Special Commission of Inquiry

into Healthcare Funding

Before: The Commissioner,
Mr Richard Beasley SC

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

Tuesday, 23 April 2024 at 12.05pm

(Day 022)

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 Richard Cheney with Mr Hilbert Chiu for NSW Health

1 THE COMMISSIONER: Yes, good morning.
2
3 MR MUSTON: I think the proposal is that this morning,
4 Commissioner, we will hear from Professor Donald MacLellan
5 first, we will see how long that takes and determine
6 whether it's an appropriate time to take perhaps a shorter
7 luncheon adjournment, say 45 minutes, but perhaps we can
8 assess whether or not the end of this witness's evidence is
9 the best time to take that when we get there.
10
11 THE COMMISSIONER: Sure.
12
13 **<DONALD MacLELLAN, sworn: [12.05pm]**
14
15 MR MUSTON: Q. Could you state your full name for the
16 record, please?
17 A. Donald Gerald MacLellan?
18
19 Q. You are the chair of the Central Coast LHD board?
20 A. Yes, indeed.
21
22 Q. You have held that role since July 2021?
23 A. Yes.
24
25 Q. And prior to that, I think you were a member of the
26 board of the Central Coast LHD from January 2019?
27 A. That's correct.
28
29 Q. You have prepared a document, as we understand it, to
30 assist the Commission, which is styled "Statement", but I'm
31 not sure that a copy of it was signed.
32 A. I haven't signed a copy.
33
34 Q. Do you have a copy of that document with you?
35 A. I'm happy to sign a copy once I've corrected one
36 mistake in the statement.
37
38 Q. We probably won't need you to physically sign it, but
39 let's go to the correction first. Which paragraph?
40 A. It is paragraph 6, the first line, where I state that
41 the board has eight members, in fact, it has nine members.
42
43 Q. Other than that correction, have you had an
44 opportunity to read the statement?
45 A. Yes.
46
47 Q. And are you satisfied that its contents are true and

1 correct?
2 A. Yes.
3
4 MR MUSTON: Thank you. That statement will form part of
5 the bulk tender in due course.
6
7 Q. Professor, could you just give us some indication of
8 what your professional background is prior to your
9 commencing as a member of the board, or perhaps
10 contemporaneous with commencing as a member of the board of
11 the LHD?
12 A. Look, my professional background is I'm a general
13 surgeon, academic surgeon, so Professor of Surgery in
14 Melbourne and then Professor of Surgery in Canberra, before
15 moving into health administration in the Hunter New England
16 Area Health Service, in various positions there. Then
17 I moved to the Ministry of Health as the program director
18 of surgery for a period of five or six years, then to the
19 Agency for Clinical Innovation for five or six years before
20 retiring, and then joining the board in 2019.
21
22 Q. You tell us in - perhaps we could bring up
23 Professor MacLellan's statement, it's [MOH.9999.0769.0001].
24 That will be brought up for you on the screen. You can
25 look at the big one over there or the one closer to you,
26 whichever is convenient. If it were me with my eyesight,
27 I would opt for the closer one.
28 A. I can see this one.
29
30 Q. You tell us in paragraph 3 that you have two main
31 functions as the board chair. The first is as part of the
32 group that interviews and chooses the chief executive of
33 the LHD, and in that sense, is it the case that the chief
34 executive of the LHD is accountable to the board?
35 A. Yes, correct.
36
37 Q. Do you think this is a useful structure with the CE
38 being accountable to the board?
39 A. Yes, I do. Choosing the chief executive is a really
40 important part of the board chair's function. The board
41 chair brings to that group, who are choosing the chief
42 executive, the local content that is required by the
43 community that the LHD serves. He or she is a member of
44 the group, includes either the secretary of health or
45 delegate, and an independent member. So there are three
46 people, at least, and gender balanced, of course, that
47 chooses chief executive. That's number 1.

1
2 Number 2 is the board chair is responsible for feeding
3 in to the performance of the chief executive and that's an
4 important function that's done in conjunction with the
5 secretary of health. Again, it gives the secretary of
6 health the local content, how he and his team are
7 performing. So I think it is an important component of the
8 work.
9
10 Q. In a practical sense, what do you think would be lost
11 if the CE had a direct line of accountability to the
12 secretary?
13 A. One of the things that in undertaking the performance
14 of the chief executive, you're also undertaking
15 a performance - his performance and his team's performance
16 about the general KPIs that are set in the service level
17 agreement. They go hand in glove.
18
19 If the service level agreement KPIs are being well
20 served, community's input is being taken care of, usually
21 that determines pretty good performance on the behalf of
22 the chief executive.
23
24 Q. Just looking at that, and we'll come back perhaps to
25 look at the KPIs in a little bit more detail, but an
26 assessment of the extent to which the KPIs are being met by
27 the LHD is something which is capable of being made by the
28 secretary or within the ministry, is it not?
29 A. Okay, so taking any single KPI from the ministry's
30 viewpoint, they would look at the local health district's
31 KPI. From the LHD's viewpoint and the board's viewpoint,
32 we will look not just at the LHD's KPI but drill down to
33 our four hospitals, two major, two sub-acute, and find out,
34 even if the KPI is appropriate to the target, perhaps one
35 of these hospitals is not achieving its KPI. So they
36 again - the local input is a really important component of
37 performance, both of the LHD and indeed the chief
38 executive.
39
40 Q. You tell us in paragraph 4 of your statement what you
41 understand to be the primary purposes of the LHD as set out
42 in section 9 of the Health Services Act. Now, is it
43 correct that those primary purposes are advanced through
44 the Caring for the Coast Strategy that you go on to tell us
45 about in your statement?
46 A. Yes, yes. Indeed, this strategy is very important in
47 achieving these goals.

1
2 Q. Could we go to paragraph 9(a) of the statement. You
3 see there you tell us about the implementation of the
4 Caring for the Coast Strategy 2019-2024?
5 A. Yes.
6
7 Q. You were obviously not the board chair at the time
8 that that strategy was prepared?
9 A. That's correct.
10
11 Q. But you were a member of the board whilst it was being
12 prepared?
13 A. No, sir. I was a member of the board after it had
14 been prepared. Largely it was prepared in 2019 - 2018, I
15 should say. I joined the board in January, as you know,
16 2019. So the Caring for the Coast Strategy was essentially
17 set at that time.
18
19 We did have a planning meeting around about
20 February/March, which is one or two months after I joined
21 the board, where we looked over the ELT and the board
22 looked over the strategy and had further discussion about
23 its potential effectiveness, et cetera. There were one or
24 two word changes, but essentially it was unchanged. So
25 I participated in that planning day.
26
27 Q. So that plan is set to expire in this year?
28 A. Yes.
29
30 Q. Presumably, there is another plan in the pipeline?
31 A. Absolutely. Yes.
32
33 Q. What has been the board's role in the preparation of
34 that plan?
35 A. Towards the end of January of this year, we had
36 a planning day, which was the - it had all board members
37 and the ELT with a facilitator sitting down to determine
38 what the next strategic plan would consist of, at least in
39 the high level and, then, subsequently, there's been
40 ongoing discussion at board level by the chief executive
41 about how the plan is being finessed, and that has followed
42 a considerable amount of consultations, both within the LHD
43 with the clinicians and, indeed, with the larger community.
44
45 We are now getting to the stage where we're pretty
46 well ready to launch the plan, probably by the end of this
47 financial year, so by the end of June, ready for its uptake

1 next year.
2
3 Q. So what has been the nature of the consultation with
4 clinicians and the community?
5 A. The chief executive and his ELT meets with the senior
6 medical staff, and the initial outline of the strategic
7 plan was put to them and feedback sought, and changes
8 occurred as a result of that - probably not in the
9 significant high-level parts of the plan, but the details
10 or subsequent details.
11
12 There's also been input from the community, the nature
13 of which I really can't let you know about, I'm not
14 familiar with it.
15
16 Q. What about the board itself? Is there a process
17 whereby the board delivers input into the formulation of
18 that strategic document?
19 A. Yes. So subsequent to the planning day, the board has
20 had the strategic plan updated on almost every board
21 meeting, but perhaps without one. So we're in April now,
22 so we certainly had one in March, an update, and I think
23 we're scheduled to either have one this month - in fact
24 I think I'm pretty sure we're going to be updated in April.
25 So the update provides the board with where the plan has
26 evolved. There is some wordsmithing that is required in
27 order to have a solid plan, and some of the subsections
28 within the plan, and it gives the board a chance to ask
29 questions or make comments.
30
31 Q. In terms of the making of comments, has it been your
32 observation through that process that the board has, in any
33 material way, changed the strategic objectives that are set
34 out in the draft plan which is currently being formulated?
35 A. In the planning day we had a very solid input to the
36 plan. You start off with more than three or four potential
37 big-ticket items, shall we put it that way, and through
38 a discussion with the ELT and the board, they will be
39 narrowed down, or have been narrowed down, to the three
40 essential ones. So there is a lot of input that the board
41 members individually as well as collectively provide to the
42 ELT. It's a very open discussion. It's not a one-way
43 street in any shape or form.
44
45 When the strategic plan comes back to the board once
46 again, we spend quite a lot of time discussing the
47 strategic plan, making sure that this isn't pie in the sky,

1 that it's actually achievable, the time frame that's
2 achievable, and if there is any words that are a bit
3 ambiguous or whatever, the board will point that out.
4
5 Q. So when you talk about the big-ticket items that
6 formed a longer list that was whittled down, what sort of
7 items, to the best you can recall, were on that list
8 initially?
9 A. I'm sorry?
10
11 Q. What sort of items?
12 A. Are on the list?
13
14 Q. You have given an indication there was a process
15 whereby a list of big-ticket items was initially presented,
16 there was a process of discussion and whittling down. What
17 sort of items are we talking about on the original list?
18 A. The current plan wishes to achieve alternatives to ED
19 attendance for the community, in other words, to provide
20 non-hospital alternates that give as good care as is
21 possible.
22
23 The wording might start off by saying, "ED avoidance",
24 for instance. Well, it's not ED avoidance. What we're
25 trying to do is provide care not required in ED and ensure
26 that the care that is given in the community or
27 non-hospital setting is efficient and appropriate to that
28 patient's requirement. So you can see that, you know, in a
29 discussion, you say, "No, no, that's not the right way.
30 I know what you are trying to say, but it's not the right
31 way to say it. It doesn't carry the full gambit of what
32 we're trying to achieve."
33
34 Q. That's a changing of the wording. The initial list
35 might have included ED avoidance as one of the big-ticket
36 items and that was, through a process of discussion,
37 rendered to something like, "Delivery of non-hospital
38 care", or, "Delivery of care in a non-ED setting", or
39 something like that?
40 A. Sorry, the wording is "Providing alternative care to
41 ED". See, moving it from just a narrow stopping them
42 coming to the ED - it's actually saying more that that,
43 it's saying not only do they not need to come, but we're
44 going provide an alternative. It broadens what we're
45 trying to achieve.
46
47 Q. That's an adjustment of one of the items that was on

1 the initial list but has survived the whittling-down
2 process. Were there other big-ticket items on the initial
3 list that you referred to earlier that were, after
4 a process of discussion with the board, taken off the list
5 or deprioritised?
6 A. I can't - no, I can't recall any that were
7 particularly taken off the list, but if I could give
8 a flavour of what might be discussed?
9
10 Q. Yes.
11 A. There was a considerable interest in ensuring our
12 carbon footprint is as low as we can possibly get it and
13 sustainable practice to reduce that carbon print. If
14 that's put - if that was put up, and I can't quite recall
15 if it was but it was certainly a hot topic, shall we say,
16 as a priority statement in the strategic plan, it really
17 isn't what we want to achieve as a priority. It can be
18 achieved, and should be achieved, as a subsection of what
19 we're doing, but not as the top-level, or at least that's
20 the sort of discussion we've had. So that would be an
21 example of one that's actually not sitting as a top
22 priority, it's not disappeared, it's not - it is still
23 being enacted and I've given one example in the statement
24 about the use of gloves. So it's still active but it's not
25 right at the very top of the strat plan.
26
27 Q. In reviewing the list of the big-ticket items as part
28 of the formulation of this next strategy plan, does the
29 board go back to the primary purposes that you have told us
30 about in paragraph 4, including to promote, protect and
31 maintain the health of the community?
32 A. Essentially, that's what guides the board. We have,
33 in the last couple of years, certainly in the last year,
34 always put the strategic plan at the very top of our board
35 papers, so you're always focused on the strategic plan.
36 The strategic plan actually achieves what that - the
37 service Act says you have to achieve.
38
39 Q. So just looking at paragraph 4 there, so paragraph 4
40 subparagraph (a) seems to neatly capture the delivery of
41 acute care to sick and injured patients who are brought in
42 to a hospital in an acute setting.
43 A. Yes.
44
45 Q. Would you agree that subparagraph (b), "Promote,
46 protect and maintain the health of the community" involves
47 a wider level of operations than the delivery of acute care

1 within the acute setting?
2 A. Yes, it's wider than just the acute care, yes.
3
4 Q. It potentially extends into the delivery of primary
5 care, would you agree?
6 A. Yes.
7
8 Q. Preventative health?
9 A. Yes. Yes, indeed.
10
11 Q. Any other particular types of care that are delivered
12 within your LHD that you think fall within that wider
13 concept of promotion, protection and maintenance of health
14 in the community?
15 A. There is a large amount of community health services
16 that are delivered by the LHD, from looking after bubs and
17 mums immediately postnatal, for kids between 1 and 5,
18 making sure their vaccinations are up, these are all
19 matters you might call primary care type action. We have
20 community health services all through the LHD delivering
21 the sorts of care that are outlined there.
22
23 The challenge that we currently have, as many LHDs
24 have, is reaching into these really vulnerable groups.
25 They are not necessarily on the internet, they are not
26 necessarily easy to communicate with or find, and so some
27 of the challenges we are now facing, and we always have
28 faced but are now facing, is how do we actually access that
29 group of people.
30
31 Q. So when you say it's a challenge, what is the real
32 source of that challenge? Is it that they are
33 intrinsically hard to find, or is it that the resources
34 available to the LHD mean that the sort of personnel levels
35 that you would need to provide that or make that discovery
36 and provide the wrap-around care to those individuals is
37 not financially --
38 A. It's a little bit of both, to be truthful. One of the
39 ways you know that you have got problems in that area is
40 they will present to the emergency department, often when
41 they are really, really unwell, delayed coming to see
42 a general practitioner or, if they don't have one, seeing
43 anyone, in fact. So the question then arises, well, how
44 can we get to those patients, that cohort of patients,
45 before they come to ED so that their general health is
46 better, so they are less likely to require a trip to ED.
47 So that's one of the biggest challenges.

1
2 Of course, one has to ensure that the resources and
3 the staff are available to look after them. We believe we
4 do have capacity in community health. We believe, as part
5 of the strategic planning that we've just talked about,
6 that some of the resources that sit just now in hospital,
7 if we're successful in getting alternate things, then those
8 resources should follow those alternate pathways to look
9 after the community. I hope that gives you a sort of broad
10 answer.
11
12 Q. In relation to the strategic plan, you tell us once
13 it's been settled upon, the board's role is one of
14 overview. I think if we go forward to paragraph 17 - I'm
15 sorry, I think "oversight" is the word you used. In doing
16 that, you tell us in that paragraph, which scrolls down to
17 the next page, that you rely very heavily on information
18 provided to the board by the chief executive and the
19 executive leadership team?
20 A. Yes.
21
22 Q. You tell us in the paragraph about some of the
23 conduits through which that information flows. Can I ask,
24 does the board engage in any of its own independent
25 investigation or fact-finding with a view to assessing or
26 providing that oversight in relation to the achievement of
27 the strategic objectives?
28 A. There are independent sources of information about
29 KPIs, independent in that one is from the Ministry of
30 Health, which is a quarterly overview of the KPIs, largely
31 from the service level agreement, and it is of benefit
32 because it gives you not just your KPIs, although they lie
33 behind our monthly meetings, but they also provide
34 comparative information about how other LHDs are faring.
35 So you can see how well you are faring against others, and
36 if you are struggling with a particular KPI, for instance,
37 falls would be a good example, there is some reassurance
38 that we're not the only ones who are struggling with this.
39 Not that that gives you any complacency, it just gives you
40 some reassurance that others are struggling.
41
42 If you are the only one that is struggling and
43 everyone else is not, then you really have a problem and
44 you have to look into it. So that's one source of
45 information which you can call independent.
46
47 The second is there is a number of clinical registries

1 that will give you information about your major hospital or
2 hospitals that are completely independent of the Ministry
3 of Health. One example would be the Australian New Zealand
4 hip fracture registry, which not only gives you the
5 information about the number of hip fractures but how
6 quickly they get to theatre, how many of those patients
7 were tested for delirium, et cetera, et cetera. So it is
8 a really rich source of information, quite independent from
9 what the ELT produces. Not that they couldn't produce it,
10 but we don't get that as a regular thing.
11
12 There are a number of other registries. There is
13 the renal dialysis registry; NSQIP, which is a North
14 American surgical quality improvement program, of which we
15 are - sorry, Gosford is a member. And there are about
16 600-odd hospitals that participate in that, mostly
17 American, but they give you data that allows you to compare
18 like with like, the same size hospital as Gosford, the same
19 sort of role it has.
20
21 Q. I might come back to the KPIs in a moment. But in
22 terms of the registries that you have told us about, it
23 sounds as though they have as their principal focus an
24 assessment of the way in which care is being delivered in
25 the acute setting.
26 A. Yes.
27
28 Q. Falls, for example, is a measure of care being
29 delivered in hospitals?
30 A. Yes, in general terms, you are correct.
31
32 Q. Does the board make any independent assessment or have
33 any ability to obtain information about the extent to which
34 some of those wider strategic objectives - that is, those
35 that are not involved in the direct delivery of acute
36 care - are being achieved?
37 A. One of the things that we've instigated at least
38 a couple of years ago is the board executive walkabouts.
39 So we - one board member and one of the executive team
40 visit either a ward or a facility in community and
41 basically it's a sort of fact-finding piece of work. We
42 ask about, always, safety and quality. If we have - for
43 instance, just as an example, if we have instituted new
44 huddles where multidisciplinary teams get together,
45 et cetera, et cetera, and it's been implemented, one of the
46 questions that I would ask is "How are the huddles? Are
47 they working? Who attends?" So you can get an

1 actual flavour as to whether or not something that is
2 supposed to have been implemented well, either happening or
3 not.
4
5 They all have safety and quality boards and each board
6 is different, because it depends on the patients they are
7 seeing. We inspect them and ask questions about them and
8 ask if there is any difficulty in achieving that safety and
9 quality.
10
11 We ask whether or not they've got enough equipment -
12 for instance, bariatric beds, that's beds for people who
13 are over about 250K. If there is not enough, then we feed
14 all that back, or the executive is there, but we feed it
15 back to the executive and notes are taken.
16
17 Then, finally, we ask are there any staff who you
18 would like to name who are above and beyond what they are
19 supposed to do, they really go the extra mile, because we
20 like to recognise them as well. So that's an independent
21 way of determining whether or not the wards and facilities
22 are acting in the way that you are anticipating from the
23 board meeting, and there are about 45 of those - 45
24 meetings per year.
25
26 Q. So those 45 meetings per year give you a sense of the
27 extent to which - or give you some sense of the quality and
28 safety --
29 A. Absolutely.
30
31 Q. -- of the services which are being delivered.
32 A. Yes, and they are - they tell us what the issues they
33 have in delivering whatever part of the service. So it is
34 an independent way. And some of these discussions are
35 brought up at the board and discussed with that broader
36 group.
37
38 Q. But do you sense that those 45 visits give you a read
39 on whether the particular service mix which is being
40 delivered through those services is adequate or appropriate
41 to promote, protect and maintain the health of the
42 community within the Central Coast?
43 A. To the extent that a one-hour visit can do that. We
44 must be a little bit cautious of overplaying it. But the
45 staff are prepared for the visit. They are astoundingly
46 honest and up-front. If something's not working very well,
47 they are very quick to tell you that that's occurring. So

1 it gives you a flavour.
2
3 Q. But, in that sense, are they saying to you things like
4 "This service is not being delivered in the best way that
5 it could be", or "There is an issue with this service that
6 needs to be adjusted in order for it to be a better
7 service", as opposed to, say, giving you insights on
8 whether or not the service is the right service to be
9 offering at all?
10 A. It gives you - it gives the executive an opportunity
11 to reflect on what's been said and if the service needs to
12 be adjusted, then one would anticipate that the ELT - the
13 chief executive and the ELT will do that. If it is
14 a really crucial piece, that becomes something that the
15 board would discuss with the ELT, and it may then become an
16 action item with a date set for it to be - whatever the
17 problem is, mitigated or resolved.
18
19 Q. Could I ask you to go forward to paragraph 18 of your
20 statement, which hopefully will be brought up for you. You
21 see there again you tell us that the bored continually
22 monitors and oversees the performance of the LHD in
23 relation to the strategic plan. You then tell us that on
24 occasions where the LHD is not performing well, that the
25 board would work with the chief executive and ELT to
26 rectify the issue. Firstly, what do you mean by the term
27 "not performing well" there?
28 A. The example I gave there is that the budget overrun
29 was very significant, $30 million.
30
31 Q. So the example you give there is a budget overrun,
32 which of course has an impact from the point of view of one
33 of the KPIs set in the service level agreement. Do you
34 have any other examples of instances in which you, as
35 a board, have concluded that the LHD was not performing
36 well?
37 A. At the same time as the $30 million, of the 14
38 hospital-acquired complications, if my memory serves me
39 right, only 7 were performing. So you have a double
40 whammy. Not only are you not performing with patient care,
41 you are not performing within the budget. So it was
42 a double whammy. It was a very serious situation that led
43 us into what's called by the ministry level 3. I had
44 a vested interest to not get to level 4, because at level 4
45 the chief executive is sacked and the board is sacked, so
46 there was a reason for the board to take this very
47 seriously.

1
2 Q. So that related to compliance with KPIs?
3 A. (Witness nods).
4
5 Q. And just to explore that, the consequence of
6 noncompliance with those KPIs, should it reach a particular
7 level, is removal of the CE and the board?
8 A. If it goes to the second - sorry, if it goes to
9 level 4 and nothing has been done to correct or mitigate
10 the problem, then that's an option for the health
11 secretary. It is an enormous option, obviously.
12
13 What happens, though, is that the ministry does put in
14 a considerable amount of effort to assist the LHD to
15 correct the problem. So in terms of $30 million, we had
16 one of the senior deputy secretaries in health come out and
17 provide a report on what needed to change in order to get
18 the $30 million disappear over three years and back to on
19 budget, and that recommendation was very useful.
20
21 There was a higher focus by the board and the HCQC on
22 those patient care KPIs. A lot of work was done at the HC,
23 the subcommittee group, to work with the ELT to try and
24 make the changes that were required to get those KPIs back
25 to the target. And that involved not only just asking
26 questions or responding to their plans, but really ensuring
27 that those plans were actually going to achieve what the
28 ELT said they would, as well as --
29
30 Q. When you refer to the plans achieving what the ELT
31 said they would, that's, do we take it, a reference to the
32 plans bringing the LHD into compliance with its KPIs as set
33 under the service level agreement?
34 A. That's correct. But the biggest driver is patient
35 care. So one of the more stubborn KPIs for quite some time
36 was falls - the rate of falls. Many attempts were made by
37 the ELT then all the way through to the wards and
38 facilities to try and mitigate falls, what's happening, and
39 one of the questions when we do the walkaround is "What are
40 you doing about falls?", et cetera, et cetera. But not
41 only do we do that, but the board also provides input,
42 additional information, to the ELT if they don't have it.
43
44 So in falls, for instance, I saw an article, and I'm
45 pretty sure it was from North Sydney, that described - it
46 was either falls or pressure injuries, I can't remember now
47 which one, from the next LHD, and gave some ways that they

1 mitigated the problem. So I photocopied that and sent it
2 off to the chief nursing and midwifery officer saying "This
3 is a really interesting article. See what they are saying.
4 Are we doing it? And perhaps we should visit
5 North Sydney". So it's also using someone like myself and
6 some of the other clinicians on the board to provide other
7 ideas for the ELT when there's been a really tough,
8 stubborn KPI that is not moving.
9
10 Q. And these are ideas which the clinicians who are
11 involved in the day-to-day care of patients within the
12 hospitals have not come up with; is that right?
13 A. If they have come up with - even if they have come up
14 with plans, one doesn't want to sit waiting for them to
15 come to fruition. If there is a publication saying "You
16 should try X or Y", and we're not doing it, then that's
17 a consideration from the ELT and a discussion with either
18 the board or the board subcommittee.
19
20 Q. While we're on the KPIs, perhaps if we could go
21 quickly to the service level agreement, which is
22 [MOH.9999.0859.0001]. You recognise that as the current
23 service agreement for the Central Coast LHD?
24 A. (Witness nods).
25
26 Q. If we could jump forward, then, to page 0021. Do you
27 see there, these are the KPIs that you have referred to in
28 the answers that you have given and, just so we're clear,
29 it's non-performance as against these KPIs which are the
30 issues that you are referring to in paragraphs 18 and 19 of
31 your statement when you talk about not performing well and
32 leading to a level 3 rating?
33 A. Yes, correct.
34
35 Q. Just in relation to them, if I could ask you to try
36 and maintain that distinction between providing relief to
37 sick injured people through the provision of care and
38 treatment that is, as I think we've already discussed,
39 something geared clearly to the delivery of acute care in
40 the hospital setting, focus your mind on that second
41 primary purpose, the promotion, protection and maintenance
42 of health in the community, in relation to that second
43 primary purpose, is it your view that the KPIs set out in
44 the document that is on the screen there and, to the extent
45 necessary, please ask that we scroll through them - is it
46 your view that those KPIs are an adequate measure of the
47 LHD's performance of that second primary purpose - that is,

1 the promotion, protection and maintenance of the health of
2 the community?
3 A. These KPIs appear to be mostly hospital-centric KPIs.
4
5 Q. So do we take from that that it would be your answer
6 that those - on your assessment, those KPIs are not really
7 an adequate measure of the extent to which the LHD is
8 promoting, protecting and maintaining the health of the
9 community to the extent it exists outside of the hospital
10 setting?
11 A. Perhaps with the exception of the mental health
12 consumer experience - that's divided into hospital-based
13 mental health consumer experience and community-based, so
14 it does give the community-based mental health consumer
15 input.
16
17 Q. In fairness, we should probably roll forward to
18 page 0024. Do you see there under the heading "People are
19 healthy and well"?
20 A. Yes.
21
22 Q. Would it be right that those KPIs maybe touch on or
23 hover around the edge of the promotion, protection and
24 maintenance of health of the community?
25 A. Yes.
26
27 Q. But would you agree that they are by no means
28 a comprehensive measure of the LHD's performance of that
29 second primary purpose?
30 A. These would be considered, I think in general terms,
31 to provide a major outlook of what is happening in
32 community health with the assistance of the LHD. So these
33 are a cohort of KPIs that are very specific to very
34 specific care conditions and, clearly, other aspects of
35 community health are not contained in these, with the
36 exception of attendance at ED, which is a reflection of
37 community care not being given and those patients coming in
38 to the emergency department.
39
40 Q. Could we perhaps go to the Caring for the Coast plan,
41 which is [MOH.9999.0866.0001]. That's the strategic plan,
42 I take it, that we've been speaking about?
43 A. Yes, sir.
44
45 Q. That is, when I say that, that's the current version,
46 not the one which is currently in the pipeline?
47 A. No, this is the one that's coming to an end this

1 financial year.
2
3 Q. If we turn over to page 0008, you see there is
4 a heading "Strategic priorities", and then there are set
5 out five particular priorities.
6 A. Yes.
7
8 Q. Would you accept that those priorities are cast at
9 a very, very high level?
10 A. Yes, they are.
11
12 Q. But the extent to which they are to be achieved as
13 part of the strategy is dealt with further on in the
14 document. So going on, dealing with the first of them,
15 "Patients, exceptional patient experience and outcomes", if
16 we turn over to page 0010, that's the extent to which the
17 document, this strategy document, sets out the objectives
18 and the means by which those objectives are to be met and
19 measured?
20 A. Yes.
21
22 Q. Again, very, very high level.
23 A. Sorry, I missed that.
24
25 Q. Again, it is cast at a very, very high level?
26 A. It's cast at high level, yes.
27
28 Q. If we look at the objectives on that page there, do
29 you see the heading "Objectives" in the yellow box, second
30 column?
31 A. Yes.
32
33 Q.
34
35 *To provide high quality care that delivers*
36 *good clinical outcomes and ensures that our*
37 *patients and consumers are treated with*
38 *compassion and respect and have a positive*
39 *experience of care.*
40
41 That, as I read it, seems to be again focused on the
42 delivery of care predominantly within the acute setting.
43 Would that be right, or do you disagree?
44 A. Well, it could be interpreted both ways, can't it? It
45 doesn't necessarily define which area they are working
46 towards. But having said that, at the time, 2018/19,
47 I think there was - I believe there was a much more - more

1 emphasis on the hospital-centric side of things, which is
2 why you are asking that question.
3
4 When I did arrive as a board member in 2019, and there
5 was pressure on ED, as there still is, I did ask about the
6 hospital in the home health care setting, you know, did we
7 have hospital in the home beds, equivalent beds, and my
8 understanding at that time, and please take this with
9 a pinch of salt, was that we had about four. Four hospital
10 in the home beds? That's really quite inadequate for
11 offloading care in the ED and providing the appropriate or
12 even better care at home.
13
14 When I was in Canberra, I was fortunate in setting up
15 the hospital in the home system in Canberra, and we at
16 least started - we started with at least 15 beds and we
17 were about 10 years behind the Alfred hospital in Melbourne
18 in setting up a HITH service. We come to 2019, I joined
19 the board, and there are four beds. Totally inadequate.
20 So I think there is, correctly, a sense that the objective
21 is probably more - probably more directed at the acute side
22 of things rather than the community side of things. But
23 I didn't participate in that formation and, you know, at
24 that time, as I said, the non-hospital community care was
25 not really adequate, even for that time.
26
27 Q. Can I ask, in your role as overseeing the compliance
28 with or the achievement by the LHD of its objectives, how
29 have you, as the board chair, interpreted the term "good
30 clinical outcomes", where it appears under the heading
31 "Objectives" there? So you see:
32
33 *To provide high quality care that delivers*
34 *good clinical outcomes ...*
35
36 A. Well, many of the KPIs that we've just discussed have
37 described the quality of care.
38
39 Q. Those KPIs as we have just discussed are very
40 hospital-centric, so that is good - in that sense, would
41 I be right in understanding that a good clinical outcome is
42 you leave the hospital better than you arrived?
43 A. Yes, I think - I think, again, it's likely that the
44 focus was more on hospital care than on non-hospital care,
45 particularly when you are talking about four hospital in
46 the home care beds.
47

1 Now, that's not at all to say that community health
2 services weren't well developed, it was just some
3 particular aspects of community health services or
4 non-hospital care weren't well developed.
5
6 Q. But in providing the monitoring and oversight, how has
7 the board approached that concept of a good clinical
8 outcome where dealing with the caring for patients arm of
9 the strategic plan?
10 A. Okay, in community, delivery of community health,
11 there are a number of KPIs that the executive leadership
12 team are responsible for, the community health services and
13 allied health. They have KPIs that are specific to the
14 service that is being delivered.
15
16 Q. Where do they arise? Where does one find them?
17 A. Some of them are associated - and I'm just getting a
18 little bit out of my depth now. Some of them are
19 associated with the funding model. Some of the community
20 health funding comes as a specific package with its own
21 KPIs, not just financial. So they would be with that ELT
22 member.
23
24 One of the things that we have focused on in the HCQC
25 in the last - while the strategic plan's been being
26 formulated, is that we need to know, I think it goes to
27 your question - we need to know far more about what's
28 happening in the community in safety and quality.
29
30 THE COMMISSIONER: The supporting documents are slightly
31 broader than acute care, aren't they - the supporting
32 documents that are referred to on that page?
33
34 MR MUSTON: They are.
35
36 THE COMMISSIONER: I don't know whether that means
37 anything or not.
38
39 MR MUSTON: We will find out.
40
41 THE COMMISSIONER: Yes.
42
43 MR MUSTON: Q. Does the board have a role in setting
44 these additional KPIs - that is, those that hover outside
45 of the service level agreement?
46 A. So in the - we're talking about patient care. A lot
47 of the work is done by the subcommittee, which is the

1 health care quality committee, and currently, we are doing
2 exactly that. So you have the board's - sorry, you have
3 the strategic plan, the high-level strategic plan. The
4 question at the HCQC and indeed the other subcommittees is
5 what is our priority to deliver that aspect of the
6 strategic plan. So we would have that - that is, the HCQC
7 will have maybe three or four specific priorities. Within
8 those priorities, the question about how you know that you
9 are actually achieving, ie, KPIs or other measures, are in
10 fact discussed, and those ones, once we've finished that
11 process, will go back to the board, either as part of the
12 deep dive that is in my statement, or as part of the
13 regular reports from HCQC to the board.
14
15 Q. Coming back to the caring for our patients portion of
16 the Caring for the Coast Strategy, you see there in the far
17 right-hand column there is a "Measures of success" heading?
18 A. Yes.
19
20 Q. Which sets out in a number of bullet points what would
21 appear to be the way in which success, or the successful
22 achievement of the objective, is to be assessed. Take
23 a chance to read through them, but is it your view that
24 those matters identified in the bullet points are really an
25 adequate measure of the extent to which the objective that
26 we've been talking about - that is, the delivery of good
27 clinical outcomes - is to be measured?
28 A. I think in very general terms they are fine at one
29 level, but they are not granular enough in order to be sure
30 that you are achieving the outcome. In terms of the PREMs
31 and PROMs, we do get that specific information, and that's
32 fine.
33
34 The elimination of unwarranted clinical variation,
35 that's a very, very large part of the clinical output. You
36 have to do a considerable amount of work to determine what
37 exactly you mean by that. I mean, in very general terms we
38 understand what we mean by that. And if I may take you
39 back to the work when I was working with ACI, they had
40 a subcommittee that, within ACI, looked at unwarranted
41 clinical variation. It struggled to come up with specific
42 targets that the LHDs could take up and, subsequently, that
43 committee doesn't exist anymore. So as a criticism of
44 anything that our strategic plan does is we are very keen,
45 ensuring that if you are going to put an objective like
46 that, that it is measurable and it is reportable, it's not
47 just a little bit of pie in the sky.

1
2 So for something like the unwarranted clinical
3 variation or something like value care that we talk about,
4 our objective is to be very specific, what condition are we
5 talking about, what's the number that's there, how do we
6 know that if - that we'll get the clinicians to work to
7 reduce the unwarranted clinical variation or poor value
8 care, rather than just having that as a very broad topic,
9 because it's very hard to achieve these things if you don't
10 know what specifically is being - so it is a criticism of
11 the previous plan that we're recognising and ensuring
12 doesn't happen in the new strategic plans.
13
14 Q. Very hard to achieve them if you don't know what they
15 really mean but equally it's very hard to ascertain whether
16 or not --
17 A. Which one, sir?
18
19 Q. Looking at them, using your example of unwarranted
20 clinical variation, as I understand your point, you say it
21 is a term so loaded with ambiguity that it makes it very
22 hard to achieve it as a target.
23 A. I think, yes, as an objective, everyone would say
24 that's a really good objective. The question then is how
25 are you achieving and what are you achieving.
26
27 Q. But, equally, it would be right, would it not, that
28 the ambiguity that is embodied in that as a concept means
29 it's almost impossible to ascertain whether or not you have
30 failed to achieve it?
31 A. Yes. May I just make one caveat, though?
32
33 Q. Yes.
34 A. In the middle of this, there were two years of COVID,
35 which blew everything apart in terms of trying to achieve
36 that strategic plan, not that it was ignored, but the focus
37 changes enormously to the COVID responses. So it's really
38 only in the last year, it's not even post COVID yet, but in
39 the last year when the worst of COVID has moved, that our
40 attention has gone to the strategic plan, not so much this
41 strategic plan, because we are better aware now of the
42 significant challenges we have at the LHD - if you just
43 take the emergency department - and that's why we've come
44 up with alternative care to the emergency department. In
45 value care, we are exploring that, but being very specific.
46 We wouldn't have that as a title, we would have something
47 that's very specific about what we're trying to reduce.

1 I will give one example?
2
3 Q. Yes, please do.
4 A. Which is knee arthroscopy for osteoarthritis of the
5 knee. There are plenty of articles that show that it
6 actually does not provide with any benefit to an
7 osteoarthritic knee. So that's one example where we would
8 work with the orthopaedic surgeons and reduce that
9 procedure, if it occurs in the LHD, and I can't tell you --
10
11 Q. That would be an instance, though, of targeting
12 something which has already been identified as low value
13 care?
14 A. Yes, absolutely.
15
16 Q. And seeking to reduce the instances of that within the
17 LHD?
18 A. Correct.
19
20 Q. What about the other side of the coin, which is where
21 you have issues which might not have been explicitly
22 identified as low value care, is there anything being done
23 as part of the assessment of your measure of success as
24 against the strategic objectives to determine the value
25 which is in fact delivered by the care provided and, if so,
26 what is it?
27 A. We would be initially almost certainly relying on
28 well-known conditions - sorry, procedures that are well
29 known to be questionable about their value care. If I may,
30 there is a publication that - you know, when this occurred
31 at the board, there was a publication sent to me by one of
32 the board members that is from the British Medical Journal,
33 2011, with a list of I think 150 conditions that would go
34 into that low value care category. So we have got plenty
35 of information to direct us, if we go down this path,
36 without having to think of other procedures.
37
38 What we would do is look at what has the biggest
39 impact on patient care - ie, numbers and effects - and
40 choose those ones initially, a spread of them, possibly,
41 that are achievable - have the clinicians with us,
42 et cetera, et cetera. So that's the broad plan but it's
43 not a specific plan as yet.
44
45 Q. Could I ask you to go back to the measures of success
46 there and do you see the final two bullet points,
47 "Elimination of avoidable delays in accessing services",

1 and "Care is accessible and available in the 'right
2 place'", et cetera. Do you see those two?
3 A. I can see those, yes.
4
5 Q. As part of the board's monitoring and oversight, to
6 what extent is the board assessing those things?
7 A. We have a good example of delays, elimination of
8 avoidable delays - maybe it is not the right words, but
9 anyway, during COVID, surgery was virtually ceased for
10 a considerable amount of time, so there was an enormous
11 backlog of surgical procedures, and the LHD, with the
12 support of the board, worked feverishly to get those
13 overdues down, and my understanding is that we were the
14 first LHD to achieve that, ie, to get back.
15
16 At the same time, our dental lists blew out as well
17 for the same reason, and particularly for children, and so
18 there has been an enormous amount of work done to get those
19 delays reduced, and they are moving in the right direction.
20 So that's a couple of examples for the first one.
21
22 Q. Those two examples, that is an elimination of
23 avoidable delays in accessing surgical services?
24 A. Yes.
25
26 Q. We were talking about elective surgery, presumably?
27 A. Yes, we are talking about elective surgery in the
28 main, but I did mention the Australian New Zealand hip
29 fracture registry just recently. In there, there was
30 a target of 48 hours between patient being seen in the ED
31 and getting to theatre. We have achieved that. So there
32 is an instance where it is not planned surgery, it's trauma
33 surgery.
34
35 As a result of that information and the information
36 coming from the ELT about the volume of trauma that
37 hospitals get, particularly Gosford - it's one of the
38 biggest trauma numbers, which is quite unusual, you
39 wouldn't expect that in Gosford - there is currently
40 a review being done by the ELT to look at how we can better
41 balance elective, ie planned, surgery and reduce the
42 delays, for instance, in any trauma, particularly hip
43 fracture trauma, and getting to theatre.
44
45 Q. So that's surgical services. You have told us about
46 dental services, which I assume is a reference to waiting
47 lists for public dental clinics.

1 A. (Witness nods).
2
3 Q. What about outpatient clinics delivered by
4 specialists, is that something that an assessment is made
5 of the extent to which unavoidable or, sorry, avoidable
6 delays in accessing --
7 A. Yes.
8
9 Q. -- those sort of services is made?
10 A. One of our areas that occasionally causes problems is
11 the readmission within 28 days, and that's particularly for
12 cohorts of respiratory problems and chronic heart failure.
13
14 One of the ways of assisting patients getting
15 appropriate treatment if they present to ED is having
16 clinics available to them, not the following, but the next
17 day, for instance, and setting those up so there is no
18 delay in getting into a clinic, so they don't bounce back
19 into ED. So that has stimulated a review of our outpatient
20 clinics by the chief executive. That review has a number
21 of recommendations to the chief executive. The board
22 hasn't discussed those yet. But it is along the lines of
23 what you are talking about. It is an example of delays
24 that are in outpatient clinic patients getting there, and
25 then you bounce back into ED, as one of the ways of
26 ensuring that they are dealt with in ED appropriately but
27 then followed up appropriately either in the outpatient
28 clinic or then, of course, with the community health
29 services.
30
31 Q. What about patients who - let me take it back a step.
32 The objective of that review was to seek to minimise
33 re-presentations within the emergency department within
34 I think you said a 28-day window?
35 A. Oh, sorry, the readmission within 28 days, yes, we're
36 monitoring that, yes.
37
38 Q. What about patients who might be out there within the
39 community who have been referred to a specialist by their
40 general practitioner, is there any assessment made of the
41 extent to which those sort of services are accessible to
42 patients within the LHD and, if so, the length of any
43 delay?
44 A. I wouldn't be able to give you a very specific answer
45 to that. What I would say is that as part of the
46 outpatient review, one of the areas that we are wanting to
47 ensure is that the access to specialist care, outpatient or

1 otherwise, is available to the PHN. So that's one of the
2 areas where the chief executive works with the PHN, he will
3 take their advice. I mean, if there is inordinate delay in
4 seeing a cardiologist, then what can we, the LHD, do to
5 mitigate that or reduce it. So that's part of the
6 discussions that would happen with the chief executive and
7 the PHN.
8
9 Q. And what about general practice - access to general
10 practice within the community of the Central Coast, is that
11 something which is assessed by the board?
12 A. The board is well aware of the problems we have in the
13 number of general practitioners in the LHD, particularly in
14 the north of the LHD.
15
16 Part of the work with the PHN and part of the work
17 we're talking about in alternative care, alternative
18 pathways to care from ED, does involve private health care.
19 So you have to - sorry, the private sector, the GP sector.
20 So you have to work, and should work, with the GPs to see
21 what parts of those pathways will assist them as well as
22 assisting the LHD. I'm not sure if I've answered your
23 question accurately.
24
25 Q. I think so. So you've mentioned an awareness on the
26 part of the board of problems with GP numbers in the
27 northern part of the LHD in particular. How are those
28 problems manifesting themselves for patients within the LHD
29 or for members of the community within the LHD?
30 A. There are two ways. One is the members of community
31 are not shy in coming forward and explaining just how
32 difficult it is to find a GP. There are plenty of ways
33 they can do that.
34
35 The second way is of course you look at the volume of
36 patients appearing in emergency departments. The volume of
37 emergency department presentations are far greater by
38 a factor of two or three, I believe, in terms of numbers,
39 in comparison to the population growth, and hospitals like
40 Wyong, which is a major hospital, are probably seeing
41 almost as many ED presentations as any other hospital in
42 New South Wales. It's quite extraordinary. And part of
43 that is a reflection of the lack of general practitioners
44 in that particular area.
45
46 Q. So insofar as the lack of general practitioners in
47 those areas are concerned, it's right, is it, that care is

1 neither accessible nor available in the right place for the
2 patients who happen to live in those areas?
3 A. A lot of them have closed their books, as it were, to
4 new patients, and where we do see new general practitioners
5 starting, it tends not to be in the north of the local
6 health district. So there is a - I can tell you there is
7 a GP clinic just opened in Terrigal. Terrigal is pretty
8 well okay for GPs, so if you are in Terrigal, that's fine,
9 but if you are in the environs of Wyong, they really would
10 benefit considerably from additional GPs.
11
12 Q. We might come back to that.
13 A. We're not sitting on that. May I say that, as you are
14 probably aware, in the southern part of New South Wales
15 they've started a joint piece of work with the Commonwealth
16 to train - jointly train the GP registrars, it's an
17 attraction and it's being rolled out I think in Tasmania.
18
19 Q. This is the single employer model?
20 A. That's correct, yes. While the ministry at this stage
21 is looking at that model closely with I think it's
22 Tasmania, we - that is the chief executive is exploring
23 other ways that we might be able to work with the general
24 practitioners, particularly the registrars, to do something
25 similar but not necessarily exactly the same way. So we're
26 not just bemoaning the fact that it is a problem, we're
27 trying to actually do something about it.
28
29 Q. Is consideration being given to standing up primary
30 health clinics delivered by the LHD in those areas where
31 there is insufficient supply of GPs?
32 A. Absolutely. Yes, one of the areas that are being
33 explored just now with surveying the community is exactly
34 that: where do we place our community hubs in the north?
35 What's the best place? It has to have public transport,
36 accessibility and all these sorts of things, and it may
37 indeed not be a hub, it may be a number of satellite areas.
38 So that question is being asked just now and getting the
39 community input.
40
41 One way where it was very successful just recently is
42 Long Jetty. Long Jetty covered a lot of the COVID patients
43 during the worst part of the pandemic. When you came out
44 of that, we asked - sorry, the LHD asked the community what
45 they wanted in Long Jetty, what sort of services do they
46 want. It is a very large survey and, as a result of that,
47 urgent care services have been put in Long Jetty, so

1 responding to the community need. So I think in answer to
2 your question, yes, we are asking the community, we are
3 trying to put the services where the community most needs
4 them.
5
6 Q. The urgent care facilities, though, are they - is it
7 contemplated that they will provide stable care with
8 continuity of the type required for good primary health
9 care?
10 A. Yes. The urgent care centres also have GPs in there
11 and the benefit for those GPs is that they've got allied
12 health, radiology, all sitting there at their fingertips,
13 as it were.
14
15 Q. So when you spoke earlier about the decisions about
16 where to locate community hubs, is it contemplated that
17 these community hubs might have GPs, salaried GPs
18 delivering primary health care to the community through
19 them?
20 A. Some of them will have. Not all of them. It depends,
21 obviously, on the services that are offered there. And it
22 is important to emphasise that it is being done with the
23 PHN. You've got to obviously work with them to ensure that
24 they are supportive of it and giving advice about that.
25 But some of them may very well have GPs in there, yes.
26
27 Q. Can we scroll down to page 0011 in that document. You
28 see there the heading "Caring for the community", which is
29 next of the high-level strategic objectives.
30 A. Yes.
31
32 Q. Again, would you accept that, at least as it appears
33 on that page, it is cast at a fairly high level?
34 A. Yes, the objectives are fairly high level.
35
36 Q. So looking at the first of those objectives "Improved
37 health and health literacy within the community", how is it
38 anticipated that the achievement of those objectives might
39 be measured?
40 A. One of the committees that existed during the
41 pre-COVID part of this strategy is the community and
42 consumer engagement committee, and one of their - one of
43 the objectives of that committee was to improve health
44 literacy through the community.
45
46 The members of that committee had been on that
47 committee for up to 10 years. In fact, their tenure was up

1 in 2020 or 2021, something like that. And so - and the
2 reason why that committee didn't really make inroads into
3 things like health literacy was it became very narrow
4 based. The consumers all had some - either they all had
5 their own chronic problem or one of the partners or family
6 had, and so it tended to bring a very narrow focus to that
7 committee and it was very hard to broaden that focus into
8 "But what does the community want?" They weren't laterally
9 becoming the voice of the community.
10
11 So when their tenure was up, we have restructured that
12 committee and, again, health literacy will be one of the
13 areas that will be focused on.
14
15 Q. So as part of the current monitoring and oversight by
16 the board of the LHD's achievement of that objective, what
17 is being measured by the board?
18 A. The committee is now called the consumer and community
19 committee - we've just dropped the word "engagement" - and
20 it is in its formative phase. I think I mentioned that in
21 the statement. So we haven't got down to that level of
22 granularity about what exactly is going to be measured. So
23 I would imagine that by the time the end of this financial
24 year comes, by July, we will have the appropriate terms of
25 reference, their priorities against the strategic plan, so
26 it's aligned and, once again, an emphasis on specific
27 measures that are real and are able to be provided.
28
29 Q. Recognising immediately that this is not a document of
30 your creation, if you look at the measures of success on
31 the far right-hand column there, would it be right to say
32 that none of those things are a terrific measure of the
33 extent to which the objective of improving the health of
34 the community within the LHD has been achieved?
35 A. To some degree some of these actually have been
36 achieved - to some degree. If you take the second one,
37 which is individuals and communities have more informed
38 choice about the care they receive, we have started a home
39 birthing service and that home birthing service was
40 instigated by a survey that went to both pregnant women and
41 those who had recently been delivered, and asked them, if
42 you had a choice for home birthing, would you wish that
43 option, and about 15 per cent, I think the figure was, said
44 yes, we would want that option. So that home birthing
45 service has now started and it has had its first 30 to 40
46 patients. So to the extent that that second dot point
47 talks about choice, that's one example that I can give you.

1
2 The second one is smoking, risky drinking and obesity
3 decreasing. You will remember in the Ministry of Health -
4 in the service level agreement, those were KPIs. We have
5 successfully reduced the amount of smoking in pregnant
6 women, more successful in the non-Aboriginal than in the
7 Aboriginal groups, but both groups have responded to that.
8 Obviously some of these objectives, like obesity is
9 decreasing, you have to be very specific about what you are
10 talking there. It is a very large --
11
12 Q. What about smoking cessation in the wider population?
13 The KPIs that I think you have referred to were targeted to
14 smoking cessation within a cohort of pregnant women.
15 A. That's correct, yes.
16
17 Q. Divided up between Indigenous and non-Indigenous?
18 A. Correct.
19
20 Q. What about smoking cessation in the wider community,
21 is that something that's assessed?
22 A. The information would be gained more from sort of
23 national or state level information about smoking. I'm
24 sure our preventive health group within the LHD would have
25 more specific information about the breadth of LHD smoking.
26 I couldn't give you an answer to what it is.
27
28 Q. But to what extent, looking at the noble objective
29 there of improved health - I mean, it is understandable.
30 A. Sorry?
31
32 Q. Looking at the objectives there on the page under the
33 heading "Objectives", the first of them is "Improved
34 health".
35 A. I would have to agree, it is a fairly broad statement.
36 No-one would necessarily disagree with it, but I'm not sure
37 how you manage --
38
39 Q. It is sound as an objective, you would agree?
40 A. Its breadth is concerning, I think.
41
42 Q. And when one then tracks across to "measures of
43 success", those items which are identified as the measures
44 of success are a pretty poor indication, aren't they, of
45 the extent to which that broad objective has been achieved?
46 A. Look, I would say to you that the lessons learned from
47 this strategic plan, albeit with two years of interruption,

1 the lessons learned are that if we're putting up strategic
2 plans and priorities, that the measures are very specific
3 and not as broad as those ones.
4
5 May I say that even with that as - those as measures
6 of success, each year you should come up with an
7 implementation plan, so you should take that very broad
8 objective and run it into very specific areas about what
9 you want to achieve that first year, second year, and
10 that's what the board will follow as well.
11
12 Q. So is that something that the board has done to date?
13 A. This is what the board is forming, its strategic plan,
14 and I just mentioned the HCQC forming its priorities to
15 achieve one of the elements of the strategic plan,
16 absolutely, and you did ask about KPIs. Yes, there will be
17 KPIs associated with it, so you will know at the end of the
18 year whether you have achieved or not achieved in a very
19 specific way.
20
21 Q. So going forward, that's the board's plan, is to take
22 what might be relatively high level strategic objectives
23 and break them down into key measures that are to be taken
24 in order to achieve those objectives in a calendar year; is
25 that right?
26 A. That's correct, and it will be done through the
27 subcommittees.
28
29 Q. And associated with that will be a set of KPIs which
30 the board will need to satisfy itself, actually measure in
31 some way achievement of those objectives?
32 A. Exactly. Quite, yes.
33
34 Q. But that currently doesn't exist - that is to say,
35 that structure is the way the board intends to proceed?
36 A. Is proceeding. I did mention the HCQC has already had
37 this discussion. We're right in the middle of the
38 priorities for HCQC based on the main objectives of the
39 strategic plan, so we're bang in the middle of doing
40 exactly that, and we hope to have all that, certainly we'll
41 be finished by the new financial year.
42
43 Q. So there is an overlap between that process and
44 clinical service planning; is that right?
45 A. Yes, the strategic plan has to reflect the clinical
46 services plan, and the clinical services plan has to
47 reflect the major challenges in the LHD. So they are all

1 connected.
2
3 Q. To what extent is the board involved in the
4 preparation of the clinical services plan?
5 A. The clinical services plan was basically undertaken by
6 the ELT in conjunction with the clinicians. So when it was
7 in an early phase of being adopted, the board had at least
8 two meetings, as far as I can recall, about the clinical
9 service plan, where the major objectives are.
10
11 Now, the clinical services plan again is worked in two
12 phases. One is the sort of high level, this is what we
13 want to achieve, so it doesn't actually say that we will -
14 we have two physicians in that specialty and we'll now make
15 it three. We have an objective, a broad objective, and
16 then how that is delivered is worked out on an annual basis
17 and the board will be involved in overseeing it, asking
18 questions how that fits in with the strategic plan, all the
19 sorts of questions that you would expect so that we're
20 confident that the CSP and the strategic plan are both
21 being enacted.
22
23 Q. So coming back to your description of what the
24 clinical services plan might involve, would it be right to
25 say that it might involve a proposal that there be an
26 endocrinology outpatients clinic, a public outpatients
27 clinic, but wouldn't descend into the detail of how many
28 endocrinologists would be on hand to staff it at any given
29 time?
30 A. It certainly doesn't name the number of
31 endocrinologists in that clinic. If there was no
32 endocrinology clinic, maybe at a high level, it would say
33 establish an endocrinology outpatient clinic, or whatever,
34 or establish an outpatient clinic that will see urgent
35 cases presented to ED rather than sort of waiting a week or
36 so. So it might define that very broad. But then you have
37 to go into very specific planning about establishing the
38 clinic, if it doesn't exist, expanding the clinic, deciding
39 how many endocrinologists you have and would that be
40 adequate, because it's going to take some pressure off the
41 ED as well as responding to the GP needs in the community.
42
43 So you can see it is sort of high level and then you
44 become more granular as the plan starts being looked at in
45 a prioritised way on an annual basis.
46
47 Q. But as considered even at that high level, it involves

1 in making decisions about what services to offer in the
2 face of what is a limited budgetary envelope; is that right
3 ?
4 A. I missed the question, sorry.
5
6 Q. Even at that high level, it involves the making of
7 relatively high level decisions about which particular
8 services to offer in the face of what is a limited
9 budgetary envelope.
10 A. Sure. But every time you consider offering a service,
11 the question is always asked about what - how we're
12 particularly providing that service currently, is there any
13 benefit in moving to a new service that (a) provides better
14 care for the patients and, (b), provides the resources to
15 allow you to do that. It's always an ongoing question.
16
17 Q. The starting point for that analysis is information
18 about the clinical needs of the community.
19 A. Absolutely, yes.
20
21 Q. What information does the board have available to it
22 on that topic?
23 A. Yes, so the clinical - the needs assessment of the LHD
24 was undertaken one or two years ago in a very detailed
25 manner and that - some of that information we see in the
26 clinical service plan as the sort of burning platform.
27 These are the problems we have, here is all the various
28 cohorts of diseases that we've got in our LHD.
29
30 Q. Who undertook that?
31 A. Sorry?
32
33 Q. Who undertook that assessment?
34 A. It was undertaken by the LHD in conjunction with the
35 ministry, as far as I can recall.
36
37 Q. And insofar as you understand it, was it an assessment
38 made of the specific needs of the population of the Central
39 Coast or was it a more general population-based estimate?
40 A. It was specifically Central Coast that we're talking
41 about, the LHD, and looking at both cohorts in terms of
42 age, disease profile, et cetera, et cetera, and location,
43 north, south, east, west of the LHD. So there was a lot of
44 information provided in that needs analysis, and that
45 information has been used as part of the strategic planning
46 process, and yes, the board did see that and it is - in the
47 early phase of writing up the strategic plan, you will find

1 in the first few pages all the graphs about what happens if
2 we don't do anything and what happens if we reduce this,
3 that and the next thing. So it actually sets up what our
4 main objective has to be for the strategic plan.
5
6 Q. What information does the board have available to it
7 with respect to the extent to which the needs of the
8 population are being met by the provision of services
9 external to the LHD - so, for example, through market-based
10 delivery of primary health care or specialist care?
11 A. I think your starting point would be that - I did
12 mention vulnerable groups. We are aware that we have
13 a requirement to improve the services in the community to
14 meet these cohorts who are appearing in the emergency
15 department who could otherwise be treated in a non-hospital
16 setting or a non-ED setting. Again, it's work you do with
17 the general practitioner. But, clearly, when you have
18 a relative paucity of general practitioners providing
19 primary care, it does put the pressure on the LHD to
20 provide those services where that paucity exists.
21
22 I wouldn't be able to say we're confident that we're
23 delivering all the services that the LHD needs currently,
24 because the needs assessment tells you precisely what you
25 need to do and part of the strategic plan is to achieve
26 that, and it is certainly the burning platform that I did
27 mention that we really need to change the way we're doing
28 things.
29
30 Q. But you mentioned earlier an understanding by the
31 board of a shortage of GPs within the northern part of the
32 LHD. So that, I gather, means the board has available to
33 it some information about the extent to which the primary
34 health care needs of the community are capable of being met
35 by GPs practising privately within the LHD. What about
36 other ways in which the primary - what about other ways in
37 which the care needs of the community, say specialist care,
38 are being dealt with other than through the LHD? Is an
39 assessment made of what is out there already meeting those
40 needs and, if so, what is it?
41 A. It is a very difficult question, actually, in many
42 parts. We don't have - at board level the information we
43 would rely on is from the LHD's preventive health group, as
44 well as the needs analysis I have just mentioned, as well
45 as information that comes from the association with the PHN
46 and the work that is done with the GP collaboratives. So
47 that's information that is able to be fed to the board,

1 usually through the chief executive's report, which is in
2 every month.
3
4 Apart from that, again, what happens in ED
5 presentations is also a reflection of what is happening in
6 the community, so in Wyong, which as I have already said is
7 an extraordinarily busy emergency department, a lot of the
8 cases - or presentations, I should say - that are seen
9 there are of the 4s and 5s, which are - some of which you
10 would probably say are primary health, 4s and 5s, and
11 really wouldn't be there if they had appropriate primary
12 health care in the community. I hope that answers your
13 question to some degree.
14
15 Q. To what extent is the board's involvement in clinical
16 service planning taking those sorts of issues into account
17 and seeking to deal with them?
18 A. It would be extraordinary if those issues were not
19 taken into account and presented to the board. The board
20 wouldn't accept that at all. The board has a very good
21 relationship with the ELT in terms of allowing a robust
22 discussion - we don't always agree with what the ELT plans
23 are - or you might not agree initially with the CSP,
24 aspects of the CSP, but the explanation that is provided by
25 the chief executive or his team will allow you to accept
26 the direction, but we'll keep a weather eye on whether or
27 not that comes to fruition.
28
29 I think it is important that even in this plan, five
30 years is a heck of a long time. You can't predict what's
31 going to happen in five years, and bang in the middle of
32 this, two years of COVID, which was entirely unpredictable.
33 So you have to split it up into what is a reasonable time
34 frame, and I think monthly - sorry, annual review of the
35 plan and prioritising the aspects of the plan that you
36 particularly wish to occur, which reflects what's happened
37 in the health sector. Health moves very quickly, as you
38 are well aware.
39
40 Q. Just picking up on your example of the shortage of GPs
41 in the northern part of the LHD, is that a new problem or
42 is it a problem which is of longstanding?
43 A. Are you talking about GPs?
44
45 Q. A GP shortage in the northern part of your LHD?
46 A. I do recall it being talked about in 2019. I don't
47 think it's a short-term issue. Certainly - so that's as

1 best I can answer that.
2
3 Q. So you would agree, would you not, that the
4 accessibility of adequate primary care to community members
5 is central to the promotion, protection and maintenance of
6 the health of the community within those areas?
7 A. Primary care is - are you asking if primary care is
8 important to the community?
9
10 Q. Yes.
11 A. Yes, absolutely, of course.
12
13 Q. Important to the community, but particularly important
14 to the promotion, protection and maintenance of the health
15 of the community?
16 A. It certainly - with the LHD, it certainly is an
17 important component of that, absolutely.
18
19 Q. So in seeking to ensure that the LHD has been
20 achieving that primary purpose, has the board raised with
21 the chief executive the need to deliver those - deliver
22 primary care in those areas where the GP market is too thin
23 to deliver that care adequately to all of the community who
24 live there?
25 A. It's a discussion that occurs very, very frequently at
26 board level.
27
28 Q. And what has been the result of those discussions?
29 A. Well, the expansion of the non-hospital care and
30 improved health care in the community. These are two parts
31 of the new strategic plan. So the whole focus there is
32 twofold. One is to protect hospital beds for those who
33 absolutely require it, protect the ED for those who require
34 it, but importantly, as I said at the very start, provide
35 community-based care, even when there is no GPs, you know,
36 some of which will, or a lot of which, might be primary
37 care. So expansion of that has - you know, the LHD and the
38 board are very supportive of that.
39
40 Q. So to the extent that this problem has existed since
41 at least 2019, is the board satisfied that the expansion of
42 primary care or urgent care has occurred to an extent which
43 is now adequately meeting the primary health care needs of
44 members of the community in those northern areas?
45 A. The best way to describe what has happened is we have
46 accelerated the non-hospital care quite enormously since
47 the new chief executive arrived. I think the number of -

1 and correct me, I may require correcting but we've got now
2 about 30 to 40, I think it's 40, HITH beds, for instance,
3 from four. The community services are being expanded, and
4 will continue to be expanded with the new strategic plan.
5 To the extent that it covers all the services that are
6 required, vis-à-vis the needs assessment, I don't think I
7 could be able to say that that's occurred, and I suspect
8 that we've still much more work to do, but I think we've
9 made enormous strides in the correct direction.
10
11 Q. In terms of the delivery of primary care through those
12 expanded services, is that delivered through salaried
13 employees of the LHD?
14 A. Some of them are done in conjunction with GPs, but
15 yes, of course, most - a lot of the officers are indeed
16 employees of the LHD.
17
18 Q. And you may not be aware, but are you aware of whether
19 any discussions or negotiations have occurred between the
20 ministry and the Commonwealth about recovering MBS payments
21 for the services, primary health care services, delivered
22 by those salaried employees?
23 A. I think that is a focus for the ministry. I'm pretty
24 sure that our chief executive and other chief executives,
25 when they have their combined meetings, raise very similar
26 questions, very similar points to the secretary, who then
27 has the ability to take it to the Commonwealth.
28
29 While we're on the cusp of Sydney, the further away
30 from the Sydney Basin, the larger the problem is in trying
31 to recruit GPs and appropriate staff, so that means half
32 the chief executives will be really pushing very hard.
33 I can't tell you what the response of the Commonwealth
34 would be, but certainly from the New South Wales state
35 viewpoint, I know directly from the secretary, when she has
36 meetings with the board chairs, mostly virtual these days,
37 she expands on what discussions are happening with the
38 Commonwealth.
39
40 Q. And insofar as she has done that, what's your
41 understanding of the status of those discussions?
42 A. The services of?
43
44 Q. Insofar as she has expanded on her negotiations with
45 the Commonwealth around those issues, to what extent - what
46 is your understanding of the point that they have reached,
47 insofar as she has told you?

1 A. I wouldn't be able to say very much about it. I know
2 that there are some moves in the aged care sector to have
3 a closer liaison with the state in delivery of aged care
4 services. I think Western Australia is one example where
5 that has occurred to a greater rather than lesser extent.
6
7 MR MUSTON: I note the time, Commissioner. I will be
8 relatively brief. We can perhaps then take the
9 adjournment, unless you would like to --
10
11 THE COMMISSIONER: What does "relatively brief" mean?
12
13 MR MUSTON: 15 minutes.
14
15 THE COMMISSIONER: All right. Keep going.
16
17 MR MUSTON: Q. Could I take you to paragraph 37 of your
18 statement, which hopefully will be brought up on your
19 screen for you. You point out some opportunities. Can
20 I just ask, in relation to the first of them - see 37(a) -
21 if you could just read that to yourself and then I will
22 just invite you to expand on what you mean by that.
23 A. One of the challenges in any large organisation - we
24 have a very large organisation - is to ensure that all the
25 staff are singing from the same hymn sheet. So we have
26 a very broad strategic plan, we've done the consultations,
27 and now we have to ensure that whatever we're prioritising
28 from that, those strategic plans are able to be taken by
29 management, middle management and frontline managers and
30 translated into what they can do to achieve that strategic
31 plan.
32
33 Q. What do you see as the board's role there? What can
34 the board add to that?
35 A. Well, the board - one of the - one of the ways that
36 the board understands what is happening at ward level or
37 facility level is the walkabouts that I mentioned already.
38
39 Secondly, if you find that some of the KPIs are not
40 being achieved, questions are then asked. Of course, the
41 ELT usually has already undertaken an understanding of why
42 that occurs, and sometimes it's because there has been
43 a less than ideal response from some managers, for
44 instance, who either mistake what is being asked of them,
45 and so there is - we will call it a re-education of them to
46 try and get them over the line to ensure that the
47 objectives in the strategic plan are there.

1
2 This is an issue in any large organisation, as you
3 might anticipate, and we certainly, at the LHD level - the
4 ELT works hard to ensure that that doesn't occur.
5
6 Q. The next point you make in 37(b) - you tell us there
7 about some work that has been done. To what extent does
8 that present as an opportunity going forward? Is it your
9 point that that work should be expanded and continued in a
10 way that would be opportune?
11 A. Yes. This path to excellence has been around for most
12 of this year, if not a little longer than that, and it's
13 been rolled out gradually, unit by unit or directorate by
14 directorate, so that it's in a managed manner, and it
15 basically gives the staff the ability to inform the staff
16 and teach the staff how to improve services and kind of
17 gives them permission to do that in line with the strategic
18 plan.
19
20 It's been very well received in the units that have
21 undertaken it, to the extent that they are then able to
22 undertake their own projects within the directorate or the
23 ward, and there are some very, very positive outcomes as
24 a result of that.
25
26 So you have an empowered staff, or more empowered than
27 they were before they did the course, and that helps
28 considerably, as you might imagine. If you have got
29 frontline staff working as a group with the managers and
30 the ELT, you are on a very strong wicket to make changes
31 that are required. And there are changes, and the best
32 ones who know what the changes are are the frontline staff
33 and frontline clinicians.
34
35 Q. Turning over to the final point you make there,
36 subparagraph (c), at the very end of that paragraph, having
37 identified changes in models of care and the potential
38 benefits and costs associated with those changing models of
39 care, you refer to a recognition by the CCLHD of the value
40 and, in order to retain it, the need to redistribute parts
41 of the budget. Can I just ask, the first question, what
42 involvement, if any, does the board have in discussions
43 around the service level agreement and the amount of money
44 which is delivered to the LHD as part of its budget?
45 A. The negotiations with the ministry for the SLA is in
46 the chief executive's responsibility.
47

1 Q. So do I take from that that the board does not see it
2 as part of its function to seek a particular budgetary
3 allocation through the SLA?
4 A. It's not responsible or involved in the budgetary
5 bottom line, no. But what it does over the year is that if
6 we are having a model of care, for instance, that is new
7 and would wish to have some seeding funding from the
8 ministry, we would be - that would be part of the
9 discussion at board level saying, you know "I hope that's
10 going to be part and parcel of the negotiations", and part
11 of the response from the chief executive back to the board
12 would be how successful that is.
13
14 So not the discussion at dollar level, but we
15 certainly would be having - the board would have its input
16 as to the sorts of areas where we believe that if the
17 ministry provides seeding or adjusts what it's doing, then
18 the board would see that as a benefit. It's a discussion
19 that would have been informed, of course, with the chief
20 executive and the ELT.
21
22 Q. I gather from the example you give us in subparagraph
23 (c) of the elderly and frail model of care, that some seed
24 funding, to use your term, was provided by the
25 ministry to --
26 A. I believe there was some seed funding, but the cost of
27 the service was higher than that, and we are in tight
28 fiscal times, as you are aware.
29
30 In order to see the benefits of that come through,
31 it's going to take longer than the time frame that we had.
32
33 So at one point the board did get a little anxious
34 about that elderly and frail model of care. Not that we
35 didn't support it, as we did, but because there were the
36 financial problems where - were evident, there was
37 discussion about whether or not this is time to drop it
38 completely, or adjust it, or amend it in some way, and so
39 it has been amended so that the costs are much reduced,
40 some more efficient project - which is fine, you have to
41 try some new things, and if it doesn't work, then you
42 change them.
43
44 Q. In relation to that particular project, was it your
45 view as the board chair that the project wasn't working or
46 that, rather, it was just not capable of being funded from
47 the budgetary envelope available?

1 A. No, it's - the advice from the chief executive was
2 that there were some parts of that project weren't working
3 as well as it was anticipated it would, and so those parts
4 have been adjusted so that that doesn't exist anymore. But
5 of course, the monetary side of things plays a part as
6 well. We've got to keep in budget.
7
8 Q. So to the extent that to keep in budget, but
9 potentially deliver new services or introduce new models of
10 care, you tell us there is a need to redistribute parts of
11 the budget. Is the word "redistribution" just a nice way
12 of saying a contraction or cutting of other services to
13 fund a new service?
14 A. I think that is maybe a bit overstating it.
15 Redistribution sometimes is a very positive thing. If you
16 are not seeing patients with major problems in ED and you
17 are managing to provide them in a non-ED setting, often
18 there is a benefit from a dollar viewpoint and certainly,
19 as I said already, all the way through, there are benefits
20 from a patient care viewpoint. So it is not always
21 contraction.
22
23 Q. Can I just explore that. Contraction - I gather what
24 you are telling us is a contraction of service might not
25 necessarily be a bad thing, if the needs are being
26 adequately met by the provision of a different service.
27 A. It is the word "contraction" that I'm struggling with.
28 If you are having less people attend ED, okay, that's
29 a contraction in numbers but it's not a contraction in the
30 service. The service is still being delivered by ED, so
31 I prefer the "redistribution of funds when they become
32 available".
33
34 Q. But there is a timing issue, isn't there, so the
35 delivery of a new model of care might, as I think you have
36 told us, have the potential to produce fiscal benefits, but
37 those fiscal benefits won't be produced immediately?
38 A. May be?
39
40 Q. They won't be produced immediately.
41 A. It depends on the - but you are right. But for
42 elderly and frail, for a new model of care, it takes some
43 funding. If you are not going to see the benefits in terms
44 of the monetary side of things, then you are under a little
45 bit of pressure to do something to make it more viable, and
46 that's what's happened.
47

1 Q. Being entirely frank, is it your view, as the chair of
2 the board, that the budgetary envelope which is provided or
3 has been provided through the current service level
4 agreement is sufficient to achieve the purposes that you
5 have - the primary purposes of the LHD that you have
6 identified in paragraph 4, that is, providing relief to
7 sick and injured people through the provision of care and
8 treatment and promoting, protecting and maintaining the
9 health of the community?
10 A. Yes, I do.
11
12 Q. You think the amount of money which is currently
13 provided to the LHD through the SLA is sufficient to
14 achieve those purposes?
15 A. I agree - I say yes to that, and just add a comment
16 that there is considerable emphasis in improving the way we
17 deliver our services that within that budgetary envelope
18 will see, I believe, some services expanded, because, you
19 know, other aspects have freed up the financial side of
20 things. So I think we're on a very positive journey in
21 terms of changing the way we deliver care, and we've talked
22 a lot about the health care in the community. There is
23 a balance always about how much you can use the budget for
24 these new models of care - and the elderly and frail was
25 a good example of that - where you can't go over budget,
26 just even if it is a good idea. So there is a balance.
27 But I think there is enough in the budget with the emphasis
28 that the ELT - the chief executive, ELT and the board has,
29 that will see us delivering better care very broadly within
30 that budget envelope.
31
32 Q. What about meeting the objectives of the strategic
33 plan? Do we gather from the answer that you have given
34 that you are satisfied that the current size of the funding
35 envelope made available through the service level agreement
36 is adequate to meet and achieve all of the objectives of
37 the strategic plan?
38 A. Yes, with a little caveat that sometimes, as the
39 elderly and frail demonstrated, that assistance from the
40 ministry is required, whether it's in seeding money or some
41 other way, and certainly the chief executive is not shy
42 about asking for that when it is appropriate. The
43 ministry, equally, wants to ensure that whatever you are
44 putting up, they see will have the benefit that you are
45 aiming at.
46
47 There is confidence in the ministry, I think now, with

1 this LHD, given the last three years of how we've changed
2 the way the financial problems have disappeared, how our
3 performance has improved immeasurably from three years ago.
4 There is confidence that if we do put something up, the
5 ministry will generally support, but the ministry obviously
6 is under the same pressures from treasury about available
7 funds.
8
9 So within the caveat that I've just given you, that we
10 wouldn't be backward about asking for seeding money if it's
11 appropriate. I think the budget is available - is
12 satisfactory.
13
14 MR MUSTON: I've got no further questions for this
15 witness, Commissioner.
16
17 THE COMMISSIONER: Q. Is the answer you have just given,
18 Professor, that you think your funding is adequate - does
19 that take into account the problems in the provision of
20 primary care in the north of your LHD?
21 A. Yes, I think these new models of care that include
22 community health care, some of that's got to be primary
23 health care type of work, so it's - I anticipate that - in
24 answer to your question, the answer is yes, I think there
25 is enough there, Commissioner, for us to provide health
26 care if it is required by the community, achieve the
27 strategic plan that we've just alluded to, but again, if
28 there is a requirement for seed funding, we will be happy
29 to ask.
30
31 THE COMMISSIONER: Sure. Thank you. Did anything - do
32 you want to ask any questions, Mr Cheney?
33
34 MR CHENEY: No, Commissioner.
35
36 THE COMMISSIONER: All right. First of all, thank you
37 very much for your time. We're very grateful and you are
38 excused, Professor.
39
40 **<THE WITNESS WITHDREW**
41
42 THE COMMISSIONER: What time would you like to - what time
43 works?
44
45 MR MUSTON: 45 minutes?
46
47 THE COMMISSIONER: Shall we make it 2.30?

1
2 MR MUSTON: 2.30 it is.
3
4 THE COMMISSIONER: All right. Let's adjourn until 2.30.
5
6 **LUNCHEON ADJOURNMENT**
7
8 THE COMMISSIONER: Yes, Dr Waterhouse.
9
10 DR WATERHOUSE: Commissioner, I call Pamela Rutledge.
11
12 **<PAMELA ANN RUTLEDGE, sworn: [2.31.pm]**
13
14 **<EXAMINATION BY DR WATERHOUSE:**
15
16 DR WATERHOUSE: Q. Can you state your full name, please?
17 A. Pamela Ann Rutledge.
18
19 Q. You are a community member on the Nepean Blue
20 Mountains Local Health District board?
21 A. I'm a member of the board. It's never been formally
22 designated as a community member. I suppose all the board
23 members are there as part of the overall governance.
24
25 Q. And you have been a member since April 2022?
26 A. Yes.
27
28 Q. Can you describe your professional background and the
29 current roles that you have apart from the board
30 membership?
31 A. Certainly. Thank you. My basic background is as
32 a social worker, but then I have worked in the health
33 system for many years, in senior executive roles and then
34 the latter part of my formal career, full -time career, was
35 as the CEO of a not for profit working in community mental
36 health called Flourish Australia, and at the moment I'm
37 also a part-time member of the Mental Health Review
38 Tribunal. I've recently been appointed as a community
39 member to the Guardianship Division of NCAT and I'm also
40 a part-time mental health commissioner, deputy mental
41 health commissioner for the Mental Health Commission, and
42 also on the board of Aspect Autism Australia.
43
44 Q. Those are roles that you hold currently?
45 A. Yes.
46
47 Q. And you have concluded the Flourish Australia one?

1 A. Yes.
2
3 Q. Why did you apply to join the board?
4 A. I've always had a strong commitment to the role of
5 health services in people's lives and to the need for
6 high-quality, safe and effective health care, and the
7 opportunity arose when the positions were advertised soon
8 after I retired.
9
10 Q. Do you have a copy of a document there titled "Outline
11 of evidence of Pamela Rutledge AM"?
12 A. I do, thank you.
13
14 Q. Have you had a chance to review that document before
15 giving evidence today?
16 A. I have, yes.
17
18 Q. To the best of your knowledge, is the content of the
19 document true and correct?
20 A. Yes.
21
22 DR WATERHOUSE: Commissioner, I will ask for the witness
23 outline to be included in the tender bundle and we might
24 bring it up on the screen. It's [MOH.9999.1061.0001].
25
26 Q. Now, if we have a look at the second half of
27 paragraph 4 of that document, you say:
28
29 *Health care needs to be closely linked with*
30 *other service sectors in its planning and*
31 *delivery. This requires decentralised*
32 *management of the health system which*
33 *I believe is the core rationale for LHDs.*
34
35 Do you see that there?
36 A. I do.
37
38 Q. I just want to separate out some of the elements of
39 those sentences. Firstly, what other service sectors do
40 you have in mind need to be integrated and linked to health
41 care?
42 A. Well, health is a huge part of our community service
43 sector, so I'm also thinking of community services in
44 general, services that are provided by the NDIS, for
45 example, disability services, the aged care sector and
46 community services that are providing information and
47 support to members of the public. So there is a vast

1 network of other services out there that health really
2 needs to rely on and work with.
3
4 Q. How do you think they should be linked for the
5 purposes of planning and delivery?
6 A. Well, partly through roles such as I have on the
7 board, so bringing people on to the board who have
8 different areas of expertise, who can comment from
9 different perspectives, and then at every level I think we
10 need to make sure that the health service providers are
11 engaging with other parts of the service system and not
12 trying to do it all themselves. So it's part of planning,
13 part of delivery. So having interagency connections around
14 every part of the health system is very important.
15
16 Q. Again you mentioned the NDIS. Can you give an example
17 of how that works with the NDIS in terms of the linkage at
18 the moment?
19 A. Yes. Well, the NDIS of course has been - is very
20 complex and has its own issues, but, for example, part of
21 what we monitor at board level in the LHD is the extent to
22 which NDIS delays and challenges are impacting the costs
23 and patient care in the LHD. So we have - in the reports
24 that we receive every month, we see the number of patients
25 that are still in hospital waiting for an NDIS package to
26 be approved or waiting for services to be provided. So
27 they are very important measures. And then we also need to
28 then make sure that we're getting back to the NDIS about
29 the need for them to understand the impact on the cost in
30 the health system that their system is having.
31
32 Q. So that's a challenge that the district experiences.
33 A. Yes.
34
35 Q. But what about in terms of the linkage of the
36 planning, et cetera?
37 A. Yes. Well, in the - let me pause for a second, rather
38 than burst out. In the operational planning, for example,
39 for any part of our LHD, we would want to understand what
40 services would be available for, for example, older people
41 leaving hospital, and it is often through people with
42 backgrounds such as mine, through the social workers in the
43 hospitals, that those services are engaged and brought into
44 the picture. But because much of what we do in the health
45 system these days is about chronic care, and often people
46 need a lot of support in their home community and
47 especially to try and enable them not to be admitted to

1 hospital, so getting those other services engaged at the
2 individual patient level and at the planning level is
3 really important. I'm not sure if I'm fully answering your
4 question.
5
6 Q. That's okay. Is it something that you feel is
7 happening well, a sort of close linkage between the
8 district and planning for NDIS services currently?
9 A. I don't think the NDIS is yet fully at the point where
10 it is - the NDIS is still very much reactive. It is market
11 driven, and so the extent to which services can engage in
12 planning about what is needed is a bit outside the remit of
13 the NDIS at the moment, I think. So I think that is an
14 ongoing challenge for us.
15
16 Q. Why do you feel that decentralised management is
17 required for there to be close links with other service
18 sectors?
19 A. Well, for my sins, I was a part of, many years ago,
20 the early planning, I was working in health planning in
21 1986 when we did the early work on the creation of area
22 health services. So the precursor, of course, was local
23 hospitals having their own boards, and that was too
24 decentralised, really. It meant that hospitals became sort
25 of individual advocates for very, very local services and
26 for very expensive services. So there was a need to bring
27 services together to create economies of scale, and I'm not
28 saying that every part of health should be decentralised,
29 of course, I'm talking about the individual patient
30 experience and the management of those interactions needs
31 to be as localised as possible to ensure that it can
32 respond to the particular needs of that community.
33
34 So, for example, in Nepean Blue Mountains, we have
35 a high proportion of Aboriginal people, 4.7 per cent of our
36 population is Aboriginal. We need to have a lot of focus
37 on liaising with our Aboriginal community and with
38 Aboriginal services. So that can really only be done by
39 the people who are delivering the services in health having
40 that sort of local liaison.
41
42 Q. Could a counter argument be made that for some service
43 linkages, it would be better to centralise it so that there
44 was consistent planning across the state between - at those
45 high levels?
46 A. Yes, of course, for high-level and specialist
47 services, there is no doubt that we do need to have the

1 pillars and have services that are specialised services
2 that are provided for a much larger population and you
3 can't deliver them effectively and at a high quality
4 without it being at that sort of level. So I suppose I'm
5 talking at the other end of the spectrum.
6
7 Q. And what do you mean by "decentralised management is
8 the core rationale for local health districts"?
9 A. Well, just harking back to my experience of working in
10 health planning and knowing how really important it was to
11 have the planning delivered close to the community so that
12 there can be consultation, so that we can nuance the
13 delivery arrangements to that local community and the
14 people who are getting the service. It is much harder to
15 do that if you are operating at a much more centralised
16 level.
17
18 Q. In your next paragraph you note that you are the chair
19 of two board subcommittees, the Aboriginal health
20 subcommittee and the joint integrated health and wellbeing
21 subcommittee. If I take the first one, the Aboriginal
22 health subcommittee, do you identify as Aboriginal
23 yourself?
24 A. No, I don't.
25
26 Q. Do you have expertise, knowledge or experience of
27 Aboriginal health?
28 A. I have worked - across my whole career, I have worked
29 with Aboriginal communities in every area of my work, but
30 I am sort of reluctantly in that role. We would greatly
31 appreciate having an Aboriginal board member.
32
33 Q. So there is no-one who identifies as Aboriginal on the
34 board?
35 A. No, not at the moment.
36
37 Q. Is there anyone on the board who identifies as having
38 expertise in Aboriginal health specifically?
39 A. No, other than - I think I would probably be the
40 most - the one who had the most experience.
41
42 Q. And in your roles, when you say you have dealt with
43 it, I mean, what particular roles have you had that have
44 had involvement at an Aboriginal health setting?
45 A. Well, I've worked - from my experience as a frontline
46 social worker and delivering services, I've worked with
47 Aboriginal people and communities; I've worked - in

1 housing, I was responsible for the establishment of our
2 Reconciliation Action Plan and working with our Aboriginal
3 staff. So I've worked in many settings with Aboriginal
4 staff and been part of growing the Aboriginal workforce and
5 understanding the background, and of course in mental
6 health, as part of being a deputy commissioner, I've been
7 very involved in the drafting of the mental health
8 strategic plans for New South Wales, and Aboriginal mental
9 health is a major focus, and an area where we know we can
10 learn so much for the rest of the population about
11 Indigenous concepts of spiritual wellbeing and physical and
12 emotional wellbeing.
13
14 Q. Going to the other committee, the joint integrated
15 health and wellbeing subcommittee, now, am I correct in
16 understanding that this is a board subcommittee for Nepean
17 Blue Mountains Local Health District?
18 A. Yes.
19
20 Q. But it is also a joint subcommittee with the PHN?
21 A. Yes.
22
23 Q. The primary health network?
24 A. Yes.
25
26 Q. And you co-chair it with a board member from the PHN;
27 is that right?
28 A. Of the PHN, that's right, yes.
29
30 Q. How does that work in terms of governance?
31 A. Well, it's supported by - well, it reports to both
32 boards. We do a regular report after each meeting that
33 goes to both boards, and we have a key staff member at
34 a senior executive level in the LHD and in the PHN who work
35 together on the workload of the committee.
36
37 Q. Who would have the ultimate say if there was
38 a disagreement in terms of a decision to be made by that
39 committee? Which board would have the ultimate sway?
40 A. I don't think we would let it get to that point. We
41 would just keep talking.
42
43 Q. But there must be times when the agenda for each is
44 different in terms of what you want to achieve?
45 A. There may be matters of emphasis, because the PHN has
46 a major role around the support of primary care and they,
47 of course, are funded by the Commonwealth and come in with

1 a strong agenda around primary care. I think it's about
2 identifying opportunities for working together and I -
3 I mean, the two years that I've been involved, I haven't
4 seen any areas of disagreement, because it is about - we're
5 working on a long-term program, really, I think it is
6 important to say, about integrated care, because we're
7 working to try and bring primary care and acute and chronic
8 health care really closer together.
9
10 Q. Given it is a subcommittee of the board that you are
11 on, why was it set up to have a dual reporting function to
12 another board as well?
13 A. That question precedes me. I would have to take that
14 on notice.
15
16 Q. Are there other subcommittees of the Nepean Blue
17 Mountains Local Health District board that also report to
18 another board?
19 A. No. No.
20
21 Q. So it is unique in that regard?
22 A. It is unique and I think it is unique across the LHDs.
23 I'm not sure, but I get that impression.
24
25 Q. What is the scope of responsibility, if I can put it
26 that way, for this subcommittee? What's the range of
27 things that it gets involved in?
28 A. It's got a fairly broad remit. I think the terms of
29 reference have been provided. I'm not sure. We are just
30 working on a new structure and new terms of reference. But
31 it's very broad and, as I say, long term, looking for
32 opportunities. So we have some immediate projects and
33 programs. For example, we have a joint regional suicide
34 prevention, mental health and suicide prevention plan, that
35 was worked up together between the two organisations, and
36 so that is jointly monitored and is about making sure that
37 services are integrated at the front end.
38
39 We are looking at a number of other program areas
40 within the LHD. For example, diabetes management has been
41 a focus, where the LHD has a number of roles, but the
42 importance of primary care and of the GPs is just
43 fundamental. So that's the sort of thing we're working on,
44 trying to look for ways to integrate those services at the
45 front end.
46
47 Q. And when you say that's what you are working on, how

1 does the committee get its work done?
2 A. Well, it's those two - the two executives, one in the
3 LHD and one in the primary health network, and they have
4 staff who will then again be working together.
5
6 Q. So it won't be a case of some projects are done by the
7 PHN, some are done by the district; they will be joint
8 projects in each case?
9 A. Mainly, yes. The ones that come to the committee
10 would be. Of course, both those people would have
11 a broader remit within their own organisation.
12
13 Q. If we can just scroll down to paragraph 7, and in 7
14 and 8 there you refer to a restructure of the governance
15 framework for the board and the subcommittees, and that
16 this is now being done to align with the state's future
17 health strategy; is that correct?
18 A. Mmm-hmm.
19
20 Q. So can I first ask you, what process was followed to
21 change the - sorry, to create this restructure, to develop
22 the new system?
23 A. The board was initially involved in getting feedback
24 on the accreditation process, and the majority of the
25 recommendations of that would have been about services and
26 processes, but there was one recommendation that was about
27 the board's processes and it was suggested that we could do
28 more to align to health futures so that there was a really
29 direct link between the KPIs in health futures and our KPIs
30 and the work of our subcommittees. So that came to the
31 board and then the --
32
33 Q. Sorry, that recommendation came to the board?
34 A. That recommendation came to the board, not highly
35 formally but as feedback from the accreditation process,
36 and then the planners, the planning team and other
37 executives did the work-up to think about how we could
38 manage our committees in a different way.
39
40 Q. And just to clarify, that's what you refer to in
41 paragraph 6, the accreditation against the national
42 standards?
43 A. Yes, yes.
44
45 Q. Was that accreditation of a particular hospital?
46 A. No, that was of the whole LHD.
47

1 Q. The whole LHD?
2 A. Yes.
3
4 Q. So when was the new structure implemented?
5 A. Well, it's just - it's in the process of being
6 implemented now, so I think the Commission may have seen
7 some documents that refer to the old structure and mine
8 that refers more to the new structure. We're just in the
9 process of finalising all the terms of reference that match
10 all the committees. But it's just - so it's very live now
11 and it did involve some discussion at the board level. For
12 example, we felt strongly, I think the recommendation was
13 that Aboriginal health, for example, be absorbed into one
14 of the other committees, but our board felt very strongly
15 that given the size of our Aboriginal population and the
16 importance of Aboriginal health in our community, that we
17 should maintain that as a separate area of focus.
18
19 Q. So what is the time frame for completing the
20 restructure implementation?
21 A. I think it's very current. It's probably next board
22 meeting, we will have the final set of terms of reference.
23
24 Q. So is this new structure intended to assist the board
25 to fulfil its statutory functions?
26 A. Well, everything we do is about fulfilling our
27 statutory functions. So the subcommittees are about making
28 sure that we have adequate coverage of all the areas of
29 governance and, yes, that - and that we have the right
30 information flow and, you know, at the moment we only have
31 seven board members, so it's also about how we make best
32 use of those people.
33
34 Q. How often does the board meet?
35 A. Monthly.
36
37 Q. And so will this new framework, in order to meet your
38 statutory functions, ensure that there are effective
39 frameworks to maintain and improve patient standards?
40 A. Well, again, one of the things that has - that is
41 being done in the terms of reference is to tighten the link
42 to the KPIs so that we have perhaps a greater clarity
43 around which committee is responsible for which KPIs, that
44 we're not reporting on the same KPI to more than one
45 committee, and that then we can perhaps simplify or
46 streamline the amount of work that the executive and the
47 staff need to do to fully inform us about progress against

1 KPIs and the other work that's going on. So it's really
2 all about patient safety. That's our - patient safety and
3 quality of care and --
4
5 Q. I might come back to the KPIs if I can.
6 A. Okay, yes.
7
8 Q. I'm sort of more interested in understanding how this
9 sort of new framework will support maintaining and
10 improving standards in terms of not just ensuring quality
11 but actually looking to the future for how standards will
12 be enhanced over time. So will the committee structure
13 that you have got now help you to do that as a board?
14 A. I think it will because it really strengthens the
15 focus of each committee and makes it clear that we're not
16 duplicating.
17
18 Q. And how does the committee structure now, and the
19 board, actually - or will it have systems, rather, when it
20 is finally implemented, that ensure that you are allocating
21 resources equitably across the community needs?
22 A. I don't think that is a particular focus of our
23 committees.
24
25 Q. Sorry, of your meetings, did you say?
26 A. Of our committees, yes, yes.
27
28 Q. What about the board, is that a particular focus for
29 the board, to ensure equitable distribution according to
30 community needs?
31 A. Absolutely, yes.
32
33 Q. And how do you do that as a board?
34 A. Well, by our focus on patient outcomes at all our
35 facilities and in all our services and ensuring that the
36 staff - we've got the right staff allocation across the
37 services. So that's - it's sort of a part - it's part of
38 the budget management and the planning process.
39
40 Q. How will the new board framework ensure that you have
41 appropriate consultation with clinicians and consumers in
42 service planning?
43 A. Well, all of our subcommittees have - or the vast
44 majority of them have consumer representatives on them who
45 come --
46
47 Q. The committees?

1 A. Yes, the committees do, yes.
2
3 Q. What about in service planning specifically?
4 A. Service planning is always very collaborative and
5 inclusive of community representatives, depending on what
6 the plan is about, but our strategic plan was developed
7 through consultation with - community consultation and with
8 consultation with the community and consumer advisory
9 groups that we have.
10
11 Q. Are there clinicians on these subcommittees of the
12 board?
13 A. Yes.
14
15 Q. On each subcommittee or just on --
16 A. Yes.
17
18 Q. -- select ones?
19 A. They are really - they are called board subcommittees,
20 but they are effectively the board meeting with the
21 relevant executives and clinicians in that area, yes.
22
23 Q. And how will the new framework for the board, from
24 a governance perspective, actually enhance the board's
25 ability to monitor the financial and operational
26 performance roles of the district?
27 A. As I said, I think it will have a tighter focus for
28 each committee on the relevant KPIs, so we have had a few
29 meetings where we've worked through which KPIs are going to
30 be reported to which committee, so that we can have again
31 that really strong focus right through to the board meeting
32 about the KPIs.
33
34 Q. Does the board direct the work of the subcommittees
35 and tell them what they need to focus on, or do the
36 subcommittees set their own agendas and just report through
37 to the board?
38 A. It's a collaborative process, because there are only
39 one or two board members on each subcommittee, so it's
40 about us getting - working with the executive and the
41 frontline staff, where appropriate, to support them, to
42 ensure that they have got the right back-up and the right
43 resources, and to complete the program that is part of the
44 operational and strategic plans.
45
46 Q. So that's the board members' influence?
47 A. Yes.

1
2 Q. Coming through to the committees; is that right?
3 A. Yes, and that would also then be reflected in the
4 board discussions.
5
6 Q. If we go to paragraph 10, you mention there that each
7 of the subcommittees meets quarterly online?
8 A. Mmm-hmm.
9
10 Q. And then there are rolling reports of the
11 subcommittees to the board?
12 A. Yes.
13
14 Q. And the director of clinical governance from your
15 district last week, when he gave evidence, mentioned that
16 after each safe care committee he prepares a report for the
17 board.
18 A. Yes.
19
20 Q. Are you familiar with those reports?
21 A. Yes.
22
23 Q. What does the board do in response to a report from
24 the safe care committee?
25 A. Well, each committee would really be reporting on what
26 we have historically called a quadrant, which is what they
27 have done in the last period, what's been achieved,
28 progress made, what risks have been identified - new risks
29 or emerging risks - what has not been achieved, and what
30 are the challenges for the next period. So we get those
31 reports and they are considered at the board meeting, and
32 if there is anything of major note there that the board
33 thinks is not being addressed, we might ask questions about
34 it and, as I said, the executive are online as well in our
35 board meetings, so we can always go straight to the
36 director and get clarification.
37
38 Q. Would it be fair to say that the subcommittee reports
39 that come to the board are mainly for noting?
40 A. They are primarily for noting, yes.
41
42 Q. Do they ever result in actions taken by the board?
43 A. Yes, they may, if there is a new or emerging risk
44 identified that has not, for example, been put on our risk
45 register or is not being given sufficient weight in our -
46 for example, in the audit and risk committee, we might
47 raise that and ask that that be taken up.

1
2 Q. Can you give an example of a specific instance where
3 that has happened, that you've taken something from either
4 the safe care committee or one of the other subcommittees
5 and it's flowed through to a board action or board
6 decision?
7 A. Well, I have referred elsewhere in my outline to the
8 professional governance committee that I also chair.
9
10 Q. We will come to that in a moment, if that's okay, but
11 that is an example.
12 A. Yes, but that is an example of where the - you know,
13 the risks around treatment of junior staff by more senior
14 staff are - they are a big issue for the health system and
15 so - yes.
16
17 Q. We will come back to that, thank you. So if I can
18 just go to paragraph 16.
19 A. Yes.
20
21 Q. Now, it says there that - you give an outline of the
22 fact that the board meetings rotate to different facilities
23 in the district?
24 A. Yes.
25
26 Q. And that this is an opportunity to connect with some
27 of the frontline staff, and you give an example there of
28 meeting with the mental health team at one of the
29 facilities and that you took that information to the board
30 meeting?
31 A. Mmm.
32
33 Q. What does the board do with information that it hears
34 from those sorts of consultations?
35 A. Well, it may be just a matter of noting it; it may be
36 an issue that we want to then build a stronger
37 communication path around to address concerns raised by
38 staff, or it may be something that is already on an action
39 log but just needs to be expedited. So it varies a lot.
40
41 Q. Can you give an example of how it might have sort of
42 guided board decision-making?
43 A. Well, I did mention earlier the - and one of the
44 things that came up at the discussion with the mental
45 health team in Lithgow was this issue, well, was an issue
46 of recent experience in our mental health services of NDIS
47 service providers - and this is highly contentious - but

1 service providers bringing - being unable to effectively
2 provide a service to a person. They might be providing
3 accommodation to a person with a very long-term mental
4 health issue and they find that they don't have the skills
5 or the resources to effectively manage that person, so
6 we've had examples of those service providers bringing
7 people in to our mental health centre, our triage service,
8 and leaving them there and, essentially, relinquishing
9 their care, which has huge implications, of course, for the
10 patient and for the service.
11
12 That was one of the issues that was raised by the
13 mental health team at Lithgow. It added to information
14 that had been provided by the mental health director at a
15 previous discussion, and so it now has added to
16 a submission that has gone from the LHD to the ministry
17 about the need to raise this with - through the NDIS
18 channels.
19
20 Q. If we go to paragraph 18, over the page, you refer
21 here to the KPIs for monitoring performance?
22 A. Yes.
23
24 Q. And you note that the board gets a dashboard. First
25 of all, are these the KPIs that are in the service
26 agreement between the district and the secretary?
27 A. Yes, largely, yes.
28
29 Q. When you say "largely", are there --
30 A. There may be other local - there are other local
31 matters that are added in that might be to do with our
32 local risk register or matters going through our audit and
33 risk process that wouldn't necessarily be part of the
34 dashboard that is constructed, as I understand it, by
35 a combination of the ministry and local resources.
36
37 Q. Are those other KPIs set by the board in order to
38 monitor the performance of the district?
39 A. Yes, and sometimes they are not KPIs, they are really
40 just monitoring progress against completion of targets or
41 project timelines, for example.
42
43 Q. Who provides the dashboard?
44 A. Well, the dashboard is - comes to us as part of our
45 chief executive's report to the board each month, and as -
46 I must admit I'm not totally clear about how much comes
47 from the ministry and how much is built locally, but it's

1 all shared data about performance against the KPIs that are
2 in the service agreement.
3
4 Q. And is the board responsible for sort of identifying
5 the trends, or are these identified by the executive and
6 presented to the board?
7 A. They are identified in the data, but the board would
8 then perhaps focus in on something that is of concern and
9 we might ask the executive, the relevant executive who is
10 online, to give us an update or clarify an issue.
11
12 Q. Now, in terms of the KPIs, the ones that are in the
13 service agreement, do you consider those effective, based
14 on your sort of long-term professional experience of KPIs
15 and so on?
16 A. Oh, they are high level, but I think they are at that
17 strategic level, and I think they need to be, because they
18 are about, you know, whole of system. The real issue for
19 us is the measures that sit underneath them, and the
20 measures are highly specific.
21
22 Q. Highly?
23 A. Highly specific, and - yes. They are very demanding,
24 very challenging measures of performance.
25
26 Q. When you say the "measures", are you talking about the
27 targets that are set?
28 A. Yes, the targets and the measures in terms of
29 monitoring, for example, our ED performance, the transfer
30 of care between ambulances and ED, those sort of measures,
31 yes.
32
33 Q. Is the number of KPIs about right, from your point of
34 view? Are there too many or too few?
35 A. I think it's about right, yes.
36
37 Q. Would you change anything, if you could, about the
38 KPIs?
39 A. Well, I'd change some things about the measures. The
40 KPIs are statements of aspiration and intent and they are
41 about what we all want our health service to do. The
42 measures are, as I say, quite challenging and they are
43 very - they are uniform across the state and so they are
44 extra demanding for an LHD like ours that has special
45 challenges.
46
47 Q. I'm going to take you now to a different document,

1 which will come up on the screen in front of you. This is
2 [MOH.9999.0796.0001]. So this is the safety and quality
3 account for reporting on 2022/2023 financial year, and then
4 the future priorities for 2023/2024, and this was published
5 in November last year. Are you familiar with this
6 document?
7 A. I remember seeing it, yes.
8
9 Q. So if we could just go to page 15 of that document to
10 start with. I don't know if we're able to make it a little
11 bigger.
12 A. Thank you.
13
14 Q. That's fine, I think. So if we look at the left side
15 of the columns there, that first column, and it talks
16 about, the third and fourth items, the overall patient
17 experience for ED patients and then the patient engagement
18 index for ED patients not admitted to hospital - do you see
19 those two lines there?
20 A. Yes, yes.
21
22 Q. And by the look of it, the status has a red cross,
23 which indicates above that the performance is outside
24 tolerance. Do you see that?
25 A. Mmm.
26
27 Q. And then underneath, there is a program, and I'm going
28 to attempt to pronounce it, Yanabuni Budyarimana, something
29 along those lines. So was this a response of the board or
30 of the Aboriginal subcommittee to those results?
31 A. I think that they probably have arisen separately.
32 I mean, we, in the Aboriginal governance committee,
33 Aboriginal health committee, do look very carefully at
34 that, at those KPIs, about Aboriginal people leaving ED
35 before they have seen anyone and about readmission and
36 re-attendance at ED, and they are issues that we would
37 spend time in Aboriginal governance committee, health
38 governance committee, talking to our Aboriginal - our
39 director of Aboriginal services about her perceptions and
40 the feedback she's getting about how well we're doing.
41
42 A lot of this goes to the question of how well all of
43 our staff understand the importance of working respectfully
44 with Aboriginal people, as with all people; how often they
45 are prepared and how well they are prepared to ask the
46 question about Aboriginality.
47

1 Q. If we just focus on this program.
2 A. Sure.
3
4 Q. It says for this program it looked at the reasons why
5 people were leaving the emergency department at their own
6 risk?
7 A. Yes.
8
9 Q. And they identified that there was a need for an
10 Aboriginal health practitioner?
11 A. Yes.
12
13 Q. So how would that program have come about? Would that
14 be through the director of Aboriginal health and her team?
15 A. Yes. Yes. But there would have been --
16
17 Q. What role?
18 A. Sorry.
19
20 Q. Sorry, no, you go on.
21 A. It would have been supported by discussion at
22 Aboriginal health subcommittee and, you know, I don't
23 remember - it may have preceded my active involvement, but
24 the usual process would be that if there was a need for
25 resources for that, we would support a case being made for
26 the resources for the Aboriginal health practitioner and
27 any other resources that were needed.
28
29 Q. So when you said earlier that the KPIs are sort of
30 divided up to avoid duplication and so on across the
31 subcommittees, which subcommittee would be responsible for
32 the patient experience and engagement index in the ED?
33 A. The health and safety - the safety and quality
34 committee would be - the patient safety committee, I'm
35 stumbling over the names, yes.
36
37 Q. Is it the one that is now called the safe care
38 committee?
39 A. Yes, the safe care committee, yes.
40
41 Q. And also called the health care quality committee; is
42 that right?
43 A. Yes.
44
45 Q. So they would be responsible for this index or these
46 KPIs?
47 A. (Witness nods).

1
2 Q. Somehow, it's been identified that there is more of an
3 issue within the Aboriginal patients of leaving hospital
4 early and not being engaged?
5 A. Mmm.
6
7 Q. And not being satisfied with their experience. Would
8 that be then referred by the safe care committee to the
9 director of Aboriginal health?
10 A. I would have to take that on notice. I think we have
11 in the reframing of the committees been looking as well at
12 how many committees the director of Aboriginal health
13 participates in and making sure that we're not
14 overburdening her. But there is agreement that while that
15 committee would have primary responsibility for acting,
16 Aboriginal health will also be informed about the
17 performance on some of these KPIs, because we are working
18 so closely with the director of Aboriginal health and her
19 team.
20
21 Q. And at what point would you be informed for something
22 like this? Would it be in the development of the program
23 to address it, or would it be at the end once it was
24 completed and you were just noting it?
25 A. In terms of the program, do you mean?
26
27 Q. This Yanabuni program?
28 A. Yes, I would - my memory is not very good about that,
29 but any new program would normally come from the director
30 of Aboriginal services to the board subcommittee through
31 her director to seek resources and to describe the intent
32 and to say what issue she is seeking to resolve, and it is
33 a big issue with patients, Aboriginal people not feeling
34 comfortable in ED and so not being able to tolerate having
35 to wait, and so this is a really important initiative.
36
37 Q. If we just go across to the other side of the page.
38 A. Yes.
39
40 Q. If we look down to health care associated infections,
41 which is the fifth item there.
42 A. Yes.
43
44 Q. And, again, its performance is outside tolerance. The
45 target is 95.8, although I'm not sure what that represents,
46 and 120.6 is the result for the district. And underneath
47 it says:

1
2 *Multi-pronged approach with initiatives*
3 *under way involving hand hygiene, vascular*
4 *access techniques and sepsis.*
5
6 So would that be something that your joint integrated
7 health and wellbeing subcommittee was involved in?
8 A. I don't think that's an issue that we have
9 particularly picked up. That's very much about in-hospital
10 service delivery and education, staff education and
11 compliance with training. So it's not something that we
12 have particularly dealt with.
13
14 Q. What about the board? Would the board --
15
16 THE COMMISSIONER: Q. When you say you couldn't work out
17 95.8 and 120.6, is that cases per 10,000?
18 A. I don't know. I wasn't able to tell. I think it's
19 going to be like that.
20
21 Q. There's some indication about hospital-acquired
22 complications being per 10,000 just at the top?
23 A. Yes. The way it is expressed, yes, rates expressed
24 per 10,000.
25
26 DR WATERHOUSE: Q. So just looking at that, so the health
27 care acquired complications are a significant issue for the
28 board to take an interest in; is that right?
29 A. Mmm, yes.
30
31 Q. So is this something that you would have discussed at
32 a board level, given the extent to which it is outside the
33 tolerance level?
34 A. I don't think we have discussed - we would discuss the
35 mitigating actions that are being taken. So particularly
36 around training, we look at how - the level of compliance
37 with training, and we would hear if the patient safety
38 committee felt there was anything really significant that
39 they needed board approval to do. Am I answering your
40 question?
41
42 Q. So what role does the board take, then, in considering
43 the health care acquired complications in particular?
44 A. Well, it's one of many where we would be asking what
45 actions are being taken to address it, and not at every -
46 not necessarily at every meeting, but we look at the KPIs,
47 and that subcommittee, the relevant subcommittee, would do

1 that in more detail and come to the board if they thought
2 there was a major issue.
3
4 Q. Can we scroll down to the next page, please, in the
5 same column at the top of the page there. So this is
6 talking about mental health peer workforce employment,
7 full-time equivalents, and it says below that again it's
8 outside the tolerance level, it says:
9
10 *Mental health are committed to supporting*
11 *the peer workforce, we have established*
12 *a professional lead for peer workers to*
13 *support them and oversee the development of*
14 *the peer workforce.*
15
16 Would this be one that your committee, your joint committee
17 with the PHN, is involved in?
18 A. Probably not, because it's about peer workers in the
19 health services, in the health system itself, rather than
20 in primary care, though there are emerging opportunities to
21 draw on peer workers. I've had experience in one of my
22 other roles about growing the peer workforce, and in fact
23 that indicator was added in as a result of the work of the
24 Mental Health Commission in our last strategic plan, saying
25 we needed to have a stronger focus on accountability for
26 growing the peer workforce.
27
28 It's a really important part of our mental health
29 initiatives. But it's not so much about the interface with
30 primary care, it's about mental health and in all our
31 mental health and suicide prevention services that we do
32 have peer workers, and the PHN would employ peer workers in
33 their suicide prevention services as well.
34
35 Q. So when you said earlier that the subcommittee that
36 you co-chair with the PHN has quite a broad remit --
37 A. Yes.
38
39 Q. -- is it actually limited only to things that involve
40 the PHN? So it's not looking at community mental health
41 care or things like that either?
42 A. Well, it's - yes, it would - it is looking at
43 community mental health and --
44
45 Q. And would there be peer workers as part of that?
46 A. There are peer workers there, yes. But that
47 accountability is one that sits fair and square on the

1 shoulders of the LHD, of the executive responsible for
2 community care and mental health, that they have to look at
3 every opportunity to grow the peer workforce.
4
5 In the primary health space, there is less a focus on
6 that, though. As I say, they would be employing peer
7 workers, but it's not an issue that requires that intense
8 joint focus, if I make myself clear.
9
10 Q. What about in relation to the suicide prevention plan
11 that you are developing with the PHN?
12 A. Yes. It would be part of that, and it certainly is
13 part of that, but it's again just a rolling responsibility
14 and accountability of the services. It hasn't surfaced as
15 a major issue requiring the focus of the committee.
16
17 Q. So where would a KPI like that sit if it's not going
18 to sit with the committee that you co-chair?
19 A. Probably in the - in one of the workforce - in the
20 workforce area as part of our recruitment and retention
21 programs.
22
23 Q. And which KPIs would you be responsible for in your
24 subcommittee, bearing in mind that it's got that dual
25 reporting?
26 A. We have - it is a very good question. So, for
27 example, as we looked at, the diabetes program, we also
28 looked at the obesity program, and so there are KPIs around
29 obesity. Any of the KPIs where there is a role, a strong
30 role, for primary care to be involved in the person's care,
31 then those are the ones that would come to that committee.
32
33 Q. Further down on the same page, in fact, there is one
34 for childhood obesity.
35 A. Yes.
36
37 Q. That refers to children with height and weight
38 recorded and it says underneath:
39
40 *Initiatives are in place to improve the*
41 *recording of height and weight across*
42 *inpatient and community settings.*
43
44 So is that one that would come under your subcommittee?
45 A. Yes, I expect so, yes.
46
47 Q. That seems to be more a measure of - not so much about

1 the level of childhood obesity, but - well, it is about
2 measuring who has actually had their weight and height
3 checked; is that correct?
4 A. Yes. I think so, yes.
5
6 Q. So it's not initiatives that are addressing childhood
7 obesity; it is an initiative that is addressing whether
8 children are weighed and their height is checked. Is that
9 right?
10 A. Yes, yes.
11
12 Q. Do you think that KPI is helpful in evaluating whether
13 an LHD has a problem with childhood obesity?
14 A. I think it is the fundamental. If we're not measuring
15 it, then we can't be doing - we can't have the information
16 and know whether it's an issue. So I think it is a core
17 part of encouraging primary care practitioners and
18 community health teams to be focusing on it.
19
20 Q. Is it enough?
21 A. I would have to take that on notice. I'm not sure
22 what other KPIs there are around addressing childhood
23 obesity. There should be some.
24
25 Q. Would they not come under your committee, whatever
26 KPIs there are for childhood obesity?
27 A. They may but, as I say, we're just reframing which
28 KPIs are going to which committees at the moment, as part
29 of that revision of the terms of reference, so I apologise,
30 I'm not a hundred per cent clear about whether that would
31 be there or not.
32
33 Q. But you would agree that purely measuring a child's
34 height and weight is not enough to say that the district is
35 actively addressing childhood obesity?
36 A. Yes, absolutely. I agree with that.
37
38 Q. We might go back to your statement, if that's okay.
39 So if we could go to paragraph 19, and you note there that
40 the board is heavily involved with the district executive
41 to address the budget, and you refer to that as being
42 a major challenge for the district where you are on the
43 board?
44 A. Mmm.
45
46 Q. What actions has the board taken in relation to this?
47 A. The board is - and the CE is currently finalising

1 a budget recovery plan to be submitted to the ministry,
2 I think shortly.
3
4 Q. Are there other actions being taken with the district
5 chief executive or the executive leadership team?
6 A. I think that's the primary focus at the moment on the
7 budget, it's about how we address deficits.
8
9 Q. That sounds like it might be a final step after a lot
10 of steps along the way; is that correct?
11 A. Yes, a lot of work happens in the organisation before
12 things are submitted to the board.
13
14 Q. And what was the board's role for this point?
15 A. The board had at our last meeting a very active robust
16 discussion about the items that are proposed for inclusion
17 in that recovery plan and asked questions about what was in
18 and what was out and - yes.
19
20 Q. If we just go down to the bottom of the page there,
21 21, you refer there to serious adverse incidents being
22 reported to the board. What does the board do with that
23 information?
24 A. Well, the board's role is always to make sure that
25 correct action is being taken or has been taken. So a lot
26 of the adverse incidents that we hear about are post hoc.
27 I mean, the chair would normally be notified of anything
28 major on the spot, but then the board is informed about
29 what action is being taken and what mitigation is proposed
30 to avoid further incidents.
31
32 Q. In the next paragraph, you refer to the People Matter
33 Employment Survey, and I would like to suggest it might be
34 the People Matter Employee Survey; does that sound correct?
35 A. It could well be correct.
36
37 Q. And you said that that identified a concerning level
38 of bullying of junior staff and that this led to the
39 establishment of the committee you mentioned before, the
40 professional governance committee?
41 A. (Witness nods).
42
43 Q. And you chair that committee; is that correct?
44 A. I do.
45
46 Q. You said that it's inspired by the Vanderbilt model
47 from the USA. Can you briefly explain firstly what the

1 Vanderbilt model is?
2 A. Well, the Vanderbilt model is an approach to early
3 intervention in matters where there is a behaviour of
4 concern by a more senior staff member, and it's been
5 evaluated and it is formally sponsored in Australia by
6 I think the Cognitive Institute, which is based in
7 Queensland, but our senior clinicians have read and been
8 very concerned about this and so have brought a proposal to
9 the board that we establish this arrangement to seek to get
10 the same results.
11
12 Q. Do you know any of the steps in the Vanderbilt model
13 that have been taken into this model you have used?
14 A. Yes. Well, it sits alongside formal policies around
15 complaints and disciplinary matters, but it is - it has -
16 once a concern is identified, then it starts with a very
17 informal, what is called a coffee chat, between an
18 appropriate more senior clinician who has a good working
19 relationship with the clinician whose behaviour has been
20 identified. So it starts with a coffee chat, which really
21 is just that and has no further implications. It's not
22 documented, it doesn't go on anyone's record; it is about
23 seeking to give the person immediate feedback, or as early
24 as possible feedback, and to help them to reflect.
25
26 Then, if the behaviour continues, then it goes through
27 the steps of a more formal complaint and can become
28 eventually a disciplinary matter through the HR system.
29
30 Q. How does your professional governance committee become
31 aware of a situation that requires intervention?
32 A. Well, we are in the process still of setting up the
33 arrangement. What we're setting up is a place on the staff
34 intranet where people can just press a button and a form
35 appears and they can submit the basic details of the issue,
36 and that will then come to the executive office of our
37 director of clinical services, and then that person will
38 then convene a meeting of our committee.
39
40 Q. The paragraph refers to intervention where a doctor's
41 behaviour to another staff member is of concern. Is the
42 committee limited to doctors' behaviour, or does it deal
43 with concerning behaviour of other staff as well?
44 A. No, this model is based around doctors. A similar
45 model could work for other disciplines, but the Vanderbilt
46 model and the work of the Cognitive Institute is initially
47 around, at this stage, doctors. I think that it's - the

1 rationale for that is that our doctors are under extreme
2 stress and pressure, as I'm sure you are hearing, and that
3 their role is so crucial as the leader of multidisciplinary
4 services across the health system, so getting in early and
5 seeking to help them to adjust their behaviour can have
6 huge ripple effects for a lot of people, and so that is
7 where we think the intervention is best placed.
8
9 Q. When you say it fits alongside the policy --
10 A. Mmm.
11
12 Q. -- can you just explain that a bit further? How does
13 it fit alongside the HR policy or whatever?
14 A. Well, it's made very clear in that the work of the
15 committee is just about that very initial first step, and
16 if the behaviour continues or the person is affected, is
17 still unhappy and they don't get any feedback from the
18 professional governance process, so if they then need to
19 make a formal complaint, that would go through the formal
20 complaint handling procedures, which is managed by - and
21 grievance procedures, which is managed by the people and
22 culture team in the LHD.
23
24 Q. You said this is being set up at the moment; is that
25 correct?
26 A. Yes, yes.
27
28 Q. Is there a plan to evaluate its effectiveness?
29 A. Yes.
30
31 Q. In paragraph 23, if we move down to that, it says that
32 the board is able to engage in planning process to the
33 extent it wishes to, and then it says that its fundamental
34 role is to provide oversight of CSP documents as a final
35 step before they go to the ministry. Now, when you say
36 that the board can be engaged to the extent it wishes to,
37 does this mean that the board has limited involvement in
38 some clinical services plans?
39 A. No, I may have misrepresented it in the way I've
40 written that. No, what I'm meaning is that as the planning
41 team goes through a community and staff consultation
42 process, board members may be part of any of those
43 processes, so that a board member who has a clinical role
44 within the hospital may be part of a clinical consultation
45 around a plan as well, and I was able, though I didn't -
46 I wasn't able to get to those meetings in the mountains,
47 the planning team ran some sessions for community members,

1 and I was able to go to those, though I wasn't able to get
2 there. But it was open to me to go or to any board member
3 to go to those as well and hear what the community was
4 saying. But, then, at the end, the process is that the
5 final document or draft documents come to the board and the
6 board has a responsibility to ensure that there are no
7 outstanding questions from our point of view.
8
9 Q. If the attendance is variable, the engagement is
10 variable, depending upon your availability and other
11 factors such as that, how does the board fulfil its
12 obligations to ensure that there is good community and
13 clinician consultation in the planning process?
14 A. Well, the planning team keeps us informed about the
15 amount of consultation they have done at different points
16 in the process. So certainly they would tell us how many
17 community meetings have been held and how many people
18 attended and how many clinical or nursing or other staff
19 meetings were held around a particular plan.
20
21 Q. Can you outline the board's actual involvement in the
22 example you give for the Blue Mountains? So you were
23 involved in that process?
24 A. Yes.
25
26 Q. What about other board members?
27 A. Well, all the board was involved in the discussion
28 around the draft, and I think I refer to the value that was
29 also gained from having the medical staff council involved,
30 because they attend the beginning of our board meetings and
31 do reports and they are able to advise the board of any
32 concerns they have got about any issue, so they are the
33 leaders of our medical services and so their input is
34 really important.
35
36 Q. In paragraph 24 you mention a joint consumer advisory
37 committee with the PHN?
38 A. Mmm-hmm.
39
40 Q. Can you just outline for me the advantage of having
41 a joint model for the purposes of the consumer advisory
42 committee, and if there are any disadvantages?
43 A. Well, that is just one part of our consumer engagement
44 program and process. That's really about bringing together
45 consumers to focus on that integration, that front of
46 service space between primary care and other services. So
47 having consumers there who are able to really focus on that

1 integration point is really valuable, and they then are
2 open to provide feedback to either - well, they provide the
3 same feedback or they might provide separate feedback to
4 the PHN and the LHD about any issue they perceive about
5 what we're doing.
6
7 Q. Are there any disadvantages of having it as a joint
8 committee?
9 A. I don't think so. I think they are very intelligent,
10 capable people. They are able to understand the dynamics
11 of the two organisations.
12
13 Q. So there is no problem with the focus of the agenda or
14 anything of that nature?
15 A. No, I don't think so.
16
17 Q. You mention in paragraph 26 that there is an
18 Aboriginal health governance committee.
19 A. That's --
20
21 Q. Is that the same as the board's --
22 A. Yes, that was the earlier name.
23
24 Q. And that has recently identified two elders to join
25 the committee?
26 A. Mmm.
27
28 Q. They are consumers, are they?
29 A. Yes, yes.
30
31 Q. So are they the only two Aboriginal people that are on
32 the committee?
33 A. No, the committee has a number of our Aboriginal
34 staff. So the director of Aboriginal health is there and -
35 we have a number of other Aboriginal staff who would
36 attend, either for every meeting or occasionally when they
37 have got something to raise or to feed back on.
38
39 Q. And just one final question in paragraph 29, your last
40 paragraph under "Waste and sustainability", you talk there
41 about the board discussing its responsibilities and
42 thinking about models of care involving care in the home
43 and avoiding hospital admission. What actions have been
44 taken by the board in relation to those discussions where
45 you are thinking about models of care?
46 A. I don't have a specific example to give you.
47 I suppose it's - it is one of the continuing themes of

1 health service planning that being able to provide care in
2 people's homes and to extend that and grow that, and to
3 have patients go home as quickly as possible, all of those
4 drivers and influences sit there in that discussion.
5
6 DR WATERHOUSE: Commissioner, I have no further questions.
7
8 THE COMMISSIONER: Mr Cheney?
9
10 MR CHENEY: No, Commissioner, thank you.
11
12 THE COMMISSIONER: Thank you very much for coming. We
13 appreciate your time. You are excused.
14
15 THE WITNESS: Thank you very much.
16
17 **<THE WITNESS WITHDREW**
18
19 MR FULLER: Thank you, Commissioner. The next witness is
20 Dr Stuart Browne. I can indicate I will need about an hour
21 with Dr Browne and unfortunately he is not available
22 tomorrow, so if I can just ask for an indulgence that you
23 sit longer today.
24
25 THE COMMISSIONER: We will try and finish, yes, that's
26 fine, thanks. What time did we start, about 2.30?
27
28 MR FULLER: Yes.
29
30 THE COMMISSIONER: I will ask if people need a break in
31 about 45 minutes, just a short one.
32
33 **<STUART MARTIN BROWNE, affirmed: [3.42pm]**
34
35 **<EXAMINATION BY MR FULLER:**
36
37 MR FULLER: Q. Can you state your full name, please?
38 A. Stuart Martin Browne.
39
40 Q. You are the clinical director of the NSW Brain Injury
41 Rehabilitation Program?
42 A. That's correct.
43
44 Q. How long have you held that role?
45 A. Less than a year.
46
47 Q. Less than a year.

1 A. I work as a rehabilitation physician, and have done
2 for more than 20 years in the Brain Injury Rehabilitation
3 Service at Royal Rehab. So that's my clinical role, and
4 I have become the clinical director of the New South Wales
5 program for the past year or so.
6
7 Q. Those are both positions in the NSW Health service or
8 appointments within --
9 A. Sorry, say that again.
10
11 Q. Those are both appointments within the NSW Health
12 service; is that right?
13 A. Yes. So my role as a rehab physician is at Royal
14 Rehab, which is an affiliated health organisation, so
15 effectively, I'm within NSW Health, yes.
16
17 Q. Was there a clinical director of the Brain Injury
18 Rehabilitation Program before you?
19 A. Yes.
20
21 Q. And who was that?
22 A. Dr Adeline Hodgkinson.
23
24 Q. Is there a particular fraction of your time that's
25 dedicated to your clinical director role?
26 A. About 50 per cent.
27
28 Q. 50, five-zero?
29 A. Yes.
30
31 Q. Do you hold any other appointments, other than the
32 clinical director and the senior staff specialist
33 appointment?
34 A. No.
35
36 Q. What does your role as clinical director of the
37 program involve?
38 A. So the New South Wales Brain Injury Rehab Program is -
39 it's a group of approximately 15 services spread somewhat
40 evenly around New South Wales, with a preponderance on the
41 metropolitan areas, and those services - their
42 responsibility is to provide rehabilitation, complex
43 rehabilitation, multidisciplinary rehabilitation, for
44 people who principally have had severe or very severe
45 traumatic brain injuries, and that particular service
46 includes inpatient units in adults and children and
47 community-based rehabilitation programs spread around

1 various regions of New South Wales. There are also
2 a couple of transitional living units which are sort of
3 a transition process from inpatient rehabilitation into the
4 community. So my role is really as the representative of
5 that particular program and I act as that clinical
6 director.
7
8 Q. You mentioned that traumatic brain injuries are
9 predominantly dealt with in the program. Can you just
10 explain what a traumatic brain injury is as opposed to
11 another kind of brain injury?
12 A. Certainly. So traumatic brain injury is injury to the
13 brain from any type of trauma. By far the most common
14 types of trauma are those injuries that are sustained from
15 motor vehicle accidents, pedestrians, assaults, falls and
16 a small proportion of people who are hit by particular
17 objects, for example. So they make up the bulk of the
18 causes of traumatic brain injury.
19
20 When the brain receives the traumatic insult, there
21 can be a wide range of pathologies that happen, there can
22 be extensive bleeding, there can be fractures of the skull,
23 there can be generalised neurological impairment throughout
24 the body. People will generally lose consciousness for
25 a period of time and, indeed, at its most severe,
26 a traumatic brain injury can lead to very prolonged periods
27 of loss of consciousness, and that contrasts with
28 a non-traumatic brain injury, and perhaps the most common
29 and well recognised is a stroke, which is due to vascular
30 obstruction leading to death or damage to part of the
31 brain.
32
33 Q. You mentioned that a wide range of pathologies may be
34 involved in or result from a traumatic brain injury. Does
35 that contrast with a non-traumatic brain injury like
36 a stroke?
37 A. Yes - yes, I would say it does, the reason being that
38 the pathophysiology of traumatic brain injury is that it is
39 effectively - the moment of impact is the start of a long
40 sequence of biological events that can happen over days and
41 weeks. There can be a lot more complications that happen
42 following trauma than we would typically see often after
43 a stroke or another type of non-traumatic injury. So it is
44 common that people require neurosurgery to remove blood
45 from the brain; it might be that the person, for example,
46 trapped in a vehicle, is being starved of oxygen due to
47 multiple rib fractures leading to poor oxygenation, so

1 there can be hypoxic or impaired oxygen supply to the brain
2 leading to additional injury on top of that trauma.
3
4 As bleeding occurs in the skull, there is an increase
5 in intracranial pressure, so there is more pressure inside
6 the skull, and that is potentially damaging the brain
7 further, so that's another insult. There are all different
8 types of electrolyte abnormalities that can occur. There
9 can be seizure complications. People are on multiple
10 medications which can have further complications. The
11 surgery itself is a dangerous procedure and can lead to
12 complications.
13
14 Q. And can we take it that those possible complications
15 lead to some complexity in the rehabilitation process for
16 traumatic brain injury?
17 A. Definitely. The reason the Brain Injury
18 Rehabilitation Program was set up about 30 years ago was
19 after some recognition that the type of impairments and
20 disabilities that people who experience traumatic brain
21 injury were demonstrating didn't necessarily fit
22 particularly well in the general rehabilitation wards that
23 existed, and indeed still exist, and that's because of
24 injury to the brain from trauma is quite widespread,
25 typically it's not confined to one area, which is often the
26 case after a stroke, and so we can get complex physical
27 impairments, there can be principally cognitive
28 impairments, difficulties with memory, with attention, with
29 judgment, insight, language - so communication impairments.
30
31 THE COMMISSIONER: Q. The seizure complications you
32 mentioned, they can be a problem well after the original
33 injury and well after the patient might have been
34 discharged from hospital?
35 A. Exactly. Yes. They can be years.
36
37 Q. And that might be - that's just one example, I'm sure.
38 A. Mmm.
39
40 MR FULLER: Q. You mentioned earlier that the Brain
41 Injury Rehabilitation Program provides services at various
42 stages in the rehabilitation process, so inpatient,
43 community, and then transitional living. Can I just go
44 through each of them one at a time and ask you to describe
45 at a high level the services that are provided through the
46 program at each of them, so starting with inpatient
47 services?

1 A. Yes, and perhaps I can give adults as an example.
2
3 Q. Yes.
4 A. There are three adult inpatient rehabilitation units
5 in Sydney and, indeed, that covers New South Wales. There
6 is the one I work at at Royal Rehab, there is a second one
7 at Liverpool and another at Westmead. They are targeting
8 what we would call working-age people, so people from sort
9 of 16 to perhaps somewhere between 65 and 70. We don't see
10 people who are outside of that range. Those patients who
11 come to us, in fact, I will switch between "patients" and
12 "clients" a lot, because it's the typical word that we
13 would use to describe our patients, our clients.
14
15 So someone would require emergency care in an acute
16 hospital, a trauma hospital, for example. It may require
17 neurosurgery, ICU admission and commonly quite a bit of
18 time in the acute hospital waiting for their acute issues
19 to start to stabilise before the person is safe enough to
20 transfer to a rehabilitation unit, and that would typically
21 happen after about a month inside the acute hospital.
22
23 The brain injury inpatient units, the three units have
24 around about - well, there are 50-odd beds throughout
25 Sydney. That's the total. And each of those three
26 services have multidisciplinary teams of doctors, nurses,
27 many allied health - physiotherapists, occupational
28 therapists, speech pathologists, neuropsychologists,
29 clinical psychologists, recreational therapists, social
30 workers, dieticians - it is quite a big multidisciplinary
31 team, and that's because the person experiencing their
32 injury has a wide range of problems. They have cognitive,
33 physical, behavioural problems are very common, and for
34 that reason, the service, the inpatient team, tends to be
35 big and bigger than a lot of the general rehabilitation
36 services have.
37
38 Following a period of inpatient rehabilitation which,
39 on average, is a few months in length, but it can be much
40 longer, it can be well over a year, the person will be safe
41 enough to discharge into the community and that may or may
42 not require extra support other than what family can
43 provide, and it's usual that the person will transfer
44 across to a community-based rehabilitation service.
45
46 I've worked in my role at Royal Rehab in the brain
47 injury community team for the last 20 years or so, so

1 that's my role, and the area that we service is a third of
2 Sydney. Each of those three adult services cover a third
3 of community.
4
5 But if someone lives outside Sydney, then they would
6 be seen by one of the other regional community
7 rehabilitation services. And in the bigger centres, so in
8 Sydney, for example, our community team is not unlike the
9 inpatient team - it's multidisciplinary, it is not as big
10 as the inpatient service but it has a wide spread of allied
11 health clinicians, including doctors and those allied
12 health professionals I mentioned before.
13
14 There are a few people, and it is quite a few people,
15 again, especially in the regions, where the person isn't
16 able to be discharged straight from perhaps an inpatient
17 service to home, because they don't have the necessary
18 supports or their recovery is necessary to continue with
19 a lot more supervision than is able to be provided, and so
20 there are a few transitional living units around New South
21 Wales and they have that transitional role. So someone
22 would be a patient, a client of the transitional living
23 unit for a period of time where they get ongoing
24 multidisciplinary therapy. So it's sort of a slower stream
25 rehabilitation with the end role of getting the person
26 home.
27
28 Q. Have we missed any aspect of the services that are
29 provided through the program? Are there outpatient
30 services, for example?
31 A. So outpatients is really a combination of community
32 rehabilitation. So the service I am involved with, we can
33 go to people, we can go to their workplaces if they've been
34 able to get back to work, we can meet them in the community
35 at their home, but also they can come to our hospital and
36 we can see them in the outpatient department.
37
38 Q. How do the services provided through the program
39 intersect with services that are funded by the NDIS, for
40 example?
41 A. So the rehabilitation service within the Brain Injury
42 Rehab Program is targeting especially the acute
43 rehabilitation, so that's within the first couple of years
44 after a traumatic brain injury. NDIS isn't really, in that
45 situation, involved in the acute rehabilitation. They are
46 not really involved in that at all. They are a care
47 support organisation and there can be a focus where people

1 can improve their capacity over time and so NDIS do have
2 that role. But the distinction between our brain injury
3 program and NDIS is that we're at the acute end and we're
4 focusing very much on improving impairments, reducing
5 disability, increasing participation.
6
7 Q. Is it the case that part of the work done by the
8 transitional living teams might include helping patients
9 get access to NDIS services at the end of their
10 rehabilitation?
11 A. Yes. Yes, I'm sure that could happen.
12
13 Q. That's not common, though?
14 A. I can't actually tell you what the number would be.
15 So a few aspects. A proportion of patients going through
16 the Brain Injury Rehabilitation Service who have had their
17 accidents through some - via - or are funded via
18 a compensation scheme, such as the lifetime care scheme
19 falling under icare, if that person remains a permanent
20 participant of icare, then they will have access to
21 rehabilitation and support for the rest of their life. Some
22 other compensation schemes, third-party compensation scheme
23 or workers comp work on a similar basis.
24
25 NDIS is not really designed for people who have
26 funding. There can be crossovers in a few examples, but
27 typically, NDIS is for people who don't have funding but,
28 nonetheless, require long-term, if not lifelong, support.
29
30 THE COMMISSIONER: Q. What level of impairment is needed
31 from a brain injury for you to qualify for the NDIS?
32 I don't have any idea.
33 A. So it's someone requires support, and it has to be
34 permanent, and there are a range of areas --
35
36 Q. What kind of support?
37 A. So it can be very obvious that someone might need
38 physical support, they might need care for their daily
39 activities. There might be problems with communication.
40
41 Q. So their motor function is so impaired that they need
42 a carer is an example?
43 A. That's right. Absolutely. The thing --
44
45 Q. And this is obviously post rehab, they have reached --
46 A. That's right.
47

1 Q. -- almost as much rehabilitation as is going to occur.
2 As a matter of obviousness, they've got permanent physical
3 impairment that requires a carer, that might be someone
4 that qualifies for the NDIS.
5 A. That's right. After someone has a period of
6 rehabilitation, there is a gradual plateauing of that
7 recovery and it would be great if that was where someone
8 was completely independent, but it often is not the case.
9
10 Q. Could that be contrasted - say someone had a very
11 serious brain injury but ultimately they may not have been
12 quite what they were but they are able to get back to the
13 job they had and adequately perform it - that's clearly
14 someone that wouldn't fall within the NDIS, or would they?
15 A. They generally wouldn't fall within the NDIS, and what
16 I have noticed is that one of the - in fact, I mentioned
17 earlier, the reason the Brain Injury Rehab Program was set
18 up initially was because of the recognition that they are
19 a different population to a lot of the patients who were
20 undergoing general rehabilitation. They are younger.
21 Cognitive impairment, behavioural impairments are much more
22 frequent. The person, being younger, there is a greater -
23 so more than two-thirds of them are male, they are often at
24 the prime of life in terms of family, work, et cetera. So
25 if someone has a profound impairment that is going to
26 impact their life, then they are going to need support for
27 many, many years.
28
29 What I have noted is that NDIS seems to recognise
30 physical impairment much more readily than cognitive
31 impairment. So --
32
33 Q. Is that because it is harder to measure?
34 A. Well, it is harder, yes, but the principles of NDIS
35 are "Does someone need support?" And if they need that
36 support, then they ultimately should be eligible for NDIS.
37 There are certainly examples I know where someone is
38 physically reasonably capable, a person can walk and talk
39 and communicate, but nonetheless, they have significant
40 cognitive impairments which prevent them from returning to
41 work. It might have behavioural issues as well, and so
42 that is a difficult group, in my experience, for NDIS to
43 clearly recognise.
44
45 Q. Is it complicated also - and please, I'm just asking
46 the question, don't think I think I'm an expert, I don't -
47 with cognitive impairment, is it right also that people

1 that have had a serious brain injury, they have a good but
2 not complete recovery, they can have good days and bad
3 days - there are days when they seem nearly at what they
4 were and other days where they are talking strangely, they
5 might, as you said before, have a seizure, that sort of
6 thing?
7 A. Mmm.
8
9 Q. Is that right?
10 A. Yes - yes and no, I guess. There are a constellation
11 of symptoms that can impact on how well someone is
12 performing on a particular day. There can be fatigue, so
13 energy problems; there can be chronic pain; there can be
14 depression and anxiety problems. So they can mean that
15 people fluctuate on a day-to-day basis.
16
17 Q. And the behaviour problems you mentioned, are they
18 inability to control emotions, or something different?
19 A. Yes, that can be one of them, definitely.
20
21 Q. What else?
22 A. So anxiety, depression, there can be - there is an
23 increased risk of psychotic illness after traumatic brain
24 injury, so I'm looking at very much the mental health area.
25 There can be post-traumatic stress disorder. So there is
26 a range of mental health concerns that people experience
27 after traumatic brain injury.
28
29 THE COMMISSIONER: Sure. Sorry, go ahead.
30
31 MR FULLER: Q. The demographic features of the patients,
32 or the typical patient that you mentioned earlier, for
33 example, being younger, predominantly male in the prime of
34 their life, is that another contrast with, for example,
35 a typical stroke patient?
36 A. Yes. So the population characteristics of people in
37 general rehabilitation units, they are older, there is
38 a greater proportion of females, there are a much greater
39 proportion of non-traumatic conditions. And perhaps this
40 is the point to mention, that there are the three adult
41 brain injury units for traumatic brain injury, but they are
42 not able to provide traumatic brain injury rehabilitation
43 for all people in New South Wales who experience traumatic
44 brain injury, because there are not enough beds.
45
46 Q. So that's because there are not enough beds; is that
47 right?

1 A. (Witness nods).
2
3 Q. Is it also that the three locations that you mentioned
4 are all effectively metropolitan Sydney - does that have an
5 impact as well?
6 A. Yes, it does have some impact. It is a long way for
7 family members in far regional New South Wales to have to
8 come to a Sydney-based Brain Injury Rehabilitation Service,
9 especially for many months, as the case may be. So yes,
10 that is an issue.
11
12 The importance, I guess, of why it happens in Sydney
13 is that there needs to be a reasonable number of patients
14 going, clients going through the units, to maintain that
15 expertise, and brain injury rehabilitation is a low volume
16 condition, thankfully, and so it would be great if there
17 was perhaps a greater spread of inpatient expertise in
18 units outside of Sydney or Newcastle, but the numbers of
19 patients that they would be receiving probably wouldn't be
20 high enough to maintain that service.
21
22 Q. About how many patients use the services provided by
23 the program generally each year?
24 A. Each year? So about 130 to 150 adults go through the
25 three adult brain injury inpatient units. Each year, there
26 are about 800 or so people being admitted to the Brain
27 Injury Rehabilitation Program. So of that 800, about 130
28 or so go through the inpatient service and then ultimately
29 into community teams. But a lot of people - in fact, the
30 majority - go straight from an acute hospital to
31 a community team, and that might be because their injury
32 isn't as severe and they've got better supports at home, or
33 it could be that the person doesn't - that there isn't
34 a bed available and so the person hasn't been able to come
35 through an inpatient rehabilitation service.
36
37 Q. You mentioned there being not enough beds,
38 effectively, in the acute inpatient units to meet the
39 patient need. Do you have a sense of how many more beds
40 would be needed?
41 A. No, I could take that on notice and actually try and
42 work it out, but there are a similar - so perhaps each year
43 there is around about 300 people coming through New South
44 Wales hospitals with serious traumatic brain injuries. So
45 the brain injury specific inpatient teams are only looking
46 after a half or so of those patients.
47

1 Now, again, there are reasons for that. Some people
2 may be a long way from Sydney and actually don't want to
3 come to Sydney because it's just - it just doesn't work for
4 the family. It may be that the person doesn't meet the
5 admission criteria, so their age might be outside of that
6 range. So you could argue potentially the number could be
7 double, but that would probably change the original goals
8 of the service, which was working age, that the greatest
9 benefit our rehab teams can have is for people to get back
10 into the community, participating, however that may be, and
11 work being a big component of that.
12
13 Q. In terms of those 670 or so patients who don't come
14 through the acute inpatient facilities, how are they
15 brought in to the Brain Injury Rehabilitation Program?
16 A. So it would be on discharge from the acute hospital
17 that there would be a referral - there would be
18 a recognition that this person can actually go home, they
19 don't need the inpatient support. So they would - we would
20 receive a referral from the acute hospital to our
21 community-based team and they would be assessed in an
22 outpatient appointment and a program organised for them,
23 a multidisciplinary rehabilitation program.
24
25 Q. Is there something about the nature of traumatic brain
26 injury compared with other kinds of injuries that you think
27 makes it appropriate to deal with at a statewide level?
28 A. So one important thing is that there are low numbers.
29 So it is - well, low volume of clients each year. It costs
30 a lot because a lot of the treatment is multidisciplinary
31 therapy, and it's often happening, or certainly the
32 population that we're targeting are young and so they have
33 many, many years ahead of them with often profound
34 disabilities, and there are similar groups that meet that
35 same idea, and spinal cord injury is one of them, and
36 severe burns is another one.
37
38 Q. The fact that the patients are often young, does that
39 mean that they may have to engage with the program's
40 services for a long period of time?
41 A. Yes.
42
43 Q. Is there any central decision-making about the nature
44 or volume of services provided through the program?
45 A. No, not within NSW Health, for example. So the
46 different brain injury rehabilitation services are really
47 managed from a funding perspective from the local health

1 district where they are located. So there isn't any
2 central decision-making capacity at all.
3
4 Q. No central decision-making capacity also in relation
5 to where the services are provided?
6 A. That's right. And, really, it's historic as to where
7 those services are located.
8
9 Q. Similarly with staffing - no central decision making
10 about staffing of the services?
11 A. No.
12
13 Q. And is there any central monitoring or oversight of
14 service provision, for example, evaluating service gaps?
15 A. No. The Brain Injury Rehab Program, of which I'm the
16 clinical director, we do have a role in bringing those
17 15 services together and we are looking at data, we are
18 hopefully trying to uncover gaps, but we don't have any
19 say, ultimately, in the service provision. That's all up
20 to the LHD.
21
22 Q. Is there consistency in the amount of funding that
23 different LHDs allocate to the program relative to their
24 needs, the needs of their population?
25 A. Yes. The inpatient services being located in Sydney
26 are seeing a greater number of people, so not surprisingly,
27 there is a greater funding amount there, but in some of the
28 regions, there are different - the services have sort of
29 changed over time and some of them have indeed moved away
30 from a multidisciplinary rehabilitation team and have
31 adopted what we would call a case management service where
32 they are trying to find externally the rehabilitation
33 supports that the person might need. So that's very much
34 in the regions where we see that.
35
36 Q. And do you see that as a problem?
37 A. There is inequities, absolutely, because different
38 regions have different make-ups of their team.
39
40 Q. And what are some of the consequences that you have
41 observed of those inequities?
42 A. So I guess the obvious thing is that people receiving
43 their community-based rehabilitation in one part of
44 New South Wales don't get the same access to therapy teams
45 as people in other parts. Now, there is obviously a big
46 divide between metropolitan and region, but there is also
47 a big - there are also variations within the regions as

1 well. So the teams are made up of different groups of
2 allied health professionals.
3
4 Q. In terms of the funding that is provided by LHDs, is
5 that typically calculated on an activity basis?
6 A. I'm not an expert in the funding models, so yes,
7 absolutely, ABF is a component. It doesn't necessarily
8 work particularly well for aspects of community-based brain
9 injury rehabilitation, and perhaps one of the most obvious
10 issues is that a lot of brain injury rehabilitation in the
11 community involves coordination, it involves planning and
12 it doesn't necessarily, for part of it, involve
13 face-to-face communication with the client, and the way
14 funding models are based, they tend to focus on
15 face-to-face therapy.
16
17 Q. Does that aspect of it, the lack - sometimes services
18 being provided remotely, mean that there may be services
19 provided from within one LHD to patients who are located in
20 a different LHD?
21 A. Not routinely, no. It can happen with some - with
22 sort of some agreements, but it's not routine, no.
23
24 Q. So often the situation you are describing where you
25 have services being provided remotely is more in rural and
26 regional areas where you might have patients living away
27 from the centres; is that right?
28 A. Yes, yes.
29
30 Q. You mentioned earlier some insurance funding being
31 available for compensable injuries - for example, lifetime
32 care being available for - that's motor accident injuries;
33 is that right?
34 A. That's right.
35
36 Q. Where does that funding go?
37 A. So it goes into the provision of the funding of allied
38 health, to the funding of equipment that people may
39 require, and to the funding of care that - so attendant
40 care workers that someone may require.
41
42 Q. Does the Brain Injury Rehabilitation Program see any
43 of that funding directly, or does it go via the LHDs?
44 A. Again, I'm not an expert there, but we don't tend to
45 see it directly.
46
47 Q. Do you understand the LHDs to have any particular

1 obligation to fund the program's services, for example, in
2 their service agreements with NSW Health?
3 A. I haven't seen their service agreements so I'm not
4 sure what their obligations are, but I would think that
5 equity is probably the starting point.
6
7 Q. What do you mean by that?
8 A. So it would be, I think, right that people in
9 different parts of New South Wales have access to a similar
10 service.
11
12 Q. And you are saying you think that would be the right
13 way to do it?
14 A. Yes.
15
16 Q. Not the way that it is in fact done now?
17 A. Well, not the way that it in some circumstances has
18 happened, yes.
19
20 Q. In some circumstances there is inequity that you have
21 mentioned in terms of the funding of brain injury
22 rehabilitation services?
23 A. Yes, yes.
24
25 Q. The program has been described as a networked service.
26 You are familiar with that description?
27 A. Yes.
28
29 Q. Do you consider that to be an accurate description of
30 the program?
31 A. It's a network in that the 15 brain injury programs
32 that we do operate together, we communicate regularly, so
33 we work in a network in that role. The three adult
34 inpatient units have a responsibility for servicing a third
35 of New South Wales each, and so there are links between the
36 regions and the inpatient rehabilitation unit that provides
37 services. So, for example, Westmead has a role in
38 providing inpatient rehabilitation for people living in a
39 third of New South Wales, so typically the middle third of
40 New South Wales. Royal Rehab covers the northern third,
41 and Liverpool covers the southern third.
42
43 So there is some connections, contact, between the
44 community teams within those individual three areas that
45 the inpatient teams are talking to. So there is some sort
46 of networking going on there.
47

1 Q. Based on your description, are we right in thinking
2 that that networking is more in the nature of information
3 sharing?
4 A. Yes.
5
6 Q. And to what extent does that networking happen with
7 the community and transitional living service providers out
8 in the regional and rural locations?
9 A. So it would be the same. So they would be in contact
10 with the acute hospitals that are servicing their area, but
11 also there is cross - the regional community teams do
12 communicate, they meet regularly to discuss the issues that
13 they are experiencing.
14
15 Q. You mentioned earlier, I think, that at the level of
16 the program - so at your level as clinical director, there
17 is some monitoring of data relating to the services
18 provided. Have I understood that correctly?
19 A. Yes. So we are looking at the number of clients who
20 come through our service, for example, length of stay.
21 There are outcomes, functional outcomes that we are
22 measuring. So that sort of demographic and somewhat basic
23 outcome numbers.
24
25 Q. Does that work rely on measurements that are done at
26 the level of the individual service provider or LHD?
27 A. Sorry, say that again.
28
29 Q. The monitoring that you are able to do at your
30 level presumably relies on measurements and work that is
31 done at the level of the individual service providers and
32 LHDs; is that right?
33 A. Yes, yes.
34
35 Q. So does that work - does your oversight depend on the
36 capacity and resources of the individual service providers
37 and LHDs to conduct that sort of monitoring measurement?
38 A. Yes, I guess so. It happens. It is one of the roles
39 that we want our teams to be doing.
40
41 Q. The program sits under the Agency for Clinical
42 Innovation; is that right?
43 A. Yes.
44
45 Q. What role does the ACI play in relation to the
46 operation of the program?
47 A. So I'm employed and a number of other people are

1 employed by ACI to act in a coordination role. We have
2 a manager, a full-time manager, we have a data manager as
3 well, and we have an education officer. So they fall under
4 ACI.
5
6 Q. Is it a fair characterisation of your evidence,
7 though, that the coordination that happens between the
8 services provided within the program is mainly at the level
9 of information sharing rather than coordinating service
10 provision or funding?
11 A. Yes.
12
13 Q. Have you observed the lack of central governance and
14 funding of the program to have any consequences for the
15 delivery of services by the program?
16 A. So I mentioned earlier about the fact that the teams
17 are - the make-up of teams are different. I think perhaps
18 one of the most important things is that in more than
19 20 years, there hasn't been an increase in the number of
20 inpatient rehabilitation beds. If anything, there's been
21 a slight reduction. So given the significant increase in
22 population, that probably puts a lot of burden on the
23 inpatient teams to be taking clients where they just are
24 unable to, because they don't have bed availability. So
25 that means that people undergo their rehabilitation in a
26 different hospital that isn't a specialty traumatic brain
27 injury service.
28
29 THE COMMISSIONER: Q. What are the potential impacts -
30 what are the impacts of that, to your knowledge?
31 A. There is evidence that people undergoing their
32 rehabilitation in specialist inpatient units have better
33 outcomes than people who are having their rehabilitation in
34 general units. It relates to experience. The more people
35 you are seeing with similar conditions, the better you
36 become at diagnosing the issues and managing those issues,
37 so I think it's as simple as that.
38
39 Q. Tell me if this is wrong. I guess you are never going
40 to get two people with exactly the same kind of traumatic
41 brain injury, but for people with relatively equivalent
42 brain injuries, is there a time factor in their
43 rehabilitation if they are in a specialist place than if
44 they are not?
45 A. So the rehabilitation happening earlier is certainly
46 seen to be more beneficial. There is, as I had said,
47 a plateauing of recovery. So it is not as though we can

1 delay excessively. So, yes, the earlier the better.
2
3 MR FULLER: Q. Do these issues that you have mentioned
4 mean that, in your view, there are brain injury patients in
5 New South Wales whose rehabilitation needs are not being
6 adequately met at the moment?
7 A. Well, they are certainly receiving their
8 rehabilitation in a facility that isn't a specialist brain
9 injury rehabilitation facility.
10
11 THE COMMISSIONER: Q. They might be getting adequate, but
12 there is adequate and then there is above adequate, might
13 be the --
14 A. Yes.
15
16 MR FULLER: Q. There is room for improvement, would you
17 say?
18 A. I'm sure within our brain injury service there is room
19 for improvement, yes.
20
21 Q. Firstly, are you aware that NSW Health designates some
22 services as supra LHD services?
23 A. Yes, I'm aware of that.
24
25 Q. And the NSW Brain Injury Rehabilitation Program is not
26 designated as a supra LHD service?
27 A. It is not.
28
29 Q. Do you know why not?
30 A. I don't know why not. That's well before my time.
31
32 Q. Is it your view that in reality, the program is
33 providing a supra LHD service?
34 A. I think we are.
35
36 Q. Do you have a view, though, as to whether designating
37 as a supra LHD service would be helpful?
38 A. Well, I do know that the spinal cord injury service,
39 for example, which is a supra LHD service, has similar
40 issues that we face in terms of they are low in number,
41 they are high in cost and the conditions are long term, so
42 I know that they have similar problems to us. So they have
43 similar issues, I think, of governance.
44
45 Q. What do you mean by "similar issues of governance"?
46 A. So I think they have the same idea of - that we've
47 been talking about, where it's the LHD that is managing the

1 particular service and making a lot of the financial
2 decisions, employment of staff, et cetera.
3
4 THE COMMISSIONER: Q. In circumstances where they are
5 also providing a statewide service?
6 A. Yes.
7
8 THE COMMISSIONER: By no means feel rushed, but I just
9 want to check, given how long we've been going, whether any
10 of the people assisting us would appreciate a 10-minute
11 break, or anyone else would appreciate a 10-minute break.
12 A five-minute break? Is that a convenient time to have
13 a five-minute break?
14
15 MR FULLER: Yes.
16
17 THE COMMISSIONER: Let's have a break until 4.35, make it
18 eight minutes. We'll come back at 4.35.
19
20 **SHORT ADJOURNMENT**
21
22 THE COMMISSIONER: Go ahead.
23
24 MR FULLER: Thank you, Commissioner.
25
26 Q. Dr Browne, if you were given the opportunity to
27 redesign the governance structure for the NSW Brain Injury
28 Rehabilitation Program, what would you do?
29 A. I would recommend that there is central oversight,
30 where there is consistency in client - clinician to client
31 ratios, where there is a similar ability to provide
32 services in the regions as well as in the metropolitan
33 areas. How that might happen would require some trials,
34 I guess, of potentially having allied health professionals
35 who are working across LHDs rather than what they are at
36 the moment, being within an LHD. I haven't actually given
37 thought to the actual way to do it, but it would be loosely
38 around those goals, I guess.
39
40 Q. Why do you think central oversight would be helpful in
41 achieving the other goals that you have mentioned?
42 A. Well, I think it would be - it seems to be an
43 important - I think perhaps an important way of ensuring
44 some degree of equity for a group who are low in number.
45 I think that's one of the important things. There aren't
46 very many people each year going through the service.
47

1 Q. In terms of funding, aside from needing more funding
2 to fund additional beds, is there anything about the
3 structure of the funding that you would do differently?
4 A. I don't think I, at this stage, have the expertise to
5 be able to answer that, I'm sorry.
6
7 Q. And you may not be able to answer this, but to the
8 extent that funding for the program is determined on an
9 activity basis, do you have a view about anything that
10 could or should be done differently there?
11 A. I - look, I choose to not answer, I think. I need to
12 think about that in more detail.
13
14 Q. I understand. In relation to technology, you
15 mentioned earlier the need for remote service provision in
16 some situations. Is there anything in particular that you
17 think the system should be looking at in terms of
18 technology that might improve overall health outcomes for
19 brain injury patients?
20 A. So a lot of brain injury rehabilitation focuses around
21 education, building capacity within the client as well as
22 families, and we've seen through COVID that a lot of that
23 can be delivered through telehealth reasonably effectively.
24 It is important, though, that there are face-to-face
25 therapies, so a combination of the two.
26
27 But given cognition is a big problem, there are many
28 impairments in areas of cognition within our clients, and
29 a lot of the way you assess that is through communication,
30 so telehealth across regions is probably the most obvious
31 starting point, I think, for having technology improve the
32 outcomes.
33
34 Q. And does that tie in with the idea you mentioned
35 earlier of possibly having health professionals able to
36 work across LHDs?
37 A. Yes.
38
39 Q. Is there anything else that we haven't mentioned that
40 you think could be done to improve access to brain injury
41 rehabilitation services in New South Wales?
42 A. I'm sorry, not off the top of my head, no.
43
44 MR FULLER: Thank you, those are my questions,
45 Commissioner
46
47 THE COMMISSIONER: Do you have any questions, Mr Cheney?

MR CHENEY: No, thank you.

THE COMMISSIONER: Thank you for coming in, Dr Browne, we appreciate your time. You are excused.

<THE WITNESS WITHDREW

THE COMMISSIONER: It is 9 o'clock tomorrow?

MR MUSTON: That's convenient, Commissioner. I'm pretty sure we can get to all we need to.

THE COMMISSIONER: All right. We'll adjourn until 9 o'clock tomorrow.

AT 4.40PM THE COMMISSION WAS ADJOURNED TO WEDNESDAY, 24 APRIL 2024 AT 9AM

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