

**Special Commission of Inquiry
into Healthcare Funding**

**Before: The Commissioner,
Mr Richard Beasley SC**

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

Wednesday, 24 April 2024 at 9.00am

(Day 023)

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

Also present:

Mr Richard Cheney with Mr Hilbert Chiu for NSW Health

1 THE COMMISSIONER: Good morning.

2

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

5

6 <JAMES WALTER MIDDLETON, sworn: [9.01am]

7

8 <EXAMINATION BY MR FULLER:

9

10 MR FULLER: Q. Professor, can you state your full name,
11 please?

12 A. Yes, James Walter Middleton.

13

14 Q. You are a professor of rehabilitation medicine at the
15 John Walsh Centre for Rehabilitation Research?

16 A. Yes, so - yes, professor of rehabilitation medicine at
17 the University of Sydney and the John Walsh Centre for
18 Rehabilitation Research.

19

20 Q. Am I right in understanding that the John Walsh Centre
21 is part of the Kolling Institute, K-O-L-L-I-N-G?

22 A. That's right. So it's part of a joint partnership
23 between the university and the Northern Sydney Local Health
24 District.

25

26 Q. You are also the clinical director of the NSW State
27 Spinal Cord Injury Service?

28 A. Yes. Yes, I'm director of - the clinical director of
29 the NSW State Spinal Cord Injury Service at the Agency for
30 Clinical Innovation. I've been the director since 2006,
31 for my sins.

32

33 Q. What is your division of time between your
34 professorial role and your role as clinical director?

35 A. I'm a half-time professor, so 0.5, and 0.3 at the
36 Agency for Clinical Innovation, and I'm a one-day-a week -
37 I have a clinical role as well with the NSW Spinal Outreach
38 Service, one day a week, which is based at the Royal Rehab
39 centre in Ryde.

40

41 Q. Can you just tell us what is the State Spinal Cord
42 Injury Service?

43 A. Yes. So the State Spinal Cord Injury Service consists
44 of inpatient and community based services. So it's
45 a highly specialised, high-cost, small-volume. Service,
46 spinal cord injuries are relatively rare but a very highly
47 complex condition, so we have three main hospitals, so

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

15
16 We also have statewide spinal outreach and rural
17 services, so they are statewide services, so metropolitan
18 or greater metropolitan based spinal outreach service and
19 a rural service with a rural coordinator in each of the
20 rural LHDs, as well as a central small team in Sydney, and
21 they are all run out of the Royal Rehab centre.

22
23 Q. Just starting with the acute services, they are
24 provided for the whole of New South Wales from the three
25 facilities you have mentioned; is that right?

26 A. That's right.

27
28 Q. And, then, in terms of the community based services,
29 do we take it that there are clinicians and other
30 practitioners based throughout New South Wales who are
31 involved in providing those services?

32 A. Well, there is a rural coordinator in each of the
33 rural LHDs, but really there are no other specialist
34 services in New South Wales, and that's one of the
35 challenges with the way the services are structured, funded
36 and governed at the moment.

37
38 Q. You mentioned the - and we will come back to that
39 issue. You mentioned the state spinal outreach service.
40 Can you just describe a bit more about what that does?

41 A. Okay. So the spinal outreach service was originally
42 funded through the GMCT, GMIT, so it was established in --

43
44 Q. Sorry to interrupt you, what are those acronyms?

45 A. So the Greater Metropolitan Task Force and - managed.
46 So that was established to look at enhancing services back
47 almost 20 - well, more than 20 years ago. So that was the

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

3
4 So that through that mechanism, the spinal outreach
5 service was established. So it's a multidisciplinary
6 service, it has a manager as well as a range of all
7 disciplines, medical - not much medical, unfortunately, but
8 medical, nursing, allied health, including social work,
9 psychology and - sorry, OT, occupational therapy and
10 physiotherapy, and we look after - the service delivers
11 sort of a community based follow-up advisory and support
12 service for 12 months post injury.

13
14 So once people are discharged into the community, it
15 supports the community reintegration, and obviously does
16 link with a range of other government and non-government
17 services to support the person's full integration into
18 society. That actually includes a vocational service
19 called INVOC as well, so again, specialised services that,
20 you know, help support people return to work.

21
22 Q. And those are all services provided through the State
23 Spinal Cord Injury Service; is that right?

24 A. So - well, they are all provided through the funding
25 arrangement with Northern Sydney Health and Royal Rehab.
26 But it has never - there hasn't been an escalation or even
27 kept pace with that over the last 20 years. So, I mean -
28 I guess we'll come back to that, but part of the
29 governance, the transparency and the understanding, at an
30 LHD level, of these services is not very good.

31
32 THE COMMISSIONER: Q. When you were talking about the
33 multidisciplinary services, you said "not much medical,
34 unfortunately". Would you like to expand on that?

35 A. Yes. So I guess originally we would have liked to
36 have had more medical support. In fact, we have just
37 appointed - we've now got a full-time medical quotient. So
38 for the last 20 years we've only really had 0.4 a doctor as
39 part of that service, and that included the rural as well
40 as the metropolitan outreach service, so myself and one of
41 my colleagues have been one day a week each.

42
43 So originally, it was part of the original proposal,
44 but we didn't have enough funding at the time, the money
45 was better spent on more allied health. But, thankfully,
46 the Royal Rehab centre recently has added 0.6 funding to
47 that. So we've just appointed, the first time - now have

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

11

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

15 A. Yes.

16

17 Q. That's right?

18 A. That's right.

19

20 Q. And in terms of the funding of those services, is that
21 ultimately coming from Northern Sydney LHD?

22 A. Yes. It's part of the funding agreement and a service
23 agreement that has not existed for - since 2012, and I know
24 Matt Mackay came and spoke to you about the various
25 challenges and reasons for that, but, yes, basically the
26 mechanism for funding of that statewide service is through
27 the Northern Sydney LHD agreement.

28

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

32 A. Yes.

33

34 Q. Is that right?

35 A. Yes.

36

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

42 A. Sorry, is it typical to engage?

43

44 Q. Is it typical, for example, that a patient engages
45 with the service at the acute stage, or do you also have
46 patients coming in later on in the rehabilitation?

47 A. Yes - well, the people - we deliver a lifelong

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

20
21 So I guess - so there is a demand that, you know,
22 currently only - well, less than half of people with spinal
23 cord injuries that require access to the specialised
24 services are getting access to it, either in the acute
25 phase or rehab and, at times, not infrequently now, the
26 first time we're finding out that someone has had a spinal
27 cord injury, often of a non-traumatic nature, is through
28 the outreach service in the community. So they have had
29 their whole journey through the acute and rehabilitation.
30 Local, general rehab service, has been without any
31 specialist support.

32
33 Q. How does that outreach service work in practice, in
34 terms of identifying potential patients or candidates for
35 services?

36 A. Well, only by word of mouth. So obviously we get
37 referrals - everyone is automatically referred through -
38 anyone that flows through the specialised services, but
39 outside of that system, it's basically through the rehab
40 services picking people up, sometimes through general
41 practitioners or community practitioners, community health
42 professionals that are aware of the service. But people do
43 fall through the cracks and sometimes we don't pick them up
44 for a year or two.

45
46 I do rural clinics quite regularly. I've been on two
47 this year - Coffs Harbour, and Moruya just last week or the

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

3
4 THE COMMISSIONER: Q. What could be done to avoid that?
5 Some kind of central registry where all health
6 professionals that are treating people with spinal injuries
7 record it on a - or some other mechanism?

8 A. Yes. Look, certainly - so we've been - we've been
9 doing a lot of work in the last five or six years about
10 a networked model of care because of this - the large
11 number of people that aren't getting access to the services
12 that they need, either in a timely way or even at all, and
13 so part of that network model would certainly be an early
14 notification system to be able to triage, a way of
15 coordinating and triaging care and coordinating care, and
16 certainly part of the - there is no centralised - we do
17 have a statewide spinal cord injury database, but that
18 again only has people who are either - who the spinal
19 services are aware of and who have either come through an
20 acute service and/or a rehab - specialised rehab service,
21 ie the three services, or through the spinal outreach
22 service or the rural outreach service.

23
24 So we are constantly picking up - can pick up as many
25 as a quarter or a third of people that are new to these
26 services through our outreach and rural services, and that
27 may be people that have fallen out of the system for years,
28 but we're also - you know, last year I think we were
29 picking up, you know, a couple of people each clinic who
30 actually hadn't had any acute or specialised
31 rehabilitation. And so the first time - they might have
32 had surgery and gone directly back to their local health
33 district, for instance, Dubbo - surgery in Sydney, directly
34 back to Dubbo - without any involvement of our state
35 services, and then we pick them up through the rural
36 outreach service and the local rehab physicians, who are
37 really great at trying to support the service as well as
38 look for help when they need it, if they are aware of the
39 person, pick these people up.

40
41 So there are a lot of people, yes, falling through the
42 crack. We certainly do need a centralised process and
43 a mechanism that provides awareness in a timely fashion of
44 people with a spinal cord injury, and we do have a project
45 that is just beginning with the Ministry of Health, looking
46 at whether we can use the patient flow portal as
47 a mechanism for identifying people with spinal cord

1 injuries across services.

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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.

1 Q. The patient flow portal that you have mentioned, does
2 that aggregate data across LHDs?

3 A. It can. It generally doesn't. So ICU, for instance,
4 does have an ICU dashboard that looks across all of the
5 services in the state as a precious resource, as it should,
6 not for spinal cord injury. So I guess that's - you know,
7 there are opportunities to do that. It hasn't been easy to
8 do that in the past, and again, because it's also
9 decentralised rather than centralised. But certainly it
10 can be done and that's something we're looking at at the
11 moment.

12
13 Q. You said it hasn't been easy to do it in the past. Is
14 that because, in your view, of the decentralised nature of
15 the service provision and governance of the State Spinal
16 Cord Injury Service?

17 A. Yes. Well, I think it comes back to a lack of
18 centralised governance. So without - so the LHDs are all
19 delivering the services. There is again a very high-level
20 one line in a service agreement to deliver spinal service -
21 statewide spinal services. Essentially, how that's
22 operationalised, what that means, how the services are
23 coordinated is not done centrally, it's done, you know,
24 within the major service hospitals.

25
26 So again, we can only know what we know, and so if we
27 don't know - and we've done a big evidence report recently
28 in the last 10 years of data that quite clearly shows that
29 less than 50 per cent of people with a spinal cord injury
30 are getting access to specialist services in a timely
31 fashion, or even at all, and a third of those are people
32 with traumatic injuries, two-thirds of those are people
33 with non-traumatic injuries.

34
35 So we've only been managing, and able to manage, you
36 know, some of the patients. Not everyone needs to be
37 managed in a specialised service, either. It's important
38 to say that. But people need access to specialist
39 services. So either through in-reach support or ultimately
40 through outreach support in the community, and often, as
41 I said, for non-traumatic injuries, people are often well
42 managed and appropriately managed in local health
43 districts, but once they are stabilised medically, then
44 they very often need specialist rehabilitation at Prince of
45 Wales or Royal Rehab, and those resources are very
46 difficult to get access to, because essentially all of the
47 people already in the system are struggling to get access

1 to those.

2
3 So we have insufficient rehabilitation, specialist
4 rehabilitation beds to enable patient flow. We have
5 bottlenecks both in intensive care and the acute services
6 at Royal North Shore Hospital and Prince of Wales are
7 backed up because we don't have - we have insufficient
8 rehabilitation beds, and also challenges in discharging
9 people from the community - you know, into the community as
10 well, in terms of access to accommodation, NDIS funding and
11 so forth.

12
13 THE COMMISSIONER: Q. When you were talking about the
14 report that was done using the last 10 years of data which
15 shows less than 50 per cent of people with a spinal cord
16 injury getting access to specialist services, who did that
17 report?

18 A. The Agency for Clinical Innovation. So, I mean, we
19 have been working with - through the Agency for Clinical
20 Innovation to look at - I guess look at a better model of
21 care. So this has been part of a long process of
22 coordination, of review of the data, of data modelling, of
23 building a business case for where - modelling improvement
24 in patient flows, timely access to care, what that would
25 look like in terms of improved outcomes, what the cost of
26 doing nothing is in terms of the preventable complications
27 and so forth. So we're certainly happy to share that
28 information, if that's helpful.

29
30 Q. I'm sure it would be. And insufficient rehabilitation
31 beds, what are we talking about there in terms of numbers?

32 A. Well, the modelling suggests that we need 18 more
33 beds, but as I said, in terms of patient flow, that number
34 could be reduced to 11 if we could get people out of
35 hospital in a more timely fashion as well. So part of the
36 optimal model of care includes a transitional living
37 accommodation model that would get people - allow people to
38 be discharged in a timely fashion. The current data
39 suggests that there are delays, a mean delay of 30 days.
40 So there is a number of beds and efficiencies in flow that
41 can be achieved through getting even half of those people
42 out in a much more timely fashion.

43
44 So again, that's more challenging because it involves
45 both - it involves a multi-system sort of approach and also
46 federal as well as state resources, such as the NDIS, that
47 are more difficult to access in a timely fashion.

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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.

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

9
10 THE COMMISSIONER: Sorry to interrupt, but when I was
11 talking with the professor, he mentioned the evidence
12 report with 10 years of data, apparently we do have that
13 report, but it's not in the tender bundle. It must be the
14 only document vaguely related to terms of reference B and D
15 or any other that is not, but you might want to consider
16 tendering it.

17
18 MR FULLER: I'm sure we can fix that, Commissioner,
19 thank you.

20
21 Q. Professor, do you think that re-establishing something
22 like the statewide planning and development branch would be
23 helpful in addressing the issues that you have identified?

24 A. I think it needs to go further than that. So the
25 strength of it was that there was a centralised approach to
26 planning, but as I mentioned, it was not linked to funding.
27 I mean, Kathy Meleady was - we were lucky. She was an
28 advocate and she could see - she saw the need, and that was
29 how that service, the rural service, did get funding. But
30 really it was fortuitous, so without that involvement - but
31 there was no, then, subsequent mechanism for implementing
32 the services.

33
34 So I actually think it needs to go much further than
35 that. I think there needs to be a centralised body or
36 a centralised mechanism that involves ACI and the LHDs and
37 various parts of the ministry responsible for financing,
38 performance, planning, et cetera, that has responsibility
39 for the overall governance, but that includes the planning,
40 the implementation, the funding, you know, the review of
41 data, so really, the performance management, the review of
42 how services are delivered, in terms of the actual - a much
43 more detailed level of specification, I think, in terms of
44 service level agreements with the LHDs. Because one of the
45 challenges over time with the funding model - and perhaps
46 I will mention the funding as well, but the funding model -
47 is that once it's been absorbed into budgets over time, and

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

11
12 So again - and it's not surprising, because as I said,
13 we're a small-volume, high-cost, highly specialised service
14 within LHDs that, you know, have all of the population
15 health, health promotion and issues to deal with, so we're
16 certainly not on their radar, and they are stretched -
17 their budgets are stretched. So it's not really the right
18 mechanism, but it is our only mechanism to try and - so the
19 rural, again, in the same way, the demand for our rural
20 services, the demand for the spinal outreach service have
21 grown enormously, and the modelling shows that really we
22 need to enhance that service by at least one and possibly
23 double its size.

24
25 Q. The modelling that you just mentioned, is that part of
26 the ACI modelling that you mentioned earlier, or is that
27 different?

28 A. Yes. Yes. But we've done - we've been working with
29 the ministry, looking at that in more detail, so we could -
30 there may be some additional documentation that breaks down
31 the modelling into a couple of - one or two pages, more
32 recently, that possibly might be of value.

33
34 Q. What part of the ministry are you working with on that
35 project?

36 A. Well, that's funding. So that's - yes.

37
38 Q. Is there any particular individual or group who you
39 are working with on that?

40 A. Well, Annette Marley is the person, Joe Portelli and
41 others. So currently we've working with Annette Marley and
42 she's been liaising with various people in the ministry and
43 has identified that we need to develop basically an NPP,
44 a new policy proposal document, this year, to put up for -
45 as a new funding proposal.

46
47 Q. When you say "we" in that answer - "we" have been

1 working with the Ministry of Health --

2 A. Yes.

3

4 Q. -- is that you with your clinical director hat or your
5 Royal Rehab hat?

6 A. No, so the royal "we", so ACI. So ACI, particularly
7 the economics, you know, the modelling, the economic parts
8 of that.

9

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

15

16 Q. Are we right in thinking that the ACI's role, or the
17 role of the service at the ACI level, is really about
18 developing the model of care and then performing data and
19 economic modelling, rather than operationalising anything
20 that comes out of that?

21 A. Yes. Yes, absolutely. So the ACI is really all about
22 developing models of care. It has no operational
23 responsibility or involvement in the day-to-day workings of
24 the LHDs, the spinal units.

25

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

34

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

47

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

7
8 Q. In one of your earlier answers, you I think again used
9 the royal "we", talking about developing service agreements
10 and business cases for the rural LHDs. When you have used
11 the royal "we" there, so --

12 A. Okay, sorry, I shouldn't. So the royal "we" in that
13 case is the LHD, so the chief executive of the LHD, myself
14 as the clinical director of the ACI, and Matt Mackay as the
15 chief executive of Royal Rehab. So, essentially, the
16 triumvirate, you know, is an agreement.

17
18 Again, there isn't really - so it is not a service
19 level agreement as such, it is essentially a memorandum of
20 understanding between - with a three-partite sort of
21 signature process. But as I said, we've tried to renew
22 those every three years. It's often challenging because
23 there are new people in the roles. So again, without any -
24 without a state approach to it - I mean, we've taken a,
25 tried to impose some sort of a governance process to it,
26 and in fact, in terms of the outreach service and
27 particularly the rural service, we do - all of the
28 coordinators in each of the local health districts report,
29 they have performance indicators, so we do monitor their
30 activity and pick up, you know, a lot of new referrals, as
31 I said, through them.

32
33 In northern New South Wales we also have the challenge
34 of cross-border flows and there is an increasing number of
35 people coming - returning particularly from the Gold Coast
36 without coordination, without rehab, just arriving back in
37 the community or back at Lismore Hospital, for instance,
38 without anyone knowing about it. So again, there are
39 issues of cross-border flows and better coordination, and
40 that goes for Canberra as well.

41
42 Q. The memoranda of understanding are between Royal
43 Rehab, you as the clinical director within the ACI, and the
44 rural LHD; is that right?

45 A. Yes.

46
47 Q. And those are documented, I assume?

1 A. Yes.

2

3 Q. The business cases that you mentioned having been
4 rejected, as I understand it - can you just elaborate a bit
5 on that?

6 A. Yes, well - so through the coordinated sort of, you
7 know, data collection that comes through each of the rural
8 coordinators, plus, as you know, we run monthly clinics,
9 interdisciplinary clinics, so we take a flying team around
10 the state each month, that has shown basically the need
11 for - and again a growing need, as I said, about a third of
12 people in each clinic are new to the clinic, and that seems
13 to continue to be the case.

14

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

20

21 Q. So these are rural coordinators based within
22 a particular rural LHD --

23 A. Yes.

24

25 Q. -- developing a business case for their own LHD to
26 fund --

27 A. Yes, with the support of the statewide service.

28

29 Q. Do you have any particular rural LHDs in mind?

30 A. Well, several. So, I mean, I could provide - I can
31 provide the details, if you like.

32

33 Q. Do you have copies of the business cases?

34 A. We could - yes, we could get them.

35

36 Q. All right.

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

40

41 Q. And those business cases, are they about expanding
42 services within the rural LHD, or is there an element of
43 trying to share the burden of funding that currently falls
44 on Northern Sydney LHD as well?

45 A. No, that's more to do with the demand within - demand
46 on the rural - local rural coordinators. So, you know,
47 there is just not enough of them, and in particular areas

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

9
10 Q. Do we understand correctly that at the moment, it is
11 the case practically that services being provided for
12 spinal injury rehabilitation in rural and regional
13 New South Wales are being subsidised by Northern Sydney
14 LHD? Would that be accurate?

15 A. I don't know that - oh, well, I think it's - yes, to
16 some extent, I guess. They're just not - the services are
17 not being - yes, we're doing the best we can.

18
19 Q. That's not intended as a criticism.

20 A. No - so there are two components to the funding, and
21 so the funding that's central, that's kept with the central
22 team, so that's a manager, you know, and four allied health
23 people, so a nurse - sorry, yes, so the equivalent of
24 a nurse, an occupational therapist, a physiotherapist and
25 a social worker, plus a manager, so five positions that are
26 part of the rural team, that's funded through Northern
27 Sydney Health. But all of the local health positions in
28 local health districts are funded - have been funded, you
29 know, previously through that money from Kathy Meleady and
30 absorbed into the local area health service budget. So
31 there is no responsibility for that, although there is
32 obviously a lot of onus on the central services to support
33 the local coordinators.

34
35 As I said, you know, it's very - it's becoming very
36 difficult with the growing demands, to meet those demands.
37 So people aren't getting - necessarily getting the support
38 that they need at the time they need it. I mean, as of
39 yesterday, a growing emerging problem is the problem of
40 severe pressure injuries. As of yesterday, there were 20
41 people around the state either in the community or in local
42 hospitals that were waiting surgery or management, so with
43 the most severe grade of a pressure injury. So, again,
44 that's a flow, a downstream effect of not having enough
45 resources, not having - I mean, we have challenges --

46
47 THE COMMISSIONER: Q. When you say "waiting for

1 surgery", do you mean delay?

2 A. Well, so delays in accessing - yes, delays in surgery,
3 but also delays in getting appropriate care. So both - you
4 know, both nursing services, specialised dressings,
5 I guess - it's not just - well, yes, it - yes, there are
6 delays in getting access to the specialist services that
7 they need because there is not - and there is enormous
8 waiting lists also, but --

9

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

12 A. Okay.

13

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

17 A. Yes.

18

19 Q. You won't need it for the purposes of these questions,
20 but can I just ask you, this tells me, or tells the
21 reader - and the data is 2017/18 - that there were, in
22 2017/18, 344 people admitted with a serious spinal cord
23 injury, and 195 patients, or 57 per cent, with a serious
24 spinal cord injury, did not receive any care at
25 a specialist hospital during their index hospitalisation.
26 Is that consistent with current percentages, in rough
27 terms, in April 2024?

28 A. Yes. So part of the recent business case modelling,
29 as I said, looked at it over 10 years, up to 2023 -
30 2022/23. So there are more - so it is consistent.

31

32 Q. Could I get your view on this. The report tells the
33 reader that at least 125 of the 195 patients, or
34 64 per cent of them, "would have likely benefited from
35 specialist services" and then it goes on to say:

36

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

43

44 Et cetera. Can you just expand on that?

45 A. Sure. So people, as I mentioned - not everyone needs
46 to be managed in a spinal unit. So those 65 per cent
47 require some level of support, so whether that's in-reach

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

8
9 Q. The report also, in general terms, tells the reader
10 that there are a medium wait time for patients to access
11 specialist services of 20 days - so that's to get into the
12 specialist service. Then it also tells the reader that
13 there are medium wait times of between 18.5 and 95.5 days
14 for discharge. That is specifically mentioning the Prince
15 of Wales. What are the consequences of - I think you have
16 mentioned the consequences of not accessing specialist care
17 in a timely fashion. What are the consequences or
18 potential consequences of delays in discharge for a spinal
19 injury patient?

20 A. Well, the delays impact on patient flow and access
21 to - so upstream --

22
23 Q. One is someone is waiting for a bed --

24 A. Upstream and access to services.

25
26 Q. And someone should be discharged who is still there?

27 A. And that includes for those people with acute injuries
28 that need it, but also the readmissions that we've talked
29 about. So some of these people with severe pressure
30 injuries, for instance, are not able to access services in
31 a timely fashion, and that's becoming an increasing
32 challenge.

33
34 The impacts on the person themselves, often there is
35 a psychological impact from getting, if you like, stuck in
36 hospital, after you are ready to discharge and get on with
37 your life. So there can be negative impacts on the person
38 as well. But it's really - the bigger impact is actually
39 on the system and the efficiency and flow that provides
40 access, and a lack of equity at the moment.

41
42 Q. What are the causes of delays in discharge for spinal
43 cord patients?

44 A. Suitable accommodation is one of them. Access to care
45 and equipment, yes. So certainly the NDIS is one aspect to
46 that, but suitable accommodation and, you know, with an
47 appropriate level of support. So often people need -

1 I mean, it's the chicken and the egg. You have to have
2 accommodation to get the care, and you have to have care to
3 get the accommodation. So it's not often - it is not easy
4 to be able to coordinate those things in a very timely
5 fashion.
6

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

18 A. Mmm.

19
20 Q. But that's not atypical of the circumstances?

21 A. Actually, it is highly typical. That has been
22 a pattern for the last four or five years, and actually --
23

24 Q. So, in other words, 10 December 2019 is not an
25 outlier?

26 A. Well, in fact, if the Commissioner is interested, we
27 provide a snapshot to NSW Health recently in terms of
28 trying to, you know, support our business case, so I can
29 provide a snapshot from three or four weeks ago that
30 actually shows a much worse situation. So I think on that
31 day at Royal North Shore Hospital, Royal North Shore
32 Hospital has 18 acute beds in the spinal unit which were
33 full, but there was another I think 42 people in total in
34 the hospital, there were four in the burns unit with severe
35 pressure injuries, I think there were seven or eight new
36 admissions in other parts of the hospital, there were five
37 people blocked up in ICU. So I'm very happy to provide
38 that, because that's, very unfortunately, not untypical of
39 the struggles that we're having.
40

41 THE COMMISSIONER: Thanks.
42

43 MR FULLER: Q. The foreword of the report, and your name
44 appears at the foot of the foreword, says, I think in
45 summary:
46

47 *The report highlights the need to redesign*

1 *the way we deliver care to people with*
2 *spinal cord injury in New South Wales to*
3 *address current gaps, challenges, and*
4 *ensure equitable access to specialist care*
5 *or specialist guided care.*
6

7 I take it the need to redesign the system is based on the
8 things that we've been discussing in your evidence today;
9 is that right?

10 A. Yes. Yes. Indeed, I mean, some - I mean, the keys to
11 it are a statewide approach, an overarching governance
12 approach and, yes, better data, data management, central
13 notification and triage,, you know, performance -
14 performance agreements and monitoring the system, system
15 outcomes, looking at patient-centred approaches. All of
16 that, yes, is outlined in that report.

17
18 Q. This was a report from August 2020. Do you know
19 whether it went to anyone within the ministry?

20 A. Yes, certainly it's been presented to the deputy
21 secretaries, so Deb Willcox and Jean-Frederic Levesque,
22 they are very aware of it, they reviewed it in a meeting
23 late last year and have been very supportive in promoting
24 further work to, you know, identify how it might be funded
25 and implemented.

26
27 Q. Is that part of what has led to the current project
28 that you have been describing today?

29 A. Yes. I mean, really it's been an ongoing discussion.
30 We met prior to - just immediately prior to COVID we
31 actually met with the previous deputy secretaries, so Nigel
32 Lyons and Susan Pearce at the time, with a previous version
33 of this report, which required further data and further
34 business development, I guess, so that's really taken us -
35 and COVID also obviously challenged everything, but it's
36 taken us another really three years to further develop the
37 thinking, the modelling and the justification for where we
38 are now.

39
40 But I think the snapshot of what is current, as well
41 as what has been, is very typical, and so in my view - and
42 I think others' - there is not really an option to do
43 nothing, but we need to obviously think carefully about
44 what that next step is and how to do it in the most
45 effective and efficient fashion and appropriately governed
46 way.
47

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

3 A. Yes.

4

5 Q. Does that designation make any practical difference to
6 the operation of the service in your view?

7 A. No, not really. I mean, there is a new health
8 technologies and specialised services committee that has
9 been set up. Essentially, that deals with new technologies
10 or services. It has no role or responsibility for existing
11 services and it largely, I think, is focusing on the
12 challenge of new technologies and advances in treatment and
13 the impacts on care that that has. But, essentially, there
14 is nothing - there is no committee, there is no mechanism,
15 there is no central oversight. So we're nominally
16 a statewide service, and certainly acknowledged to be that,
17 and as I said, I guess it's articulated through a line or
18 two in a service agreement with a few LHDs, but beyond
19 that, it doesn't really mean anything.

20

21 Q. To the extent that funding of the services provided
22 through your service is determined on an activity basis, do
23 you have a view as to whether that is appropriate for the
24 sort of services that you provide?

25 A. Yes, well, we know it isn't. So one of my PhD
26 students actually did some work in the last couple of
27 years, 2019, that did look at the cost of delivering care
28 versus the funding provided through activity-based funding.
29 So that looked at what is called the DNR, the district
30 network return, so the actual cost, the buckets costing -
31 the buckets of cost that are allocated through the LHDs and
32 through, then, the actual funding provided through the NWAU
33 activity-based funding model, and the activity-based NWAUs
34 significantly underfunded the actual cost by about
35 25 per cent.

36

37 Q. And why is that?

38 A. Well, I mean, I think because it's - the activity
39 weights are not appropriate for, you know, the highly
40 specialised, highly complex nature of spinal cord injury,
41 brain injury, those sort of - they have never been - they
42 just aren't suitable. They underestimate the complexity.

43

44 Q. Is that work by your PhD student published?

45 A. Yes, it's published. I can share it with you and it's
46 been shared with the activity - the Commission as well.

47

1 Q. Sorry, which Commission is that?

2 A. The Productivity Commission, so - yes.

3

4 Q. Just, finally, do you see any expanded role for
5 technology in helping to address any of the issues you have
6 identified with the availability of spinal cord injury
7 rehabilitation services?

8 A. Well, I mean, technology plays an important part in
9 people's lives, in enhancing people's lives with spinal
10 cord injury. Certainly, you know, even motorised
11 wheelchairs are highly expensive, so access to technology
12 is important.

13

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

24

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

35

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

39

40 Q. And do you think that having a centralised governance
41 and funding model would help to facilitate the rolling out
42 of those sorts of technologies for a service such as yours?

43 A. Yes, no, absolutely. Again, it's about
44 prioritisation, it's about understanding the technology -
45 any technology, how appropriate it is, and implementing
46 that. One of the challenges of not having a centralised
47 approach at the moment is that it is only the people -

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

13

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

16

17 THE COMMISSIONER: Thanks.

18

19 Q. Can I just ask you, the PhD student you mentioned that
20 did work on ABF and spinal cord injuries, and you said you
21 had shared that with the Productivity Commission, have you
22 discussed or shared that with the pricing authority,
23 IHACPA?

24 A. Sorry, it is the pricing authority.

25

26 Q. Okay. I thought it might have been. What was the
27 outcome of those - sharing it?

28 A. Well, they were certainly interested, but it didn't
29 result in a change in the NWAU.

30

31 Q. Just so we don't have to Google it - I don't know
32 whether it's directly relevant - you were talking about new
33 technologies and spinal cord stimulation. What is that?

34 A. So it's electrical stimulation applied, so it is
35 a stimulation - stimulator that provides an electrical
36 current to the lower part of the spinal cord and
37 increases - it can improve the flow of information in
38 partially damaged nerves so that people may be able to have
39 enhancement of their muscle control or muscle function when
40 the stimulator is on.

41

42 But it was really an example.

43

44 Q. Understood.

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

1 would have cost implications and - yes.

2

3 Q. On that theme and just for my own curiosity, Mr Musk's
4 Neuralink, is that science fiction or has that got real
5 possibilities?

6 A. I guess we'll wait and see.

7

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

9

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

11

12 <EXAMINATION BY MR CHIU:

13

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

16

17 A. Sure.

18

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

22

23 A. Yes.

24

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

26

27 A. Yes.

28

29 Q. And you are the co-chair of that network?

30

31 A. That's right.

32

33 Q. What does the network do?

34

35 A. Well, the network coordinates activity, I guess, in
36 terms of planning and development. It monitors, you know,
37 data. So it is really a network that supports the
38 clinicians.

39

40 Q. Which clinicians? Clinicians within your service
41 or --

42

43 A. Well, clinicians - the network has about 400 members,
44 so it's not just the spinal units, it's a network across
45 New South Wales.

46

47 Q. Does the network have any role in oversight of the
State Spinal Cord Injury Service?

48

49 A. Well, there is - I mean, its function largely is in
50 terms of planning for - you know, service planning and
51 development and models of care and quality - supporting
52 quality and outcomes. So we run - we have various
53 committees, subcommittees in terms of looking - you know,

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

8
9 THE COMMISSIONER: Q. A pressure injury tool kit is one
10 of the things --

11 A. Yes, so pain management tool kit. We've recently
12 developed a health maintenance tool to support
13 self-management. In terms of algorithms for managing
14 autonomic dysreflexia, a whole raft of resources. And one
15 of the byproducts of the work of the network for developing
16 this new model of care has been the development of
17 resources for non-specialist centres, services, and that is
18 supporting - so that's done collaboratively with
19 clinicians, for instance, nurses and others, at some of the
20 main centres.

21
22 MR CHIU: Q. Just pausing there, as someone who has
23 a role in both the service and the network, do you see that
24 the network might be - and say "no" if you don't think this
25 is the case - an appropriate vehicle for the centralised
26 governance that you were talking about?

27
28 THE COMMISSIONER: Just before you answer that question,
29 what is the difference between the service and the network?

30
31 MR CHIU: Q. Professor, you can explain the difference
32 between the service and the network?

33
34 THE COMMISSIONER: The reason I'm asking is that the ACI
35 describes this as the State Spinal Cord Injury Service,
36 which it also then says what's the network structure of the
37 State Spinal Cord Injury Service .

38
39 MR CHIU: The witness gave some evidence about being
40 co-chair of something separate, a network with 400 people.

41
42 Q. Perhaps you could tell us the difference between the
43 two?

44 A. So as I said, the statewide - so the ACI doesn't have
45 any operational role, so we're not - we don't coordinate
46 services. We support a network of clinicians that deliver
47 services to people with spinal cord injury, and so our role

1 is more in planning development and supporting a clinical
2 network to deliver services in a statewide fashion, with no
3 governance - overarching governance of that.
4

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

8 A. Mmm.
9

10 Q. Things of that order?

11 A. Yes.
12

13 Q. To support a wide range of clinicians.

14 A. Yes.
15

16 Q. Would that be correct?

17 A. Yes.
18

19 Q. But doesn't have any operational oversight or
20 activity?

21 A. No.
22

23 Q. And then, separately from that, there is the NSW State
24 Spinal Cord Injury Service, which you are the head of?

25 A. Well, the service is a nominal service. So as I said,
26 the --
27

28 Q. What do you mean by "nominal service"?

29 A. Well, the NSW Health acknowledges that there is
30 a State Spinal Cord Injury Service. The ACI - but as
31 I said, there is no governance of that per se. So what the
32 ACI does is coordinate a network of clinicians who deliver
33 those services and support both specialist and
34 non-specialist clinicians to provide and improve the
35 delivery of services.
36

37 Q. So when you say there should be a centralised
38 governance of the service, what exactly do you have in
39 mind? Are you talking about service agreements? Can you
40 tell us what you have in mind in practical terms?

41 A. Yes, sure. Well, I think there has to be a framework
42 that supports the delivery of statewide services. So that
43 would - it must include, as I said - I mean the ACI is part
44 of the, if you like, planning, but it really has to include
45 the LHDs, it has to include the ministry and not - and
46 various parts of the ministry, because spinal cord injury
47 really crosses, you know, and draws on every part of the

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

9
10 Q. So do you mean, rather than just being a service which
11 is a collection of clinical activities provided in a number
12 of places, it needs to become an organisation that sits
13 within ministry?

14 A. Yes.

15
16 Q. And that organisation --

17 A. It needs to be organised as such.

18
19 Q. And, as I understand it, one of the advantages of that
20 is it would have its own separate funding directly from
21 ministry; is that correct?

22 A. Well, that's - you know, it needs - yes, it needs
23 funding. The service needs funding. It needs to be
24 appropriately funded and there needs to be clear -
25 a clear - yes, I think the funding needs to be identified
26 and separate rather than filtered down through LHDs.

27
28 Q. But the problem of it being filtered down through LHDs
29 is that it then needs to compete against other demands -
30 many, many demands that the LHD has --

31 A. Yes.

32
33 Q. -- for the provision of all its services?

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

44
45 The two ICUs, for instance, are highly specialised.
46 So not every ICU in New South Wales has anywhere near the
47 same level of expertise for spinal cord injury management

1 as the two ICUs at Royal North Shore Hospital and - so I'm
2 just saying that those sorts of - those things are hard to
3 identify at a local level, and particularly, as you said,
4 when there is competing demands, which are constant.
5 There's constantly --
6

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

11 A. Mmm, yes.
12

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

15 A. Yes.
16

17 Q. And outreach staff as well?

18 A. Yes.
19

20 Q. Allied health staff?

21 A. Yes.
22

23 Q. Nursing staff?

24 A. Yes.
25

26 Q. So would you agree, there is some advantage, isn't
27 there, of providing funding to the service through the LHD
28 because of that overlap in the way service is provided?

29 A. Well, yes and no. So the "yes" is that the services
30 and the LHDs obviously need to be funded. How they are
31 funded is - it doesn't matter, in a way, as long as it's
32 very transparent, it is very clear, and what is being
33 purchased and provided for that amount of money, which is
34 appropriately costed to meet the demand, actually flows in
35 a way - in a particular way.
36

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

1 a delineation of what is statewide services, highly
2 specialised and super specialty staff, as distinct from
3 other staff.
4

5 Now, that's not to say that, you are right, there is
6 plenty of advantage in staff rotations and, you know,
7 nursing and so forth, but there needs to be a maintained
8 level of specialty, and so we've seen those competing
9 demands over the years - and I've been around for 30 years
10 and seen numerous cuts of beds, for instance, you know,
11 four beds that are just shut over time, you know, suddenly,
12 and I'm going 20 years, 30 years back, but I've seen
13 repeatedly, every time there are cost pressures, there are
14 requirements to improve efficiencies and effectiveness and
15 et cetera. It unfortunately has a proportionate impact on
16 the services to the LHD, and that's inappropriate.
17

18 Q. If that's the case, Professor, it sounds like the
19 source of the problem might not necessarily be a separate
20 line of funding but, rather, a funding model for the entire
21 LHD that has a view for the future, has a view for present
22 needs rather than necessarily based on historical need;
23 would you agree with that?

24 A. Well, I think that's part of it, but I still think
25 that there needs to be oversight of that at a central
26 level. So the funding, however it flows down to the local
27 health district, needs to be identified centrally and it
28 needs to be managed, monitored, and as I said, it needs to
29 be supported by more detailed agreements with the LHDs
30 about what services are to be provided, what is the level
31 of, as you said, staffing and expertise, what are the
32 outcomes, you know, all of that.
33

34 Q. Just one final thing, Professor. You mentioned that
35 the current framework started in 2015, I think that was
36 something you referred to earlier?

37 A. Well, the current framework started - really has
38 existed forever. I mean, in 2015, the previous statewide
39 services development branch ceased to exist, so I guess
40 things became more decentralised.
41

42 Q. Are you familiar with the NSW Health governance review
43 that was undertaken in 2011 as a source of those changes in
44 2015?

45 A. I can't say I can remember it.
46

47 MR CHIU: No more questions.

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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?

- 1 A. Correct.
- 2
- 3 Q. And prior to that, you were a member of the Sydney
4 Local Health District board from 2011 to 2016?
- 5 A. Correct.
- 6
- 7 Q. I think you are currently the chair of the Council of
8 Board Chairs?
- 9 A. Correct.
- 10
- 11 Q. The Commission has been provided with an outline of
12 the evidence that you would be willing to give. Have you
13 had an opportunity to review that document?
- 14 A. Yes, I have.
- 15
- 16 Q. I understand there is a correction that you may wish
17 to make to it?
- 18 A. There is one correction that was advised to me this
19 morning, just the name of one of the documents.
- 20
- 21 Q. I think we can probably - I might be able to help you
22 with that. I think the correction is at paragraph 5
23 subparagraph (k), there is a reference to a document which
24 should be the Northern Sydney LHD Clinical Governance
25 Framework 2022-2025?
- 26 A. Yes.
- 27
- 28 Q. Other than that correction, are you content that the
29 document is true and correct to the best of your knowledge?
- 30 A. Yes, I am.
- 31
- 32 MR MUSTON: That document will in due course form part of
33 the bulk tender.
- 34
- 35 Q. Perhaps we could get a copy of the statement up on the
36 screen. It is [MOH.9999.0765.0001]. You are, Mr Danos,
37 free to look at your hard copy or the version of it on the
38 small screen next to you or the big screen in front of you?
- 39 A. I brought a hard copy, which might be easier for me to
40 look at, I think.
- 41
- 42 Q. Whatever is most comfortable for you. Could I ask you
43 to turn to paragraph 11, please. You see in that
44 paragraph you tell us what the functions of the board
45 prescribed by section 28 of the Health Services Act are.
46 In paragraph 11(b), one of those functions that you tell us
47 about is to approve systems to support the efficient and

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

9
10 Q. What do you as a board chair understand the needs to
11 be - needs of the community to be served there are, within
12 that context?

13 A. Well, I think it goes to the issue of community
14 consultation and engagement and understanding what are the
15 expectations of the community, what health services will be
16 provided by the district, and how those health services
17 will link in with, for example, primary care, that is not
18 the responsibility of the district; aged care, which is not
19 the responsibility of the district as well.

20
21 Q. You are familiar, I'm sure, with section 9 of the
22 Health Services Act which prescribes the purposes of the
23 LHD?

24 A. Mmm.

25
26 Q. Which includes to provide relief to the sick and
27 injured people through the provision of care and treatment?

28 A. (Witness nods).

29
30 Q. You probably have to say "yes" out loud. I note you
31 are nodding?

32 A. Yes. Yes.

33
34 Q. For the benefit of the transcript. Which seems to
35 capture fairly neatly the delivery of acute care in a
36 hospital setting; would you agree?

37 A. Yes.

38
39 Q. But also one of the purposes of the LHD is to promote,
40 protect and maintain the health of the community?

41 A. So we provide sub-acute services, we provide education
42 around health, we have a public health unit, we have
43 community and youth health services. So yes, all of that
44 is encompassed by what you have described.

45
46 Q. So you agree that the promotion, protection and
47 maintenance of health of the community is something which

1 contemplates the delivery of health care outside that acute
2 setting?

3 A. That is correct, yes.

4

5 Q. You said a moment ago that the - well, I infer that
6 the promotion, protection and maintenance of the health of
7 the community did not extend to primary care because that
8 was the responsibility of the Commonwealth; did
9 I understand you correctly in saying that?

10 A. Well, that is correct. The funding of GPs and primary
11 care is via Medicare. It's not contemplated or included
12 within the budget of the district. Of course, we regularly
13 liaise with the GP community, including through the primary
14 health network, but we are not providers of primary care,
15 although there are instances, for example, through urgent
16 care centres, of which we have one at Mona Vale, where we
17 come closer to doing that, and of course we do have people
18 who turn up to the emergency department with conditions
19 that might otherwise be suited to visiting a GP, but we do
20 not provide a GP clinic, as such.

21

22 Q. Your LHD is relatively well served by GPs?

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

35

36 Q. Acknowledging that GP services are funded by the
37 Commonwealth through Medicare as a funding model, there is
38 nothing that carves out the delivery of primary health care
39 from the obligations of the LHD to the extent that that
40 market based model is not working, is there?

41 A. Well, look, I think two comments for that. One is, if
42 you look at our service agreement, the annual service
43 agreement, I don't believe there is anything in the service
44 agreement about providing primary care, as such, but we are
45 the safety net for the health of the public, and so if
46 people can't find a GP or can't get into a GP, inevitably,
47 they will turn up at a public hospital.

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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

1 assessment - the starting proposition is the LHD needs to
2 deliver on those purposes.

3 A. Yes.

4
5 Q. As part of that process, an assessment must be made of
6 the needs of the community, the health needs of the
7 community?

8 A. Yes.

9
10 Q. Next part of that process might be making an
11 assessment of the extent to which those health needs are
12 met by services delivered external to the LHD?

13 A. Yes.

14
15 Q. Including, for example, services delivered by GPs who
16 are being funded in a market based system through Medicare?

17 A. Yes.

18
19 Q. To the extent that, in making the assessment of those
20 factors, the LHD comes to the view that there is a gap
21 which is not being - a gap in, say, primary care, which is
22 not being filled by GPs, then it remains part of the
23 LHD's - would you agree that it remains part of the LHD's
24 obligation to step in and deliver that care in some way?

25 A. Well, we have - let me answer it this way: we would
26 refer to the service agreement to see what we are funded
27 for and what we are expected to deliver. If we saw
28 a market failure, clearly, we would speak to the ministry.
29 We would speak to the PHN to seek to address it. And I'm
30 not talking exclusively medical. This could be home
31 nursing, it could be allied health, podiatry in the
32 community. We have a community health unit which reports
33 directly to the chief executive, so I would hope that we
34 would be aware of these factors.

35
36 But it would not be right to say that we would step in
37 and provide or set up, for example, a GP clinic. We would
38 see the consequences of it probably by virtue of people
39 starting to attend our emergency department with conditions
40 which might otherwise be addressed by a GP, but I don't
41 think our board would see it in any way that we would
42 therefore need to go out and set up a GP clinic or start
43 employing GPs.

44
45 But it is in our interests to have a healthy
46 community, because the healthier the community, the fewer
47 the presentations to the emergency department.

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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,

1 obviously?

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

9

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

14 A. Correct.

15

16 Q. Was any information provided to the board in relation
17 to that strategic plan preparation in relation to the
18 health needs of the population?

19 A. Yes. We of course would have taken detailed
20 information and advice from the chief executive and - who
21 at that time was Deb Willcox - and the direct reports to
22 the chief executive.

23

24 Q. Do you have a recollection of what that information
25 was? Was it reports on health needs assessment, or were
26 there --

27 A. Yes. Well, I don't have the information in front of
28 me, but it would have talked about things like population
29 projections, health projections, changes in models of care,
30 particular demographics of the community, different parts
31 of the community having different illness presentations,
32 ageing of the population, the fact that we have a very
33 significant number of aged care facilities within the
34 district. All of that information would have been collated
35 and presented as part of the development of the strategic
36 plan.

37

38 Q. Do you recall it involving any assessment of the
39 extent to which the health care needs of the community
40 within the LHD were being delivered by services external to
41 the LHD?

42 A. I believe so, because we - one of the direct reports
43 to the chief executive is the director of community health
44 services, so we would have heard that, just as we would
45 have heard from the director of mental health services, to
46 understand what are the mental health needs of the
47 community.

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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

1 there a view of the board, as you understand it, that
2 outcomes as a strategic direction should encompass more
3 than just coming out of a hospital after an acute procedure
4 better than you went in?

5 A. Well, I think that's why we separate outcomes and
6 experiences and, ideally, both are positive. I mean,
7 sadly, you can have a very good outcome and a very poor
8 experience and, probably worse still, you can have a very
9 good experience and a very poor outcome, but we look to see
10 that our patients come out well treated and feeling that
11 they have been respected, that they - you are familiar with
12 the concept of patient-centric care, that they have
13 received patient-centric care, they have been respected by
14 the staff, that they feel that their health - they have
15 been - and this is part of our strategic language, but we
16 have been partners with them in their health care.

17
18 Q. In terms of those outcomes, I understand you are
19 dealing with outcomes of patients who have had an
20 interaction, say, a hospital admission or a particular
21 procedure at the hospital. What about wider health
22 outcomes of the population of the LHD - that is to say,
23 that they are, to use that language that we were using
24 earlier - their health was promoted, protected and
25 maintained?

26 A. Oh, absolutely. So let me give you an example.

27
28 Q. How is that measured?

29 A. So - well, if I can give you two examples.

30
31 Q. Yes.

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

43
44 Then, a number of the KPIs that we are subject to or
45 subjected to under the service agreement pick up things
46 like, you know, readmission rates and smoking rates and
47 smoking in pregnancy rates. So we're very, very conscious

1 of what are measures - sorry, we're conscious as, of
2 course, is the ministry - as what are appropriate measures
3 to demonstrate that you have a healthy community.
4

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

9 A. Yes, I can see that.

10

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

13 A. Yes.

14

15 Q. You recognise that as the Northern Sydney LHD
16 strategic plan?

17 A. I do, and there might even be a photo of me on the
18 next page.

19

20 Q. You will undoubtedly be smiling in it, otherwise you
21 would be an outlier.

22 A. I am familiar with the document, thank you, yes.

23

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

26

27 MR MUSTON: Q. Could we then jump forward to page 0024.
28 You see set out there is a series of strategies or what
29 might be described as high-level objectives?

30 A. Yes, this is what we describe as the strategic plan on
31 a page.

32

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

38 A. Correct.

39

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

43 A. Correct.

44

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

1 A. Yes, within the context of it being a plan on a page,
2 yes.
3

4 Q. So a little bit more detail in relation to how that is
5 to be achieved is contained in the balance of the document.
6 Perhaps if we go forward to 0032. Just sticking with the
7 theme of the safe, high quality connected care, you see
8 there - this is the page which seeks to elaborate a little
9 bit more on the means by which the higher objective is to
10 be achieved?
11 A. I do.
12

13 Q. Again, looking at 2.2 as an example, would you agree
14 that each of those bullet points set out there is cast at
15 a fairly high level as the means by which the objective is
16 to be achieved?
17 A. Correct.
18

19 Q. Can we turn over to 0034, just sticking with that
20 particular strategic objective. You see there, under the
21 heading "Essential metrics", there is "Measure"?
22 A. Yes.
23

24 Q. That's the way, is it, in which the extent to which
25 the objectives are being achieved is to be measured?
26 A. Yes. It provides granularity and specificity for what
27 you have described as the sort of higher-level description
28 of the strategic objectives.
29

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

1 of these quantitative --

2

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

6

7 *Ensure clinical care and services are both*
8 *effective and delivered efficiently with*
9 *a focus on eliminating unwarranted*
10 *variation.*

11

12 And the next one perhaps is a better example:

13

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

19

20 Are those things success - success as against those
21 objectives really being measured by any of these metrics in
22 a quantitative sense?

23 A. They are some of the measures. I wouldn't say that
24 they are the totality of the measures. But again, within
25 the limitations of not producing a tome as a strategic
26 plan, they indicate the sorts of things that are
27 appropriate to the relevant strategic objective.

28

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

34

35 Q. So that would extend to, if we go back to page 0024 -
36 do you see the third column along there, "Keeping people
37 healthy and well" - am I right in understanding that that
38 is more of a focus on those non-inpatient delivered
39 services?

40 A. Well, yes, some of them are. For example, we talked
41 about vaping a moment ago and we talked about youth problem
42 gambling. They would be possibly relevant there. But if
43 you looked at the fifth column, about, for example,
44 "advance and translate research and innovation", that could
45 be measured in a whole number of ways - how many
46 publications are put out by our researchers, it could be
47 how many collaborative arrangements have we got, it could

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

8
9 Q. When you say "some granularity", what sort of
10 information is being assessed in relation to population
11 health?

12 A. In relation to population health?

13
14 Q. Yes.

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

20
21 Q. What about the extent to which the services being
22 offered by the LHD - the health services being offered by
23 the LHD are continuing to meet the needs of the population,
24 to what extent is that being assessed?

25 A. Well, I think that would be assessed on a continuous
26 basis. It would not be something --

27
28 Q. In what way?

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

41
42 New things come along - climate change, the impact of
43 climate change on health, whether people are now suffering
44 some element of vaccine fatigue, are we going to see fewer
45 people vaccinated coming in to the winter season. So
46 constant assessment because it is a dynamic \$2.4 billion
47 business and it is part of the - you would have seen the

1 chief executive provides the board with a detailed monthly
2 report which runs to about 20 pages and we publish that
3 report each month on the web. That report indicates,
4 against each of the divisions of the district, what are the
5 stresses and strains, what are the risks.
6

7 You would have seen also, I believe, at the back of
8 the CE's monthly report, there is a report from each of the
9 facilities and each of the services and they talk about
10 what are the risks, the emerging risks within the facility
11 or the service. So constant assessment of those sorts of
12 things. Because the one thing nobody likes in health is
13 surprise.
14

15 Q. These are measures of the extent to which the system
16 is responding to the demand which is being placed upon it?

17 A. Well, as I said, there are lead and there are lag
18 indicators. In many respects, lead indicators are, you
19 know, critical, because we need to prepare for what is
20 coming.
21

22 Some of the information we receive by way of lag
23 indicators can be three or six months old. So it's viewing
24 both sets of indicators to make sure that we have a dynamic
25 and responsive health system.
26

27 Q. What about the extent to which the services - I will
28 come back to my earlier question - what about the extent to
29 which the services being delivered through the LHD are
30 actually meeting the needs of the population? Let's take
31 an example of that - access to a specialist outpatient
32 clinic in a particular field of specialisation, say
33 endocrinology. Is any measure being made of the extent to
34 which the population's needs in terms of endocrinologists
35 are being met within - by the health services delivered
36 within the LHD?

37 A. I would say probably indirectly, because we would be,
38 as a board, the chief executive and the board would be
39 monitoring complaints. If people are saying they can't get
40 to an endocrinologist or any other specialist, we would
41 ultimately hear that. I would hope that the director of
42 medical services would be telling us that we're down on
43 endocrinologists or we're down on nurses. We hear these
44 things all the time, particularly with the staffing
45 struggles that the whole health system has had during and
46 post COVID. We do. Whether it is reported to us under the
47 heading "Are we meeting the health needs", probably not,

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

4
5 Q. Could we come to the service agreement that you have
6 mentioned a few times. It's document [MOH.9999.0795.0001].

7 A. That's not --

8

9 Q. I have given the wrong number there, I think. I think
10 it should in fact be [MOH.9999.0913.0001].

11 A. Very good, thank you, yes.

12

13 Q. Do you recognise that document as the 2023 --

14 A. I do. No photo of me in that but I do recognise it.

15

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

20 A. Yes, I am.

21

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

27 A. Well, I am familiar with them.

28

29 Q. Yes.

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

43

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

1 is: to what extent do you think these KPIs or achievement
2 of them reflects the success of the LHD against, say, its
3 strategic objectives set out in the strategic plan?

4 A. Well, as I said, I think they are a necessary
5 component but not the complete component, because these
6 KPIs, as valuable and relevant as they are, don't tell you
7 a great deal about the culture of the organisation, they
8 don't tell you about the level of engagement of staff
9 within the organisation. I mean, if you've got bad
10 results, it might be because you've got poor engagement or
11 poor culture, but they don't tell you those sorts of
12 things. They don't tell you whether you've got an
13 organisation that has got a capacity to innovate, that's
14 agile, that's got dysfunction in it. That's another part -
15 a key part - of the role of the board to look more broadly
16 than simply at the KPIs.

17
18 Q. It's possible, isn't it, that an organisation or an
19 LHD which is meeting its KPIs as set out in the service
20 level agreement is nevertheless failing to achieve the
21 goals set out in its strategic plan?

22 A. Yes, for the reason I gave - you could have
23 a high-functioning district which is getting very good
24 PROMs and PREMs results, but there is no culture in the
25 place, or you've got warring factions within the district.

26
27 Q. It's also possible, isn't it, that an LHD could be
28 meeting all of the requirements of the KPIs set out in the
29 service level agreement but, nevertheless, failing to
30 deliver on its statutory purpose that we've been through,
31 being to provide relief to the sick and injured people
32 through the provision of care and treatment and to promote,
33 protect and maintain the health of the community?

34 A. I think that is unlikely. Anything is possible, but
35 I think it's unlikely.

36
37 Q. Why do you say it is unlikely?

38 A. Well, given the breadth of the KPIs that are mandated
39 by the service agreement, which I'm sure reflects - well,
40 I'm confident reflects the ministry's view of what is the
41 responsibility of NSW Health in terms of delivering health
42 services to the community --

43
44 Q. I'm interested in your view, whether it's your view
45 that these KPIs are a fair measure of, say, the LHD's
46 performance of those statutory functions.

47 A. Yes, I do believe they are, yes. But without

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

5
6 Q. You said a moment ago that you considered it unlikely
7 that an LHD that was meeting these KPIs would be failing to
8 deliver on its statutory function. Why is that? What
9 leads to you that view? Is it something about the KPIs
10 themselves or is it just --

11 A. I think just the breadth of the KPIs in terms of
12 moving people through the hospital quickly and effectively
13 and getting the results, not having people getting
14 bloodline infections above, you know, a level that is
15 tolerable and so on. I just think the breadth of the KPIs
16 suggests that if you are meeting those, you are doing
17 a good job vis-à-vis the community.

18
19 Q. So do I gather from that that it's your view that if
20 an LHD which is capable of meeting at least this broad
21 range of KPIs is likely to be able to fulfil its statutory
22 purpose as well?

23 A. Yes, yes.

24
25 Q. Even if that's possibly not being measured by the KPIs
26 in a quantitative way?

27 A. If the LHD is meeting the KPIs and presumably at
28 a performance level zero, because it is performing well and
29 meeting the KPIs, then yes, I believe it is fulfilling its
30 statutory function.

31
32 Q. Can I ask in relation to - so we have our statutory
33 plan, or our strategic plan?

34 A. Strategic plan, yes.

35
36 Q. Then that's delivered through, I think you have told
37 us, a range of other documents which includes, does it, the
38 clinical services plan?

39 A. Correct.

40
41 Q. What involvement does the board, at your LHD, have in
42 the preparation of that clinical services plan?

43 A. Well, the current clinical services plan for the
44 district is to 2024, so we are in the process of doing
45 a new clinical services plan. We had the draft clinical
46 services plan come to the board meeting last week. It's
47 a very substantial document. It's about 300 or so pages.

1
2 The purpose of it coming to the board last week was
3 for the board to give its approval for that document now to
4 move to the next step, which is broad engagement, including
5 community engagement. So the board is - like any strategic
6 plan or similar document, we want to know the provenance of
7 the current draft, how it relates to the previous clinical
8 services plan, the recommendations that were made in the
9 previous clinical services plan, have they been carried
10 through, what were the consequences of carrying them
11 through, were there any that were not carried through, what
12 has changed - well, clearly COVID has come along and that's
13 changed a lot of the delivery of services. We've got
14 things like artificial intelligence, we've got now new
15 arrangements within the ministry around consolidation of
16 research. There are new models of care emerging. There
17 are changed population demographics.

18
19 Take St Leonards, densification of the suburb, high
20 rise and so on. We've had migrant populations move into
21 the Ryde area, culturally and linguistically diverse
22 communities and so on. So all of that, as a board - our
23 job is not to write the clinical services plan. Our job is
24 to make sure that there is a satisfactory and transparent
25 process by which the clinical services plan is developed,
26 and we've got a strong team that has done that, and then as
27 a board we need to be satisfied that there will be
28 appropriate engagement and consultation so that everybody
29 who is a relevant stakeholder can feel that they have had
30 the opportunity to contribute to the clinical services
31 plan, which then becomes a five-year document and becomes
32 relevant to the planning of new services, the planning of
33 new facilities and infrastructure.

34
35 Q. Do you see it as part of the role of the board to
36 satisfy itself that the services which are to be proposed
37 to be delivered through the clinical services plan align
38 with the needs, health needs, of the community not being
39 delivered through sources external to the LHD?

40 A. Yes, subject to the rider that - my earlier comments
41 that there are some services that we are not providing,
42 we're not funded for by the ministry. But to understand -
43 of course we need to understand the health needs of the
44 community in developing a clinical services plan.

45
46 Q. Just coming back to that answer, you refer to services
47 which you are not funded by the ministry to deliver. If it

1 were the board's view that there was a service that, under
2 the statutory obligation of the LHD, it ought be
3 delivering, but it was not included amongst the body of
4 funding provided, what would you see the role of the board
5 as being?

6 A. Well, we would take - well, through the chief
7 executive and with the support of the board, we would take
8 it up with the ministry.

9
10 Q. And if the ministry said "Well, we're not going to
11 give you any further funding", how does one deal with that
12 situation as a board?

13 A. Well, it is difficult, but we cannot provide services
14 if we are not funded to provide them. We can try to enter
15 into partnerships with NGOs and others to see whether some
16 workaround can be found, but we - yes, we can talk to other
17 local health districts so, you know, you are aware, for
18 example, that Northern Sydney is the state spinal unit
19 centre of excellence, the burns centre of excellence, so we
20 have patients coming into our district for those services
21 and we have patients from our district going out of our
22 district for services. It becomes a topic of discussion to
23 see what solution can be found.

24
25 Q. Dealing with that example of the service that is not
26 being delivered within your LHD by some external source,
27 a view's been reached by the board that it ought be
28 delivered as part of the performance of the LHD's statutory
29 function but ministry has not decided to provide further
30 funding for it, does that not mean it's the ministry that's
31 making the decision about what services are to be delivered
32 through the LHD in that instance?

33 A. Well, I think - we are in a - this might be
34 a different question or a different answer, but we are in a
35 three-way relationship in the running of the health service
36 for the district - between the ministry, the executive of
37 the district, and the board. And that's how it has been,
38 I think, since at least 2011, when things were changed from
39 it being a Department of Health to a Ministry of Health,
40 and it is a very effective relationship which is
41 a three-way relationship. So we would have a discussion
42 about it. But we could talk to the minister, for example -
43 you are probably aware that there have been issues around
44 additional mental health, youth mental health services on
45 the Northern Beaches and the like, and we started
46 constructive conversation with the ministry to see how
47 those can be funded.

1
2 We can look perhaps to philanthropic funds or sources
3 of philanthropic moneys if we haven't got the funds. But
4 at the end of the day, we can only operate within the
5 budget that is made available to us.
6

7 Q. So to come back to my question, doesn't that mean
8 that, to the extent that the budget that has been provided
9 to you is determined by the ministry, is it not in the
10 instance that we're talking about the ministry that's
11 ultimately making the decision about whether this
12 additional service is to be delivered through the LHD?

13 A. Yes, but it's very rare that a service is needed at
14 the snap of the fingers. There's usually considerable
15 planning time to know what additional services will be
16 required and within that planning period, so long as you've
17 got your ear to the ground as to what is coming along, that
18 is when you would initiate conversations with the ministry,
19 which is no different to the development of the annual
20 services agreement where there is ongoing discussion about
21 how many NWAUs we think we need to deliver and what we
22 think the level of demand for particular services will be
23 within the district.
24

25 Q. What do you consider to be the consequences of the LHD
26 failing to deliver on its strategic direction, for the
27 board?

28 A. Well, I don't think we have failed to deliver, so it's
29 a hypothetical question.
30

31 Q. I certainly didn't suggest that you had failed to
32 deliver, but as an incentive to deliver, what do you see to
33 be the consequences for a failure to deliver, if there were
34 one?

35 A. Well, I'm not sure what the consequences would be,
36 because I don't think - this is very hypothetical, but
37 I mean, vis-à-vis the ministry, we would not have failed to
38 deliver, because the ministry presumably would have taken
39 the view, well, if it's not in the service agreement, there
40 is no need for it to be delivered, or at least to be
41 delivered at this point in time. So I don't think we would
42 be censured in any way by the ministry under the service
43 agreement. But we would very vigorously take up the matter
44 with the ministry and with the minister, if we thought that
45 there was a material unmet need within the community.
46

47 Q. What about the consequences for the chief executive,

1 were the LHD to fail to deliver on the goals of its
2 strategic plan?
3 A. If the chief executive were to fail --
4
5 Q. If the LHD were to fail in the board's view to deliver
6 on the objectives of its strategic plan, what would the
7 consequences for the chief executive be?
8 A. Well, this would - so we're not talking about - you
9 are not asking me about services that we're not --
10
11 Q. Not asking about that?
12 A. This is just a break, you know, next question "If the
13 chief executive didn't deliver on services".
14
15 Q. The two are not unrelated, to the extent that services
16 need to be delivered as part of the delivery of the
17 achievement of the strategic objectives. But let's take it
18 to the strategic plan?
19 A. Okay. That's why I wanted clarity on that.
20
21 Q. So the strategic plan has a key range of things --
22 A. Yes.
23
24 Q. -- which the LHD, delivered through a range of
25 documents, is seeking to achieve?
26 A. Yes.
27
28 Q. To the extent that the LHD fails to achieve on any of
29 those objectives - just let's start again with the board.
30 What would you regard as being the potential consequences
31 for the board of a failure to deliver on those strategic
32 objectives?
33 A. The consequences for the board?
34
35 Q. Yes.
36 A. Well, you would have to look at what was the item that
37 was failed. You know, if you are in the middle of
38 a pandemic, for example --
39
40 Q. Let's stick with business as usual.
41 A. Okay. Well, business as usual, the role of the - the
42 board has set the strategy and it's the role of the chief
43 executive to deliver on the strategy within the envelope of
44 resources that is made available to the chief executive.
45 So if the chief executive and the team of the chief
46 executive were not meeting objectives, this would be
47 raised, of course, with the chief executive; it would also,

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

11
12 Q. Having regard to the very high level at which the
13 strategic objectives are cast, it's difficult, really,
14 isn't it, to know whether or not those objectives are being
15 achieved or not?

16 A. No, I don't agree with that. As I said, we get
17 a six-monthly traffic light report, which is pretty blunt.
18 It's much more inclined to put red or orange ink on the
19 page than to gloss everything over with green ink. But
20 it's also something that is reflected - I meet with the
21 chief executive for an hour every Friday morning throughout
22 the year. It would be raised in that context.

23
24 If board members were concerned, I'm sure that they
25 would raise it with me. We have the opportunity for an
26 in camera session at the beginning of each board meeting
27 and board members would raise those things with me. So it
28 would not go unnoticed and it would not go uncommented on.
29 But it is a complex, complicated business, and some things
30 which maybe in 2022 looked like a high priority could be
31 maybe slightly - might be reduced in priority in 2023 or
32 2024, or subsumed by something else.

33
34 But I just want to say, I take the view that if you
35 are on performance level zero, which is unusual because
36 zero is the best level to be on - if you are on performance
37 level zero, it's a very strong indication that the ministry
38 considers that it is a well-managed district, having regard
39 to the totality of all the objectives, all the KPIs.

40
41 Q. But being on level zero - again, correct me if I have
42 misunderstood it - means you are meeting the targets set by
43 the KPIs in the service level agreement?

44 A. Yes. Well, yes, and I think also that - I would add
45 to that my assessment is and the ministry is confident with
46 the manner in which the district is being run and managed.

47

1 Q. But again, does that confidence derive from anything
2 more than an assumption that, if you are meeting the KPIs,
3 then everything else must also be going pretty well?

4 A. I haven't sat in on a performance meeting for some
5 time. I used to sit in on them when I was at Sydney Local
6 Health District. Back in those days, they were very
7 broad-ranging conversations. They went through all the -
8 they went through in detail all the KPIs, but there was
9 also a lot of qualitative discussion around the direction
10 in which the district was heading. I would imagine that
11 there would be quite a lot of discussion around risk and
12 issues like staff turnover and so on, because it's the
13 nature of the business is more than just the KPIs.

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

18 A. Yes.

19
20 Q. Could I ask, how does the board make that review of
21 its own performance?

22 A. Okay. So I write to board members in around September
23 in each year saying that it's time to start thinking about
24 the annual review of board performance. I invite board
25 members at that point to indicate whether they think we
26 should do the review internally or bring in an external
27 facilitator.

28
29 We brought in an external facilitator a few years ago.
30 It was an interesting exercise that obviously has a cost to
31 it. We didn't feel that it necessarily added more than we
32 could do internally.

33
34 So if I give you the example of the internal process,
35 I will then write - I will send - I've brought a copy of
36 the questionnaire that I send. May I refer to that?

37
38 Q. Yes.

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

41
42 *The annual board assessment provides the*
43 *opportunity for each of you to provide*
44 *feedback and suggestion on the current and*
45 *future working of the board and its*
46 *committees.*

47

1 *We welcome both written and verbal feedback*
2 *and suggestions. In making your*
3 *suggestions, please be mindful of the role*
4 *and function of the board as set out in*
5 *section 28 of the Health Services Act.*
6

7 And then I say, "Please give me your name":
8

9 *Provide up to three things where the board*
10 *arrangements are working well.*
11

12 *Please identify up to three things where*
13 *you believe board arrangements should be*
14 *done differently or could be improved.*
15

16 *Please provide any board feedback on board*
17 *arrangements.*
18

19 *Please provide any feedback on the*
20 *effective and efficient operation of the*
21 *board and committees.*
22

23 *Please provide any feedback on the board*
24 *chair.*
25

26 But that should be directed to the deputy chair rather than
27 to me, and then I say:
28

29 *In terms of your performance as a board or*
30 *committee member, please identify up to*
31 *three areas where you feel you are making*
32 *a positive contribution.*
33

34 *In terms of the performance as a board or*
35 *committee member, please identify up to*
36 *three areas where you feel you would*
37 *benefit from training or development.*
38

39 *Please provide any feedback or assessment*
40 *of your personal and special attributes,*
41 *competence, effectiveness, performance.*
42

43 *Please identify any other matters of*
44 *a personal or general nature that you would*
45 *like to raise as part of the annual board*
46 *assessment.*
47

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

4
5 Q. So that information is gathered.

6 A. Yes.

7
8 Q. What is done with it?

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

21
22 Q. Have you had an occasion to deal with what you
23 perceive to be a poor performance by a board member?

24 A. Do you want --

25

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

28

29 THE COMMISSIONER: Sure. MFI 7.

30

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

32

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

36 A. Yes.

37

38 Q. How do you deal with that situation, or how did you
39 deal with that situation?

40 A. Well, candidly --

41

42 Q. That's what we require here.

43 A. Yes, well, you know, candidly, if I think a board
44 member is either struggling or the board member might be
45 out of his or her depth or they're not engaged, I will let
46 them know. You know, the appointment of board members is
47 a ministerial appointment and normally board members are

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

5
6 I have had no, you know, egregiously underperforming
7 board members, but, yes, I have had to have some of those
8 blunt discussions, and that's part of being the chair.

9
10 Q. Can I turn back to the issue around --

11
12 THE COMMISSIONER: We may not have identified that
13 document very well. I have just said "7", it got a nod.
14 MFI 7 is - what is it called?

15
16 MR MUSTON: MFI 7 is a document headed "NSLHD September
17 2023 board survey".

18
19 THE COMMISSIONER: Thank you.

20
21 MR MUSTON: It will in due course probably form part of
22 the tender.

23
24 Q. Can I come back to the performance of the chief
25 executive?

26 A. Yes.

27
28 Q. At the moment, it's right, is it, that the chief
29 executive, at least as you understand it, reports to the
30 board?

31 A. That is correct.

32
33 Q. If it were suggested to you that the arrangements for
34 the reporting of chief executives should be adjusted such
35 that there is a single line of accountability to the
36 secretary, how would you respond to that?

37 A. I wouldn't be in favour of that. I think --

38
39 Q. Why not?

40 A. Well, I should say, before I answer that question, at
41 the end of each year I sit down with the chief executive
42 and the secretary and we have a three-way discussion on how
43 the chief executive has performed in the year completed,
44 what are the ambitions of the chief executive in the year
45 going forward, what are areas where the chief executive
46 might want to improve or refocus or whatever. So it is
47 a three-way discussion.

1
2 Under our legislation - I can't recall the exact
3 section, but at the back of the Health Services Act - the
4 board, whilst effectively the employer of the chief
5 executive, is not able to terminate the chief executive
6 without the concurrence of the secretary. So it is very
7 much a three-way relationship.
8

9 Q. I suppose my question is: what would be lost if it
10 became a two-way relationship between the CE and the
11 secretary, in your view?

12 A. In my view. Well, I think when you are the chief
13 executive of an organisation reporting to the board but
14 ultimately your performance is only assessed by a third
15 party, it's got to - it must in some way compromise the
16 effectiveness of the relationship between the board,
17 represented by me as the chair, and the chief executive.
18 A sensible chief executive will understand in a sense
19 regardless of what the reporting lines are, that it is
20 a three-way relationship and that a successful chief
21 executive needs to enjoy a strong relationship with both
22 his or her board and the secretary.
23

24 So I wouldn't, you know, be overly worried, because
25 there were - the employment of the chief executive is
26 delegated to the board under the legislation. But I think
27 the current arrangement - the current arrangement works
28 well. I don't see anything in the current arrangement that
29 isn't working well, so I would probably say leave it as it
30 is. And, in any event, I have a three-way conversation
31 with the chief executive and the secretary routinely, and
32 at the end of each year as part of the annual performance
33 appraisal.
34

35 Q. Can we jump forward to paragraph 48 in your statement?

36 A. 48? Yes, thank you.
37

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

40 A. Yes.
41

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

45 A. Yes.
46

47 Q. The monitoring of action taken in response to

1 incidents?

2 A. Yes.

3

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

6 A. Yes.

7

8 Q. In relation to the last one, how is that monitoring
9 undertaken, as you understand it - that is, the LHD's
10 progress on safety and quality performance in health care?

11 A. Okay, so we have one of the mandated committees of the
12 board is the health care quality committee, which in my
13 case is chaired by Professor Emeritus Mary Chiarella. It
14 does the heavy lifting around safety and quality and, then,
15 at each board meeting, Mary provides both a verbal and
16 a written report to the board on what are the key issues,
17 certainly any outliers or trends, and then we publish our
18 annual safety and quality report, which is something we
19 started publishing about three years ago, or four years
20 ago.

21

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

31

32 Q. Well, in terms of the board's role, the clinical
33 council within the hospital deals with accreditation issues
34 or within a hospital deals with accreditation issues as
35 against the national standards; is that right?

36 A. I'm not sure that is right. We've just gone through
37 accreditation last year. We had five of our facilities
38 accredited because there had been a bit of a backlog during
39 COVID.

40

41 Q. Within the broad structure of the LHD, who do you
42 understand, or what body do you understand, is principally
43 responsible for dealing with that accreditation process?

44 A. The chief executive and, under the chief executive,
45 the executive director of patient experience and clinical
46 governance.

47

1 Q. Central to what they are doing in performing that role
2 is quality and safety?
3 A. Yes.
4
5 Q. And the extent to which quality and safety is mandated
6 by the standards, that's something done externally to the
7 LHD?
8 A. Well, the accreditation is done externally.
9
10 Q. And the determination of the standards against which
11 hospitals are accredited?
12 A. Yes. Well, they are national standards, yes.
13
14 Q. You are familiar with the work of the CEC within the
15 ministry?
16 A. I am.
17
18 Q. And also with the patient safety first unit?
19 A. Yes.
20
21 Q. Those two bodies deal, do they, with incidents and -
22 well, the way in which - they make an assessment of the way
23 in which incidents are dealt with?
24 A. Look, I can't - I'm not sure what happens within the
25 ministry on those, but I know that if there is some serious
26 incident and there is a reportable incident brief, it goes
27 off to the ministry, but it also goes off to our safety -
28 our HCQC.
29
30 Q. Cutting to the chase, what, in your view, does the
31 board or the oversight of the board in relation to these
32 issues - safety, incident management and response - add to
33 what is already being done by the CEC and the patient
34 safety first unit?
35 A. Well, I think we - you know, we localise it, because
36 the relevant incident has happened at the district. We
37 have ministry policies on things like open disclosure, but
38 we want to make sure that if some incident has occurred, we
39 have understood why it has occurred and, even more
40 importantly, what will be done - what is the learning from
41 the incident and how will we ensure that we share the
42 learning, not only at the hospital or facility where it
43 occurred but our other facilities and services, and how do
44 we try to make sure that it doesn't happen again, and if
45 there has been some human failure, if additional training
46 is required, what it is that - what is needed and how is
47 that implemented. So I think the localisation of the

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

8
9 Q. So it is your view that whatever work is being done by
10 the CEC and the patient safety first unit has insufficient
11 local focus to provide --

12 A. No, no, no. I'm not saying it has insufficient local
13 focus at all. It is high-quality work. But we want to
14 take that work and bring it to the district and localise it
15 and learn from it and implement it at the district, and
16 that --

17
18 Q. In a way that those bodies are not able to do?

19 A. Well, no, I'm not saying they are not able to do it,
20 but they are providing information. The question then is,
21 what is the district --

22
23 Q. Is it your view that they are currently doing it?

24 A. Well, my understanding is, yes, they are. But how do
25 we take what they say and what they recommend and make it
26 part of our standard operating procedures and lessons
27 learned and opportunities for improvement within the
28 district?

29
30 Q. Could I ask you to go to paragraph 52 of your
31 statement?

32 A. Yes.

33
34 Q. Here you tell us about the particular priorities in
35 relation to the health needs of Aboriginal or Torres Strait
36 Islander people?

37 A. So I should start off by saying we have a relatively
38 small Aboriginal and Torres Strait Islander population
39 within Northern Sydney. I think we have probably no more
40 than about 5,000 people who identify as Aboriginal or
41 Torres Strait Islander, but we have a number of specific
42 services and facilities, a number of them coming out of
43 Hornsby Hospital, which seek to address not only the health
44 needs but the health anxieties and health propensities of
45 people with an Aboriginal or Torres Strait Islander
46 background.

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

2 A. Yes.

3

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

8 A. My --

9

10 Q. Wait till I have asked you the question. My question
11 is, what has the board done to satisfy itself that the LHD
12 is complying with those requirements?

13 A. Well, we have a director of Aboriginal health
14 services, Peter Shine, who comes to the board to present at
15 least annually, but we see Peter more regularly as we get
16 out and about. We've got an Aboriginal health plan within
17 the district. We have on our board - one of our board
18 members has particular knowledge of Aboriginal health. So
19 I think all those factors combined, and of course, the KPIs
20 that we have to achieve that are relevant to Aboriginal and
21 Torres Strait Islander health - I think across those four
22 elements the board can be satisfied that what it is doing
23 is appropriate. We also have a number - we regard
24 ourselves as really quite innovative in a number of ways
25 with some of the programs that we are trialling within the
26 district, and there is a lot of open communication between
27 the director of Aboriginal health services and the board,
28 including myself. So I think across all of those factors,
29 we're satisfied that we are doing what we're required to do
30 for our Aboriginal and Torres Strait Islander population.

31

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

35

36 THE COMMISSIONER: Twelve.

37

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

40

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

43

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

1 Monday, I will --
2
3 THE COMMISSIONER: It is not convenient to me, that's the
4 problem, and I'm currently in charge. I'm really sorry
5 about that, though.
6
7 THE WITNESS: That's all right.
8
9 THE COMMISSIONER: We might have to come back and finish
10 the witness on Monday.
11
12 THE WITNESS: Would there be some flexibility to - because
13 I may be looking after my granddaughter Sophia one day, so
14 I just need to juggle that, if I can.
15
16 MR MUSTON: I'm sure we can accommodate.
17
18 THE COMMISSIONER: Okay. We might liaise with you as to
19 what time on Monday suits you best. My apologies for that.
20
21 THE WITNESS: No, no, that's fine.
22
23 THE COMMISSIONER: All right. We will adjourn until --
24
25 MR MUSTON: 10 o'clock Monday.
26
27 THE COMMISSIONER: -- 10 o'clock on Monday. But if
28 earlier suits Mr Danos, we can sit earlier than 10 as well.
29
30 THE WITNESS: All right. Thanks.
31
32 THE COMMISSIONER: All right. We will adjourn until some
33 time on Monday.
34
35 **AT 12.00PM THE COMMISSION WAS ADJOURNED TO MONDAY, 29 APRIL**
36 **2024 AT 10AM**
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