Special Commission of Inquiry

into Healthcare Funding

Before: The Commissioner,
Mr Richard Beasley SC

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

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(Day 023)

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Also present:

Mr Richard Cheney with Mr Hilbert Chiu for NSW Health

THE COMMISSIONER: Good morning.

MR FULLER: Good morning, Commissioner. The first witness today is Professor James Middleton.

<JAMES WALTER MIDDLETON, sworn: [9.01am]

<EXAMINATION BY MR FULLER:

MR FULLER: Q. Professor, can you state your full name, please?
A. Yes, James Walter Middleton.

Q. You are a professor of rehabilitation medicine at the John Walsh Centre for Rehabilitation Research?
A. Yes, so - yes, professor of rehabilitation medicine at the University of Sydney and the John Walsh Centre for Rehabilitation Research.

Q. Am I right in understanding that the John Walsh Centre is part of the Kolling Institute, K-O-L-L-I-N-G?
A. That's right. So it's part of a joint partnership between the university and the Northern Sydney Local Health District.

Q. You are also the clinical director of the NSW State Spinal Cord Injury Service?
A. Yes. Yes, I'm director of - the clinical director of the NSW State Spinal Cord Injury Service at the Agency for Clinical Innovation. I've been the director since 2006, for my sins.

Q. What is your division of time between your professorial role and your role as clinical director?
A. I'm a half-time professor, so 0.5, and 0.3 at the Agency for Clinical Innovation, and I'm a one-day-a week - I have a clinical role as well with the NSW Spinal Outreach Service, one day a week, which is based at the Royal Rehab centre in Ryde.

Q. Can you just tell us what is the State Spinal Cord Injury Service?
A. Yes. So the State Spinal Cord Injury Service consists of inpatient and community based services. So it's a highly specialised, high-cost, small-volume. Service, spinal cord injuries are relatively rare but a very highly complex condition, so we have three main hospitals, so

Royal North Shore Hospital, which is also a level 6 trauma service, has an acute spinal cord injuries unit. The Royal Rehab centre has rehab beds, so that comprises the northern, if you like, half of the state - a little bit more, actually. And then Prince of Wales Hospital has both an acute and rehabilitation service for the southern half of the state. So geographically, about two-thirds of the spinal cord injuries in New South Wales are north, are in the northern sector, so they are geographically - they're kind of organised geographically, and somewhat historically, there were two units that grew up on each side of the harbour under strong leaders, John Grant and Professor John Yeo and Professor Richard Jones, in the past.

We also have statewide spinal outreach and rural services, so they are statewide services, so metropolitan or greater metropolitan based spinal outreach service and a rural service with a rural coordinator in each of the rural LHDs, as well as a central small team in Sydney, and they are all run out of the Royal Rehab centre.

Q. Just starting with the acute services, they are provided for the whole of New South Wales from the three facilities you have mentioned; is that right?
A. That's right.

Q. And, then, in terms of the community based services, do we take it that there are clinicians and other practitioners based throughout New South Wales who are involved in providing those services?
A. Well, there is a rural coordinator in each of the rural LHDs, but really there are no other specialist services in New South Wales, and that's one of the challenges with the way the services are structured, funded and governed at the moment.

Q. You mentioned the - and we will come back to that issue. You mentioned the state spinal outreach service. Can you just describe a bit more about what that does?
A. Okay. So the spinal outreach service was originally funded through the GMCT, GMTT, so it was established in --

Q. Sorry to interrupt you, what are those acronyms?
A. So the Greater Metropolitan Task Force and - managed. So that was established to look at enhancing services back almost 20 - well, more than 20 years ago. So that was the

first sort of injection of new funding for quite a long time, really.

So that through that mechanism, the spinal outreach service was established. So it's a multidisciplinary service, it has a manager as well as a range of all disciplines, medical - not much medical, unfortunately, but medical, nursing, allied health, including social work, psychology and - sorry, OT, occupational therapy and physiotherapy, and we look after - the service delivers sort of a community based follow-up advisory and support service for 12 months post injury.

So once people are discharged into the community, it supports the community reintegration, and obviously does link with a range of other government and non-government services to support the person's full integration into society. That actually includes a vocational service called INVOC as well, so again, specialised services that, you know, help support people return to work.

Q. And those are all services provided through the State Spinal Cord Injury Service; is that right?
A. So - well, they are all provided through the funding arrangement with Northern Sydney Health and Royal Rehab. But it has never - there hasn't been an escalation or even kept pace with that over the last 20 years. So, I mean - I guess we'll come back to that, but part of the governance, the transparency and the understanding, at an LHD level, of these services is not very good.

THE COMMISSIONER: Q. When you were talking about the multidisciplinary services, you said "not much medical, unfortunately". Would you like to expand on that?
A. Yes. So I guess originally we would have liked to have had more medical support. In fact, we have just appointed - we've now got a full-time medical quotient. So for the last 20 years we've only really had 0.4 a doctor as part of that service, and that included the rural as well as the metropolitan outreach service, so myself and one of my colleagues have been one day a week each.

So originally, it was part of the original proposal, but we didn't have enough funding at the time, the money was better spent on more allied health. But, thankfully, the Royal Rehab centre recently has added 0.6 funding to that. So we've just appointed, the first time - now have

just appointed a 0.8 younger staff specialist, which is great. So we now have two of us, a full-time component, and also someone for the future of the service. But that's all been done through the Royal Rehab centre, not through negotiations, unfortunately, with NSW Health, with Northern Sydney Health. So there hasn't been any mechanism, apart from local awareness of the growing need for greater medical support in, you know, managing the risks and delivering, you know, the best services and advice for and supporting the interdisciplinary team as well.

Q. Those services being provided through Royal Rehab, firstly, they are being provided for the whole of New South Wales from Royal Rehab?
A. Yes.

Q. That's right?
A. That's right.

Q. And in terms of the funding of those services, is that ultimately coming from Northern Sydney LHD?
A. Yes. It's part of the funding agreement and a service agreement that has not existed for - since 2012, and I know Matt Mackay came and spoke to you about the various challenges and reasons for that, but, yes, basically the mechanism for funding of that statewide service is through the Northern Sydney LHD agreement.

Q. So are we right in thinking that it is a choice being made by Royal Rehab to use some of its funding from the LHD in this way?
A. Yes.

Q. Is that right?
A. Yes.

Q. Just coming back to the service itself, before we move on to some more issues of funding and governance, is it typical that a patient engages with the State Spinal Cord Injury Service at the very beginning of their rehabilitation process?
A. Sorry, is it typical to engage?

Q. Is it typical, for example, that a patient engages with the service at the acute stage, or do you also have patients coming in later on in the rehabilitation?
A. Yes - well, the people - we deliver a lifelong

continuum of care and service, so people can come into the service at any stage. So after their acute injury, we certainly ideally manage the most complex people in the specialised services. But people - people have traumatic injuries and there is a growing number of people having non-traumatic injuries. So the traumatic injuries are fairly straightforward in the sense that they - you know, the trauma services look after them and there are problems with patient flow, which we can talk about. But in terms of non-traumatic injuries, and by that I mean injuries such as myelopathies from spinal stenosis, transverse myelitis, so viral or bacterial infections, epidural abscesses that cause pressure on the spinal cord, vascular accidents, surgical misadventure, a whole range of different etiologies, and with an ageing population, there are now more injuries from non-traumatic injuries than traumatic injuries, and there is also a growing number of older very active people who are also having traumatic injuries from falls as well as motor vehicle accidents.

So I guess - so there is a demand that, you know, currently only - well, less than half of people with spinal cord injuries that require access to the specialised services are getting access to it, either in the acute phase or rehab and, at times, not infrequently now, the first time we're finding out that someone has had a spinal cord injury, often of a non-traumatic nature, is through the outreach service in the community. So they have had their whole journey through the acute and rehabilitation. Local, general rehab service, has been without any specialist support.

Q. How does that outreach service work in practice, in terms of identifying potential patients or candidates for services?
A. Well, only by word of mouth. So obviously we get referrals - everyone is automatically referred through - anyone that flows through the specialised services, but outside of that system, it's basically through the rehab services picking people up, sometimes through general practitioners or community practitioners, community health professionals that are aware of the service. But people do fall through the cracks and sometimes we don't pick them up for a year or two.

I do rural clinics quite regularly. I've been on two this year - Coffs Harbour, and Moruya just last week or the

week before. We often pick up people, you know, some time down the line.

THE COMMISSIONER: Q. What could be done to avoid that? Some kind of central registry where all health professionals that are treating people with spinal injuries record it on a - or some other mechanism?
A. Yes. Look, certainly - so we've been - we've been doing a lot of work in the last five or six years about a networked model of care because of this - the large number of people that aren't getting access to the services that they need, either in a timely way or even at all, and so part of that network model would certainly be an early notification system to be able to triage, a way of coordinating and triaging care and coordinating care, and certainly part of the - there is no centralised - we do have a statewide spinal cord injury database, but that again only has people who are either - who the spinal services are aware of and who have either come through an acute service and/or a rehab - specialised rehab service, ie the three services, or through the spinal outreach service or the rural outreach service.

So we are constantly picking up - can pick up as many as a quarter or a third of people that are new to these services through our outreach and rural services, and that may be people that have fallen out of the system for years, but we're also - you know, last year I think we were picking up, you know, a couple of people each clinic who actually hadn't had any acute or specialised rehabilitation. And so the first time - they might have had surgery and gone directly back to their local health district, for instance, Dubbo - surgery in Sydney, directly back to Dubbo - without any involvement of our state services, and then we pick them up through the rural outreach service and the local rehab physicians, who are really great at trying to support the service as well as look for help when they need it, if they are aware of the person, pick these people up.

So there are a lot of people, yes, falling through the crack. We certainly do need a centralised process and a mechanism that provides awareness in a timely fashion of people with a spinal cord injury, and we do have a project that is just beginning with the Ministry of Health, looking at whether we can use the patient flow portal as a mechanism for identifying people with spinal cord

injuries across services.

So part of the challenge is actually looking at how you find data across LHDs. There is a lot of - most of the data, you know, the patient flow, is all managed well and tightly within LHDs but not across LHD boundaries, and often not in any sort of coordinated fashion.

MR FULLER: Q. You mentioned a patient flow portal. What is that?
A. So it is essentially a dashboard, so it is a portal in each of the local - well, in each hospital. So it is essentially a dashboard of all the beds in every hospital and it records who is in the bed, what their demographics are, what their clinical characteristics are, what their diagnoses are, some of the codes - the IPC codes, for instance, surgical codes and so forth. So it is a way of identifying people in particular beds, you know, their lengths of stay. There is a component of that called "Waiting for What", so it also records reasons for people's discharge delays, for instance, the delays with accessing the NDIS or equipment or care or, you know, if people are going to a nursing home, getting access to that.

So each hospital has - does that, and it is a pretty robust now, system, and then each LHD often looks at patients - patient flows and how to manage those flows across their local health district and then, also, these patients can flow between local health districts for the statewide services, but again, there isn't any overarching governance or overarching coordination of any of that. There isn't a sort of way of prioritising who gets where, so in terms of right care, right place, right time, there isn't currently any systematic way of doing that.

A lot of people are getting to the right place, but we know that many people aren't, and certainly the people that don't get to the statewide service, you know, hospitals, the acute hospitals, Prince of Wales and particularly Royal North Shore Hospital, for the more complex multi-trauma patients, if there are delays in transfer, then they have delays in - often delays in surgery and decompression, and we know that time to spine or time to surgical decompression is a very important component of care to improve their neurological outcomes, to reduce their complications and so forth.

Q. The patient flow portal that you have mentioned, does that aggregate data across LHDs?
A. It can. It generally doesn't. So ICU, for instance, does have an ICU dashboard that looks across all of the services in the state as a precious resource, as it should, not for spinal cord injury. So I guess that's - you know, there are opportunities to do that. It hasn't been easy to do that in the past, and again, because it's also decentralised rather than centralised. But certainly it can be done and that's something we're looking at at the moment.

Q. You said it hasn't been easy to do it in the past. Is that because, in your view, of the decentralised nature of the service provision and governance of the State Spinal Cord Injury Service?
A. Yes. Well, I think it comes back to a lack of centralised governance. So without - so the LHDs are all delivering the services. There is again a very high-level one line in a service agreement to deliver spinal service - statewide spinal services. Essentially, how that's operationalised, what that means, how the services are coordinated is not done centrally, it's done, you know, within the major service hospitals.

So again, we can only know what we know, and so if we don't know - and we've done a big evidence report recently in the last 10 years of data that quite clearly shows that less than 50 per cent of people with a spinal cord injury are getting access to specialist services in a timely fashion, or even at all, and a third of those are people with traumatic injuries, two-thirds of those are people with non-traumatic injuries.

So we've only been managing, and able to manage, you know, some of the patients. Not everyone needs to be managed in a specialised service, either. It's important to say that. But people need access to specialist services. So either through in-reach support or ultimately through outreach support in the community, and often, as I said, for non-traumatic injuries, people are often well managed and appropriately managed in local health districts, but once they are stabilised medically, then they very often need specialist rehabilitation at Prince of Wales or Royal Rehab, and those resources are very difficult to get access to, because essentially all of the people already in the system are struggling to get access

to those.

So we have insufficient rehabilitation, specialist rehabilitation beds to enable patient flow. We have bottlenecks both in intensive care and the acute services at Royal North Shore Hospital and Prince of Wales are backed up because we don't have - we have insufficient rehabilitation beds, and also challenges in discharging people from the community - you know, into the community as well, in terms of access to accommodation, NDIS funding and so forth.

THE COMMISSIONER: Q. When you were talking about the report that was done using the last 10 years of data which shows less than 50 per cent of people with a spinal cord injury getting access to specialist services, who did that report?
A. The Agency for Clinical Innovation. So, I mean, we have been working with - through the Agency for Clinical Innovation to look at - I guess look at a better model of care. So this has been part of a long process of coordination, of review of the data, of data modelling, of building a business case for where - modelling improvement in patient flows, timely access to care, what that would look like in terms of improved outcomes, what the cost of doing nothing is in terms of the preventable complications and so forth. So we're certainly happy to share that information, if that's helpful.

Q. I'm sure it would be. And insufficient rehabilitation beds, what are we talking about there in terms of numbers?
A. Well, the modelling suggests that we need 18 more beds, but as I said, in terms of patient flow, that number could be reduced to 11 if we could get people out of hospital in a more timely fashion as well. So part of the optimal model of care includes a transitional living accommodation model that would get people - allow people to be discharged in a timely fashion. The current data suggests that there are delays, a mean delay of 30 days. So there is a number of beds and efficiencies in flow that can be achieved through getting even half of those people out in a much more timely fashion.

So again, that's more challenging because it involves both - it involves a multi-system sort of approach and also federal as well as state resources, such as the NDIS, that are more difficult to access in a timely fashion.

MR FULLER: Q. Do you think that multi-system approach that you think is required would be facilitated by having central coordinated governance and, if so, why?
A. It can only be achieved with central and coordinated governance and management; coordination of resources; clear funding that is adequate and clear. None of it - so I think the missing - a very important missing piece in all of this is the governance. There is no centralised governance. There is no executive sponsorship. It's very difficult to escalate issues, because there is no mechanism for doing that.

So all of the governance that exists is local governance, and none of it is at a statewide level. The only - I mean, in the past, so until about 2015/16, there was, at the ministry, a statewide services development branch called the SSDB that was run by Kathy Meleady. It was essentially a very valuable place to go. It was mainly involved with statewide planning, which - and its responsibility was to update specialised statewide plans every five years. It wasn't a mechanism for supporting their implementation, but it certainly was a mechanism where we could identify gaps, we could raise issues, and Kathy Meleady was very supportive in terms of helping to, over time, provide some funding for growth, and so the spinal rural outreach service, the rural spinal cord injury service, was actually funded by - through money procured through that statewide services development branch, based on an extensive research project that we did over six years to develop the model, to evaluate the model across rural New South Wales, and that was funded by the Motor Accidents Authority then, now icare.

So essentially, we were fortunate that we had very good level - good evidence and Kathy had the opportunity to provide some additional funding that ultimately then flowed down to - so that's the money. That was $500,000, one year to set up the central component, so the rural team at Royal Rehab that became part of the spinal outreach service that had already existed for several years by then, and then another 500,000 the subsequent year to fund rural coordinator positions in each of the LHDs, and that essentially formed, you know, the funding base that has remained, administered through Northern Sydney LHD, but never reviewed since then in terms of, you know, growth.

So again, you know, that's - that proved very valuable, but without that, you know, there is no way, really, to grow funds, to raise issues, to highlight. We've highlighted - certainly this report has and all the work that's being done at the moment and the ministry's looking at it carefully as well with us, particularly the funding aspects - that can only be done through a centralised mechanism.

THE COMMISSIONER: Sorry to interrupt, but when I was talking with the professor, he mentioned the evidence report with 10 years of data, apparently we do have that report, but it's not in the tender bundle. It must be the only document vaguely related to terms of reference B and D or any other that is not, but you might want to consider tendering it.

MR FULLER: I'm sure we can fix that, Commissioner, thank you.

Q. Professor, do you think that re-establishing something like the statewide planning and development branch would be helpful in addressing the issues that you have identified?
A. I think it needs to go further than that. So the strength of it was that there was a centralised approach to planning, but as I mentioned, it was not linked to funding. I mean, Kathy Meleady was - we were lucky. She was an advocate and she could see - she saw the need, and that was how that service, the rural service, did get funding. But really it was fortuitous, so without that involvement - but there was no, then, subsequent mechanism for implementing the services.

So I actually think it needs to go much further than that. I think there needs to be a centralised body or a centralised mechanism that involves ACI and the LHDs and various parts of the ministry responsible for financing, performance, planning, et cetera, that has responsibility for the overall governance, but that includes the planning, the implementation, the funding, you know, the review of data, so really, the performance management, the review of how services are delivered, in terms of the actual - a much more detailed level of specification, I think, in terms of service level agreements with the LHDs. Because one of the challenges over time with the funding model - and perhaps I will mention the funding as well, but the funding model - is that once it's been absorbed into budgets over time, and

that is a good example, the rural money, you know, both for the central service or the central team that is driven out of Royal Rehab but also for the rural coordinators, that's been absorbed into the local health district budgets, but there's no way, then, of reviewing it, increasing that money. We have had to develop some service level agreements with each of the rural LHDs. Some of them are not signed. There's often not good awareness of the services. And we've had three business cases for enhancement rejected by those LHDs in the last 12 months.

So again - and it's not surprising, because as I said, we're a small-volume, high-cost, highly specialised service within LHDs that, you know, have all of the population health, health promotion and issues to deal with, so we're certainly not on their radar, and they are stretched - their budgets are stretched. So it's not really the right mechanism, but it is our only mechanism to try and - so the rural, again, in the same way, the demand for our rural services, the demand for the spinal outreach service have grown enormously, and the modelling shows that really we need to enhance that service by at least one and possibly double its size.

Q. The modelling that you just mentioned, is that part of the ACI modelling that you mentioned earlier, or is that different?
A. Yes. Yes. But we've done - we've been working with the ministry, looking at that in more detail, so we could - there may be some additional documentation that breaks down the modelling into a couple of - one or two pages, more recently, that possibly might be of value.

Q. What part of the ministry are you working with on that project?
A. Well, that's funding. So that's - yes.

Q. Is there any particular individual or group who you are working with on that?
A. Well, Annette Marley is the person, Joe Portelli and others. So currently we've working with Annette Marley and she's been liaising with various people in the ministry and has identified that we need to develop basically an NPP, a new policy proposal document, this year, to put up for - as a new funding proposal.

Q. When you say "we" in that answer - "we" have been

working with the Ministry of Health --
A. Yes.

Q. -- is that you with your clinical director hat or your Royal Rehab hat?
A. No, so the royal "we", so ACI. So ACI, particularly the economics, you know, the modelling, the economic parts of that.

I mean really - so the ACI, I mean in terms of our model of care, it's really drawn, in terms of implementation, in terms of, you know, the modelling, the economic analysis, all of those parts of it have been drawn together through the ACI.

Q. Are we right in thinking that the ACI's role, or the role of the service at the ACI level, is really about developing the model of care and then performing data and economic modelling, rather than operationalising anything that comes out of that?
A. Yes. Yes, absolutely. So the ACI is really all about developing models of care. It has no operational responsibility or involvement in the day-to-day workings of the LHDs, the spinal units.

Obviously, all of the work that we've done, in that report and the subsequent reports, has been done with an immense amount of consultation through, you know, all of the various parts of the ministry, the LHDs, all of our clinician network across New South Wales, the acute surgeons and so forth, the chief executives in each of the - in the two major LHDs and Royal Rehab as well. So it's been a very collaborative process.

We've also engaged with the services who are not specialist services. So the three hospitals, for instance, Westmead, Liverpool and John Hunter, are the three trauma services, major trauma services that do also care - provide a lot of care for people with spinal cord injuries, and a number of them are not necessarily transferred to the services in a timely way, or can be, just because of the resource limitations we've talked about. So we've again had an extensive conversation with those services, as well as some others, about the pressures on them, the impacts on their services in terms of the acute services, in terms of, you know, delays in rehab, and so forth.

That's all included in the documentation, the evidence and the modelling to look at how we would coordinate and govern a better - and manage a better networked model of care to make sure that people get access to the right level of care in a timely fashion wherever they are in the system.

Q. In one of your earlier answers, you I think again used the royal "we", talking about developing service agreements and business cases for the rural LHDs. When you have used the royal "we" there, so --
A. Okay, sorry, I shouldn't. So the royal "we" in that case is the LHD, so the chief executive of the LHD, myself as the clinical director of the ACI, and Matt Mackay as the chief executive of Royal Rehab. So, essentially, the triumvirate, you know, is an agreement.

Again, there isn't really - so it is not a service level agreement as such, it is essentially a memorandum of understanding between - with a three-partite sort of signature process. But as I said, we've tried to renew those every three years. It's often challenging because there are new people in the roles. So again, without any - without a state approach to it - I mean, we've taken a, tried to impose some sort of a governance process to it, and in fact, in terms of the outreach service and particularly the rural service, we do - all of the coordinators in each of the local health districts report, they have performance indicators, so we do monitor their activity and pick up, you know, a lot of new referrals, as I said, through them.

In northern New South Wales we also have the challenge of cross-border flows and there is an increasing number of people coming - returning particularly from the Gold Coast without coordination, without rehab, just arriving back in the community or back at Lismore Hospital, for instance, without anyone knowing about it. So again, there are issues of cross-border flows and better coordination, and that goes for Canberra as well.

Q. The memoranda of understanding are between Royal Rehab, you as the clinical director within the ACI, and the rural LHD; is that right?
A. Yes.

Q. And those are documented, I assume?

A. Yes.

Q. The business cases that you mentioned having been rejected, as I understand it - can you just elaborate a bit on that?
A. Yes, well - so through the coordinated sort of, you know, data collection that comes through each of the rural coordinators, plus, as you know, we run monthly clinics, interdisciplinary clinics, so we take a flying team around the state each month, that has shown basically the need for - and again a growing need, as I said, about a third of people in each clinic are new to the clinic, and that seems to continue to be the case.

So in fact, through the - well, with the support of the rural manager and myself, the local coordinators and their supervisor or manager have basically put together a business case that they have submitted to their chief executives, which have not been successful.

Q. So these are rural coordinators based within a particular rural LHD --
A. Yes.

Q. -- developing a business case for their own LHD to fund --
A. Yes, with the support of the statewide service.

Q. Do you have any particular rural LHDs in mind?
A. Well, several. So, I mean, I could provide - I can provide the details, if you like.

Q. Do you have copies of the business cases?
A. We could - yes, we could get them.

Q. All right.
A. So certainly - yes. It's probably better that we make sure that we give the right details rather than off the top of my head.

Q. And those business cases, are they about expanding services within the rural LHD, or is there an element of trying to share the burden of funding that currently falls on Northern Sydney LHD as well?
A. No, that's more to do with the demand within - demand on the rural - local rural coordinators. So, you know, there is just not enough of them, and in particular areas

there is - you know, they are fractional and they might - and some, in several of the LHDs, they are enormous geographic areas where you've got, you know, 200 people that you are looking after and travelling and so forth. So in several cases, we've wanted to fund an extra half position to be an extra person in another part of the LHD, for instance, so in terms of, you know, one based in Dubbo and one based in Orange or Bathurst.

Q. Do we understand correctly that at the moment, it is the case practically that services being provided for spinal injury rehabilitation in rural and regional New South Wales are being subsidised by Northern Sydney LHD? Would that be accurate?
A. I don't know that - oh, well, I think it's - yes, to some extent, I guess. They're just not - the services are not being - yes, we're doing the best we can.

Q. That's not intended as a criticism.
A. No - so there are two components to the funding, and so the funding that's central, that's kept with the central team, so that's a manager, you know, and four allied health people, so a nurse - sorry, yes, so the equivalent of a nurse, an occupational therapist, a physiotherapist and a social worker, plus a manager, so five positions that are part of the rural team, that's funded through Northern Sydney Health. But all of the local health positions in local health districts are funded - have been funded, you know, previously through that money from Kathy Meleady and absorbed into the local area health service budget. So there is no responsibility for that, although there is obviously a lot of onus on the central services to support the local coordinators.

As I said, you know, it's very - it's becoming very difficult with the growing demands, to meet those demands. So people aren't getting - necessarily getting the support that they need at the time they need it. I mean, as of yesterday, a growing emerging problem is the problem of severe pressure injuries. As of yesterday, there were 20 people around the state either in the community or in local hospitals that were waiting surgery or management, so with the most severe grade of a pressure injury. So, again, that's a flow, a downstream effect of not having enough resources, not having - I mean, we have challenges --

THE COMMISSIONER: Q. When you say "waiting for

surgery", do you mean delay?
A. Well, so delays in accessing - yes, delays in surgery, but also delays in getting appropriate care. So both - you know, both nursing services, specialised dressings, I guess - it's not just - well, yes, it - yes, there are delays in getting access to the specialist services that they need because there is not - and there is enormous waiting lists also, but --

Q. Can I just ask you a few questions about that, because I've just been sent the report you referred to.
A. Okay.

Q. "Evidence and Utilisation of Spinal Cord Injury Services in New South Wales, August 2020" - that's the one you were referring to?
A. Yes.

Q. You won't need it for the purposes of these questions, but can I just ask you, this tells me, or tells the reader - and the data is 2017/18 - that there were, in 2017/18, 344 people admitted with a serious spinal cord injury, and 195 patients, or 57 per cent, with a serious spinal cord injury, did not receive any care at a specialist hospital during their index hospitalisation. Is that consistent with current percentages, in rough terms, in April 2024?
A. Yes. So part of the recent business case modelling, as I said, looked at it over 10 years, up to 2023 - 2022/23. So there are more - so it is consistent.

Q. Could I get your view on this. The report tells the reader that at least 125 of the 195 patients, or 64 per cent of them, "would have likely benefited from specialist services" and then it goes on to say:

> *Better outcomes are associated with treatment in a specialist unit, hospital-acquired complications are more common in patients who are transferred to specialist care after two days of acquiring a spinal cord injury.*

Et cetera. Can you just expand on that?
A. Sure. So people, as I mentioned - not everyone needs to be managed in a spinal unit. So those 65 per cent require some level of support, so whether that's in-reach

support, whether that's management in the acute unit or in the specialist rehab unit. So, again, better triage and an awareness of - so a central notification system with triage and referral and timely transfer, you know, with an appropriate number of beds and an in-reach and augmentation of the in-reach and outreach service would provide access to services for those people.

Q. The report also, in general terms, tells the reader that there are a medium wait time for patients to access specialist services of 20 days - so that's to get into the specialist service. Then it also tells the reader that there are medium wait times of between 18.5 and 95.5 days for discharge. That is specifically mentioning the Prince of Wales. What are the consequences of - I think you have mentioned the consequences of not accessing specialist care in a timely fashion. What are the consequences or potential consequences of delays in discharge for a spinal injury patient?
A. Well, the delays impact on patient flow and access to - so upstream --

Q. One is someone is waiting for a bed --
A. Upstream and access to services.

Q. And someone should be discharged who is still there?
A. And that includes for those people with acute injuries that need it, but also the readmissions that we've talked about. So some of these people with severe pressure injuries, for instance, are not able to access services in a timely fashion, and that's becoming an increasing challenge.

The impacts on the person themselves, often there is a psychological impact from getting, if you like, stuck in hospital, after you are ready to discharge and get on with your life. So there can be negative impacts on the person as well. But it's really - the bigger impact is actually on the system and the efficiency and flow that provides access, and a lack of equity at the moment.

Q. What are the causes of delays in discharge for spinal cord patients?
A. Suitable accommodation is one of them. Access to care and equipment, yes. So certainly the NDIS is one aspect to that, but suitable accommodation and, you know, with an appropriate level of support. So often people need -

I mean, it's the chicken and the egg. You have to have accommodation to get the care, and you have to have care to get the accommodation. So it's not often - it is not easy to be able to coordinate those things in a very timely fashion.

Q. The report also gives - every day is going to be different, but it gives a snapshot of the circumstances relating - well, a patient flow snapshot, and the day chosen was 10 December 2019. Accepting that every day will be different to some degree, on that day there were six patients waiting to be discharged, another seven waiting for an acute bed, and - sorry, I should be more accurate. There were, it looks like, six waiting to be discharged from the Prince of Wales; there were seven waiting for an acute bed; and there were others waiting to be admitted to another bed. I assume it's different every day.
A. Mmm.

Q. But that's not atypical of the circumstances?
A. Actually, it is highly typical. That has been a pattern for the last four or five years, and actually --

Q. So, in other words, 10 December 2019 is not an outlier?
A. Well, in fact, if the Commissioner is interested, we provide a snapshot to NSW Health recently in terms of trying to, you know, support our business case, so I can provide a snapshot from three or four weeks ago that actually shows a much worse situation. So I think on that day at Royal North Shore Hospital, Royal North Shore Hospital has 18 acute beds in the spinal unit which were full, but there was another I think 42 people in total in the hospital, there were four in the burns unit with severe pressure injuries, I think there were seven or eight new admissions in other parts of the hospital, there were five people blocked up in ICU. So I'm very happy to provide that, because that's, very unfortunately, not untypical of the struggles that we're having.

THE COMMISSIONER: Thanks.

MR FULLER: Q. The foreword of the report, and your name appears at the foot of the foreword, says, I think in summary:

The report highlights the need to redesign

the way we deliver care to people with spinal cord injury in New South Wales to address current gaps, challenges, and ensure equitable access to specialist care or specialist guided care.

I take it the need to redesign the system is based on the things that we've been discussing in your evidence today; is that right?
A. Yes. Yes. Indeed, I mean, some - I mean, the keys to it are a statewide approach, an overarching governance approach and, yes, better data, data management, central notification and triage,, you know, performance - performance agreements and monitoring the system, system outcomes, looking at patient-centred approaches. All of that, yes, is outlined in that report.

Q. This was a report from August 2020. Do you know whether it went to anyone within the ministry?
A. Yes, certainly it's been presented to the deputy secretaries, so Deb Willcox and Jean-Frederic Levesque, they are very aware of it, they reviewed it in a meeting late last year and have been very supportive in promoting further work to, you know, identify how it might be funded and implemented.

Q. Is that part of what has led to the current project that you have been describing today?
A. Yes. I mean, really it's been an ongoing discussion. We met prior to - just immediately prior to COVID we actually met with the previous deputy secretaries, so Nigel Lyons and Susan Pearce at the time, with a previous version of this report, which required further data and further business development, I guess, so that's really taken us - and COVID also obviously challenged everything, but it's taken us another really three years to further develop the thinking, the modelling and the justification for where we are now.

But I think the snapshot of what is current, as well as what has been, is very typical, and so in my view - and I think others' - there is not really an option to do nothing, but we need to obviously think carefully about what that next step is and how to do it in the most effective and efficient fashion and appropriately governed way.

Q. The State Spinal Cord Injury Service is identified by NSW Health as a supra LHD service. You are aware of that?
A. Yes.

Q. Does that designation make any practical difference to the operation of the service in your view?
A. No, not really. I mean, there is a new health technologies and specialised services committee that has been set up. Essentially, that deals with new technologies or services. It has no role or responsibility for existing services and it largely, I think, is focusing on the challenge of new technologies and advances in treatment and the impacts on care that that has. But, essentially, there is nothing - there is no committee, there is no mechanism, there is no central oversight. So we're nominally a statewide service, and certainly acknowledged to be that, and as I said, I guess it's articulated through a line or two in a service agreement with a few LHDs, but beyond that, it doesn't really mean anything.

Q. To the extent that funding of the services provided through your service is determined on an activity basis, do you have a view as to whether that is appropriate for the sort of services that you provide?
A. Yes, well, we know it isn't. So one of my PhD students actually did some work in the last couple of years, 2019, that did look at the cost of delivering care versus the funding provided through activity-based funding. So that looked at what is called the DNR, the district network return, so the actual cost, the buckets costing - the buckets of cost that are allocated through the LHDs and through, then, the actual funding provided through the NWAU activity-based funding model, and the activity-based NWAUs significantly underfunded the actual cost by about 25 per cent.

Q. And why is that?
A. Well, I mean, I think because it's - the activity weights are not appropriate for, you know, the highly specialised, highly complex nature of spinal cord injury, brain injury, those sort of - they have never been - they just aren't suitable. They underestimate the complexity.

Q. Is that work by your PhD student published?
A. Yes, it's published. I can share it with you and it's been shared with the activity - the Commission as well.

Q. Sorry, which Commission is that?
A. The Productivity Commission, so - yes.

Q. Just, finally, do you see any expanded role for technology in helping to address any of the issues you have identified with the availability of spinal cord injury rehabilitation services?
A. Well, I mean, technology plays an important part in people's lives, in enhancing people's lives with spinal cord injury. Certainly, you know, even motorised wheelchairs are highly expensive, so access to technology is important.

In terms of - we've certainly, through COVID, I think, appreciated that we can do more through telehealth, so certainly part of the network model and a lot of our rural work anyway does encapsulate use of telehealth as well. But a lot of what we do can't be done remotely, or at least it needs to be - you know, we need to build capacity, you know, locally as well. So there is education and capacity building, and so that supports a telehealth model. But certainly, yes, we will be embracing as much use of technology to support the model.

I mean, there are certainly new technologies that are emerging, so, for instance, one of the more promising technologies at the moment is spinal cord stimulation, so epidural spinal cord stimulation. That's again still in research and development, but coming into clinical practice, and so that is an example that, if that became a modality that was more commonly accessible, there is an example of a new technology that may be around the corner that suddenly would provide, you know, enhancement to people's functional abilities.

So certainly, yes, there is a range. Obviously mobile phones - there are lots of sorts of technology now, and uses for technology are growing all the time.

Q. And do you think that having a centralised governance and funding model would help to facilitate the rolling out of those sorts of technologies for a service such as yours?
A. Yes, no, absolutely. Again, it's about prioritisation, it's about understanding the technology - any technology, how appropriate it is, and implementing that. One of the challenges of not having a centralised approach at the moment is that it is only the people -

people managed through the acute services, so through the three hospitals, so through Royal North Shore Hospital, through Prince of Wales and through Royal Rehab, that have access to specialist sort of funding for equipment. So again, all of the 50 or more per cent at the moment that are not being managed through the services, some of them not with the same level of severity or complexity, but they don't get the same access to wheelchairs, to seating and various types of mattresses and so forth in the same way that the specialist services do, and again, that's iniquitous and that needs to be tackled, and with the central governance approach, that could be managed better.

MR FULLER: Thank you, Professor. Those are my questions, Commissioner.

THE COMMISSIONER: Thanks.

Q. Can I just ask you, the PhD student you mentioned that did work on ABF and spinal cord injuries, and you said you had shared that with the Productivity Commission, have you discussed or shared that with the pricing authority, IHACPA?
A. Sorry, it is the pricing authority.

Q. Okay. I thought it might have been. What was the outcome of those - sharing it?
A. Well, they were certainly interested, but it didn't result in a change in the NWAU.

Q. Just so we don't have to Google it - I don't know whether it's directly relevant - you were talking about new technologies and spinal cord stimulation. What is that?
A. So it's electrical stimulation applied, so it is a stimulation - stimulator that provides an electrical current to the lower part of the spinal cord and increases - it can improve the flow of information in partially damaged nerves so that people may be able to have enhancement of their muscle control or muscle function when the stimulator is on.

But it was really an example.

Q. Understood.
A. It is in research and development. It's not - it was an example of an exciting - potentially exciting therapy that may - that if it was to be implemented more broadly

would have cost implications and - yes.

Q. On that theme and just for my own curiosity, Mr Musk's Neuralink, is that science fiction or has that got real possibilities?
A. I guess we'll wait and see.

THE COMMISSIONER: Mr Cheney, do you have any questions?

MR CHENEY: Mr Chiu is going to ask some questions.

<EXAMINATION BY MR CHIU:

MR CHIU: Q. Professor, my name is Hilbert Chiu and I'm representing NSW Health in this inquiry.
A. Sure.

Q. I just wanted to ask you first some questions about the Agency for Clinical Innovation. We've been calling it the ACI.
A. Yes.

Q. Does it have a spinal cord injury network within ACI?
A. Yes.

Q. And you are the co-chair of that network?
A. That's right.

Q. What does the network do?
A. Well, the network coordinates activity, I guess, in terms of planning and development. It monitors, you know, data. So it is really a network that supports the clinicians.

Q. Which clinicians? Clinicians within your service or --
A. Well, clinicians - the network has about 400 members, so it's not just the spinal units, it's a network across New South Wales.

Q. Does the network have any role in oversight of the State Spinal Cord Injury Service?
A. Well, there is - I mean, its function largely is in terms of planning for - you know, service planning and development and models of care and quality - supporting quality and outcomes. So we run - we have various committees, subcommittees in terms of looking - you know,

monitoring the quality. So we have a statewide database, we monitor outcomes, so quality of outcomes. We provide - we look at education and provide education and training and support development of resources, so we have developed a lot of specialised resources for treatment algorithms, clinical advice, resources, clinical guidelines. So all of that to support better practice.

THE COMMISSIONER: Q. A pressure injury tool kit is one of the things --
A. Yes, so pain management tool kit. We've recently developed a health maintenance tool to support self-management. In terms of algorithms for managing autonomic dysreflexia, a whole raft of resources. And one of the byproducts of the work of the network for developing this new model of care has been the development of resources for non-specialist centres, services, and that is supporting - so that's done collaboratively with clinicians, for instance, nurses and others, at some of the main centres.

MR CHIU: Q. Just pausing there, as someone who has a role in both the service and the network, do you see that the network might be - and say "no" if you don't think this is the case - an appropriate vehicle for the centralised governance that you were talking about?

THE COMMISSIONER: Just before you answer that question, what is the difference between the service and the network?

MR CHIU: Q. Professor, you can explain the difference between the service and the network?

THE COMMISSIONER: The reason I'm asking is that the ACI describes this as the State Spinal Cord Injury Service, which it also then says what's the network structure of the State Spinal Cord Injury Service .

MR CHIU: The witness gave some evidence about being co-chair of something separate, a network with 400 people.

Q. Perhaps you could tell us the difference between the two?
A. So as I said, the statewide - so the ACI doesn't have any operational role, so we're not - we don't coordinate services. We support a network of clinicians that deliver services to people with spinal cord injury, and so our role

is more in planning development and supporting a clinical network to deliver services in a statewide fashion, with no governance - overarching governance of that.

Q. So would it be correct to say, to summarise that, within the ACI there is something called the network. The network does mostly planning, training, education?
A. Mmm.

Q. Things of that order?
A. Yes.

Q. To support a wide range of clinicians.
A. Yes.

Q. Would that be correct?
A. Yes.

Q. But doesn't have any operational oversight or activity?
A. No.

Q. And then, separately from that, there is the NSW State Spinal Cord Injury Service, which you are the head of?
A. Well, the service is a nominal service. So as I said, the --

Q. What do you mean by "nominal service"?
A. Well, the NSW Health acknowledges that there is a State Spinal Cord Injury Service. The ACI - but as I said, there is no governance of that per se. So what the ACI does is coordinate a network of clinicians who deliver those services and support both specialist and non-specialist clinicians to provide and improve the delivery of services.

Q. So when you say there should be a centralised governance of the service, what exactly do you have in mind? Are you talking about service agreements? Can you tell us what you have in mind in practical terms?
A. Yes, sure. Well, I think there has to be a framework that supports the delivery of statewide services. So that would - it must include, as I said - I mean the ACI is part of the, if you like, planning, but it really has to include the LHDs, it has to include the ministry and not - and various parts of the ministry, because spinal cord injury really crosses, you know, and draws on every part of the

ministry, and so part of the problem with statewide services and coordinating this at a statewide level is that there is no body, there is no mechanism, there is no committee, advisory committee, framework, that supports that. So it needs to involve - it needs to be driven by NSW Health. I think it probably needs to sit under the - you know, whatever it is, I think it needs to sit under the responsibility of ideally a deputy secretary.

Q. So do you mean, rather than just being a service which is a collection of clinical activities provided in a number of places, it needs to become an organisation that sits within ministry?
A. Yes.

Q. And that organisation --
A. It needs to be organised as such.

Q. And, as I understand it, one of the advantages of that is it would have its own separate funding directly from ministry; is that correct?
A. Well, that's - you know, it needs - yes, it needs funding. The service needs funding. It needs to be appropriately funded and there needs to be clear - a clear - yes, I think the funding needs to be identified and separate rather than filtered down through LHDs.

Q. But the problem of it being filtered down through LHDs is that it then needs to compete against other demands - many, many demands that the LHD has --
A. Yes.

Q. -- for the provision of all its services?
A. That's right. Yes. It competes, but it also doesn't - it doesn't - there is no way of then having it reviewed and funding appropriately, you know, increased over time. So it becomes - you know, it becomes noise rather than signal and it's not - yes, there is no way of identifying even where that money is. The services - the LHDs, you know, obviously - I mean, spinal cord injury is very complex and so it draws on, basically, services across every part of the hospital and in highly costly, highly specialised ways.

The two ICUs, for instance, are highly specialised. So not every ICU in New South Wales has anywhere near the same level of expertise for spinal cord injury management

as the two ICUs at Royal North Shore Hospital and - so I'm just saying that those sorts of - those things are hard to identify at a local level, and particularly, as you said, when there is competing demands, which are constant. There's constantly --

Q. Pausing there, sorry, Professor, you were just referring to the ICUs. It occurs to me that the service is, to a degree, provided through the staff within the LHD; is that correct?
A. Mmm, yes.

Q. And other things that are shared with other services within the LHD, like ICUs?
A. Yes.

Q. And outreach staff as well?
A. Yes.

Q. Allied health staff?
A. Yes.

Q. Nursing staff?
A. Yes.

Q. So would you agree, there is some advantage, isn't there, of providing funding to the service through the LHD because of that overlap in the way service is provided?
A. Well, yes and no. So the "yes" is that the services and the LHDs obviously need to be funded. How they are funded is - it doesn't matter, in a way, as long as it's very transparent, it is very clear, and what is being purchased and provided for that amount of money, which is appropriately costed to meet the demand, actually flows in a way - in a particular way.

So one of the challenges - I will just say, one of the challenges, in terms of this competing demand, whenever there's been pressures on the health system to reduce costs at each of the LHDs, that cost is distributed across the hospital and spinal cord injury services have always taken the same, an equivalent cut, and some of the examples of that have meant that staff that, you know, are essentially spinal unit delineated staff, have then had to be removed to other roles in the hospital. That's not an uncommon situation. So what it does is diffuse and de-specialise or, you know - it doesn't allow us to allow - to maintain

a delineation of what is statewide services, highly specialised and super specialty staff, as distinct from other staff.

Now, that's not to say that, you are right, there is plenty of advantage in staff rotations and, you know, nursing and so forth, but there needs to be a maintained level of specialty, and so we've seen those competing demands over the years - and I've been around for 30 years and seen numerous cuts of beds, for instance, you know, four beds that are just shut over time, you know, suddenly, and I'm going 20 years, 30 years back, but I've seen repeatedly, every time there are cost pressures, there are requirements to improve efficiencies and effectiveness and et cetera. It unfortunately has a proportionate impact on the services to the LHD, and that's inappropriate.

Q. If that's the case, Professor, it sounds like the source of the problem might not necessarily be a separate line of funding but, rather, a funding model for the entire LHD that has a view for the future, has a view for present needs rather than necessarily based on historical need; would you agree with that?
A. Well, I think that's part of it, but I still think that there needs to be oversight of that at a central level. So the funding, however it flows down to the local health district, needs to be identified centrally and it needs to be managed, monitored, and as I said, it needs to be supported by more detailed agreements with the LHDs about what services are to be provided, what is the level of, as you said, staffing and expertise, what are the outcomes, you know, all of that.

Q. Just one final thing, Professor. You mentioned that the current framework started in 2015, I think that was something you referred to earlier?
A. Well, the current framework started - really has existed forever. I mean, in 2015, the previous statewide services development branch ceased to exist, so I guess things became more decentralised.

Q. Are you familiar with the NSW Health governance review that was undertaken in 2011as a source of those changes in 2015?
A. I can't say I can remember it.

MR CHIU: No more questions.

THE COMMISSIONER: Did anything arise out of that?

MR FULLER: No, thank you, Commissioner.

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

THE WITNESS: Thank you.

<THE WITNESS WITHDREW

MR FULLER: Mr Muston will take the next witness.

MR MUSTON: The next and last witness for the day is Trevor Danos.

I note the time, Commissioner. I think we've been sitting for an hour and a half, so --

THE COMMISSIONER: Do you want to --

MR MUSTON: -- for the benefit of the transcriber, perhaps we will take a short adjournment now.

THE COMMISSIONER: I'm delirious with pain, so I'd forgotten. We will take a 15-minute break until 10.45.

SHORT ADJOURNMENT

THE COMMISSIONER: Yes.

MR MUSTON: I call Trevor Danos.

<TREVOR EGON DANOS, sworn: [10.45am]

<EXAMINATION BY MR MUSTON:

MR MUSTON: Q. Could you state your full name for the record, please?
A. Trevor Egon Danos.

Q. You are chair of the North Sydney LHD board?
A. That is correct.

Q. You have held that role since January 2017?

A. Correct.

Q. And prior to that, you were a member of the Sydney Local Health District board from 2011 to 2016?
A. Correct.

Q. I think you are currently the chair of the Council of Board Chairs?
A. Correct.

Q. The Commission has been provided with an outline of the evidence that you would be willing to give. Have you had an opportunity to review that document?
A. Yes, I have.

Q. I understand there is a correction that you may wish to make to it?
A. There is one correction that was advised to me this morning, just the name of one of the documents.

Q. I think we can probably - I might be able to help you with that. I think the correction is at paragraph 5 subparagraph (k), there is a reference to a document which should be the Northern Sydney LHD Clinical Governance Framework 2022-2025?
A. Yes.

Q. Other than that correction, are you content that the document is true and correct to the best of your knowledge?
A. Yes, I am.

MR MUSTON: That document will in due course form part of the bulk tender.

Q. Perhaps we could get a copy of the statement up on the screen. It is [MOH.9999.0765.0001]. You are, Mr Danos, free to look at your hard copy or the version of it on the small screen next to you or the big screen in front of you?
A. I brought a hard copy, which might be easier for me to look at, I think.

Q. Whatever is most comfortable for you. Could I ask you to turn to paragraph 11, please. You see in that paragraph you tell us what the functions of the board prescribed by section 28 of the Health Services Act are. In paragraph 11(b), one of those functions that you tell us about is to approve systems to support the efficient and

economic operation of NSLHD to ensure NSLHD manages its budget to ensure performance targets are met, and to ensure NSLHD resources are applied equitably to meet the needs of the community served by NSLHD. That's a mouthful. Could I just ask you in relation to that, what did you have in mind when you referred to the "needs of the community"?
A. Well, this is wording taken from the legislation, so we as a board seek to apply it as we read it.

Q. What do you as a board chair understand the needs to be - needs of the community to be served there are, within that context?
A. Well, I think it goes to the issue of community consultation and engagement and understanding what are the expectations of the community, what health services will be provided by the district, and how those health services will link in with, for example, primary care, that is not the responsibility of the district; aged care, which is not the responsibility of the district as well.

Q. You are familiar, I'm sure, with section 9 of the Health Services Act which prescribes the purposes of the LHD?
A. Mmm.

Q. Which includes to provide relief to the sick and injured people through the provision of care and treatment?
A. (Witness nods).

Q. You probably have to say "yes" out loud. I note you are nodding?
A. Yes. Yes.

Q. For the benefit of the transcript. Which seems to capture fairly neatly the delivery of acute care in a hospital setting; would you agree?
A. Yes.

Q. But also one of the purposes of the LHD is to promote, protect and maintain the health of the community?
A. So we provide sub-acute services, we provide education around health, we have a public health unit, we have community and youth health services. So yes, all of that is encompassed by what you have described.

Q. So you agree that the promotion, protection and maintenance of health of the community is something which

contemplates the delivery of health care outside that acute setting?
A. That is correct, yes.

Q. You said a moment ago that the - well, I infer that the promotion, protection and maintenance of the health of the community did not extend to primary care because that was the responsibility of the Commonwealth; did I understand you correctly in saying that?
A. Well, that is correct. The funding of GPs and primary care is via Medicare. It's not contemplated or included within the budget of the district. Of course, we regularly liaise with the GP community, including through the primary health network, but we are not providers of primary care, although there are instances, for example, through urgent care centres, of which we have one at Mona Vale, where we come closer to doing that, and of course we do have people who turn up to the emergency department with conditions that might otherwise be suited to visiting a GP, but we do not provide a GP clinic, as such.

Q. Your LHD is relatively well served by GPs?
A. Yes, it's - look, it is a relatively high socioeconomic standing group. That doesn't mean, though, that, you know, it is necessarily wealthy, or that people don't want to have bulk billing. We have some quite distinct regions within our LHD. The populations on the Northern Beaches, for example, are quite different to the populations at Ryde, and they are different again to maybe the population at Mosman but, look, we have relatively good health of our people within the district, which probably reflects the fact that we have relatively good access to GPs and also to a very, very good local health district providing good hospital services.

Q. Acknowledging that GP services are funded by the Commonwealth through Medicare as a funding model, there is nothing that carves out the delivery of primary health care from the obligations of the LHD to the extent that that market based model is not working, is there?
A. Well, look, I think two comments for that. One is, if you look at our service agreement, the annual service agreement, I don't believe there is anything in the service agreement about providing primary care, as such, but we are the safety net for the health of the public, and so if people can't find a GP or can't get into a GP, inevitably, they will turn up at a public hospital.

Q. I will come back to the service agreement in a moment, but you would agree, wouldn't you, that the purpose and functions of the LHD are those described principally by the legislation that creates it?
A. Correct.

Q. And not by the service agreement by which it is asked to do certain things?
A. Yes. Well, I do agree with that.

Q. And to the extent that, for example, there was a deficiency in the delivery of primary care through GPs within your LHD, as part of the LHD's obligation to promote, protect and maintain the health of the community, you would agree, wouldn't you, that the LHD would need to step in to deliver that primary care, if there was a gap?
A. I don't know that "step in" --

MR CHENEY: I should object to that question in that form. There is no context given to it. The question was to the extent that the GPs are falling short the LHD should step in.

THE COMMISSIONER: The way I understood --

MR MUSTON: I can reformulate the question.

THE COMMISSIONER: What I understood, to help you, you were putting to the witness - and I might be wrong about this, so that will help you as well - was that in directing the witness's attention to the statutory obligations in section 9 of the services Act, I actually think (a) and (b) could be read as containing an obligation to provide any form of health care, including primary care. I mean, (a) is "relief to sick persons" - that could be primary care; (b), "promote, protect and maintain", could all be primary care. The fact that the Commonwealth decides it will have a Medicare system is sort of beside the point about the statutory obligation. Is that how I should have understood your question?

MR MUSTON: That is essentially my question.

Q. Let me just break it down into a few. So you have heard the Commissioner characterise those statutory purposes in the way that he just has. If the LHD makes an

assessment - the starting proposition is the LHD needs to deliver on those purposes.
A. Yes.

Q. As part of that process, an assessment must be made of the needs of the community, the health needs of the community?
A. Yes.

Q. Next part of that process might be making an assessment of the extent to which those health needs are met by services delivered external to the LHD?
A. Yes.

Q. Including, for example, services delivered by GPs who are being funded in a market based system through Medicare?
A. Yes.

Q. To the extent that, in making the assessment of those factors, the LHD comes to the view that there is a gap which is not being - a gap in, say, primary care, which is not being filled by GPs, then it remains part of the LHD's - would you agree that it remains part of the LHD's obligation to step in and deliver that care in some way?
A. Well, we have - let me answer it this way: we would refer to the service agreement to see what we are funded for and what we are expected to deliver. If we saw a market failure, clearly, we would speak to the ministry. We would speak to the PHN to seek to address it. And I'm not talking exclusively medical. This could be home nursing, it could be allied health, podiatry in the community. We have a community health unit which reports directly to the chief executive, so I would hope that we would be aware of these factors.

But it would not be right to say that we would step in and provide or set up, for example, a GP clinic. We would see the consequences of it probably by virtue of people starting to attend our emergency department with conditions which might otherwise be addressed by a GP, but I don't think our board would see it in any way that we would therefore need to go out and set up a GP clinic or start employing GPs.

But it is in our interests to have a healthy community, because the healthier the community, the fewer the presentations to the emergency department.

Q. Could I ask you to go back to paragraph 5 of your statement, or your outline, sorry?
A. Yes.

Q. You tell us there that the board is responsible for setting the strategic direction and overseeing an effective governance and risk management framework for the LHD, et cetera. Can I ask, in relation to that, what is the board's role in a practical sense in setting the strategic direction? How does it go about doing that?
A. So you are aware that we have now a strategic plan 2023 - yes, 2023-2027 - no, 2022-2027.

Q. We will come to the detail of that in a moment, but if that's the launch point, what's the board's role in the creation of that document?
A. Well, it is the top document within the district's hierarchy of documents, leaving aside the service agreement. It's clearly the role of the board to ensure that there is a current strategic plan, and from the strategic plan we cascade down a whole number of other plans, clinical services, strategic assets, workforce, and so on.

Q. So in the creation of that strategic plan, what role does the board play? What does it --
A. Well, ultimately, a key role, because the board signs off on the strategic plan, but the board wants to know what is the process, of course, for the development of that strategic plan, how does it relate to the immediately preceding strategic plan, what worked well in the preceding strategic plan, what didn't work well, what has changed. So, for example, we were in the middle of COVID when we did 2022-2027, the whole framework for ambulatory care had changed, we weren't having people coming in to the hospital for ambulatory care as had been in the past, and we wanted to, of course, be confident that there had been very wide and appropriate consultation of all relevant stakeholders leading up to the development of the strategic plan.

Q. So what information is actually provided to the board to enable it to play that role?
A. So we had several board workshops, including a strategy day, where we had an external facilitator.

Q. Who attended them - the external facilitator,

obviously?
A. Board members and, look, from memory I think we - well, we had - certainly we had senior members of the executive. I would have to check, you know, who else was there, but I think it would have - it may have included university partners, representatives of the PHN. It was a strategy day to develop and set the pathway for the development of the strategic plan.

Q. We were discussing a moment ago an assessment being made of the health needs of the population within the LHD as part of determining what might be required to be delivered?
A. Correct.

Q. Was any information provided to the board in relation to that strategic plan preparation in relation to the health needs of the population?
A. Yes. We of course would have taken detailed information and advice from the chief executive and - who at that time was Deb Willcox - and the direct reports to the chief executive.

Q. Do you have a recollection of what that information was? Was it reports on health needs assessment, or were there --
A. Yes. Well, I don't have the information in front of me, but it would have talked about things like population projections, health projections, changes in models of care, particular demographics of the community, different parts of the community having different illness presentations, ageing of the population, the fact that we have a very significant number of aged care facilities within the district. All of that information would have been collated and presented as part of the development of the strategic plan.

Q. Do you recall it involving any assessment of the extent to which the health care needs of the community within the LHD were being delivered by services external to the LHD?
A. I believe so, because we - one of the direct reports to the chief executive is the director of community health services, so we would have heard that, just as we would have heard from the director of mental health services, to understand what are the mental health needs of the community.

Q. So, as the board chair, what did you regard as being the conceptual targets, as it were, when setting the strategic directions? What was the board, as you understood it, setting out to achieve in setting its strategic direction?
A. Well, look, in simple terms, the two most important things are ensuring that patients have appropriate outcomes and that they have appropriate experiences within the health system. But beyond that, looking to see what is in the service agreement, projecting forward. You know, if we were doing a strategic plan now we would be thinking a lot about artificial intelligence and the impact of that on the delivery of health services. We would be thinking a lot about workforce planning because we know that COVID has really created havoc with workforce and workforce planning going forward. So looking to project, making sure that within the plan there was opportunity to innovate, to research the sorts of partnerships that we would want to have both with universities and industry partners. It's setting the pathway of where you want the district to be in five years' time or over the five-year period, and to ensure that we believe Northern Sydney LHD is a very high-performing district, and that, at the end of that five-year period, both absolutely and in relative terms, it would continue to be a high-performing district.

Q. Two of the central themes that you raised at the outset there, patient experience and patient outcomes, in dealing with them in that order, patient experience, do we take that as meaning that patients should have a - their experience of interacting with health services delivered by the LHD is as quick and pleasant as is possible?
A. So the two acronyms are PREMs and PROMs. You've probably come across those. So experiences of people, say, yes, you know "I was happy, I was communicated with well". We don't necessary use things like net promoter scores, but essentially would you be recommending to a family or friend to have their treatment here.

And outcomes, of course, is that "I went in to have my hip replaced and I came out with the hip replaced and it's working well".

Q. So the outcomes in that sense refers to the immediate outcome of an acute intervention, like a hip replacement procedure, but do you have a view that outcomes - or is

there a view of the board, as you understand it, that outcomes as a strategic direction should encompass more than just coming out of a hospital after an acute procedure better than you went in?
A. Well, I think that's why we separate outcomes and experiences and, ideally, both are positive. I mean, sadly, you can have a very good outcome and a very poor experience and, probably worse still, you can have a very good experience and a very poor outcome, but we look to see that our patients come out well treated and feeling that they have been respected, that they - you are familiar with the concept of patient-centric care, that they have received patient-centric care, they have been respected by the staff, that they feel that their health - they have been - and this is part of our strategic language, but we have been partners with them in their health care.

Q. In terms of those outcomes, I understand you are dealing with outcomes of patients who have had an interaction, say, a hospital admission or a particular procedure at the hospital. What about wider health outcomes of the population of the LHD - that is to say, that they are, to use that language that we were using earlier - their health was promoted, protected and maintained?
A. Oh, absolutely. So let me give you an example.

Q. How is that measured?
A. So - well, if I can give you two examples.

Q. Yes.
A. We had at our most recent board meeting last week the head of the health promotions unit present to us and two particularly important topics presented to us were vaping and problem gambling, problem gambling by young people at school and the like. So we asked a number of questions around that: "What sort of programs are in place? Do you have sufficient resources to get out and about? Are you working with the schools? How are you working with local councils?" We've actually got the health promotions group coming to one of the board breakfasts I think in June or July. So absolutely we do that.

Then, a number of the KPIs that we are subject to or subjected to under the service agreement pick up things like, you know, readmission rates and smoking rates and smoking in pregnancy rates. So we're very, very conscious

of what are measures - sorry, we're conscious as, of course, is the ministry - as what are appropriate measures to demonstrate that you have a healthy community.

Q. Maybe we will go to the strategic plan, which is [MOH.9999.0824.0027]. Probably 0001 is where we should probably start to make sure we're all dealing with the same document. Do you see that on the screen?
A. Yes, I can see that.

Q. Perhaps if we can go to page 0001 just to make sure we've got the right document.
A. Yes.

Q. You recognise that as the Northern Sydney LHD strategic plan?
A. I do, and there might even be a photo of me on the next page.

Q. You will undoubtedly be smiling in it, otherwise you would be an outlier.
A. I am familiar with the document, thank you, yes.

THE COMMISSIONER: Regardless of what the subject of the photograph is doing, they are always smiling.

MR MUSTON: Q. Could we then jump forward to page 0024. You see set out there is a series of strategies or what might be described as high-level objectives?
A. Yes, this is what we describe as the strategic plan on a page.

Q. So looking just, for example, at safe, high quality connected care there, I gather that the text in blue is the aspiration, and that the text in black underneath that, commencing 2.1, 2.2, et cetera, are some of the means by which that objective is sought to be achieved?
A. Correct.

Q. Would you agree that both the objective - well, let's take it in turn. The objective is cast at a fairly high level?
A. Correct.

Q. And would you also agree that the measures by which it is sought to be achieved are also cast at a very high level, dealing with that one?

A. Yes, within the context of it being a plan on a page, yes.

Q. So a little bit more detail in relation to how that is to be achieved is contained in the balance of the document. Perhaps if we go forward to 0032. Just sticking with the theme of the safe, high quality connected care, you see there - this is the page which seeks to elaborate a little bit more on the means by which the higher objective is to be achieved?
A. I do.

Q. Again, looking at 2.2 as an example, would you agree that each of those bullet points set out there is cast at a fairly high level as the means by which the objective is to be achieved?
A. Correct.

Q. Can we turn over to 0034, just sticking with that particular strategic objective. You see there, under the heading "Essential metrics", there is "Measure"?
A. Yes.

Q. That's the way, is it, in which the extent to which the objectives are being achieved is to be measured?
A. Yes. It provides granularity and specificity for what you have described as the sort of higher-level description of the strategic objectives.

Q. We might need to - if you need to scroll through the document to go back, please let us know, but do you say that those measures identified there in the blue box really are any sort of a measure of the extent to which, say, the objective in 2.2 is being achieved? If you need to scroll back to page 32 that sets them out in detail, please just ask the operator.
A. Look, I can probably answer it this way: there is both qualitative and quantitative achievement of those strategic objectives. The strategic document is intentionally a high-level document and from it we develop a number of other plans. You are probably aware we have a six-monthly traffic light report that is presented to the board by the chief executive against all of the strategic objectives, and we publish that on the internet. So there is no intention to hide behind the high-level notion. We will describe it, but some of the description needs to be qualitative and some of it needs to be quantitative. Some

of these quantitative --

Q. Just sticking with the quantitative ones set out there on page 34, though, for example, one of the means by which the objective described in 2.2 is to be met is to:

> *Ensure clinical care and services are both effective and delivered efficiently with a focus on eliminating unwarranted variation.*

And the next one perhaps is a better example:

> *Deliver care to patients that is holistic and considers their home social situation and other conditions to support their recovery and reduce the risk of readmission.*

Are those things success - success as against those objectives really being measured by any of these metrics in a quantitative sense?
A. They are some of the measures. I wouldn't say that they are the totality of the measures. But again, within the limitations of not producing a tome as a strategic plan, they indicate the sorts of things that are appropriate to the relevant strategic objective.

But a lot of those relate to inpatient services, and there is a lot of services provided by the district that are not necessarily inpatient, for example, which is why, as I said, you need a combination of both qualitative and quantitative assessment.

Q. So that would extend to, if we go back to page 0024 - do you see the third column along there, "Keeping people healthy and well" - am I right in understanding that that is more of a focus on those non-inpatient delivered services?
A. Well, yes, some of them are. For example, we talked about vaping a moment ago and we talked about youth problem gambling. They would be possibly relevant there. But if you looked at the fifth column, about, for example, "advance and translate research and innovation", that could be measured in a whole number of ways - how many publications are put out by our researchers, it could be how many collaborative arrangements have we got, it could

be how much NHMRC or other funding have we got, how much philanthropic funding that we have, which is why I think the board takes a broad overview of these things and in the semi-annual traffic light report looks to see, with some granularity, what management is saying or what the executive is saying against each of those strategic objectives.

Q. When you say "some granularity", what sort of information is being assessed in relation to population health?
A. In relation to population health?

Q. Yes.
A. Look, I'd have to go back and consult the detail on that, but it goes back to the things I talked about, you know, women smoking in pregnancy, a lot of focus around, of course, Aboriginal or Torres Strait Islander specific metrics, things like vaping rates in schools and so on.

Q. What about the extent to which the services being offered by the LHD - the health services being offered by the LHD are continuing to meet the needs of the population, to what extent is that being assessed?
A. Well, I think that would be assessed on a continuous basis. It would not be something --

Q. In what way?
A. Well, through reports from the chief executive and, indirectly, through the chief executive from his direct reports, to understand where - if we're getting more people turning up to the emergency department, triage 4 or triage 5, than would otherwise be the case, what does that mean? What's the cause of it? These are very - you know, these are very large and complex businesses. The annual budget of the district is 2.4 billion. A great deal of focus is put on risk and in the context of risk trends as well, and both looking forward to trends, so forward projecting, lead indicators, and lag indicators, that come to us. So we're very much aware.

New things come along - climate change, the impact of climate change on health, whether people are now suffering some element of vaccine fatigue, are we going to see fewer people vaccinated coming in to the winter season. So constant assessment because it is a dynamic $2.4 billion business and it is part of the - you would have seen the

chief executive provides the board with a detailed monthly report which runs to about 20 pages and we publish that report each month on the web. That report indicates, against each of the divisions of the district, what are the stresses and strains, what are the risks.

You would have seen also, I believe, at the back of the CE's monthly report, there is a report from each of the facilities and each of the services and they talk about what are the risks, the emerging risks within the facility or the service. So constant assessment of those sorts of things. Because the one thing nobody likes in health is surprise.

Q. These are measures of the extent to which the system is responding to the demand which is being placed upon it?
A. Well, as I said, there are lead and there are lag indicators. In many respects, lead indicators are, you know, critical, because we need to prepare for what is coming.

Some of the information we receive by way of lag indicators can be three or six months old. So it's viewing both sets of indicators to make sure that we have a dynamic and responsive health system.

Q. What about the extent to which the services - I will come back to my earlier question - what about the extent to which the services being delivered through the LHD are actually meeting the needs of the population? Let's take an example of that - access to a specialist outpatient clinic in a particular field of specialisation, say endocrinology. Is any measure being made of the extent to which the population's needs in terms of endocrinologists are being met within - by the health services delivered within the LHD?
A. I would say probably indirectly, because we would be, as a board, the chief executive and the board would be monitoring complaints. If people are saying they can't get to an endocrinologist or any other specialist, we would ultimately hear that. I would hope that the director of medical services would be telling us that we're down on endocrinologists or we're down on nurses. We hear these things all the time, particularly with the staffing struggles that the whole health system has had during and post COVID. We do. Whether it is reported to us under the heading "Are we meeting the health needs", probably not,

but we are hearing and receiving sufficient information to know where the pinch points are and where strife is coming from and where focus and attention needs to be directed.

Q. Could we come to the service agreement that you have mentioned a few times. It's document [MOH.9999.0795.0001].
A. That's not --

Q. I have given the wrong number there, I think. I think it should in fact be [MOH.9999.0913.0001].
A. Very good, thank you, yes.

Q. Do you recognise that document as the 2023 --
A. I do. No photo of me in that but I do recognise it.

Q. I don't think there are any photographs in any of these. So I think you have referred to - or are you familiar with the KPIs which are required to be met under that agreement?
A. Yes, I am.

Q. Could we perhaps go directly to them. They commence at page 0021. Ask if you need to scroll through them, but can I ask you this: to what extent do you think the KPIs, which are set out in this document, are a fair measure of the LHD's performance against its strategic goals?
A. Well, I am familiar with them.

Q. Yes.
A. I think they are perhaps a necessary but not a complete indication of the performance of the district. We've talked previously about, you know, qualitative assessment of performance. KPIs are very important because it is what the ministry assesses us on, and when we get our performance rating from the ministry, monthly or quarterly, that tells us whether we are on track, and the monthly report from the chief executive runs through those KPIs, or a number of key ones of those KPIs, and calls out any where we are out of the zone where we want to be, plus we get reports, or the district and we get reports separately on a lag basis from the ministry identifying not only what our performance is but what our relative performance is.

Q. Not for one moment disputing the importance of KPIs, but my question is directed more to whether, in your view, these, the things being measured by these KPIs, are the appropriate things to be measuring. So my first question

is: to what extent do you think these KPIs or achievement of them reflects the success of the LHD against, say, its strategic objectives set out in the strategic plan?
A. Well, as I said, I think they are a necessary component but not the complete component, because these KPIs, as valuable and relevant as they are, don't tell you a great deal about the culture of the organisation, they don't tell you about the level of engagement of staff within the organisation. I mean, if you've got bad results, it might be because you've got poor engagement or poor culture, but they don't tell you those sorts of things. They don't tell you whether you've got an organisation that has got a capacity to innovate, that's agile, that's got dysfunction in it. That's another part - a key part - of the role of the board to look more broadly than simply at the KPIs.

Q. It's possible, isn't it, that an organisation or an LHD which is meeting its KPIs as set out in the service level agreement is nevertheless failing to achieve the goals set out in its strategic plan?
A. Yes, for the reason I gave - you could have a high-functioning district which is getting very good PROMs and PREMs results, but there is no culture in the place, or you've got warring factions within the district.

Q. It's also possible, isn't it, that an LHD could be meeting all of the requirements of the KPIs set out in the service level agreement but, nevertheless, failing to deliver on its statutory purpose that we've been through, being to provide relief to the sick and injured people through the provision of care and treatment and to promote, protect and maintain the health of the community?
A. I think that is unlikely. Anything is possible, but I think it's unlikely.

Q. Why do you say it is unlikely?
A. Well, given the breadth of the KPIs that are mandated by the service agreement, which I'm sure reflects - well, I'm confident reflects the ministry's view of what is the responsibility of NSW Health in terms of delivering health services to the community --

Q. I'm interested in your view, whether it's your view that these KPIs are a fair measure of, say, the LHD's performance of those statutory functions.
A. Yes, I do believe they are, yes. But without

detracting from my comment that I think the board has a very legitimate interest in looking at other things, such as culture and engagement and inert capacity to innovate and agility and absence of dysfunctionality.

Q. You said a moment ago that you considered it unlikely that an LHD that was meeting these KPIs would be failing to deliver on its statutory function. Why is that? What leads to you that view? Is it something about the KPIs themselves or is it just --
A. I think just the breadth of the KPIs in terms of moving people through the hospital quickly and effectively and getting the results, not having people getting bloodline infections above, you know, a level that is tolerable and so on. I just think the breadth of the KPIs suggests that if you are meeting those, you are doing a good job vis-à-vis the community.

Q. So do I gather from that that it's your view that if an LHD which is capable of meeting at least this broad range of KPIs is likely to be able to fulfil its statutory purpose as well?
A. Yes, yes.

Q. Even if that's possibly not being measured by the KPIs in a quantitative way?
A. If the LHD is meeting the KPIs and presumably at a performance level zero, because it is performing well and meeting the KPIs, then yes, I believe it is fulfilling its statutory function.

Q. Can I ask in relation to - so we have our statutory plan, or our strategic plan?
A. Strategic plan, yes.

Q. Then that's delivered through, I think you have told us, a range of other documents which includes, does it, the clinical services plan?
A. Correct.

Q. What involvement does the board, at your LHD, have in the preparation of that clinical services plan?
A. Well, the current clinical services plan for the district is to 2024, so we are in the process of doing a new clinical services plan. We had the draft clinical services plan come to the board meeting last week. It's a very substantial document. It's about 300 or so pages.

The purpose of it coming to the board last week was for the board to give its approval for that document now to move to the next step, which is broad engagement, including community engagement. So the board is - like any strategic plan or similar document, we want to know the provenance of the current draft, how it relates to the previous clinical services plan, the recommendations that were made in the previous clinical services plan, have they been carried through, what were the consequences of carrying them through, were there any that were not carried through, what has changed - well, clearly COVID has come along and that's changed a lot of the delivery of services. We've got things like artificial intelligence, we've got now new arrangements within the ministry around consolidation of research. There are new models of care emerging. There are changed population demographics.

Take St Leonards, densification of the suburb, high rise and so on. We've had migrant populations move into the Ryde area, culturally and linguistically diverse communities and so on. So all of that, as a board - our job is not to write the clinical services plan. Our job is to make sure that there is a satisfactory and transparent process by which the clinical services plan is developed, and we've got a strong team that has done that, and then as a board we need to be satisfied that there will be appropriate engagement and consultation so that everybody who is a relevant stakeholder can feel that they have had the opportunity to contribute to the clinical services plan, which then becomes a five-year document and becomes relevant to the planning of new services, the planning of new facilities and infrastructure.

Q. Do you see it as part of the role of the board to satisfy itself that the services which are to be proposed to be delivered through the clinical services plan align with the needs, health needs, of the community not being delivered through sources external to the LHD?
A. Yes, subject to the rider that - my earlier comments that there are some services that we are not providing, we're not funded for by the ministry. But to understand - of course we need to understand the health needs of the community in developing a clinical services plan.

Q. Just coming back to that answer, you refer to services which you are not funded by the ministry to deliver. If it

were the board's view that there was a service that, under the statutory obligation of the LHD, it ought be delivering, but it was not included amongst the body of funding provided, what would you see the role of the board as being?
A. Well, we would take - well, through the chief executive and with the support of the board, we would take it up with the ministry.

Q. And if the ministry said "Well, we're not going to give you any further funding", how does one deal with that situation as a board?
A. Well, it is difficult, but we cannot provide services if we are not funded to provide them. We can try to enter into partnerships with NGOs and others to see whether some workaround can be found, but we - yes, we can talk to other local health districts so, you know, you are aware, for example, that Northern Sydney is the state spinal unit centre of excellence, the burns centre of excellence, so we have patients coming into our district for those services and we have patients from our district going out of our district for services. It becomes a topic of discussion to see what solution can be found.

Q. Dealing with that example of the service that is not being delivered within your LHD by some external source, a view's been reached by the board that it ought be delivered as part of the performance of the LHD's statutory function but ministry has not decided to provide further funding for it, does that not mean it's the ministry that's making the decision about what services are to be delivered through the LHD in that instance?
A. Well, I think - we are in a - this might be a different question or a different answer, but we are in a three-way relationship in the running of the health service for the district - between the ministry, the executive of the district, and the board. And that's how it has been, I think, since at least 2011, when things were changed from it being a Department of Health to a Ministry of Health, and it is a very effective relationship which is a three-way relationship. So we would have a discussion about it. But we could talk to the minister, for example - you are probably aware that there have been issues around additional mental health, youth mental health services on the Northern Beaches and the like, and we started constructive conversation with the ministry to see how those can be funded.

We can look perhaps to philanthropic funds or sources of philanthropic moneys if we haven't got the funds. But at the end of the day, we can only operate within the budget that is made available to us.

Q. So to come back to my question, doesn't that mean that, to the extent that the budget that has been provided to you is determined by the ministry, is it not in the instance that we're talking about the ministry that's ultimately making the decision about whether this additional service is to be delivered through the LHD?
A. Yes, but it's very rare that a service is needed at the snap of the fingers. There's usually considerable planning time to know what additional services will be required and within that planning period, so long as you've got your ear to the ground as to what is coming along, that is when you would initiate conversations with the ministry, which is no different to the development of the annual services agreement where there is ongoing discussion about how many NWAUs we think we need to deliver and what we think the level of demand for particular services will be within the district.

Q. What do you consider to be the consequences of the LHD failing to deliver on its strategic direction, for the board?
A. Well, I don't think we have failed to deliver, so it's a hypothetical question.

Q. I certainly didn't suggest that you had failed to deliver, but as an incentive to deliver, what do you see to be the consequences for a failure to deliver, if there were one?
A. Well, I'm not sure what the consequences would be, because I don't think - this is very hypothetical, but I mean, vis-à-vis the ministry, we would not have failed to deliver, because the ministry presumably would have taken the view, well, if it's not in the service agreement, there is no need for it to be delivered, or at least to be delivered at this point in time. So I don't think we would be censured in any way by the ministry under the service agreement. But we would very vigorously take up the matter with the ministry and with the minister, if we thought that there was a material unmet need within the community.

Q. What about the consequences for the chief executive,

were the LHD to fail to deliver on the goals of its strategic plan?
A. If the chief executive were to fail --

Q. If the LHD were to fail in the board's view to deliver on the objectives of its strategic plan, what would the consequences for the chief executive be?
A. Well, this would - so we're not talking about - you are not asking me about services that we're not --

Q. Not asking about that?
A. This is just a break, you know, next question "If the chief executive didn't deliver on services".

Q. The two are not unrelated, to the extent that services need to be delivered as part of the delivery of the achievement of the strategic objectives. But let's take it to the strategic plan?
A. Okay. That's why I wanted clarity on that.

Q. So the strategic plan has a key range of things --
A. Yes.

Q. -- which the LHD, delivered through a range of documents, is seeking to achieve?
A. Yes.

Q. To the extent that the LHD fails to achieve on any of those objectives - just let's start again with the board. What would you regard as being the potential consequences for the board of a failure to deliver on those strategic objectives?
A. The consequences for the board?

Q. Yes.
A. Well, you would have to look at what was the item that was failed. You know, if you are in the middle of a pandemic, for example --

Q. Let's stick with business as usual.
A. Okay. Well, business as usual, the role of the - the board has set the strategy and it's the role of the chief executive to deliver on the strategy within the envelope of resources that is made available to the chief executive. So if the chief executive and the team of the chief executive were not meeting objectives, this would be raised, of course, with the chief executive; it would also,

of course, be raised in the chief executive's annual performance assessment. It would probably be reflected in the performance rating of the district. I think the ministry would make its views on those sorts of things known, and there would be some sort of recovery plan or turnaround plan identified as to how to address the relevant strategic objective that was not being met, subject to there not being, you know, some valid reason to say "Well, life has changed and we are reprioritising", or it's been subsumed by some other objective.

Q. Having regard to the very high level at which the strategic objectives are cast, it's difficult, really, isn't it, to know whether or not those objectives are being achieved or not?
A. No, I don't agree with that. As I said, we get a six-monthly traffic light report, which is pretty blunt. It's much more inclined to put red or orange ink on the page than to gloss everything over with green ink. But it's also something that is reflected - I meet with the chief executive for an hour every Friday morning throughout the year. It would be raised in that context.

If board members were concerned, I'm sure that they would raise it with me. We have the opportunity for an in camera session at the beginning of each board meeting and board members would raise those things with me. So it would not go unnoticed and it would not go uncommented on. But it is a complex, complicated business, and some things which maybe in 2022 looked like a high priority could be maybe slightly - might be reduced in priority in 2023 or 2024, or subsumed by something else.

But I just want to say, I take the view that if you are on performance level zero, which is unusual because zero is the best level to be on - if you are on performance level zero, it's a very strong indication that the ministry considers that it is a well-managed district, having regard to the totality of all the objectives, all the KPIs.

Q. But being on level zero - again, correct me if I have misunderstood it - means you are meeting the targets set by the KPIs in the service level agreement?
A. Yes. Well, yes, and I think also that - I would add to that my assessment is and the ministry is confident with the manner in which the district is being run and managed.

Q. But again, does that confidence derive from anything more than an assumption that, if you are meeting the KPIs, then everything else must also be going pretty well?
A. I haven't sat in on a performance meeting for some time. I used to sit in on them when I was at Sydney Local Health District. Back in those days, they were very broad-ranging conversations. They went through all the - they went through in detail all the KPIs, but there was also a lot of qualitative discussion around the direction in which the district was heading. I would imagine that there would be quite a lot of discussion around risk and issues like staff turnover and so on, because it's the nature of the business is more than just the KPIs.

Q. Could I ask you to go to paragraph 14 of your statement where you tell us about the board's annual review of its own performance?
A. Yes.

Q. Could I ask, how does the board make that review of its own performance?
A. Okay. So I write to board members in around September in each year saying that it's time to start thinking about the annual review of board performance. I invite board members at that point to indicate whether they think we should do the review internally or bring in an external facilitator.

We brought in an external facilitator a few years ago. It was an interesting exercise that obviously has a cost to it. We didn't feel that it necessarily added more than we could do internally.

So if I give you the example of the internal process, I will then write - I will send - I've brought a copy of the questionnaire that I send. May I refer to that?

Q. Yes.
A. I'm very happy to table that if you wish. So it goes - it is a one-pager, this is from last year. It says:

The annual board assessment provides the opportunity for each of you to provide feedback and suggestion on the current and future working of the board and its committees.

We welcome both written and verbal feedback and suggestions. In making your suggestions, please be mindful of the role and function of the board as set out in section 28 of the Health Services Act.

And then I say, "Please give me your name":

Provide up to three things where the board arrangements are working well.

Please identify up to three things where you believe board arrangements should be done differently or could be improved.

Please provide any board feedback on board arrangements.

Please provide any feedback on the effective and efficient operation of the board and committees.

Please provide any feedback on the board chair.

But that should be directed to the deputy chair rather than to me, and then I say:

In terms of your performance as a board or committee member, please identify up to three areas where you feel you are making a positive contribution.

In terms of the performance as a board or committee member, please identify up to three areas where you feel you would benefit from training or development.

Please provide any feedback or assessment of your personal and special attributes, competence, effectiveness, performance.

Please identify any other matters of a personal or general nature that you would like to raise as part of the annual board assessment.

Finally, please identify whether you would like to meet with the chair by telephone or face-to-face.

Q. So that information is gathered.
A. Yes.

Q. What is done with it?
A. So then I collate it, as necessary, I discuss it with the board deputy chair, and then I have one-on-one meetings with each of the board members, usually in around November, as I indicated by phone or by face-to-face, whatever they prefer, or by Teams, to run through my feedback. Generally, then, at the end of that exercise, when I've met with all of the board members, I will put out a note to the entire board saying "Look, here are some of the common themes that have emerged. Here are some of the learnings. These are some of the things that I would now like us to accommodate to change our own processes, because I think there is an opportunity for improvement".

Q. Have you had an occasion to deal with what you perceive to be a poor performance by a board member?
A. Do you want --

Q. Perhaps you could hand us that document. We might have it marked.

THE COMMISSIONER: Sure. MFI 7.

MFI #7 DOCUMENT HEADED "NSLHD SEPTEMBER 2023 BOARD SURVEY".

MR MUSTON: Q. Sorry, my question was have you had an occasion to deal with any situation where you perceive there to be a poor performance by a board member?
A. Yes.

Q. How do you deal with that situation, or how did you deal with that situation?
A. Well, candidly --

Q. That's what we require here.
A. Yes, well, you know, candidly, if I think a board member is either struggling or the board member might be out of his or her depth or they're not engaged, I will let them know. You know, the appointment of board members is a ministerial appointment and normally board members are

for a fixed term, you know, two or three years. I'm very happy to say to a board member, you know "If you're not enjoying it, if you're not contributing, maybe it's time to move on".

I have had no, you know, egregiously underperforming board members, but, yes, I have had to have some of those blunt discussions, and that's part of being the chair.

Q. Can I turn back to the issue around --

THE COMMISSIONER: We may not have identified that document very well. I have just said "7", it got a nod. MFI 7 is - what is it called?

MR MUSTON: MFI 7 is a document headed "NSLHD September 2023 board survey".

THE COMMISSIONER: Thank you.

MR MUSTON: It will in due course probably form part of the tender.

Q. Can I come back to the performance of the chief executive?
A. Yes.

Q. At the moment, it's right, is it, that the chief executive, at least as you understand it, reports to the board?
A. That is correct.

Q. If it were suggested to you that the arrangements for the reporting of chief executives should be adjusted such that there is a single line of accountability to the secretary, how would you respond to that?
A. I wouldn't be in favour of that. I think --

Q. Why not?
A. Well, I should say, before I answer that question, at the end of each year I sit down with the chief executive and the secretary and we have a three-way discussion on how the chief executive has performed in the year completed, what are the ambitions of the chief executive in the year going forward, what are areas where the chief executive might want to improve or refocus or whatever. So it is a three-way discussion.

Under our legislation - I can't recall the exact section, but at the back of the Health Services Act - the board, whilst effectively the employer of the chief executive, is not able to terminate the chief executive without the concurrence of the secretary. So it is very much a three-way relationship.

Q. I suppose my question is: what would be lost if it became a two-way relationship between the CE and the secretary, in your view?
A. In my view. Well, I think when you are the chief executive of an organisation reporting to the board but ultimately your performance is only assessed by a third party, it's got to - it must in some way compromise the effectiveness of the relationship between the board, represented by me as the chair, and the chief executive. A sensible chief executive will understand in a sense regardless of what the reporting lines are, that it is a three-way relationship and that a successful chief executive needs to enjoy a strong relationship with both his or her board and the secretary.

So I wouldn't, you know, be overly worried, because there were - the employment of the chief executive is delegated to the board under the legislation. But I think the current arrangement - the current arrangement works well. I don't see anything in the current arrangement that isn't working well, so I would probably say leave it as it is. And, in any event, I have a three-way conversation with the chief executive and the secretary routinely, and at the end of each year as part of the annual performance appraisal.

Q. Can we jump forward to paragraph 48 in your statement?
A. 48? Yes, thank you.

Q. I will just give you a short moment to remind yourself of what that paragraph, and, say, paragraph 49, tells us?
A. Yes.

Q. You see there a clinical quality improvement framework that you describe seems to involve three issues: role delineation?
A. Yes.

Q. The monitoring of action taken in response to

incidents?
A. Yes.

Q. And the monitoring of the LHD's progress on safety and quality performance in health care?
A. Yes.

Q. In relation to the last one, how is that monitoring undertaken, as you understand it - that is, the LHD's progress on safety and quality performance in health care?
A. Okay, so we have one of the mandated committees of the board is the health care quality committee, which in my case is chaired by Professor Emeritus Mary Chiarella. It does the heavy lifting around safety and quality and, then, at each board meeting, Mary provides both a verbal and a written report to the board on what are the key issues, certainly any outliers or trends, and then we publish our annual safety and quality report, which is something we started publishing about three years ago, or four years ago.

So the board receives, you know, a great deal of information, and I think having somebody like Mary, who has a clinical background - there is a very serious interrogation of the executive and our director of patient experience and clinical governance and, as I said, it's reported up to the board and we, as appropriate, call out any issues that we're concerned with and, as necessary, get people to come and talk to the board on those issues that are called out.

Q. Well, in terms of the board's role, the clinical council within the hospital deals with accreditation issues or within a hospital deals with accreditation issues as against the national standards; is that right?
A. I'm not sure that is right. We've just gone through accreditation last year. We had five of our facilities accredited because there had been a bit of a backlog during COVID.

Q. Within the broad structure of the LHD, who do you understand, or what body do you understand, is principally responsible for dealing with that accreditation process?
A. The chief executive and, under the chief executive, the executive director of patient experience and clinical governance.

Q. Central to what they are doing in performing that role is quality and safety?
A. Yes.

Q. And the extent to which quality and safety is mandated by the standards, that's something done externally to the LHD?
A. Well, the accreditation is done externally.

Q. And the determination of the standards against which hospitals are accredited?
A. Yes. Well, they are national standards, yes.

Q. You are familiar with the work of the CEC within the ministry?
A. I am.

Q. And also with the patient safety first unit?
A. Yes.

Q. Those two bodies deal, do they, with incidents and - well, the way in which - they make an assessment of the way in which incidents are dealt with?
A. Look, I can't - I'm not sure what happens within the ministry on those, but I know that if there is some serious incident and there is a reportable incident brief, it goes off to the ministry, but it also goes off to our safety - our HCQC.

Q. Cutting to the chase, what, in your view, does the board or the oversight of the board in relation to these issues - safety, incident management and response - add to what is already being done by the CEC and the patient safety first unit?
A. Well, I think we - you know, we localise it, because the relevant incident has happened at the district. We have ministry policies on things like open disclosure, but we want to make sure that if some incident has occurred, we have understood why it has occurred and, even more importantly, what will be done - what is the learning from the incident and how will we ensure that we share the learning, not only at the hospital or facility where it occurred but our other facilities and services, and how do we try to make sure that it doesn't happen again, and if there has been some human failure, if additional training is required, what it is that - what is needed and how is that implemented. So I think the localisation of the

issue - I mean, we benefit greatly, of course, from the work done by the CEC, no question about that. But we want to bring it back - coming back to PROMs and PREMs, we want outstanding results in our district, and I think to simply say "Well, it's gone to the ministry, we don't need to hear about it anymore" would detract from getting it right at the district and learning about it.

Q. So it is your view that whatever work is being done by the CEC and the patient safety first unit has insufficient local focus to provide --
A. No, no, no. I'm not saying it has insufficient local focus at all. It is high-quality work. But we want to take that work and bring it to the district and localise it and learn from it and implement it at the district, and that --

Q. In a way that those bodies are not able to do?
A. Well, no, I'm not saying they are not able to do it, but they are providing information. The question then is, what is the district --

Q. Is it your view that they are currently doing it?
A. Well, my understanding is, yes, they are. But how do we take what they say and what they recommend and make it part of our standard operating procedures and lessons learned and opportunities for improvement within the district?

Q. Could I ask you to go to paragraph 52 of your statement?
A. Yes.

Q. Here you tell us about the particular priorities in relation to the health needs of Aboriginal or Torres Strait Islander people?
A. So I should start off by saying we have a relatively small Aboriginal and Torres Strait Islander population within Northern Sydney. I think we have probably no more than about 5,000 people who identify as Aboriginal or Torres Strait Islander, but we have a number of specific services and facilities, a number of them coming out of Hornsby Hospital, which seek to address not only the health needs but the health anxieties and health propensities of people with an Aboriginal or Torres Strait Islander background.

Q. Can I ask you to jump forward to paragraph 53?
A. Yes.

Q. You tell us there that the board is satisfied that the LHD complies with the requirements set out in the Aboriginal Health Impact Statement and guidelines. My question is --
A. My --

Q. Wait till I have asked you the question. My question is, what has the board done to satisfy itself that the LHD is complying with those requirements?
A. Well, we have a director of Aboriginal health services, Peter Shine, who comes to the board to present at least annually, but we see Peter more regularly as we get out and about. We've got an Aboriginal health plan within the district. We have on our board - one of our board members has particular knowledge of Aboriginal health. So I think all those factors combined, and of course, the KPIs that we have to achieve that are relevant to Aboriginal and Torres Strait Islander health - I think across those four elements the board can be satisfied that what it is doing is appropriate. We also have a number - we regard ourselves as really quite innovative in a number of ways with some of the programs that we are trialling within the district, and there is a lot of open communication between the director of Aboriginal health services and the board, including myself. So I think across all of those factors, we're satisfied that we are doing what we're required to do for our Aboriginal and Torres Strait Islander population.

MR MUSTON: I note the time, Commissioner. I am trying to recall exactly when it was we were supposed to be concluding today.

THE COMMISSIONER: Twelve.

MR MUSTON: I don't have a huge amount more to go but I do have a little bit, but if 12 is a hard deadline.

THE COMMISSIONER: It is. We might have to come back on Monday, unfortunately. Is that terribly inconvenient?

THE WITNESS: I would have to check my diary. This is my third or fourth reschedule this week. It probably would be more convenient - if it's not too much longer, it would be more convenient to finish today. But if it has to be

Monday, I will --

THE COMMISSIONER: It is not convenient to me, that's the problem, and I'm currently in charge. I'm really sorry about that, though.

THE WITNESS: That's all right.

THE COMMISSIONER: We might have to come back and finish the witness on Monday.

THE WITNESS: Would there be some flexibility to - because I may be looking after my granddaughter Sophia one day, so I just need to juggle that, if I can.

MR MUSTON: I'm sure we can accommodate.

THE COMMISSIONER: Okay. We might liaise with you as to what time on Monday suits you best. My apologies for that.

THE WITNESS: No, no, that's fine.

THE COMMISSIONER: All right. We will adjourn until --

MR MUSTON: 10 o'clock Monday.

THE COMMISSIONER: -- 10 o'clock on Monday. But if earlier suits Mr Danos, we can sit earlier than 10 as well.

THE WITNESS: All right. Thanks.

THE COMMISSIONER: All right. We will adjourn until some time on Monday.

AT 12.00PM THE COMMISSION WAS ADJOURNED TO MONDAY, 29 APRIL 2024 AT 10AM

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