is that right?

1 A. Yes, that's right.
2
3 Q. How did the reporting structure work whilst were you
4 in that role?
5 A. It was slightly different in that St Vincent's, being
6 a private organisation, so my responsibilities were to the
7 group - accountabilities and responsibilities to the group
8 CEO for St Vincent's Health Australia, as well as to the
9 board, but with a dotted line to the secretary. So that
10 dotted line manifests in ways like my appointment required
11 the consent of the secretary.
12
13 Q. And did St Vincent's have an agreement with the
14 ministry for the services it would provide?
15 A. Yes, we had a service agreement.
16
17 Q. Was that similar in kind to the service agreement you
18 see now in your role as CE of this local health district?
19 A. Yes.
20
21 Q. We'll come to that in a moment. What do you
22 understand the function of a local health district to be?
23 A. It has a couple of primary functions. Firstly, to
24 care for the sick and injured; and, secondly, to promote
25 and protect the health of the community in its local area.
26
27 Q. Those are functions that are drawn from provisions of
28 the Health Services Act; is that right?
29 A. Yes.
30
31 Q. Would you turn ahead to paragraph 112 of your
32 statement, please.
33 A. Yes.
34
35 Q. In this section you have identified some
36 opportunities, and we will return to some of them a little
37 bit later, but I just want to take you at the moment to,
38 under that heading of "Role delineation"; do you see that?
39 A. Yes.
40
41 Q. Under (a), just have a read of that subparagraph and
42 let me know when you have finished.
43 A. Yes.
44
45 Q. What is the state level responsibility that you refer
46 to there in the second line?
47 A. Sorry, what is the state level?

1
2 Q. Yes, you see in the second line you say "in line with
3 our state-level responsibility", do you see that?
4 A. Yes.
5
6 Q. What are you referring to there?
7 A. The role of the local health district.
8
9 Q. That being the one we've just explored coming from the
10 section 9 in particular of the Health Services Act; is that
11 right?
12 A. Yes.
13
14 Q. Then you say in the brackets "(not filling primary
15 care and Commonwealth Government gaps)". Do you see that?
16 A. Yes.
17
18 Q. What are the gaps in particular that you are referring
19 to there?
20 A. Look, I'm - there I'm thinking about things like, for
21 example, on weekends where general practice, primary care,
22 may not be open and so emergency departments of hospitals
23 take up that service. I'm thinking of front door primary
24 care services like physiotherapy that, if a patient is
25 unable to pay for them themselves, or if they don't have
26 private insurance, then hospital clinic physiotherapy
27 services would take up that care. I'm thinking of those
28 kinds of examples.
29
30 Q. So that having been clarified, what is the issue that
31 you are driving at in paragraph (a), subparagraph (a) under
32 the heading of "Role Delineation"? What is the opportunity
33 that you are identifying?
34 A. It is probably not very articulately worded but what
35 I'm really thinking is there are a whole range of services
36 that are delivered by public hospitals that could safely
37 and appropriately be delivered by primary care providers
38 such as general practice, residential aged care facilities,
39 that are currently, due to either a lack of service, a lack
40 of hours of service, have to be taken up by public hospital
41 services.
42
43 Q. So, by that paragraph, we shouldn't understand you to
44 suggest that there is no role for the local health district
45 in the provision of primary care where it is needed?
46 A. No, there is absolutely a role. So there is a role in
47 health promotion, for example, in public health; there is

1 a role with very vulnerable people; there is also a role
2 for the other jurisdictions as well.
3
4 Q. What about where there may not be available primary
5 care in a particular part of an LHD, does the LHD have
6 a role to play in the provision of that care in such
7 a circumstance?
8 A. Definitely we become the service of the last resort in
9 those environments.
10
11 Q. Is there a role for the LHD to proactively provide
12 primary care in such a circumstance?
13 A. Yes, in the absence of other jurisdiction, yes.
14
15 Q. Can I take you back to paragraph 14, please.
16 A. Yes.
17
18 Q. Here you introduce the district's strategic plan.
19 I understand this wasn't prepared whilst you were at the
20 district; correct?
21 A. Correct.
22
23 Q. But have you familiarised yourself with it since you
24 have arrived?
25 A. Yes.
26
27 Q. What's its purpose?
28 A. Its purpose is to set out the direction for the local
29 health district's allocation of clinical services over the
30 next five years and to address some of the challenges that
31 the district faces over those five years.
32
33 Q. Are you familiar with how plans like this are put
34 together?
35 A. Yes.
36
37 Q. What is the general process that goes into developing
38 a strategic plan at district level?
39 A. So I can draw upon specifically my experience at
40 St Vincent's. So that involved, first of all, a review of
41 the status from the previous strategic plan, so what was
42 achieved, what was not achieved. It then involves a review
43 of relevant policy at a Commonwealth and state level that
44 relates to health. We then undertake a very specific
45 planning process, looking at the detail around patient
46 flow, cross-area flows, new models of care, any
47 technological changes. There is then a very wide

1 consultation with clinicians, with key stakeholders like
2 our consumers, for example, the colleges. It's then
3 a matter of synthesising all that and then having some
4 further consultation with the ministry, with the pillars,
5 with the planning unit in the ministry, with our university
6 partners, to then really land on what is the strategic
7 intent for the health service over the next five or, in
8 some cases, 10 years.
9
10 Q. In what way, if at all, does that process involve an
11 analysis of the health needs of the relevant population?
12 A. Well, it involves very specific work around the health
13 needs of the local population. So we consult with
14 communities around their needs, so, for example, in the
15 case of St Vincent's, consulting with local homeless health
16 providers and supported accommodation services.
17 St Vincent's has the largest proportion of homeless people
18 presenting to any emergency department in the state, and so
19 that was one example of trying to really understand the
20 local population need.
21
22 We then draw upon various data, the ministry's able to
23 assist with data on the health needs of local populations.
24 We draw upon things like the census, for example, and local
25 government also is an important stakeholder in
26 understanding community need as well.
27
28 Q. In that answer, you mentioned data from the ministry
29 on the health needs of local populations. What does that
30 data tell you?
31 A. It tells us things like referral flows from different
32 parts of the system. If you take St Vincent's, for
33 example, there is very much a local population that it
34 serves. There is then an outer ring of service that is
35 more a broader metropolitan Sydney, and then the tertiary
36 and quaternary services that St Vincent's provides, drawing
37 upon broader rural and regional pathways. So the ministry
38 is able to provide us with data around those flows, able to
39 provide us with health information relating to specific
40 conditions. Take heart failure, for example: what are the
41 projections around heart failure in the population? So
42 they really help us to understand the detail around the
43 health needs of the population.
44
45 Q. How is that data concerning health needs of the
46 population used in the development of a strategic plan?
47 A. Well, the data is used to then adjust what the

1 strategic direction might be. So, for example, if we take
2 transplant, heart/lung transplant, for example, able to
3 understand what are the flows from new technology, new
4 models of care, so that we can then plan our
5 infrastructure, plan the delivery of our services to match
6 that need.
7
8 Q. Just taking you to the current Northern Sydney
9 strategic plan, it's [MOH.9999.0824.0001].
10 Professor Schembri, you will just see, there is a screen
11 over here or one to your right, whichever is more
12 comfortable for you.
13 A. Thank you.
14
15 Q. So that's the current Northern Sydney Local Health
16 District strategic plan?
17 A. Yes, it is.
18
19 Q. If we go ahead in the document to internal page 24,
20 here we have what is described as a strategy map. Are you
21 familiar with this page?
22 A. Yes, I am.
23
24 Q. So across the top we have six headline statements?
25 A. Yes.
26
27 Q. And they are, I think you say in your statement,
28 aligned, as I think you put it, with the NSW Health future
29 health strategy; is that right?
30 A. Yes, they are.
31
32 Q. What's the purpose of aligning a strategic plan at
33 district level to the NSW Health future health strategy?
34 A. So the future health strategy is really setting out
35 the statewide direction to address the challenges and
36 opportunities over the next 10 years, and so at a local
37 level, this is about us really adjusting that future health
38 strategy to the local needs of the people of Northern
39 Sydney.
40
41 Q. Then you will see beneath each heading there is
42 a range of - I will call them dot points, but 1.1, 1.2,
43 et cetera. Do you see that?
44 A. Yes.
45
46 Q. Are they performance targets, for want of a better
47 term, to meet the headline objective?

1 A. Yes, these are really actions to realise that
2 high-level goal.
3
4 Q. Do you have a view about whether, taken as a whole,
5 this strategy map provides a pathway to meet the functions
6 and objectives of the district to promote, protect and
7 maintain the health of its population?
8 A. Yes, I do, because it includes our broad functions
9 around the care of the sick and injured, as well as
10 population health, health promotion, looking at preventing,
11 protecting the community.
12
13 Q. When measuring performance against the strategic
14 plan - I think you mentioned earlier that you meet with the
15 board and the secretary on that issue; is that right?
16 A. Yes, yes.
17
18 Q. How well a measure do these objectives reflect whether
19 the LHD is achieving its primary purpose to promote,
20 protect and maintain the health of its population?
21 A. Sorry, do you mind saying that again?
22
23 Q. Yes. Each of these - I will try to use your language,
24 because mine was inapt - actions to realise a high-level
25 goal --
26 A. Yes.
27
28 Q. -- when determining whether or not those actions have
29 been achieved, how well does the achievement of those
30 actions reflect whether the district has achieved its
31 primary function to promote, protect and maintain the
32 health of its population?
33 A. Well, I think they do by their comprehensive nature.
34
35 Q. When you say "their comprehensive nature", which, if
36 any, are directed to meeting the health needs of the local
37 population?
38 A. Well, keeping people healthy, for example, has
39 a series of actions to meet the health needs of the
40 population - for instance.
41
42 Q. These are relatively high-level statements, would you
43 agree?
44 A. Yes, they are, but what sits underneath these are
45 further actions and initiatives, so these are really just a
46 top-level summary.
47

1 Q. How do what sits beneath these high-level statements
2 get taken into account in determining whether those goals
3 have been reached?
4
5 THE COMMISSIONER: Take an example, like 3.2, if that's
6 convenient.
7
8 MR GLOVER: Q. Yes, let's take 3.2, "decrease the burden
9 of disease by reducing risk factors and promoting health
10 and wellness"?
11 A. Yes.
12
13 Q. I will take it from your earlier answer there are
14 a number of initiatives that sit below that target;
15 correct?
16 A. Yes.
17
18 Q. And how are they taken into account - that is, each of
19 the initiatives that sit below - in determining whether the
20 aim in 3.2 has been realised?
21 A. Well, we measure those. So in 3.2, for example, would
22 be our work in responding to the vaping epidemic,
23 particularly amongst young people, and so there are
24 a series of actions around reducing the risk of vaping
25 amongst young people. Those actions are measured and
26 reported on a regular basis. So, yes, that would be an
27 example.
28
29 Q. Where do all these initiatives that sit below the
30 strategic plan sit?
31 A. They sit in action plans. So for each of these, we
32 have executive sponsors who are leading those programs of
33 work across the district, and they report up through
34 a range of our governance processes, where we have regular
35 monitoring. So, yes, that would be the system.
36
37 Q. If we go ahead to page 38, internal page 38, using the
38 example of 3.2, are these some of those actions that sit
39 beneath the headline?
40 A. Yes.
41
42 Q. And is it the case that, for each of these, there will
43 be an executive sponsor, to pick up your term?
44 A. Yes.
45
46 Q. Who will be responsible for driving the initiative to
47 meet that target?

1 A. Yes, that's right.
2
3 Q. And how are they - you may have said this and I may
4 have missed it - reported back and then taken into account?
5 A. So we have a structured reporting-back process that's
6 coordinated by my office on a quarterly - minimum of
7 a quarterly basis, but each month at our senior leadership
8 team meeting, each of the executive sponsors will give
9 a report by exception of any of those actions and issues
10 that might be at risk of progressing, that require
11 a broader response from the leadership team.
12
13 Then, in my regular catch-ups with each of the exec
14 sponsors, we have an opportunity then to troubleshoot as
15 well. So we have a formal reporting back structure that
16 goes all the way to our board, at least twice a year, and
17 then we have the informal monthly process as well.
18
19 Q. Are the objectives set out in the strategic plan like
20 this reviewed on a regular basis?
21 A. They are reviewed on a monthly basis through our
22 senior leadership team process.
23
24 Q. My question probably wasn't clear, for which
25 I apologise. Each of the objectives and the targets that
26 sit below that --
27 A. Mmm-hmm.
28
29 Q. -- are the objectives and those targets reviewed
30 during the life of the plan, or only when it comes time to
31 develop the next one?
32 A. Unless there is a particular change of circumstance -
33 if there is a new health issue; if there is a change in
34 model of care that is material that would warrant a change
35 to those objectives and targets - but generally speaking,
36 it would be for the life of the plan.
37
38 Q. Let's just assume that a new health issue has emerged
39 in your district --
40 A. Mmm-hmm.
41
42 Q. -- how would that be factored into the framework of an
43 existing strategic plan like this one?
44 A. We would have the opportunity to review, and as the
45 strategic plan is a board-approved document, we would be
46 able to go back to our board to ask for a variation.
47

1 Q. Can we go back to the statement, please, and to
2 paragraph 62.
3
4 THE COMMISSIONER: Q. You mentioned, as an example in
5 relation to 3.2 on the previous document - you say the
6 vaping epidemic particularly amongst younger people, you
7 say you measure those and there are a series of actions
8 around reducing the risk of vaping amongst younger people.
9 There is a whole lot of information about vaping on the
10 Northern Sydney website, the LHD website, but are the
11 actions you are referring to statewide actions, or are they
12 Northern Sydney LHD specific?
13 A. Talking about specific Northern Sydney actions. So,
14 for example, amongst some parts of our district, we have
15 a high proportion of children and young people vaping, and
16 so we actually have kicked off a specific program of work
17 to understand what's driving that, working with young
18 people as peer navigators to advise us around what is
19 driving that vaping culture, what are the pressures, the
20 barriers to support, and so we're actually working with
21 young people themselves in those communities.
22
23 Q. Who in the LHD takes responsibility for that or
24 undertakes that sort of work?
25 A. We have a health promotion team and we have a specific
26 tobacco minimisation team, as well as a youth health peer
27 team. But we also work with the primary health network and
28 local schools as well.
29
30 THE COMMISSIONER: Thanks.
31
32 MR GLOVER: Q. If we can have the statement back on the
33 screen, please, and to paragraph 62. That's on page 15 of
34 the hard copy, Professor Schembri, if that assists?
35 A. Thank you.
36
37 Q. Do you have that?
38 A. Yes, I do.
39
40 Q. Just have a read of that and let me know when you have
41 finished?
42 A. Yes, yes, thank you.
43
44 Q. What's the purpose of a clinical services plan in your
45 view?
46 A. This is the detailed plan for how we will organise and
47 deliver our clinical services over a five-year period.

1
2 Q. How, if at all, does it relate to the strategic plan?
3 A. Well, it comes out of the strategic plan. So the
4 strategic plan really sets the overall direction for the
5 health service and the challenges that it will face. The
6 clinical services plan is then really about bringing to
7 life that strategy in how we deliver our services.
8
9 Q. The district is currently engaged in a process to
10 develop a new clinical services plan; is that right?
11 A. It is in final draft.
12
13 Q. Can you just describe the process of how you or your
14 district has gone about developing that plan to the point
15 where it is in final draft stage?
16 A. Yes. So the first step involves a review of the
17 previous clinical services plan to understand any gaps, to
18 understand recommendations that were made in that earlier
19 plan, whether or not they were delivered and, if they
20 weren't delivered, what were the barriers and issues.
21
22 It then involves a very comprehensive consultation
23 with our clinical networks, so, for example, the maternity
24 network, neurosciences. Each of the facilities then have
25 an opportunity to have input into understanding what are
26 their needs. We then have, through our various governance
27 pathways, an opportunity for further consultation and
28 development, so, for example, this month at our clinical -
29 our district clinical council, the clinical services plan
30 was presented for a final draft, a final consultation.
31
32 We're now at the point where we have broad public
33 consultation. So it's going out to the primary health
34 network, to our partner organisations, universities, local
35 community consumer groups, for a final round of
36 consultation.
37
38 Q. So aside from the consultation process that you have
39 described, what other types of analysis are undertaken by
40 the LHD in developing its clinical services plan?
41 A. So there is a review of any potential model of care
42 changes. There is a review of the detailed patient flows
43 between and in and out of the district.
44
45 Q. Just pausing there on patient flows, is that a measure
46 to assess likely demand on the LHD's services?
47 A. Yes, and also referral patterns as well, understanding

1 the flow from general practice, understanding the flows
2 from our rural and regional partners, but also
3 understanding opportunities to flow within the district,
4 so, for example, Hornsby Hospital has recently undergone
5 a very major redevelopment. That allows us to look at
6 whether or not there are, for example, some surgical
7 services that could safely, appropriately, be now delivered
8 at Hornsby, freeing up Royal North Shore Hospital to be
9 able to do the high-end quaternary service. So that's an
10 example of that work around flow.
11
12 Q. Does any part of the analysis undertaken by the LHD in
13 developing a clinical services plan involve an assessment
14 of the current health status of the population within the
15 district?
16 A. Yes, it does.
17
18 Q. How is that done?
19 A. It's done through a range of measures. So looking at
20 the census, for example. One of the very important aspects
21 for our clinical services plan is Northern Sydney has
22 a very high rate of people over 75 years - in fact, I think
23 the highest in the state. So that means our CSP needs to
24 be sensitive to how we deliver services to older people.
25
26 Q. So that tells you you've got an ageing population.
27 A. Yes.
28
29 Q. A high proportion of people over the age of 75,
30 I think you said?
31 A. Yes.
32
33 Q. What else does the census data tell you about the
34 health status of the population within the district, if
35 anything?
36 A. Well, we also have, for example, other data sources,
37 so private health insurance uptake in the community; we
38 have, in Northern Sydney, high rates of private health
39 insurance; and we have a number of private sub-acute
40 facilities. So that influences the decisions that we make
41 around the CSP.
42
43 Q. Just before you go on, what does the rate of private
44 health insurance uptake or the number of private facilities
45 in the district tell you about the health status of the
46 population within it?
47 A. Well, it can be an indicator of overall socioeconomic

1 status of the community, and we know that there are perhaps
2 some illnesses and diseases that might be experienced of
3 less incidence because of that socioeconomic status.
4
5 Q. Is there any analysis done of whether or not those
6 illnesses or diseases that might be experienced at a lower
7 rate because of the higher socioeconomic status are in fact
8 experienced at a lower rate within the district?
9 A. Yes. Yes.
10
11 Q. In what way?
12 A. Well, the team review that, looking at not only the
13 socioeconomic status but also looking at, say, cancer
14 incidence, to try and match up.
15
16 Q. Aside from the census data or the private health
17 insurance data, is there any other data that is analysed
18 for the purposes of undertaking an assessment of the health
19 status of the population within the district?
20 A. Yes. So there is the Atlas of Clinical Variation,
21 which I know the team consults on.
22
23 Q. Just tell us what the Atlas of Clinical Variation is.
24
25 THE COMMISSIONER: Q. That's the federal atlas, isn't it?
26 A. Yes.
27
28 MR GLOVER: Q. What does it tell you?
29 A. It tells us about clinical variation, whether that be
30 in illness and disease, whether it be in procedures, and
31 how local communities might differ. So the atlas might
32 show, for example, that in one community there's high rates
33 of a certain procedure compared to another area. It's an
34 indicator of variance for us to consider.
35
36 Q. So the variance being rates of presentation for
37 a particular type of procedure, is that what you have in
38 mind?
39 A. Yes, it could be.
40
41 Q. And what conclusions might be drawn from a particular
42 variance that can be observed in your district?
43 A. Well, it could be, for example, in the case of
44 rehabilitation services, so we have a very high rate of
45 private rehabilitation usage in our district in Northern
46 Sydney. That would be an example.
47

1 Q. Are there any other sources of data that are relied on
2 in analysing the health status of the district's
3 population?
4 A. Yes, there is a suite of public health and health
5 promotion, so things like vaccination uptake, mental health
6 status, language spoken at home. I would do an injustice
7 to try and be exhaustive, but there is a suite of
8 information that the team draw upon.
9
10 Q. In addition to plans like the strategic plan and the
11 clinical services plan, is it the case that the board of
12 the district might also highlight particular priorities
13 from time to time?
14 A. Yes.
15
16 Q. Has that happened since your appointment to the
17 district?
18 A. Yes. Yes.
19
20 Q. Could we go to [MOH.9999.1109.0001]. This is a letter
21 from Mr Danos to you of 11 September. I will ask the
22 operator to scroll slowly so you can refamiliarise yourself
23 with it.
24
25 THE COMMISSIONER: Just before you ask a question about
26 it.
27
28 Q. Just to clarify, right at the - so we're clear about
29 this - right at the beginning of Mr Glover's questions back
30 at page 2253 [of the live transcript], when you were
31 asked - I'm only asking this because this is a letter from
32 your chairman - when you were asked about:
33
34 *... if it were to be suggested to you that*
35 *the arrangements for reporting of CEs*
36 *should be adjusted such that there is*
37 *a single line of accountability to the*
38 *secretary, what would you say?*
39
40 And you gave your answer about a matrix model - you recall
41 that?
42 A. Yes.
43
44 Q. And then I asked whether Mr Glover's question meant no
45 boards at all, and Mr Glover referred to 193 of Health
46 submission. The way I read that submission is not
47 a submission by NSW Health that the board should be done

1 away with, they make a submission about strengthening - the
2 board perhaps focusing more on local engagement and local
3 communities. The submission actually says:
4
5 *Reviewing employment arrangements for chief*
6 *executives to ensure a single line of*
7 *accountability to the secretary of*
8 *NSW Health could also be undertaken.*
9
10 Now, I could be wrong, but the way I take that is
11 a submission that there should be consideration to a change
12 in the employment relationship such that the chief
13 executive is, instead of being employed by the LHD/the
14 board, employed by - the employment relationship is with
15 the secretary of health/the ministry.
16 A. Mmm-hmm.
17
18 Q. Do you have a view about that?
19 A. I think the - this is a personal view --
20
21 Q. Of course.
22 A. -- the matrix model allows the secretary the
23 opportunity to instruct, direct and for CEs to be
24 accountable to her, at the same time, recognising the local
25 needs of districts and communities that the board has the
26 ability to have some influence in the CE's work.
27
28 THE COMMISSIONER: Thank you.
29
30 MR GLOVER: Q. The accountability to the secretary in
31 that answer arises through the performance of the LHD as
32 a whole; is that right?
33 A. Yes.
34
35 Q. I think I asked you but I now can't remember, whether
36 you recall this letter that I have put on the screen?
37 A. Yes, I do.
38
39 THE COMMISSIONER: I think you only asked him to read it.
40
41 MR GLOVER: Q. I take it you have had some discussions
42 with Mr Danos about the contents of this letter from time
43 to time?
44 A. I have, yes.
45
46 Q. In terms of board priorities, how do you go about
47 considering them and actioning them in your day-to-day

1 function?
2 A. So the board priorities help frame the work that I do,
3 but they are not the exclusive source of work. In this
4 letter, for example, the chair has given some indication of
5 some possible areas of focus, which I take into
6 consideration.
7
8 Q. In the fourth paragraph, the one commencing "This time
9 the State will face", et cetera, do you see that?
10 A. Yes.
11
12 Q. This letter was written prior to the execution of the
13 most recent service agreement?
14 A. Yes, it was.
15
16 Q. Did the prediction that Mr Danos makes in that
17 paragraph come to pass, in your view?
18 A. I wouldn't describe it as "harsh".
19
20 Q. What would you describe it as?
21 A. Challenging.
22
23 Q. Where Mr Danos, in the second line, says "where
24 customary juggling will not work", do you see that?
25 A. Yes.
26
27 Q. What did you understand him to mean by that, when you
28 read this letter?
29 A. I think there he is talking about us - actually, I'm
30 not sure what he's meaning by that.
31
32 Q. If we go over the page, do you see there he says:
33
34 *The Board is supportive of tough and*
35 *potentially radical decisions being made by*
36 *you ...*
37
38 Do you see that?
39 A. Yes.
40
41 Q. Aside from the general support of the board for its
42 chief executive, what did you understand him to be
43 conveying to you in that passage?
44 A. My interpretation of that was that the board and the
45 chairman were really inviting me to think creatively around
46 how we manage our financial situation and that no issue
47 would potentially be off the table, and that I should

1 consider all - all options.
2
3 Q. Including deprioritisation of services, as Mr Danos
4 puts it?
5 A. Yes.
6
7 Q. Have you had to do that since your appointment as CE?
8 A. Not currently, no.
9
10 Q. Is it something that's under active consideration?
11 A. Yes.
12
13 Q. Were you involved in the process that led up to the
14 execution of the most recent service agreement between the
15 ministry and - I withdraw that, between the secretary and
16 the district?
17 A. Most. I started in July, so this budget, of course,
18 was a little bit different, this cycle, because of the
19 delayed state budget, but it certainly had started prior to
20 my arrival and then I was actively involved from July.
21
22 Q. The delay in the finalisation of those agreements,
23 given your appointment time, gave you scope to be involved
24 in that process, I take it?
25 A. Yes, that's right.
26
27 THE COMMISSIONER: Q. What, in the second-last
28 paragraph, did you understand Mr Danos to mean by "the new
29 normal"?
30
31 *The board's view is that the messaging to*
32 *staff about the 'new' normal will be*
33 *important.*
34
35 Did you have a discussion with him about what that meant?
36 A. Yes, he was meaning about a constrained budget
37 environment.
38
39 Q. So the new normal really refers to the constraints
40 that he's been talking about in the letter before this?
41 A. Yes, yes.
42
43 MR GLOVER: Q. I think earlier you described the current
44 environment as challenging?
45 A. Yes.
46
47 Q. In what way is it challenging?

1 A. Well, clearly we have a number of factors that are
2 putting pressure on the budget. Our workforce, for
3 example, premium labour, some of the workforce issues, are
4 an example of that. The escalation in cost relating to
5 goods and services is an example. We have some very major
6 redevelopment work in the district, and we're challenged by
7 the rising price of materials and labour. So they would be
8 some examples.
9
10 Q. Does the current budget envelope available to you
11 provide you with sufficient means to meet those challenges?
12 A. Well, we could always do with more, but I recognise
13 that that is the envelope that we have been provided, and
14 so we make it work.
15
16 Q. Just before I leave this letter, in the last
17 paragraph, the one - or second-to-last, I should say, the
18 one that the Commissioner just took you to, in the second
19 sentence, Mr Danos says:
20
21 *The Board endorses honest and transparent*
22 *communication with staff, not only because*
23 *it is the right thing to do but for the*
24 *reasons mentioned earlier about culture ...*
25
26 Do you see that?
27 A. Yes.
28
29 Q. Have you had some discussions with Mr Danos about
30 that?
31 A. Yes.
32
33 Q. What do you understand him to be conveying to you in
34 that section of the paragraph?
35 A. To really - reinforcing the importance of
36 communicating with my staff around the state of our budget
37 and what are the different actions that we are taking, but
38 also inviting our staff to share their ideas and
39 suggestions for how we manage some of these challenges.
40
41 Q. Does that include things like if a proposal is put for
42 consideration and there just isn't enough funding to
43 support it, even if it be otherwise commendable, giving
44 that answer to the staff?
45 A. Yes.
46
47 Q. As to why it can't be supported?

1 A. Agree, yes.
2
3 Q. Why is that important?
4 A. Well, for a couple of reasons. One, if a person has
5 taken the time to prepare some work that they believe will
6 bring benefit, at the very least there is a courtesy to
7 provide feedback. But it also, in providing feedback,
8 encourages more feedback. If you are to get a brick wall,
9 you are never going to put anything up again, are you, so
10 I make it my point that even if the answer is "No", that
11 that is informed, and there is - I always try to give an
12 indication of how we might be able to get to a "yes".
13
14 Q. And would you agree that an important part of
15 consultation processes generally is closing that loop -
16 that is, explaining why a particular decision has been
17 made?
18 A. Yes, I do.
19
20 Q. And if the decision has been made for the reason, or
21 primarily the reason, that the funding isn't available to
22 support it, that's something that should be communicated to
23 the proponents of the plan?
24 A. Yes.
25
26 Q. I was going to take you now to the most recent
27 services agreement, which is at [MOH.9999.1109.0001]. No,
28 it is not. That's a letter. I'm sorry,
29 [MOH.9999.0913.0001]. I apologise to the operator. Could
30 you describe the process that led to the execution of this
31 agreement, to the extent that you were involved?
32 A. Yes. So there was a series of roadshows with the
33 ministry, with my executive, and those roadshows included
34 information on the service agreement, key policy and
35 priorities that would be included. It includes
36 a discussion around the activity purchase and the activity
37 model, any adjustments.
38
39 We have an opportunity to have input into the activity
40 levels. We have an opportunity to have a discussion around
41 any service changes that the district might be having in
42 the year that could affect our activity, for example. Then
43 there is a process internally, through our board finance
44 committee, as well as our full board, for endorsement for
45 the chair and myself to then sign the agreement.
46
47 Q. So let's just break that up a little. The roadshows

1 that you have described?
2 A. Yes.
3
4 Q. This is the ministry presenting to the district; is
5 that right?
6 A. Yes, it is.
7
8 Q. Is that done on a one-on-one basis or the districts
9 together for that particular part of the process?
10 A. So it's done district by district, because there is
11 not one - every district is going to have different issues,
12 so it's done locally.
13
14 Q. And in the answer, you mentioned there is an ability
15 to have input on activity levels?
16 A. Yes.
17
18 Q. How much input can you have on proposed activity
19 levels in this process?
20 A. Well, in my experience, I've found there to be very
21 good hearing. So if I think about, for example - during my
22 time at St Vincent's, the bone marrow transplant cancer
23 ward was being redeveloped and there was a period of
24 18 months when the ward was out of action, so there was no
25 activity that could be generated in that environment. So
26 that would have a flow-on effect for the baseline for the
27 next year.
28
29 The ministry was able to - we were able to negotiate
30 that we would be recognised for that activity loss in the
31 future, so that we wouldn't be penalised.
32
33 Q. That was an example at St Vincent's?
34 A. Yes.
35
36 Q. What about in the lead-up to the execution of the
37 agreement that we see on the screen? How much input was
38 the district able to have in activity targets prior to the
39 signing of this agreement?
40 A. A lot of that discussion occurred prior to my time
41 in July.
42
43 Q. Who was the CE before you?
44 A. Mr Gregory.
45
46 Q. He acted in that role, did he, before your
47 appointment?

1 A. Yes, yes.
2
3 Q. Can we scroll down to page 14, please. So this is the
4 budget within the services agreement?
5 A. Yes.
6
7 Q. When you speak of activity levels, in terms of the
8 district having an opportunity for input, that's the target
9 volume expressed in NWAU; is that right?
10 A. Yes.
11
12 Q. Is there any opportunity to negotiate on the price
13 that is paid per NWAU - that is, the state efficient price?
14 A. No.
15
16 Q. Scroll down to page 15. There you will see in the
17 third line from the bottom a comprehensive expenditure
18 review savings allocation of $13.3 million. Do you see
19 that?
20 A. Yes.
21
22 Q. Do you have an understanding of what that relates to?
23 A. Yes.
24
25 Q. What is it?
26 A. It includes the whole of government comprehensive
27 expenditure review savings. So these are things like
28 travel, legal, advertising, consultants, labour hire, for
29 example. And there is about a 1.3 million in there for us
30 to make savings in those areas. It's then made up of
31 procurement savings. There is then also a local
32 initiatives savings as well. So it has a couple of
33 components.
34
35 Q. Is there an ability for the district to have input in
36 the negotiation process as to how much that allocation
37 should be?
38 A. Yes. So, for example, travel - take that as an
39 example. We operate on behalf of the state the New South
40 Wales voluntary assisted dying support service, and as part
41 of that, we have an access program, and we also have
42 a pharmacy program, that has our clinicians and pharmacists
43 going to - travelling to all parts of the state. That's
44 clinical travel, and so we've been able to negotiate with
45 the ministry that that be set aside so that it's not
46 included in those travel savings.
47

1 Q. Prior to the execution of the services agreement, is
2 there any assessment about whether the comprehensive
3 expenditure review savings allocation target is one that is
4 realistic for the district?
5 A. Well, it's set by government through the whole of
6 government savings. We've provided feedback on some of
7 those. So, for example, legal expense is quite high for
8 Northern Sydney, because we have two complicated PPPs, and
9 so we've been able to have some direct discussion and
10 negotiation around that.
11
12 Q. Can we scroll down to page 21. This is the KPIs?
13 A. Yes.
14
15 Q. Is there an opportunity for the district to have input
16 into this section of the services agreement prior to it
17 being executed?
18 A. Yes.
19
20 Q. In what way?
21 A. We have the opportunity through the roadshow to raise
22 any KPIs that we think could be amended or ceased, and one
23 example was the mental health readmissions. So in fact, it
24 might be good care that there is a readmission in the
25 mental health context. So that would be an example of
26 where we've had input.
27
28 Q. So that's on the particular KPI?
29 A. Yes.
30
31 Q. What about the targets that are set out in the
32 services agreement? Is there an opportunity for the LHDs
33 to have input as to those target ranges?
34 A. Yes. Through the roadshow, if we feel that the
35 thresholds don't reflect the real world, then we have the
36 opportunity to have some input into that.
37
38 Q. And it is against these KPIs that the overall
39 performance of the district is measured; correct?
40 A. Yes, that's right.
41
42 Q. Do you have a view as to whether the KPIs, taken as
43 a whole, provide a reasonable measure of how the district
44 fulfills its purpose of promoting, protecting and
45 maintaining the health of its population?
46 A. I think the suite of KPIs take into account not only
47 quality and safety, but also timely access and other

1 service measures. So I think, as best KPIs can, they give
2 a good indication of the performance of the health service
3 against how we're caring for our community.
4
5 THE COMMISSIONER: Q. What would the subject matter -
6 you used an example, young people and vaping. Does that
7 fit anywhere under the healthy and well - people are
8 healthy and well - KPIs?
9 A. I think from memory, Commissioner, there is a measure
10 around tobacco. Whether it is specific to vaping --
11
12 THE COMMISSIONER: Smoking during pregnancy.
13
14 MR GLOVER: Perhaps if the operator could scroll down to
15 section 3?
16
17 THE COMMISSIONER: Smoking during pregnancy; pregnant
18 women; getting healthy; children immunised; HPV; hospital
19 and drug consultations; CA; domestic violence; sustaining
20 families.
21
22 Q. Is it there?
23 A. No, so it's a good example --
24
25 Q. Is it somewhere else?
26 A. It is an example, Commissioner, where we are able to
27 go back to the ministry to say "We believe vaping is
28 a serious concern and there should be some measure". And
29 I know those conversations are under way.
30
31 Q. They are being had at the moment, are they?
32 A. Yes.
33
34 MR GLOVER: Q. In an earlier answer you said:
35
36 *So I think as best KPIs can, they give*
37 *a good indication of the performance of the*
38 *health service against how we're caring for*
39 *our community.*
40
41 By that answer, do we take it you accept there are some
42 limitations in measuring the performance of an LHD against
43 its core functions set out in section 9, as we've
44 discussed?
45 A. Yes, and the issue that the Commissioner has just
46 raised is an example of that, where there is an urgent and
47 pressing issue in the community, vaping, that currently

1 isn't taken through the service agreement KPI regime.
2
3 Q. Can I take you to another letter from Mr Danos. It's
4 [MOH.9999.0832.0001]. I will ask the operator to scroll
5 slowly. Have you seen this letter before?
6 A. Yes, I have.
7
8 Q. The copy that the Commission has been provided with is
9 undated, although it is referred to for the purposes of the
10 transcript at paragraph 54 of Mr Danos's outline. Can we
11 go back to the first page. I just want to ask you some
12 things about it. In that range of dot points, about
13 halfway down, you might see the dot point, "your high level
14 physical and virtual visibility, both internally and
15 externally". Do you see that?
16 A. Yes.
17
18 Q. Is that something that you have placed a particular
19 focus upon since your appointment as chief executive?
20 A. Yes, very much. As the new chief I felt it very
21 important that I was on the floor as much as I could be to
22 understand the issues for our district and to hear directly
23 from patients and staff about our work and the
24 opportunities that we had.
25
26 Q. In that answer you mentioned staff. Is it
27 particularly important to engage physically with members of
28 your staff across the district?
29 A. I think it's --
30
31 THE COMMISSIONER: That's a really strange question.
32
33 MR GLOVER: I'm sorry. I know what I'm trying to ask.
34
35 THE COMMISSIONER: I understood what you meant but you
36 might want to get it looking differently on the transcript.
37
38 MR GLOVER: I will rephrase it. It will read really
39 weird.
40
41 Q. Do you see there being particular benefits in engaging
42 face-to-face with staff across the district?
43 A. Yes, I do.
44
45 Q. What are they?
46 A. Well, you are able to directly hear from people about
47 their experience in an unfiltered, uncensored manner, so

1 it's one way of me doing my due diligence around how the
2 district is performing. I will tell you, one of the best
3 places to know how things are is to spend time in a
4 hospital waiting room and talking to patients, because you
5 learn pretty quickly about what are some of the issues and
6 challenges that they face.
7
8 Q. In that answer, you referred to hearing in an
9 unfiltered and uncensored manner. Why do you think that's
10 important?
11 A. Well, as chief, you receive information from a very
12 broad range of sources, and I place great weight on meeting
13 with my staff directly and having conversations with them
14 and similarly with patients, so that I hear directly from
15 them.
16
17 Q. Has another one of the focuses been on clinician
18 engagement across the district?
19 A. Very much so.
20
21 Q. What steps have you taken since being appointed to
22 your role in that area?
23 A. So I had a 120-day plan that had a very clear
24 structured engagement with our clinicians. So, for
25 example, I met with our junior medical officers; I met with
26 the resident medical officers association, right through to
27 the other end of our medical workforce, working and meeting
28 with all of the medical staff councils across our district.
29 I have met with our heads of department, our clinical
30 network leads, our nursing leads, our allied health leads
31 and we established, in my first months, a youth advisory
32 board to hear directly from our younger clinicians as well.
33
34 Q. Why is effective engagement with clinicians across the
35 district important?
36 A. Well, they are the eyes and ears of our health
37 service, and so having the opportunity for our clinicians
38 to have direct input into the running of the health service
39 is really critical. They know what is best for patients in
40 our communities and ensuring that they have a voice is
41 really critical to me as a chief.
42
43 Q. Are you familiar with the model by-laws?
44 A. I am.
45
46 Q. They set up a number of councils that you are required
47 to have across the district; correct?

1 A. Yes, yes.
2
3 Q. Do you have a view about whether the structure of
4 those councils provides an effective means of engagement
5 with clinicians in the manner that you have described to us
6 today?
7 A. Yes, I do. So we have - I will take clinical councils
8 first. In all of our facilities, including mental health,
9 drug and alcohol, we have clinical councils. I have had an
10 opportunity to meet and hear from them, and through that
11 engagement there has been service changes, requests for
12 different models of care that have been able to come
13 through. If I take Ryde for example, the Ryde clinical
14 council was really crucial in the safe staging of the Ryde
15 redevelopment that's currently under way, how that will
16 work in practice. The clinical council had a very
17 important role in providing advice to us.
18
19 The medical staff councils are in all of our
20 facilities. Again, if I take Ryde, in meeting with them,
21 they believe that with the redevelopment, there is an
22 opportunity to expand urology services, and so we've been
23 able to work with the Ryde team, with our clinical network
24 and the Ryde medical staff council around urology services.
25
26 Q. Let's take that as an example. So a proposal has come
27 from the council to expand services in that area?
28 A. Yes.
29
30 Q. What is the process of how it's considered, reviewed,
31 implemented or determined not capable of being supported as
32 the case may be?
33 A. Yes, so in that example, the Ryde medical staff
34 council held the view that with the increased theatre
35 activity that the new hospital will provide, it would be
36 safely and appropriately able to deliver urology services.
37
38 We then have sat down and asked our clinical network
39 to provide us with some feedback and advice around whether
40 or not that's a model of care that can be supported by the
41 college, by the role delineation for Ryde Hospital, and
42 then, through the budget-build process, we will look to
43 then consider whether we reallocate services - so, for
44 example, reallocate from Royal North Shore, to free up
45 theatre activity time in North Shore to be able to do the
46 higher-end work, and transfer services across to Ryde. So
47 that would be the process that we're undertaking right now.

1
2 Q. And that hasn't reached its conclusion yet?
3 A. No, we're working through it now.
4
5 Q. On page 2 of the letter, which is just on the screen
6 to your right there, Professor, about a third of the way
7 down, there is a series of dot points. Do you see that?
8 A. Yes.
9
10 Q. Again, Mr Danos introduces them by expressing support
11 for tough and potentially radical decisions. The first dot
12 point refers to "high cost, low value services"; do you see
13 that?
14 A. Yes.
15
16 Q. Do you understand what he was referring to in that
17 bullet point?
18 A. Yes.
19
20 Q. What was it?
21 A. So these are services that might have, either through
22 custom and practice or through models of care not adapting
23 to contemporary practice and evidence, that deliver little
24 or no value. So an example would be, in our context that
25 we're working on, those procedures that - surgical
26 procedures that could be safely and appropriately managed
27 as a day-only procedure rather than an overnight procedure,
28 or a procedure that might have a number of nights' stay
29 converted to a single night's stay. That would be an
30 example of some of that low value care that we're
31 reviewing.
32
33 Q. Other than procedures that might turn into day-only
34 procedures, are there any other - is there any other work
35 being done to identify instances of low value care?
36 A. Yes, there is. In fact, at our clinical council
37 in June, we will have a special workshop on low value care.
38 So there is a piece of work under way with all of our
39 clinical networks to identify instances of low value care
40 that we can look to either divest or amend, and that
41 includes allied health. I'm an allied health clinician,
42 and so, you know, one of the things that drives me crazy is
43 what is known as the six-minute walk where a four-year
44 trained physiotherapist will supervise a patient doing
45 a six-minute walk. Now, that can safely and appropriately
46 be done by a physio assistant, freeing up the four-year
47 trained physio to practise at the top of their licence.

1
2 So it's looking not just at surgical procedures, it's
3 looking at allied health, it's looking at all of our models
4 of care, and particularly focusing on how can we deliver
5 care better, outside the hospital environment.
6
7 Q. In that answer, perhaps scope of practice is a key
8 consideration as well; is that right?
9 A. Yes.
10
11 Q. In the second dot point on that page, Mr Danos refers
12 to "services provided to the community that duplicate
13 offerings from the private and NGO sectors"; do you see
14 that?
15 A. Yes.
16
17 Q. Do you understand what he was referring to in that dot
18 point?
19 A. Yes.
20
21 Q. What was it?
22 A. That there are services, so, for example, allied
23 health services, that might be provided by the hospitals,
24 but are also provided in the community setting or are
25 provided by non-government organisations. So he is asking
26 me to review, is there an opportunity for us to focus on
27 those services that aren't already provided by alternate
28 providers.
29
30 THE COMMISSIONER: Q. But "provided to the community" -
31 it might be necessary to provide that to public patients or
32 people that can't otherwise access or pay for private and
33 NGO sectors?
34 A. Yes, yes.
35
36 MR GLOVER: Q. Can we go back to your statement, please,
37 and to paragraph 31.
38
39 THE COMMISSIONER: Are you finished with that letter?
40
41 MR GLOVER: I am, yes.
42
43 THE COMMISSIONER: It has the world's longest to-do list.
44 That's just me talking out loud.
45
46 MR GLOVER: If we went through all of it, we would be here
47 on Monday.

1
2 Q. It is on page 9 of the hard copy, Professor, if that
3 assists?
4 A. Thanks. Thank you.
5
6 Q. In paragraph 31 and over the page down to 33, you tell
7 us about how the ministry monitors the performance of the
8 district, including against the service agreement; correct?
9 A. Yes. So we have quarterly performance meetings with
10 the district where we have a structured discussion relating
11 to our performance against the service agreement.
12
13 Q. So that's against the KPIs and the budget?
14 A. Yes.
15
16 Q. What about issues like the Commissioner raised with
17 you where there might be an initiative or a program that
18 sits outside the KPIs or the budget as listed in the
19 services agreement - is that taken into account in those
20 discussions?
21 A. Yes, it can be. So it's not exclusively about the
22 KPIs. Other matters can be brought forward as well.
23
24 Q. Aside from those quarterly meetings, I think you
25 said - quarterly?
26 A. Yes.
27
28 Q. Is there any other engagement with the ministry as to
29 the LHD's performance on an ongoing basis?
30 A. Yes, so all of the senior executives participate in
31 ministry-led leadership forums, so our director of finance,
32 for example, meets on a monthly basis with the ministry
33 finance team and all of the finance directors around the
34 state, around structured discussions relating to that area
35 of work. Of course, all the chief executives meet with the
36 ministry leaders on a monthly basis through the senior
37 executive forum. That provides another opportunity for
38 that engagement around performance. Then we have a weekly
39 phone hook-up with all the chiefs and the deputy secretary
40 of system performance, specifically around patient flow,
41 and that occurs on a Thursday. So they are some examples.
42
43 Q. Can we go to paragraph 9 of the statement, please.
44 A. Yes.
45
46 Q. Here you identify there are two AHOs that the Northern
47 Sydney LHD has partnership arrangements with, HammondCare

1 and Royal Rehab.
2 A. Yes.
3
4 Q. Why do you describe them as partnership arrangements?
5 A. Well, they are partners in the delivery of care in our
6 district.
7
8 Q. Can we go down to paragraph 22.
9 A. Yes.
10
11 Q. There you tell us that Royal Rehab Group has declined
12 to sign a service agreement on the basis that it believes
13 it is underfunded. Do you see that?
14 A. Yes.
15
16 Q. Before we come to the detail, have you been involved,
17 since your time as CE of this district, with the process of
18 negotiating a service agreement with either one of the AHOs
19 that operate within your district?
20 A. Towards the tail end.
21
22 Q. What is that process?
23 A. So it operates very similarly to how we engage with
24 all of our facilities and services. So there is a regular
25 governance meeting that is held. Our finance teams meet
26 separately with the finance teams of the two AHOs to work
27 through the detail around the finances, and then, through
28 our governance meeting, we have the opportunity to talk
29 through with them about what the service agreement that the
30 district has received - what are the key issues and
31 challenges and then how that relates to the AHO
32 specifically.
33
34 Q. What involvement, if any, does the ministry have in
35 that process?
36 A. With the AHOs?
37
38 Q. Yes.
39 A. It is predominantly, in my experience, a district-led
40 process.
41
42 Q. In that answer, where you said "it operates very
43 similarly to how we engage with all our facilities and
44 services", to what level is there negotiation between the
45 district and the AHO about the services that are to be
46 provided and the funding that will be allocated to provide
47 those services?

1 A. So as I said, first up, there is a detailed process
2 with our finance teams and then there is discussion with
3 the AHO around any particular change in activity or
4 services that they might have or any particular needs.
5 There is a discussion. There is a structured process
6 there.
7
8 Q. Does that process include a consideration of what it
9 would cost the AHO to deliver the services that are being
10 sought by the district?
11 A. Yes.
12
13 Q. How does that occur?
14 A. Well, there is an analysis of what the activity level
15 is and what is the cost of care, and so that process occurs
16 year on year.
17
18 Q. When you say "cost of care", what do you mean?
19 A. Literally - so the cost to provide the care that that
20 AHO delivers.
21
22 Q. How is that assessment undertaken by the district?
23 A. Well, the finance teams work together to understand
24 the buckets of cost and how they all roll up.
25
26 Q. In paragraph 22 where you say that Royal Rehab has
27 declined to sign a service agreement on the basis that it
28 believes it is underfunded, are you aware of how long that
29 situation has persisted?
30 A. I understand it to be over 10 years.
31
32 Q. And how did you form the understanding of the reason
33 why Royal Rehab has declined to sign a service agreement
34 that you set out in paragraph 22?
35 A. Because they told me.
36
37 Q. When?
38 A. In the numerous meetings that I had with the service.
39 I think I've met with them on at least four occasions since
40 I started.
41
42 Q. One of those meetings was this week?
43 A. Last week.
44
45 Q. End of last week?
46 A. Yes.
47

1 Q. What prompted that meeting?
2 A. It was a longstanding appointment that had been made
3 earlier in the year. So it was a regular catch-up with the
4 CE of the group. It had been in the diary for some time.
5
6 Q. When you say in paragraph 22 that Royal Rehab believes
7 it is underfunded, do you have a view as to whether or not
8 that is in fact the position?
9 A. Well, one of the challenges that I have is, I don't
10 have data to support the claim that they are underfunded.
11 Back in December, there was - I put a request to the
12 organisation to prepare a business case that particularised
13 the issues so that I could understand where the
14 underfunding sits. At the moment, I don't have visibility
15 of that detail.
16
17 THE COMMISSIONER: Q. That was a request in writing?
18 A. In December, it was a verbal request, and then
19 followed up in writing last week.
20
21 Q. Last week. Okay.
22 A. Yes.
23
24 Q. What information did you seek in December to be
25 included in the business case?
26 A. So, Commissioner, it was really arising from an
27 earlier conversation. So the service had made
28 representations at the end of the year to the Minister for
29 Health. The outcome of those representations was for the
30 service to meet with the ministry. The ministry advised
31 that the best way forward would be for the service to
32 prepare a detailed business case of the gaps in funding
33 that they believe, and in December, I reinforced that
34 message, that that was the best path forward.
35
36 Q. But what does "a detailed business case" mean?
37 A. So it would be a review of the model of care as it
38 stands today; what is the cost of care, how that is made
39 up, both in direct and indirect buckets of costs; what is
40 the revenue model; what are the opportunities around
41 private insurance or compensable payments; what does the
42 NWAU weighting bring? So it is really about building up an
43 analysis of what is the service providing and what is the
44 cost of care, and what is the current revenue and, then,
45 what is the gap.
46
47 Q. And those items you have just raised, they are, to

1 your knowledge, not information that either the LHD or the
2 ministry doesn't have from Royal Rehab?
3 A. No, we don't have a full set.
4
5 MR GLOVER: Q. Does the LHD or the ministry have any of
6 it?
7 A. Some of it, yes.
8
9 Q. What does the LHD have available to it?
10 A. Well, we have information on the funding that the
11 ministry/the district provide, for example. We have
12 information on things like the weighting of the NWAU. But
13 we don't have a true picture of the cost buckets for the
14 service.
15
16 Q. Following the meeting last week, you sent the letter
17 to Mr Mackay of Royal Rehab; is that right?
18 A. Yes.
19
20 Q. It is [MOH.9999.1110.0001], if we can bring that up on
21 the screen, please. This is the letter you sent?
22 A. Yes, it is.
23
24 Q. In it, you refer about halfway down the
25 paragraph commencing "With regard to your request"; do you
26 see that?
27 A. Yes.
28
29 Q.
30 *... not in a position to consider a request*
31 *for additional funding without robust*
32 *justification and data.*
33
34 Do you see that?
35 A. Yes.
36
37 Q. That's a reference, is it, to the need for a business
38 case as you've described in your evidence this morning?
39 A. Yes, it is.
40
41 Q. Did you set out to Mr Mackay each of the items that
42 you required information about, like you did earlier in
43 your answer today?
44 A. Not in the letter, but I have made the offer in
45 writing and also verbally, that we will work very closely
46 with the service to build that business case.
47

1 THE COMMISSIONER: Q. Just before you go to that, and
2 I appreciate how long you have been the CE:
3
4 *I am advised that despite multiple requests*
5 *over the years, we are yet to receive*
6 *a business case from Royal Rehab Group.*
7
8 Were you told what "multiple" means? Does it mean two or
9 does it mean 20 or does it mean --
10 A. Yes. So the service, pre-COVID, was advised by the
11 then leadership team of the need to prepare a business
12 case, and that has been reinforced over - many times over
13 the past years.
14
15 Q. Was that - were those requests in writing or were they
16 oral, or both?
17 A. I believe they were a mix of verbally and in writing.
18
19 Q. Have you seen the written requests?
20 A. No. There are minutes of meetings, for example, where
21 it is referenced, the need for a business case.
22
23 Q. And where the business case is referred to, does it go
24 through the kinds of data you said you want to see in a
25 business case, or does it just refer to "a business case",
26 in general terms?
27 A. I don't think it goes to the detail.
28
29 MR GLOVER: Q. Would setting out the detail of precisely
30 what the LHD requires to consider a request like this be
31 useful, in your view?
32 A. In the letter?
33
34 Q. Or at all, in writing?
35 A. Yes, and the - yes.
36
37 Q. Further down in the paragraph - the next
38 paragraph down, I'm sorry:
39
40 *I also reiterate ...*
41
42 Do you see that?
43 A. Yes.
44
45 Q. You say:
46
47 *... that Royal Rehab Group is afforded*

1 *multiple opportunities to provide input*
2 *into the Service Agreement ...*
3
4 Is that the process that you have described earlier in your
5 answer about the negotiations in the lead-up to a services
6 agreement being executed with AHOs?
7 A. Yes.
8
9 Q. Although no service agreement has been executed with
10 Royal Rehab for some time, does that process nevertheless
11 take place?
12 A. Yes, it does.
13
14 Q. In circumstances where there is no services agreement,
15 how does the district monitor the performance of Royal
16 Rehab in the provision of the services to the district?
17 A. Well, we still adopt the same processes and systems as
18 if the service agreement was signed. So we have the formal
19 structured governance meetings. They still occur. Our
20 operations team meets more frequently, sometimes on
21 a weekly basis, with the service. So the spirit and the
22 function of the service agreement is fulfilled.
23
24 Q. In the next paragraph down, you refer to a proposal to
25 retain own source revenue. Do you see that?
26 A. Yes.
27
28 Q. Just describe what is within the concept of "own
29 source revenue" as it relates to Royal Rehab Group?
30 A. So these would be predominantly patient payments, so
31 patients who pay privately, private health insurance,
32 compensable motor vehicle insurance, those kinds of patient
33 payments.
34
35 Q. And when you say "it represents a double payment", in
36 what way does retention of own source revenue of that kind
37 represent a double payment as it relates to Royal Rehab
38 Group?
39 A. So for the private patients, for the private beds,
40 there is an NWAU that is attributable to that bed. The
41 double dip would be then a private insurance or
42 a compensable private payment. So it would be double
43 dipping in that regard.
44
45 Q. But only to the extent that Royal Rehab was being
46 fully funded by the LHD to provide that service; correct?
47 A. Yes.

1
2 Q. In the next paragraph down, the longer one starting
3 "The agreed next step" - do you see that?
4 A. Yes.
5
6 Q. The last sentence, "Once completed", do you have that?
7 A. Yes.
8
9 Q. Just have a read of that sentence and let me know when
10 you have finished.
11 A. Yes.
12
13 Q. What's the purpose of presenting the business case to
14 the ministry?
15 A. Well, we would need the endorsement and support of the
16 ministry if there was to be a change to the service
17 agreement to the funding model for Royal Rehab. So just
18 for example, for illustration, if Royal Rehab were to keep
19 their own source revenue, for example, that would not be
20 a decision that I would be able to make alone. It would be
21 one that we would need to engage with the ministry on.
22
23 Q. Is that because there is some policy that sits at
24 ministry level relating to own source revenue?
25 A. Yes.
26
27 Q. Is that the only reason why it would be needed to be
28 referred to the ministry?
29 A. I would be - I'm conscious that we have a range of
30 AHOs in the system, and I would want to engage my ministry
31 colleagues, because there may well be system-wide impact of
32 any change for Royal Rehab.
33
34 Q. Royal Rehab provide a statewide service; is that
35 right?
36 A. For spinal patients? Yes.
37
38 Q. Beyond the boundaries of your district?
39 A. Yes.
40
41 Q. But it is managed entirely by your district; is that
42 right?
43 A. Correct.
44
45 Q. Do you see benefit in a service of that kind being
46 managed at ministry level rather than within your district?
47 A. I can see a model working both ways. So I appreciate

1 that Royal Rehab has patients that they accept from across
2 the state, and that may warrant a broader statewide
3 governance model. On the other side, the majority of
4 patients that Royal Rehab treats are coming directly from
5 the spinal unit at Royal North Shore Hospital, and they are
6 very much embedded in the patient flows of our district.
7 So I can see both ways.
8
9 MR GLOVER: Is that a convenient time?
10
11 THE COMMISSIONER: It is. Do you know what - you have
12 been on your feet, so maybe tell me after the break what
13 you want to do in terms of when we take - when we adjourn
14 for the day.
15
16 MR GLOVER: Yes.
17
18 THE COMMISSIONER: Okay.
19
20 MR GLOVER: I will have another look at the next witness
21 and see how long I think I need.
22
23 THE COMMISSIONER: When do you want me to adjourn to,
24 11.50, or take 20 minutes? What do you want me to do, 15
25 or 20?
26
27 MR GLOVER: 15, Commissioner.
28
29 THE COMMISSIONER: All right. We will come back at 11.50.
30 Thanks.
31
32 **SHORT ADJOURNMENT**
33
34 THE COMMISSIONER: Yes.
35
36 MR GLOVER: Q. Before the break, I asked you some
37 questions about the process that precedes the finalisation
38 of a service agreement with AHO. Do you remember those
39 questions?
40 A. Yes.
41
42 Q. And you gave a general description. I just wanted to
43 explore a couple of things with you in the context of Royal
44 Rehab Group. Although there is no services agreement, is
45 it your understanding that each year there is an
46 understanding in kind of the services that will be provided
47 by Royal Rehab and the funding that will be provided by the

1 LHD in return for the provision of those services; is that
2 right?
3 A. Yes.
4
5 Q. And that's the case in the current year as well?
6 A. Yes, it is.
7
8 Q. And do we understand - do I understand correctly that
9 you had some involvement in the process that led to the
10 identification of the services that were to be provided by
11 Royal Rehab, firstly?
12 A. Yes.
13
14 Q. And the funding that would be made available to them
15 for the provision of those services; is that right?
16 A. Yes.
17
18 Q. And in considering the amount of funding that would be
19 provided by the district to Royal Rehab for those services,
20 was any part of your consideration the cost of care, as you
21 described earlier?
22 A. Mmm-hmm, yes.
23
24 Q. How did you take that into account?
25 A. So, for example, the Weemala service, which is the
26 service provided by Royal Ryde, is for people with profound
27 disabilities, and those services are funded based on the
28 actual number of patients, people, and as a person either
29 no longer requires that level of care or passes away, then
30 the funding level should reduce to match the actual number
31 of people receiving the service. So in this most recent
32 year, there was an agreement to reallocate some of that
33 Weemala money to support Royal Ryde. So that was an
34 example of where the district was able to negotiate with
35 the service on their cost buckets.
36
37 Q. That's a particular part of the service that is
38 provided by Royal Rehab; correct?
39 A. Yes.
40
41 Q. How did you take into account the cost of care for the
42 other services provided by Royal Rehab?
43 A. So another example would be the recent purchase of six
44 additional spinal beds, and there was a negotiation for
45 a bed day rate, rather than the more traditional NWAU
46 funding model. So there was that negotiation with Royal
47 Rehab, which they believe is a better funding mechanism for

1 their cost of care.
2
3 Q. You have told Mr Mackay in the letter that we looked
4 at earlier that the district requires justification and
5 data to support its consideration of whether, as Mr Mackay
6 suggests, Royal Rehab receives sufficient funding to
7 provide the services it does; correct?
8 A. Yes.
9
10 Q. And in your earlier answers, you said that one of the
11 things that you are unable to analyse without that data is
12 the cost of care.
13 A. Mmm-hmm.
14
15 Q. Is that right?
16 A. Mmm-hmm. Yes.
17
18 Q. So how is it that in determining the amount of funding
19 that would be made available to Royal Rehab in the most
20 recent period, you were able to take into account the cost
21 that would be incurred by Royal Rehab in delivering that
22 care?
23 A. So the team were able to - with the information that
24 they have, were able to look at what is opportunities to
25 support Royal Rehab through some additional funding, and so
26 the Weemala is an example of that, the six additional
27 spinal beds are another example of that.
28
29 Q. Perhaps I will ask it in a different way. Are you in
30 a position, sitting here today, to make an assessment of
31 what it costs Royal Rehab to provide the care that it
32 provides through the district?
33 A. We don't have the full - I don't have the full
34 information.
35
36 Q. When you say "the full information", what more
37 information do you require, just on the cost of care, from
38 Royal Rehab to make that assessment?
39 A. Well, they say, for example, that their capital needs,
40 their repairs, maintenance, renewals, their equipment
41 needs, are not fully funded, but I don't have the detail of
42 that.
43
44 Q. So is it the case that, to the extent that cost of
45 care is being factored in to your considerations, or the
46 district's considerations, of how much funding will be made
47 available to Royal Rehab, it's on some historical

1 assessment; is that right?
2 A. With escalation and - yes.
3
4 Q. What's the escalation?
5 A. It's a composite of goods and services and also
6 salaries and wages.
7
8 Q. Was that assessment undertaken in the most recent
9 period?
10 A. Yes, it was.
11
12 Q. Can I take you back to your statement, please?
13 A. Yes.
14
15 Q. To paragraph 112, page 26 of the hard copy, Professor,
16 if you'd prefer to use that.
17 A. Yes.
18
19 Q. In this section of your statement, you identify
20 a number of opportunities related to governance?
21 A. Yes.
22
23 Q. And the first heading, "Value based health care", and
24 we have discussed some of those initiatives earlier in your
25 evidence?
26 A. Yes.
27
28 Q. Just subparagraph (b) under that heading, would you
29 have a read of that subparagraph and let me know when you
30 have finished.
31 A. Yes.
32
33 Q. So there are perhaps two, maybe more, concepts in that
34 paragraph. One is integration across the services in the
35 districts; correct?
36 A. Yes.
37
38 Q. And the second is better integration with services
39 being provided by other sectors; is that right?
40 A. Yes.
41
42 Q. Could we just take them one at a time. What do you
43 see as an opportunity for better integration throughout the
44 district with services?
45 A. So these would be examples of, if we take our surgical
46 work, for example, where we can better integrate our
47 surgical pathways across all of our district. So at the

1 moment, for example, Hornsby Hospital has recently had
2 a very major redevelopment. That gives us the opportunity
3 now to look at how can we better integrate Hornsby at
4 a higher level of surgical activity, either through volume
5 or acuity, and take some of the pressure off other
6 facilities, like Royal North Shore Hospital. So there is
7 an opportunity there that is currently under way, looking
8 at upper GI surgery. That would be an example.
9
10 Q. That type of analysis is looking to an efficient
11 deployment of the resources across the district; is that
12 right?
13 A. Yes, and recognising North Shore's unique role in our
14 district as the tertiary and quaternary service.
15
16 Q. The second concept in that paragraph was better
17 integration with other parts of the sector?
18 A. Yes.
19
20 Q. What do you have in mind as opportunities in that
21 space?
22 A. So perhaps an example that I'm very familiar with is
23 my time at St Vincent's. So patients who have a heart or
24 a lung transplant require a very extensive post-transplant
25 model of care, and for many of those patients, they travel
26 from their home regions back to St Vincent's for that care,
27 and in many instances, that care could safely and
28 appropriately be delivered in home communities. So that's
29 an example of better integration, particularly with the
30 advent of remote monitoring and virtual care, which allows
31 the specialty tertiary service at St Vincent's, able to
32 work with local general practice and the local hospital in
33 those rural and regional communities.
34
35 Q. Outside of those specific examples, are there other
36 opportunities to better integrate the operations of the
37 district with the primary care sector?
38 A. Yes, there are, and I'm really enthused and excited by
39 one of those opportunities, which is around collaborative
40 commissioning. So this is a project that we would like to
41 scale up across our district.
42
43 Q. Just perhaps pausing there, tell us what the
44 collaborative commissioning initiative is in your district?
45 A. So this is a partnership with the primary health
46 network and the district, focusing on patients who are
47 frail and elderly, predominantly those who are over 75

1 years old, and it's about joining up our services, working
2 with general practice, working with the specialist
3 geriatric services, to look at models of care outside of
4 the emergency department and outside of being admitted to
5 care. So in just one year's time, there has been
6 a $10 million saving in care that would have been delivered
7 in the emergency department or admitted. The cost of the
8 service was 3.6 million. So there is a $6 million saving
9 that we can reinvest back into our frontline services. So
10 that example, we want to scale it up now for other kinds of
11 services, be that in chronic and complex medicine, for
12 instance.
13
14 Q. What other engagement --
15
16 THE COMMISSIONER: Q. Can I just ask, the figures that
17 you have mentioned --
18 A. Yes.
19
20 Q. -- where are they available, the $10 million saving,
21 the $3.6 million cost?
22 A. There is an evaluation, Commissioner, which we could
23 provide.
24
25 Q. Who did the evaluation? Was it internal or --
26 A. Yes, in partnership with the PHN.
27
28 Q. And you mentioned you would like to scale up other
29 similar collaborative commissioning projects?
30 A. Yes.
31
32 Q. And you were mentioning chronic disease?
33 A. Mmm.
34
35 Q. Are you adequately funded to do these scale-ups that
36 you are mentioning?
37 A. So this particular initiative received pilot funding
38 from the ministry. However, I think what it's shown me is,
39 there is an opportunity for us to do this as ordinary
40 business, and so one of the areas that I'm wondering about
41 is in chronic heart failure, for example. So we will look
42 now, in partnership with the PHN, around what are other
43 opportunities for us to scale up this collaborative
44 commissioning.
45
46 Q. One of the things I was going to ask also was that in
47 the project that you were talking about for patients who

1 were frail and elderly, you mentioned the PHN. Is some of
2 the funding from the PHN as well as from the LHD?
3 A. Yes, yes. It's a joint project.
4
5 Q. So 50:50, is it?
6 A. I'm not sure about their proportion, but both
7 contribute, yes.
8
9 MR GLOVER: Q. How are the particular collaborative
10 commissioning initiatives identified within your district?
11 A. Well, this one was through a process of sitting down
12 with our clinicians to understand what are some of the
13 immediate challenges, and it was in the context for
14 supporting the emergency department, and in our district,
15 with a very significant older population, it really came
16 from that need.
17
18 Q. I think you have mentioned your next target, for want
19 of a better term, for this project might be chronic heart
20 failure?
21 A. Yes.
22
23 Q. How have you arrived at that target?
24 A. Again, looking at where - where are the health needs
25 of the communities that have a potentially avoidable
26 pathway through the ED or an avoidable pathway from being
27 admitted.
28
29 Q. Aside from diverting what might be potential
30 presentations to ED or admissions, what are the benefits of
31 collaborative commissioning initiatives in your view?
32 A. Well, I think there are many. Our patients tell us
33 that they prefer to be treated at home; they prefer to be
34 cared for at home, and so that's one example of how
35 collaborative commissioning can bring benefit.
36
37 Hospitals, you know, are very busy places, and for
38 older people, they can at times be confusing and
39 distressing, so being able to provide care in a setting
40 other than hospital is good for patients. It frees up our
41 staff in those ED environments to be able to see patients
42 more quickly; it improves access. And as the initial
43 financial analysis showed, it provides an opportunity of
44 savings that can be reinvested into the health system.
45
46 Q. Tell me if you can't answer this without looking at
47 the document, but do any of the LHD's KPIs in the services

1 agreement pick up implementation of collaborative
2 commissioning initiatives?
3 A. Not directly, but they have indirectly around ED
4 performance; there are preventible hospitalisation KPIs.
5 So indirectly it would be picked up.
6
7 Q. Aside from collaborative commissioning, what
8 engagement does the district have with the PHN?
9 A. It's very strong. So we have very formal engagement.
10 For example, once a year we have a joint board meeting
11 between Northern Sydney and the PHN boards - our two boards
12 come together. We have a joint executive that meets on
13 a bi-monthly basis. Members of the district and staff of
14 the district and staff of the PHN, we sit on each other's
15 committees, like clinical council, for example. Then,
16 informally, the CE of the PHN and I meet every six weeks or
17 so. So we're very much embedded, and then our operational
18 teams meet on a regular and ongoing basis doing shared
19 work.
20
21 Q. Aside from collaborative commissioning, are there any
22 other joint initiatives or projects that have been
23 identified from that extensive engagement that you have
24 described?
25 A. Yes, one that's in development now is - I think it's
26 called Compassionate Communities, and it's really looking
27 at addressing social isolation in the community,
28 particularly amongst vulnerable people. And so there's
29 a pilot, I think from memory, in Hornsby, where our mental
30 health, our health promotion teams, are working together
31 with the PHN to provide opportunities and initiatives to
32 address social isolation.
33
34 Q. Does any of that engagement between the district and
35 the PHN seek to identify gaps, whether availability or
36 accessibility to primary care?
37 A. Yes. So we undertake a needs analysis between the PHN
38 and the district. The one that I'm most familiar with is
39 my time at Central and Eastern Sydney PHN, where together
40 with Sydney Local Health District and South East Sydney and
41 St Vincent's, there was joint needs analysis into a range
42 of areas, like homelessness, mental health, drug and
43 alcohol, chronic care, and so those needs analyses are
44 really looking to identify for communities where are gaps
45 in service and how might the joint work of the district and
46 the PHN address those gaps.
47

1 Q. Is a needs analysis of that kind something that's been
2 undertaken in your current district?
3 A. I believe so. I'm not over the detail, though.
4
5 Q. Back to that subparagraph (b) under the heading "Value
6 based health care", we've dealt with primary care, but you
7 also mention integration between the disability and aged
8 care sectors. What do you see as opportunities for better
9 integration with the disability and aged care sectors?
10 A. Well, I think one example would be in aged care, where
11 we can work more closely with residential aged care
12 facilities to prevent what could be unnecessary transfers
13 from the facility to the emergency department. An example
14 is a catheter change. That can safely and appropriately be
15 done in the residential aged care facility. Often because
16 of workforce challenges in the RACF, they're not able to do
17 that, and so for us, having the ability to in-reach into
18 residential aged care facilities to be able to offer that
19 service so that a patient doesn't need to be uprooted from
20 their home and be taken to ED would be an example of that.
21
22 Q. Are there any barriers that you perceive to being able
23 to achieve that type of integration with the aged care
24 sectors?
25 A. Well, it's - workforce is clearly one component of it.
26
27 Q. The availability of workforce, is that what you mean?
28 A. Beg your pardon?
29
30 Q. The availability of workforce?
31 A. Yes, yes.
32
33 Q. Any others?
34 A. One of the things I know the team are working on is
35 looking to upskill nurses in the residential aged care
36 facilities so that they have the scope of practice to be
37 able to do these kinds of procedures.
38
39 MR GLOVER: Thank you, Professor. I've no further
40 questions.
41
42 MR CHIU: I have a few questions, Commissioner.
43
44 **<EXAMINATION BY MR CHIU**:
45
46 MR CHIU: Q. Professor, if I could take you to
47 paragraph 62 of your statement.

1 A. Thank you.
2
3 Q. You gave some evidence earlier about the current
4 preparation of the next clinical services plan. You recall
5 that?
6 A. Yes.
7
8 Q. Will that next CSP include the collaborative
9 commissioning initiatives that you are currently
10 undergoing?
11 A. Very prominently.
12
13 Q. And are you aware if - and tell me if you are not -
14 other districts also incorporate collaborative
15 commissioning in their CSPs?
16 A. I believe a couple of the other districts have
17 collaborative commissioning programs. Whether they are
18 incorporated in the CSP, I'm not aware.
19
20 Q. You gave some evidence earlier about the process of
21 gathering data in order to prepare a CSP. Do you recall
22 that?
23 A. Yes.
24
25 Q. Can you explain to the Commissioner what role the
26 PHN's health needs assessment has in that process?
27 A. So it really identifies what are the health needs of
28 the community; it considers any gaps in service for those
29 communities; it draws out population health data, so the
30 experience of cardiovascular disease, for example, in that
31 particular community. So it's a targeted, focused needs
32 analysis.
33
34 Q. Having recently gone through the process of preparing
35 a CSP, are there any areas of data that you wish you had
36 more of or better coverage over?
37 A. I think some of the data around the statewide flows,
38 patient flows; data on the private health would also be
39 useful - private health utilisation, yes.
40
41 Q. And in your view, is there anything that could be done
42 to gain better access to that data?
43 A. I believe the ministry holds that data, so for us, it
44 would be working closely with the ministry.
45
46 MR CHIU: No further questions.
47

1 THE COMMISSIONER: Thank you.
2
3 Q. Does that answer apply also to the private health data
4 you were talking about?
5 A. Yes, that's what I was meaning, yes, Commissioner.
6
7 THE COMMISSIONER: Thank you. Nothing arising out of
8 that?
9
10 MR GLOVER: No, Commissioner.
11
12 THE COMMISSIONER: Thank you very much, Professor. We're
13 very grateful for your time. You are excused.
14
15 THE WITNESS: Thank you.
16
17 **<THE WITNESS WITHDREW**
18
19 MR GLOVER: The next witness is Mr Scott McLachlan.
20
21 THE COMMISSIONER: Have you formed a view about how you
22 want to utilise the time?
23
24 MR GLOVER: I have made some inquiries of those assisting
25 us, and if suitable to you, we propose to sit until 1.30.
26
27 THE COMMISSIONER: 1.30, okay. That's fine.
28
29 MR GLOVER: If that is convenient, in an effort to try to
30 finish Mr McLachlan, if possible.
31
32 **<SCOTT MATTHEW MCLACHLAN, sworn:** **[12.15pm]**
33
34 **<EXAMINATION BY MR GLOVER:**
35
36 MR GLOVER: Q. State your full name, please?
37 A. Scott Matthew McLachlan.
38
39 Q. Are you currently the chief executive of the Central
40 Coast LHD; is that right?
41 A. Yes, I am.
42
43 Q. You assumed that post in November 2021?
44 A. I sure did.
45
46 Q. Prior to that, you were the chief executive of Western
47 NSW LHD; is that right?

1 A. Yes.
2
3 Q. From about January 2013?
4 A. Yes.
5
6 Q. Until November 2021?
7 A. Yes.
8
9 Q. And prior to that, you had an operations role in the
10 Hunter New England district as it was variously named from
11 time to time; is that right?
12 A. I sure have, yes.
13
14 Q. You made a statement on 9 April to assist the
15 Commission; is that right?
16 A. Yes.
17
18 Q. It is [MOH.9999.0762.0001]. We will bring that up on
19 the screen. I see you have a hard copy there.
20 A. Yes.
21
22 Q. Have you had a chance to read it again before giving
23 evidence today?
24 A. Yes.
25
26 Q. Is it true and correct?
27 A. Yes.
28
29 Q. What do you understand the functions of a local health
30 district to be?
31 A. Well, for the Central Coast, that's a population of
32 350,000. Our role is to promote, protect and maintain the
33 health of those 350,000 people, to provide a range of both
34 primary, secondary and tertiary health services to the
35 population, and to help link them in to the other services
36 that they might need.
37
38 Q. How does the district go about planning the deployment
39 of its resources to meet that objective?
40 A. That's an extensive process that we're in the middle
41 of at the moment with revising a strategic plan for the
42 next three, six, 10 years - a clinical services plan that
43 really looks at the services that we provide now, the
44 changes that need to happen for all of those services for
45 our population's needs. But starting back at the start of
46 that, an extensive health needs assessment and profile.
47 Now, that's a process that we've undertaken over the last

1 two years with the primary health network in taking stock
2 of the health needs of the community, the forecasts into
3 the future with the population growth, the changing health
4 profile and with a large and growing ageing profile that's
5 a significant consideration, and looking at where within
6 the region the health issues are most prevalent that we
7 will need to tailor and target our services to support that
8 population.
9
10 Q. Do you see the completion of that health needs
11 assessment as the first step in the process of planning
12 services looking forward?
13 A. Yes.
14
15 Q. And you mentioned in that answer that it's been
16 undertaken with the PHN; is that right?
17 A. Yes, sure has. So we have an ongoing alliance with
18 the primary health network that joins us together formally
19 to undertake a range of coordinated primary and secondary
20 care services, but also understand the health issues at
21 a whole-of-system level for our community. Now, that meant
22 two years ago taking stock of the health needs, jointly
23 investing in that health needs assessment and profile.
24 There is a process where the primary health network needs
25 to deliver that to the Commonwealth on a regular basis.
26 That was a really critical first step in a number of steps
27 in us revising our clinical services plan, to first of all
28 understand the health issues for our community.
29
30 Now, for the Central Coast community, that meant
31 looking at about 50-plus health indices and down to
32 a community or a suburb level, understanding what each of
33 those looked like for that community. Now, that meant
34 across the whole of the Central Coast there was a wide
35 range of both socioeconomic, health issues, disadvantage
36 and population challenges. So that was an incredibly
37 productive process with the primary health network to help
38 us narrow down to a community level where the health issues
39 were the greatest or needed some other support.
40
41 Q. So this is a process undertaken jointly by the LHD and
42 the PHN?
43 A. Yes, it is.
44
45 Q. What's the LHD's particular involvement in that
46 process?
47 A. Quite extensive. So from our public health, health

1 promotion, health planning teams investing significantly
2 into the data and analysis that NSW Health holds. There is
3 a fantastic resource called Health Statistics New South
4 Wales that helps us draw a lot of this population level
5 information for use in that process.
6
7 The primary health network brought to the table a lot
8 of analysis and information from general practice, from
9 other primary care providers, from Commonwealth sources.
10 So it was a - I have got to say it was a productive process
11 in joining up those two to help us get a whole picture of
12 the community's health needs.
13
14 Q. And that process having been undertaken, how is it
15 then used by the district in its planning?
16 A. Sure. So that's an extensive process that the
17 ministry helps out with and the structured clinical service
18 planning process. So this clinical service plan that was
19 developed and released about nine months ago started with
20 the health needs of our population and understanding that,
21 presenting that to our senior clinicians and broader
22 stakeholders, having a conversation about, first of all,
23 our current service demands, the types of services that
24 we're providing to the whole of our community, and trying
25 to take stock of is that really fitting with the health
26 needs of our community, and particularly some of the
27 growing demands in our community that we now will face in
28 the future.
29
30 Q. Just before you go on, can I explore that concept with
31 you? So there is a demand analysis, so by that, do we
32 understand that there is analysis of what has happened
33 historically in terms of presentations and admissions; is
34 that right?
35 A. Absolutely, yes.
36
37 Q. And then there is another analysis undertaken as to
38 whether those demand trends fit with what is being seen in
39 the analysis of what is actually needed within the region;
40 is that right?
41 A. Yes.
42
43 Q. How does that analysis play out in real terms?
44 A. So at the very basic level, a population level
45 forecast that forecasts out to 2031 and 2036, so knowing
46 those population growth across the region and within the
47 region, down to suburb level where the future housing

1 developments and other things are planned, that will see
2 population growth.
3
4 Understanding within the population the different age
5 groups and brackets of our population that will grow. Now,
6 for the Central Coast, that means a really significant
7 growth in the age population, of both 70 years of age and
8 over 85, in particular, the really high users of health
9 services.
10
11 So at the very start, that informs the future growth
12 trajectory for our emergency department, our acute
13 services, our outpatient services and our community-based
14 services.
15
16 At a population level, it helps us understand the
17 disease profile of our population now and likely growth
18 into the future. That's a process that the state helps out
19 with in understanding for a certain socioeconomic
20 population what the likely future growth is of diabetes, of
21 heart failure, of a range of other chronic conditions; of
22 things like childhood development issues. And so all of
23 those things go into our clinical service planning.
24
25 And, at the start of that, taking stock of the growth
26 in recent years of our activity and demands across
27 different parts of our services. For us, an example would
28 be our emergency departments have grown twice or three
29 times faster than our population growth in recent years,
30 and that's become challenging for our emergency departments
31 to maintain their services.
32
33 We take that and look forward in the next five, 10,
34 15 years at what the likely growth and service demand might
35 be.
36
37 Q. So a lot of those measures relate to demand on the
38 system. What about the particular types of services that
39 might be required and where they might be required? How
40 does that analysis assist you to forecast those types of
41 matters?
42 A. So at the broad population level, in breaking those
43 down to different age groups and disease profiles, that
44 helps us narrow down in what are the types of services we
45 will need to provide.
46
47 Q. What do you mean by "disease profiles"?

1 A. So if we can take an example of our chronic disease
2 rates across the Central Coast, they have continued to
3 climb above both state and national levels. We know that
4 into the future, we will have a much higher rate of
5 diabetes, of heart failure, of chronic respiratory illness
6 and a range of other things, and culminating with
7 a significant growth in the aged population means we will
8 see a greater reliance and need for acute based health
9 services and for us to play a role in some of the ongoing
10 complex care navigation and coordination for people with
11 chronic disease and multiple chronic diseases.
12
13 Q. I take it in your years as CE of two districts, you
14 are quite familiar with the process leading to the
15 finalisation of a service agreement between the secretary
16 and the district; is that right?
17 A. I sure am.
18
19 Q. Can you describe, from your current perspective as CE
20 of the Central Coast LHD, how that process operates?
21 A. Sure. So it's grown and evolved over the years to be
22 a fairly mature process with the ministry that typically
23 kicks off - I say "typically" because it was interrupted
24 with the COVID impacts - in around November every year with
25 a roadshow from the ministry that will come out and start
26 the conversation around the current environment health
27 services are in in New South Wales, their likely
28 forecasting of some of the priorities in the service
29 agreement, the funding envelope, the activity pressures and
30 some of the changes to performance metrics or other focus
31 areas for the local health district.
32
33 That's a stage that also enables the local health
34 district to put forward some priorities for coming years,
35 of both potential enhancements but also conversation around
36 those proposed KPIs and activity levels.
37
38 That's got a three-stage process culminating in
39 around May with the final stages of that negotiation
40 process that I've got to say is a good, healthy and mature
41 environment.
42
43 Q. Just go to the most current services agreement,
44 [MOH.9999.0859.0001]. It will be on the screen just to
45 your right, Mr McLachlan, or the one across the room,
46 whichever is easier for you.
47 A. Sure.

1
2 Q. I take it you are fairly familiar with this document?
3 A. I sure am.
4
5 Q. I just want to ask you a few questions about it. In
6 an earlier answer you said that the process was one of
7 negotiation; correct?
8 A. Yes.
9
10 Q. Which parts of the agreement are open to negotiation
11 from the point of view of a local health district?
12 A. First of all, starting at the activity levels, that
13 there is a good conversation about our current activity
14 recording, the pressures that our services are feeling, the
15 year to date stocktake - because it is done at a certain
16 time of the year and what that might look like for a full
17 year forecast; any changes that we would like to see, be
18 doing different activity groups. An example there might be
19 a shift from acute inpatient services to non-admitted
20 services so the --
21
22 Q. Sorry to interrupt you, I will just show you page 14
23 of the agreement which might assist in this passage.
24 A. Sure.
25
26 Q. So the activity targets that you have been referring
27 to are the target volume expressed in NWAU?
28 A. Yes.
29
30 Q. And the shifting of categories that you are about to
31 describe there are those first four items, are they?
32 A. Yes, they are.
33
34 Q. So the district was able to negotiate with the
35 ministry about those targets and the categories into which
36 they would fall; is that right?
37 A. We certainly had a conversation about the potential
38 shift between those categories. I think the reality is the
39 overall NWAU target is what it is, but the shift between
40 categories is where we would really want to see us both
41 tactically move some services into the community, and
42 that's a major arm of our clinical services plan and our
43 strategic plan, and so matching activity levels with our
44 strategy to see patients cared for in the home or out of
45 hospital was something we wanted to see.
46
47 Q. When you say "the activity target is what it is", what

1 do you mean by that?
2 A. Well, we know that every year we will see a certain
3 volume of patients. In the activity levels this year there
4 has been some growth, but we're within about 1 per cent of
5 being on track to achieve the targets. So it's
6 a reasonable target. It is something that we want to make
7 sure that is reasonable, that there is a conversation
8 around that in the service agreement negotiations.
9
10 Q. Further down on that page, there are some negative
11 entries in red. Do you see that?
12 A. Sure do.
13
14 Q. What do they relate to?
15 A. So they, on that screen there, are revenue items, but
16 I think you are referring to the next screen over, if I can
17 just check - yes, thank you. So the first one is an
18 adjustment to some of our funding level because of
19 variation from some of the performance indicators. Some of
20 those were hospital-acquired complications and/or
21 readmissions and other things that the state would love to
22 see us lift our performance, and happy to say that that has
23 happened in the last 12 months.
24
25 Q. So those adjustments resulted in approximately
26 $950,000 deduction to the budget; is that right?
27 A. Yes.
28
29 Q. Do you see that as an effective incentive to manage
30 the performance of the LHD?
31 A. Well, the main incentive is for us to provide good
32 care for our patients, no question. These indicators raise
33 the bar of the level and type of service that we provide to
34 our patients. We don't want to see patients coming back to
35 hospital unnecessarily. We don't want to see patients
36 receiving infections or other impacts from being in
37 hospital. So that, to be honest, is the main driver. It's
38 helped to sharpen with a financial impact as well, knowing
39 that if we turn around those indicators that aren't
40 performing, we will receive further funding with that.
41
42 Q. Does an adjustment of that kind pose any particular
43 challenges for the district from a budget perspective?
44 A. Well, out of the billion dollar budget, you know,
45 close to a million dollars is, you know, a lot of incentive
46 to see us improve the performance.
47

1 Q. The next item, "Comprehensive expenditure review
2 savings". We've heard a little bit of evidence about that,
3 but how does that relate to the operations of your
4 district?
5 A. So every year we know that we need to find
6 efficiencies and savings in the way that we provide
7 services. That's been the case for all of my 25 years in
8 health. But this, to be honest, is a real sharpening
9 across the whole of government in some areas of savings
10 that we know that we do have some efficiency opportunities
11 in, whether that's travel costs, legal costs, consultancy
12 costs or, in particular, the procurement opportunities at
13 a whole-of-system level, gaining some economies of scale
14 and some purchasing leverage with some of our suppliers in
15 the purchasing of goods. We know that there are a lot of
16 opportunities to further that.
17
18 Q. I appreciate in that answer you mentioned
19 a whole-of-government approach. Is there any opportunity
20 for the district to have input prior to the execution of
21 this agreement about what that target would be?
22 A. Yes, there is, but there is a healthy conversation
23 with the ministry about areas of opportunity that we have
24 been able to identify that are on the radar at the
25 statewide level, and things that could be leveraged beyond
26 that. We do have a conversation about the financial
27 position of the local health district, how this
28 comprehensive savings allocation will help us deliver on
29 that.
30
31 Q. Does that conversation include an assessment about
32 whether the target is a realistic one for the LHD to
33 achieve?
34 A. We know that the last three financial years we've been
35 able to find significant savings across the local health
36 district that are beyond this, so I actually do have some
37 confidence that this is within our reach.
38
39 Q. Is that part of the assessment that is made prior to
40 the execution of the agreement?
41 A. Yes.
42
43 Q. Is that an assessment undertaken by the LHD or the
44 ministry, or both?
45 A. Both. It is informed by some of the forward-year
46 forecast savings that are both requested of health and we
47 have an opportunity and availability to find those; some

1 areas of particularly procurement reform that will see
2 savings identified in coming years. Those are broken down
3 to individual products where both HealthShare and the state
4 are intending to go out to procure at a cheaper price,
5 hopefully, for the local health districts.
6
7 Q. Can we come down to page 21, the KPIs. What
8 opportunity was there for your LHD, prior to the execution
9 of this agreement, to negotiate in relation to the KPIs?
10 A. Some of the KPIs are national-level KPIs, some are
11 statewide that have targets agreed across the whole of the
12 state, and some are local KPIs where we do talk with the
13 ministry about the realistic targets and the areas of
14 reform that we need to achieve to deliver on those. So
15 there is, as I say, three levels of those and
16 a conversation around them.
17
18 Q. When you say "local KPIs", what do you have in mind in
19 referring to local KPIs?
20 A. So one area of those, a number of pages over in this
21 document, would be our readmission to hospital within
22 28 days for patients in the acute sector, that we've seen
23 regular continued decreases in the KPI in recent years.
24 The agreement with the ministry was reached out of the dual
25 conversation about what a realistic target was to see
26 a further decrease in the current year, and that's been set
27 at a district level and, for us, we flow that down through
28 our services.
29
30 Q. If we go to page 23 of the document, towards the foot
31 of that page, "Unplanned hospital readmissions" - is that
32 the one you had in mind?
33 A. Yes.
34
35 Q. And is the area of discussion and negotiation with the
36 district about not the KPI itself but the target of
37 reduction on previous year, for example, in the first of
38 the columns?
39 A. Yes. That's right.
40
41 Q. Do you have a view about whether, taken as a whole,
42 these KPIs provide a reasonable assessment of how well the
43 LHD is achieving its purpose as you have described earlier
44 in your evidence of protecting, promoting and maintaining
45 the health of the residents of the district?
46 A. I think they do. I think they are one part of that
47 system-wide measure and picture. It's certainly a major

1 priority for the local health district, for the board,
2 myself, to deliver on the service agreement.
3
4 Q. You said in that answer it was one part of the
5 consideration. What are the others?
6 A. Well, there is a wide variety of services that we're
7 funded to provide. Those come in the form of our
8 activity-based funded services, our block-funded services,
9 and then some narrow specialty services that continue to
10 grow, both from the state and from the Commonwealth over
11 recent years now. Each of those services comes with their
12 own set of metrics or measures and funding requirements,
13 and so it's a balance of all of those being pulled
14 together, that the service agreement is a helpful
15 perspective over the vast majority of that.
16
17 Q. You report to the board; is that right?
18 A. Yes, I do.
19
20 Q. Do you, in your many years as a CE, see particular
21 benefits in the CE of an LHD reporting to the board?
22 A. I do.
23
24 Q. What are they?
25 A. I do. I thoroughly enjoy having a board and the
26 intellect, the accountability and support from a board.
27 We've got a high-calibre board on the Central Coast that
28 brings together quite an exquisite group of people
29 dedicated to the Central Coast, that they have the Central
30 Coast's health services in their best interests and provide
31 guidance, advice and some focus for me in delivering on
32 those services.
33
34 Q. What particular benefits do you see in a CE being
35 accountable to a board, on the one hand, as opposed to,
36 say, the secretary on the other?
37 A. Well, it is a balance. I think the board helps us
38 focus, particularly for the Central Coast, on the health
39 needs, the services we provide and a range of things that
40 are within our control to directly influence and manage for
41 the Central Coast health services.
42
43 The secretary and the ministry's role I actually see
44 as a supportive one in helping to guide and direct both
45 those health services for the coast, the network of health
46 services across the whole of the state and for our
47 population to access. So it is a dual responsibility.

1
2 Q. How, in a practical sense, does the board help you as
3 a CE focus on the needs of the community within the Central
4 Coast LHD?
5 A. So in the planning of our health needs, our clinical
6 service plan and now our strategic plan that's in final
7 stages of development, the board's been incredibly
8 involved. That's been from board dedicated planning days
9 and sessions to regular ongoing dialogue with the board
10 about our current services, our future growth and
11 development, the priorities of those and the capacity of
12 those and some options or alternatives that we may or will
13 need to take in the future.
14
15 The board, on a regular monthly basis, holds us
16 accountable to the delivery of those, both at the board
17 level and all of the subcommittees of the board. That has
18 now got a quite extensive process around it with a board
19 stocktake on a monthly basis of the delivery of both the
20 major strategy pieces and any issues with those. A regular
21 deep-dive process that the board has into some of their
22 special subject areas and accountabilities, particularly
23 with the subcommittees that report through to the board.
24
25 Q. Do you engage with the chair of the board outside of
26 those formal meetings and structures?
27 A. I certainly do.
28
29 Q. On what sort of matters?
30 A. On a weekly basis, the board chair and I have
31 a regular dialogue, Wednesday afternoons, that takes stock
32 of any emerging issues, future strategy priorities, issues
33 emerging across the whole-of-health service delivery and
34 any feedback from the board and guidance for the future of
35 the organisation.
36
37 Q. When you say "feedback from the board", does that
38 sometimes include priorities that the board would like to
39 see advanced in the LHD?
40 A. Yes, it does.
41
42 Q. How do you manage board priorities of that kind
43 amongst other planning that has happened within the
44 district and meeting the KPIs set out in the services
45 agreement?
46 A. Well, it's an open conversation with the board. We
47 have a fairly frank and open dialogue about the service

1 pressures and demands across the organisation, the tactics
2 and strategies that we're trying to deploy to best manage
3 those and provide good patient care, the tension points
4 around those and things that we would like to be doing, the
5 challenges in delivering those, and so I've got to say it's
6 a good productive dialogue around that.
7
8 Q. Do I take it from your answers this morning that you
9 are in favour of the current structure - that is, the
10 current board structure and how it operates in the system?
11 A. Yes, I am.
12
13 Q. Do you see opportunities for improvement?
14 A. Always. I think health services are always evolving
15 in both Central Coast certainly, in a bigger reform and
16 transformation of the services at a system and a national
17 level - I think there will always be changes to that.
18
19 Q. Do you have any particular things in mind as being an
20 improvement to the current structure?
21 A. I think at a local health district level, our ability
22 to change and reform the way services are provided has got
23 a lot of opportunity to it, particularly with a push to see
24 more patients cared for either in their home or in
25 clinic-based settings that changes a lot of what
26 traditionally has been a hospital-based type service.
27 I think at a system level, there is a lot of opportunity to
28 improve the information we have available, the analysis of
29 that, the benchmarking and support for the local health
30 district. I see some real opportunity in the future
31 development of some of the pillars and the support services
32 for the local health district.
33
34 Q. We might come back to some of those a little later,
35 but in that answer you referred to the ability of the
36 district to change and reform the way services are
37 provided.
38 A. Mmm.
39
40 Q. What did you have in mind?
41 A. So an example I will give, the last 12 months saw us
42 grow a new hospital in the home service, a service that
43 cares for patients that otherwise would have needed to be
44 in hospital, in their homes, with a specialist care team of
45 both doctors, nurses and allied health clinicians that both
46 follow up face-to-face in the home, in clinics, or in a
47 virtual sense, and monitoring patients in those settings.

1 That has been a really rapid growth and development, and
2 part of that service has also been a support model for
3 complex, frail, elderly patients that also need some extra
4 levels of support in their home.
5
6 Now, for our services to be sustainable into the
7 future and I think to provide good care for our community,
8 that needs to double, if not triple, into the future. That
9 will need a whole range of supports, whether it's funding
10 and resourcing to a lot of clinical networking, new
11 diagnostics and clinical support services.
12
13 Q. What change, whether at a district or a system level,
14 do you see as being required to achieve those aims?
15 A. So at the moment, that's got a strong level of support
16 from all of our clinical leaders, a priority that we've
17 been through a process of discussing in the clinical
18 service plan that we've formed and our now strategic plan,
19 that that has become a really obvious solution, a gap in
20 the Central Coast, that we have needed to resource. The
21 discussion amongst our senior clinicians is how they go
22 a step further in identifying what is both best practice
23 and new evidence that is emerging from around the world and
24 around New South Wales, identifying within hospital the
25 patients that could be cared for at home and not needing to
26 be in hospital for a longer stay in hospital, and at the
27 front door of our emergency departments, finding the
28 patients that don't need admitting to hospital and
29 intervening in that journey to support them being cared for
30 at home and plugged in to our hospital in the home and
31 a whole range of other community-based services that we
32 provide.
33
34 Q. Just before I leave the services agreement, if we
35 could go back to page 14, please, operator, I have asked
36 you some questions about the target volume earlier. To
37 what extent do those targets take into account the health
38 needs of the population within the district as you
39 understand it?
40 A. Sure. So the current activity levels that are
41 a reflection of the health needs of our community.
42
43 Q. In what way?
44 A. Beyond the current activity, there is a model that
45 takes into account with one of the three lenses, an equity
46 lens, that helps to take stock of both the population
47 growth and parts of the population that have a higher

1 health need that would warrant extra levels of activity
2 into emergency, acute, outpatient and community-based
3 services.
4
5 That's a process that is continually renewed at the
6 time of both the census and as a part of our clinical
7 service planning, understanding our population at a much
8 greater level. That equity adjuster is one part of
9 a stocktake of the health needs of the community.
10
11 Q. Can we go back to your statement, please, and to
12 paragraph 31.
13
14 THE COMMISSIONER: Q. When you say - when you have
15 talked about in the last 12 months you are growing your new
16 hospital in the home service, and you mentioned that for
17 services to be sustainable into the future, you need to
18 double, if not triple. I take it that's a reference to
19 services that aim to keep people out of the acute setting?
20 A. Mmm.
21
22 Q. Is that right?
23 A. Yes, it is.
24
25 Q. Because if you don't, as a matter of obviousness, with
26 ageing population, chronic disease, the activity levels for
27 providing acute services and hence the cost of providing
28 acute services is going to reach that unsustainable level
29 that you are talking about.
30 A. Yes.
31
32 MR GLOVER: Q. In paragraph 31 you tell us about
33 integrated care and the work of the district with the
34 primary health network?
35 A. Mmm.
36
37 Q. Can you just describe to us in day-to-day terms what
38 that work looks like and what it's seeking to achieve?
39 A. Sure. So for nearly 10 years, as you can see, the
40 primary health network and the local health district have
41 had a joined-up approach to trying to better connect
42 services for people in need of those services, whether it's
43 vulnerable, youth, people with multiple chronic conditions,
44 and a range of other health issues. Now, that has evolved
45 over the last 10 years with a formal mechanism now designed
46 of an alliance with the primary health network that was
47 formed back in 2018. That came between - sorry, 2017.

1 That came from an evaluation of the integrated care journey
2 over the previous five years, the need to formally bring
3 together both the Commonwealth and state levels of both
4 care coordination funding and service delivery, provide
5 support to clinicians and services to better organise their
6 services for those populations that need it.
7
8 Out of that process, we found opportunity to agree on
9 what was four priority areas for our population across the
10 Central Coast through a process of consulting with both
11 community, a range of primary care providers and GPs, our
12 acute care clinicians and others, to understand where were
13 some of the fractures in care that needed addressing and
14 issues for the community.
15
16 Q. Just pausing there, what do you mean by "fractures in
17 care"?
18 A. I think we would all appreciate that as a patient,
19 trying to navigate a complex health system, sometimes
20 that's not well organised, whether it's from general
21 practice in the connection through to specialist care,
22 through to social care and support services. Even within
23 the local health district there was a lot of opportunities
24 identified to better organise patients' journey through the
25 health system, both in the communication with those
26 patients, the information transfer, the connection in a
27 helpful way and an easy way for them to different parts of
28 their care.
29
30 Q. What about identifying gaps in the availability of
31 care?
32 A. Certainly.
33
34 Q. Does the LHD have a role to provide primary care where
35 there might be a gap either as to availability or
36 accessibility to some of the community?
37 A. We do provide a range of primary care services
38 already, right through from our public health capability,
39 our health promotion services, a lot of our community-based
40 care services. An example I would give you there is our
41 child and family health nurses that provide a lot of
42 ongoing support to children from, you know, close to
43 the time when they are born, right up to the age of five,
44 and so a lot of early screening, diagnostic intervention
45 and support for those kids at that age and their families.
46
47 Q. That's obviously being delivered in your district

1 because there has been an assessment of the need for that
2 service to be provided by the district?
3 A. Yes.
4
5 Q. In paragraph 32 you tell us about a Central Coast GP
6 collaboration panel. What is the purpose of that panel?
7 A. So that panel has come directly from both our
8 integrated care journey and the development of the
9 alliance, in recognising the really crucial role that GPs
10 play in the whole of the health system and wanting, first
11 of all, engagement and advice from GPs about both the
12 pressures that general practice is feeling and under, the
13 connection for patients and the needs of patients across
14 the Central Coast, some of the gaps in services and issues
15 that they are facing and needing support with.
16
17 That GP panel has over the years evolved with some
18 very sharp advice about the things that the local health
19 district needs to do to change some of our services and the
20 things that general practice could use in support and
21 workforce solutions and a whole range of other things
22 that - you know, particularly through the COVID outbreak
23 experience, it was really clear.
24
25 Q. Is better integration between the acute services
26 delivered by the district and those provided by general
27 practice in the community important in your view?
28 A. Oh, it is critical.
29
30 Q. Why?
31 A. It is absolutely crucial, I think. The needs of our
32 community demand a health system that is well organised and
33 connected to make that easy for them to access to
34 coordinate the care for people with complex and ongoing
35 health issues.
36
37 We clearly have a situation where general practice,
38 with some of the workforce constraints and population
39 growth, doesn't have the capacity to see all of the needs
40 of the community, and so we do find ourselves wrapping
41 a lot of support around GPs but also stepping in to provide
42 some of those support services in the advent of that.
43
44 Q. And that is necessary to fulfil the function of the
45 LHD that you described earlier in your evidence; correct?
46 A. Yes.
47

1 Q. Is there anything that could be done at a system level
2 to better enable the integration between care in the acute
3 setting and care delivered by GPs in the community?
4 A. At a system level over the last 10 years NSW Health
5 has evolved a lot of things that do support integrated care
6 and better coordinating care for patients with chronic and
7 ongoing health issues.
8
9 An example I would give you is the patient flow portal
10 that at a statewide level is a collation of all of the
11 information that we have on patients coming through our
12 emergency departments, our acute services, our
13 community-based services, that helps to take stock of their
14 health issues, apply an algorithm across those based on
15 some best practice evidence from around the world and
16 across our integrated care journey, to help predict and
17 forecast some of the risk of both needing further acute
18 care over the coming 12 months and to apply some evidence
19 of if we intervened with some support, what that would mean
20 for those patients in avoiding or averting some of that
21 acute care journey. Now, that has been a fantastic
22 development over the last three, five years, particularly
23 for some groups within our population that we know are at
24 high risk of those complications.
25
26 Q. That's some work that has already been done?
27 A. Mmm.
28
29 Q. Is there anything else that could be done at a system
30 level that is not already under way that could better
31 enable the integration between care delivered in the
32 community setting and that delivered in the community by
33 GPs - sorry, I think I put "community" twice. I will
34 withdraw it and start again. In that answer you have told
35 us about some things that have already been done and
36 implemented in the system. What I want to explore with you
37 is, is there anything that is not yet under way that could
38 better integrate care delivered in the acute setting with
39 care delivered by GPs in the community, and if so, what do
40 you think that might be?
41 A. Certainly. One of the developments out of our
42 alliance has been a model for the elderly population for
43 the Central Coast called ALICE, which is all inclusive care
44 for the elderly, which has at the heart of it a vision
45 around enabling older people to stay fit, healthy and well
46 and engaged in their community at the outset, but right
47 through to a network of complex care that helps to provide

1 for older people the range of supports they need in both
2 the complex medical care, some of their social care and
3 other things.
4
5 That has been a vision that has been brought about
6 through the Central Coast Research Institute, the primary
7 health network, the local health district, regional
8 New South Wales, our local council and a range of other
9 support providers on the Central Coast that have come
10 together over the last 12 months, tested out in a number of
11 our localities what this would mean for our older
12 population, communities like The Entrance and Long Jetty
13 that has a number of thousands of older people that, to be
14 honest, have come together to help us understand what
15 support they need from daily living right through to this
16 complex care.
17
18 Q. So this is an initiative that is being developed and
19 tested in your district; correct?
20 A. It is.
21
22 Q. Is there anything that the ministry could be doing to
23 better enable integration between care delivered in the
24 acute setting with general practice and, if so, what is it?
25 A. I think there is a lot of attempts across NSW Health
26 to provide support to general practice, both in workforce
27 solutions, in integration and information being provided to
28 general practice, the two-way dialogue with the general
29 practice around complex patient needs and care, the
30 discharge planning, the attempts from Lumos to provide
31 information and access to their data. I think to take that
32 to the next level would mean some more mature funding
33 mechanisms and support for the local health districts and
34 general practice to come together.
35
36 Q. What does that look like in real terms?
37 A. I think the attempt of the collaborative commissioning
38 model has been a good start to that journey. I was
39 involved in one back in Western New South Wales in my time
40 out there. This ALICE model in the Central Coast certainly
41 has all of the components, I think, that will need a change
42 and evolution to the funding mechanism, the support for
43 general practice and the wrap-around support for older
44 people as well.
45
46 Q. When in those answers you referred to more mature
47 funding models or a change in evolution to the funding

1 mechanism, what do you have in mind as being necessary to
2 support the development of the initiatives that you have
3 just referred to in that answer?
4 A. So at the heart of that is a shift in line with our
5 clinical service plan and our major strategy to more
6 community and ambulatory types of care, so clinic
7 outpatient setting care, and some funding mechanisms to
8 support and incentivise that.
9
10 Q. Like what? Give us an example? What do you mean?
11 A. So I think shifting more into the community - the
12 example I gave earlier of growing our hospital in the home
13 and complex care for our aged population will need further
14 funding to support that. Now, that can come in the form of
15 our local health district out of our billion dollars of
16 resources, looking at the things that we need to shift and
17 change to support that with our existing workforce and
18 other solutions.
19
20 I certainly know through the collaborative
21 commissioning models and other solutions, there is funding
22 available and some opportunities within that, and the early
23 signs from the Commonwealth in the National Health Reform
24 Agreement and other things, I would hope, will come to
25 a funding opportunity for those --
26
27 THE COMMISSIONER: Q. Your billion dollars, though, of
28 resources, you've got to cover all your acute services out
29 of that?
30 A. Yes.
31
32 Q. So the hospital in the home is a priority that exists
33 after you have provided all those acute services; correct?
34 A. Commissioner, I'd also say it's a chicken and egg. It
35 is a question of priorities and which way you see that.
36 I think the clinical evidence would say that there is so
37 much more that can be done now in the home than five, 10,
38 15 years ago, and that's evolving rapidly with the
39 development of new technology, new drugs, all of the AI
40 developments and others, that say patients don't need to be
41 in hospital as long, or at all in some cases.
42
43 Now, that, for me, means balancing up our billion
44 dollars of resources, a conversation around how we shift
45 focus of some of our services to support care in the
46 home --
47

1 Q. Perhaps what I meant was you can be as efficient as
2 possible with your acute care services, but you still have
3 to provide them?
4 A. We do.
5
6 Q. You can't not. And it's with budgetary money that's
7 left over that you might engage with these more innovative
8 programs that might ultimately get better health outcomes
9 and perhaps save money, but in the longer term rather than
10 the short-term requirement of having to provide acute
11 services; correct?
12 A. Yes.
13
14 MR GLOVER: Q. When you spoke in your answers about
15 mature funding models, is one of the issues, picking up on
16 your answers to the Commissioner, that there may need to be
17 particular funding from the ministry, say, to the LHD, to
18 fund the development of these models, which will have
19 longer term benefits to the overall budget situation, but
20 in the short term, needs to sit alongside the funding
21 envelope necessary to deliver the demands on acute care?
22 A. Yes, and that has occurred in recent years. The
23 ministry, let's say, seed funded for the first 12 months
24 the hospital in the home service, an aged care, frail and
25 elderly model, that had both hospital and in the home
26 components to it, that would see this evolve with the
27 activity being delivered in those services as the longer
28 term funding solution for them.
29
30 Q. Is seed funding for 12 months sufficient to enable the
31 development, piloting, scaling of an initiative like this?
32 A. Well, the last few years has seen some real challenges
33 in finding workforce, and so our ability to stand up these
34 new models was really constrained by finding the
35 workforce - like every health system across the state and
36 the country, was in the same boat, and so that has taken us
37 a longer term than the first 12 months.
38
39 Q. I will approach it in a slightly different way. Do
40 you see there being benefit in seed funding, as you put it,
41 for new initiatives being provisioned over a longer period
42 to enable it to be developed, rolled out and evaluated?
43 A. Yes, for some services, yes.
44
45 Q. Can we go ahead to paragraph 78 of your outline,
46 please. In paragraphs 78 to 80 you mention some
47 opportunities, some of which you have given some way-points

1 to in your earlier answers. If we just start with
2 paragraph 78, there you tell us that the role of the
3 ministry, pillars and boards have changed to reflect the
4 new environments, particularly through COVID in the
5 pandemic response. Is there something in particular that
6 you had in mind when writing those words?
7 A. Well, the last three years saw us have to be very
8 agile in maintaining a range of services for our community
9 but standing up a range of new services and supports for
10 the COVID response. I've got to say the New South Wales
11 health system did that in a quite positive and incredible
12 way, if I reflect on, say, the role of HealthShare, that
13 stood up within days new supply routes for whether it was
14 gloves, pathology products or a range of other things.
15
16 Q. So is that first sentence of paragraph 78 limited to
17 the pandemic period, or is it continuing after?
18 A. Both.
19
20 Q. To the extent it relates to the current, if I can put
21 it that way, what did you have in mind as being the new
22 environment?
23 A. Well, I think we had a lot of things change through
24 the COVID period and now, the last I would say six to nine
25 months, we've started to see a resuming of a typical trend
26 in health service delivery and access. Now, that has seen
27 some changes to services over the years, and so this really
28 has needed the state system to take stock of what that
29 means, the role of the ministry, the boards, the pillars
30 have slightly adapted over the last six and 12 months.
31
32 Q. In what way?
33 A. If I reflect on the role of the ACI, the CEC, they
34 have stepped further into focused outcomes and evidence of
35 different models. I've got to say the ACI, through the
36 pandemic period, was incredibly useful in focusing evolving
37 attention - sorry, outcomes and evidence, the new models of
38 care and supporting the system to change the current
39 service delivery. That, I think, has been helpful for some
40 of those statewide agencies to step further into that role.
41
42 Q. In paragraph 79 you tell us the role of LHD boards has
43 broadened over the years and being clarified at the moment
44 with smaller board membership which will need a revision to
45 the structures, et cetera. Do you see that?
46 A. Yes.
47

1 Q. First of all, directing your attention to what you say
2 has been the broadening of the role of the LHD boards,
3 what, in particular, did you have in mind when writing
4 those words?
5 A. So in my nearly 11 years as a chief executive, the
6 role of the board has broadened. That has been a stepped
7 approach, I think, from the ministry in clarifying for the
8 boards their responsibilities across the performance of the
9 local health district, the governance mechanisms and
10 a number of years ago there was a shift in the
11 accountability for boards in being the main, I will call
12 it, hiring and firing of the chief executive with the
13 secretary's agreement. But that did shift. The
14 predominant role of the boards is a more front and centre
15 role. There is an intention at the moment to further shift
16 the size of the local health district boards, and I think
17 some of the membership of those.
18
19 Q. So what is the particular opportunity that you see in
20 this area?
21 A. I think some clarity over the role of the board and
22 the ministry in this. Quite often there is overlap in
23 those areas and that's understandable given the ministry
24 and the statewide direction for health services instructs
25 them and guides the boards in some of the performance
26 management and governance of that. We have a good robust
27 relationship with the ministry around our performance
28 management as well as the board has that with myself.
29
30 Q. In paragraph 80 you note that whilst the pillars and
31 the LHDs work well together, there is an opportunity for
32 increased sharing of innovation and new developments
33 between the LHDs and the pillars, in particular the ACI and
34 the CEC?
35 A. Mmm.
36
37 Q. What did you have in mind in particular as being the
38 opportunity in this area?
39 A. Sure. So I think out of all my years' experience in
40 health, I see health evolving at more and more of a rapid
41 pace in the models of care delivery, the outcomes, the
42 evidence, the new research. That, to be honest, needs
43 someone to help, I think, the local health districts take
44 stock of those new evolutions in the way that care is
45 provided, the way that we can organise our system. The ACI
46 and CEC play a really crucial role, in my perspective, that
47 we couldn't stand up at a local health district level, at

1 taking stock of international trends, in statewide
2 evolutions in the way that care is provided. One of the
3 examples I would give is in the evolution of both hip and
4 knee replacement procedures for patients, evolving with
5 a lot more support around mobilisation of those patients,
6 the nearly day-only surgery for the vast majority of those
7 patients. That's something that the ACI and to some degree
8 the CEC have helped us change and evolve those models.
9
10 Q. So, in that answer, I think you mentioned someone to
11 help the health districts take stock of new evolutions.
12 A. Mmm.
13
14 Q. What in particular would assist you in your role as CE
15 to take stock of new evolutions?
16 A. So I think the ongoing focus around translational
17 research is one area that we really do struggle to have
18 a vision across all of the emerging evidence and research
19 that happens, understand what needs to be translated into
20 clinical practice care.
21
22 Q. So that's the issue, as you see it?
23 A. Yes.
24
25 Q. What's the solution there from your perspective?
26 A. The solution there I do see is both, let's say, the
27 ACI and, within that pillar, the research group, helping to
28 take stock of those changes in clinical practice, outcomes
29 for patients and others, giving clear advice to the local
30 health districts in both a policy sense and clinical change
31 management and support to see those changes happen.
32
33 THE COMMISSIONER: Q. I was going to ask you, isn't that
34 the role of the ACI, but you see there is something missing
35 there?
36 A. It is. I think it's happening at a faster and faster
37 pace, Commissioner, but that's our challenge, with the
38 evolution of AI, all of the new technologies, the new drugs
39 and other things, that that's a nearly exponential growth,
40 and I think that's where the support really will be needed.
41
42 Q. So what is the extra help beyond what the ACI does?
43 That's what I'm curious for your answer about.
44 A. I think the next evolution of support and change
45 management, I'd call it, for our health services to adapt
46 from our current way of working to a future model. That is
47 the role of the ACI. A lot of that sits with the local

1 health districts in our busy days, that that's something
2 that we struggle to keep up with in the evolving, fast
3 nature of health service delivery. Juggling many balls at
4 one time to --
5
6 Q. The ACI has a lot of clinical networks. You are
7 talking about something slightly broader that's looking at
8 the whole system, is it?
9 A. I think it is sharpening the impact of all of those
10 clinical networks in helping to see, you know, best
11 practice care for different patient groups, all the support
12 that needs to happen, and possibly on the ground practical
13 support in change.
14
15 MR GLOVER: Q. What do you mean by "sharpening the
16 impact" - what does that mean in real terms?
17 A. Well, I think across the whole of the state's network,
18 there is a big variety in the services that are provided,
19 from small rural hospital to big quaternary hospitals.
20 Sometimes, in describing a model of care, it might need to
21 be more specific and narrow to the groups of patients that
22 that is most relevant for.
23
24 Q. So what you are talking about is targeting the advice
25 to the audience that it is being delivered to; is that
26 right?
27 A. Yes.
28
29 Q. And is that something that you perceive isn't done at
30 least regularly enough at the moment?
31 A. It could always be improved. I think we've got a big
32 system and I think yes, we can do it better.
33
34 MR GLOVER: I don't have anything further, thank you,
35 Commissioner.
36
37 THE COMMISSIONER: Q. Can I just ask a very general
38 question, and it's workforce, not governance, but it is
39 very general. You have given some evidence today, and in
40 your submission you have given us some details, about your
41 ageing population, population health, all those sorts of
42 demographic matters. Your LHD is relatively close to
43 greater Sydney, at least part of it is?
44 A. Mmm.
45
46 Q. The regional LHDs, I think all of them in their
47 submission and at least one so far in their actual

1 evidence, I think at least partly driven by remoteness,
2 have talked to us about some fairly acute difficulties
3 about attraction and retention of staff?
4 A. Mmm.
5
6 Q. Does your LHD experience those difficulties, or not to
7 the same extent?
8 A. Yes, we do to a lesser extent than a lot of those
9 rural and remote regions.
10
11 Q. You do, but not as acutely as perhaps Far West
12 New South Wales or Western New South Wales?
13 A. Yes.
14
15 Q. To a greater extent, though, than the metropolitan
16 LHDs?
17 A. Yes, we do.
18
19 Q. Forgive me if I've forgotten, and I haven't got it
20 here, but was that something you raised in your written
21 submission to us? I don't recall it. It might be
22 something we need to follow up with you at a later time --
23 A. I'd have to check. Yes, happy to.
24
25 Q. -- to see what those issues are. There are also, of
26 course, going to be some workforce hearings, so it can
27 probably be done then?
28 A. Sure.
29
30 THE COMMISSIONER: Mr Chiu.
31
32 MR CHIU: I have no questions, Commissioner
33
34 THE COMMISSIONER: Nothing arose out of that?
35
36 MR GLOVER: No.
37
38 THE COMMISSIONER: Thank you very much for your time, sir,
39 we're very grateful. You are excused.
40
41 THE WITNESS: Thank you.
42
43 **<THE WITNESS WITHDREW**
44
45 MR GLOVER: That's all the evidence for today,
46 Commissioner.
47

1 THE COMMISSIONER: That's it for the day. Did you want to
2 start - it was Wednesday you were thinking about a slightly
3 earlier start, wasn't it, rather than tomorrow?
4
5 MR GLOVER: Would you just pardon me for a moment?
6
7 THE COMMISSIONER: Yes, go ahead.
8
9 MR GLOVER: I'm told 10am tomorrow and a potential for 9am
10 Wednesday, but we're just confirming availabilities.
11
12 THE COMMISSIONER: All right. We will adjourn until 10am
13 tomorrow, thank you.
14
15 **AT 1.20PM THE COMMISSION WAS ADJOURNED TO**
16 **TUESDAY, 23 APRIL 2024 AT 10AM**
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