Special Commission of Inquiry

into Healthcare Funding

Before: The Commissioner,
Mr Richard Beasley SC

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

Tuesday, 6 August 2024 at 10am

(Day 045)

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

Also present:

Mr Richard Cheney SC with Mr Hilbert Chiu for NSW Health

THE COMMISSIONER: Good morning.

MR MUSTON: The next witness, Commissioner, is Dr Anderson.

<TERESA MAREE ANDERSON, sworn: [10.01am]

<EXAMINATION BY MR MUSTON:

MR MUSTON: Q. Dr Anderson, could you state your full name for the record again?
A. Teresa Maree Anderson.

Q. And you are, currently, the chief executive of the Single Digital Patient Record Implementation Authority?
A. Yes, a mouthful.

Q. It is. A role that you took up on 27 May of this year?
A. Yes.

Q. Prior to that, between 1 January 2011 and 26 May of this year, you were the chief executive of the Sydney Local Health District?
A. That's correct.

Q. You've prepared a number of statements to assist the Inquiry with its work, but the one I wish to take you to for present purposes is that dated 30 July 2024?
A. Yes.

Q. Do you have a copy of that statement with you?
A. I do.

Q. Have you had an opportunity to read that statement before giving your evidence today?
A. I have.

Q. I understand there are a couple of corrections that you wish to make to it?
A. Yes, please.

Q. If you could take us through them, perhaps starting by reference to the paragraph number and then telling us what you would wish to correct?
A. Thank you. So paragraph 3. I actually provided the statement on 31 January, not on 29 January.

Q. Thank you. There's a further correction, I think?
A. Yes.

Q. Paragraph 128?
A. Paragraph 128. So annexure N is the correct version at the time of my 24 April 2023 letter. The version I was referring to was from May 2022.

Q. So that's a paragraph that deals with the terms of reference. There's an annexure N to Dr Cheung's affidavit --
A. Yes, that's correct.

Q. -- which is the version that was a current version at the time you sent the letter to him?
A. Correct.

Q. The version that you've included as an annexure to your statement was an earlier iteration?
A. Was the earlier version, yes.

Q. Thank you. In the first sort of 56-odd paragraphs of your statement you set out for us in some detail the technical avenues available to staff members within the Sydney Local Health District for the airing of workplace grievances.
A. Yes.

Q. We've received some evidence that suggests that there is a strong culture within medicine not to speak up about concerns that one might have for fear of reprisal or being seen as being a difficult person. Do you agree that that's one of the challenges that exists within the health system when one is dealing with the medical workforce?
A. In part.

Q. When you say "in part", what do you mean by that?
A. We do have many clinicians who appear to feel free to speak up, and there are some who have indicated that they don't.

Q. But would it be right to say that of those who are disinclined to speak up, for the reasons which I've just identified, it's very difficult to reach any meaningful view about what proportion of the workforce they make up because they don't speak up?

A. It's very challenging.

Q. During your period as chief executive of the Sydney Local Health District, you were involved in the introduction of a role of the chief wellness officer?
A. Correct.

Q. Could you explain what that officer's role was and what it was anticipated that they would bring to the district?
A. Thank you. It came on the back of our basic physician trainees putting a proposal to me in a program that we call "The Pitch", where staff can pitch ideas, and it came out of concern around the suicide of a number of JMOs across NSW Health, not in Sydney Local Health District, but they were colleagues of our basic physician trainees. And so they put a proposal about a staff wellbeing and support program for junior medical staff, and that included looking at their psychological wellbeing, their physical wellbeing but also mentoring and supporting them through challenging environments - health is really challenging.

So after that, the idea of a chief wellness officer, a medical clinician who came from the organisation, was put to me and I thought it was a great idea, supported that --

Q. Just pausing there, roughly when did that happen, do you recall?
A. That was around 2018/19, those discussions occurred, and there was a program, an evidence-based program in Stanford in the US, so I supported Bethan Richards to go and study that program, so that what we were doing was based on evidence rather than based on, you know, a good idea.

That program was initially at Royal Prince Alfred Hospital. It was very successful, great feedback from the junior medical staff indicating that they felt very supported by it, and that was reflected in some of the results of the national junior medical officer survey - the title probably is wrong, but that's a regular survey that occurs across the whole of Australia.

So then we determined, and with the support of the ministry, extended that program to my - MDOK, which was not just about junior medical staff but also senior medical staff, recognising the challenges that they experience, and

then we've expanded that across Concord and Canterbury hospitals as well.

Q. So that expansion of the My District OK program serendipitously perhaps occurred before the pressures of COVID were brought to bear upon the health system?
A. Yes. And they did a lot of work during COVID to support staff on the ground. It was a really difficult time for everyone.

Q. And that support that was being provided, was that occurring across all three facilities --
A. Correct.

Q. -- within the health district?
A. Yes.

Q. Another aspect, we were told by Dr Richards of the program, was the creation of the Sydney Local Health District wellbeing database?
A. Correct.

Q. You're familiar with that as a project that the group was undertaking?
A. Yes.

Q. Did you consider it to be a valuable resource?
A. I did.

Q. There was some evidence given about concerns around the weaponisation of data that was potentially being collected through that process. Did you have a view in relation to that or was that something that was raised with you at any time?
A. It was never raised with me.

Q. In terms of the value that the wellbeing database brings to the system, we're told that it addresses what are gaps in the "People Matter" survey. Did you understand it to --
A. It complements that.

Q. -- have that benefit? It complements it to the extent that there are gaps in the "People Matter" survey because it lacks the granularity that might be needed to get a proper read on how things are happening in a particular facility or a particular department?

A. It is more at the department level, and there are questions in the wellbeing survey, which is evidence based, based on the Stanford study, and the questions are different to those in the "People Matter" survey. I think both are really valuable, but certainly it gives more granular data.

I should state that as the chief executive, I didn't have access to that database. Bethan would talk to me about areas that required focus, but I personally did not see the data because I didn't think it was appropriate.

Q. You couldn't log into it, for example?
A. Oh, definitely not.

Q. But the chief wellness officer reported directly to you --
A. Correct.

Q. -- in the structure at the health district?
A. Yes.

Q. And it was open to you to ask her, from time to time, if you had particular questions that you felt that valuable data might have assisted you with --
A. Yes.

Q. -- to provide that information?
A. Mmm.

MR MUSTON: Could I ask the operator to bring up to the screen the statement of Bethan `Richards, which is [MOH.9999.2147.0001], and if we could scroll to page 9.

Q. Could I ask you, Dr Anderson, just to read paragraph 34 of that statement to yourself, in which Dr Richards tells us her view about the morale and her observations of what led to a decline in morale at Concord.
A. Yes, thank you.

Q. Were you aware, say, from the time at which this chief wellness officer and the gathering of information that has been alluded to in paragraph 34 commenced, of those concerns being held by at least a proportion of the medical staff at Concord?
A. Yes, I was aware.

Q. Did you have any reason to think that the concerns that were held by at least a proportion of the medical staff at Concord were not, at least in the minds of those people, genuine concerns?
A. I agree they were genuine concerns.

Q. You have told us in your statement at paragraph 113, referring in particular to subparagraph (a), about a document which was provided or disseminated by Associate Professor Cheung on 2 May, which was, you described as his nomination document. That's a document that he was putting forward to seek election to the position of chair of the medical staff council at Concord?
A. Yes.

Q. Would it be right that the concerns which we've just looked at in paragraph 34 of Dr Richards' statement were broadly consistent with those which were being put forward by Dr Cheung in his nomination document?
A. Broadly, yes.

Q. That is to say, the concerns that he was raising in that document were consistent with the concerns you've told us that a proportion of the staff - you understood a proportion of the staff at Concord to genuinely hold?
A. Yes.

Q. You presumably saw Dr Cheung's nomination correspondence at the time it was circulated?
A. I did.

Q. Did it cause you any concerns?
A. It did.

Q. What were those concerns?
A. It was really the language. Although I actually agreed with the sentiment, because at the time there were ongoing challenges in terms of the physical facilities and we were working closely with the clinicians on the planning for the redevelopment of Concord hospital, the staff were understandably frustrated that it took some time to get the redevelopment of Concord on to the capital program, and that was because there's so many competing interests across the whole of NSW Health, it was hard to get Concord on to the capital program, and the clinicians were understandably frustrated by that.

Part of the problem with expanding services at Concord is that you needed the facilities to be able to expand them. So there was a real desire to increase the complexity of many of the services at Concord, but you couldn't do that without having adequate facilities.

So we did put a lot of energy into the clinical services planning and then into getting Concord onto the capital program, and initially we were successful in getting 250 million, which was challenging to be able to make a real difference for Concord, so we continued to work with the ministry and managed to get another 100 million, for the 341 million for the redevelopment.

Because aged care and rehabilitation services were in 1941 army ramp wards, which were not fit for purpose, in the clinical services planning with the clinicians, it was determined that that would be the most appropriate focus for the redevelopment in addition to cancer services, which would enable that increase in complexity of services for cancer, including a PET scanner.

Q. We've heard about, in some of the material, a stage 1 and a stage 2 of the Concord redevelopment. Are you able to explain, perhaps by reference to what you've just told us, what that staging involved?
A. Thank you. So when we did the initial plans for Concord, it was for the whole, and when you're putting in your capital asset plan, you put in what you want for the whole. But unfortunately, for those competing reasons that I mentioned, we were only successful in getting 341 million, which meant that we had to prioritise what would go into stage 1, and we continued the planning for stage 2, which would have included the emergency department, radiology, an expansion of ICU and theatres.

We did that in consultation with senior clinicians and junior clinicians across Concord hospital. But I think it actually contributed to a divide, because there were those who went into the beautiful new shiny building and those who did not, and, you know, I regret that that feeling was there.

Q. One of the concerns that was raised, that has been identified by Dr Richards and has been raised by Dr Cheung, is a perception that there was under-resourcing within particular departments at Concord - you understood that to

be one of the concerns?
A. Yes.

Q. Just to try and understand the answer you gave a moment ago, it's your view that the separation of the stage 1 and the stage 2, which had the effect that certain departments were going to continue, at least in terms of the physical infrastructure that they had, as they were whilst others were being improved, might have exacerbated that sense, within some departments, of under-resourcing being a problem?
A. Yes, and we tried to address that. So when the stage 1 was completed and moved in, in February 2022, we undertook planning and refurbishment of areas that were decanted as part of the redevelopment. So haematology, for example, moved into the new building, so we've refurbished that area, and that will be used for the osteoarthritis program and vascular medicine on level 5 east. We refurbished that ward, which was a cancer ward, and that was changed to a surgical short-stay, and the priorities for that were developed by Concord hospital.

Q. So you mentioned --

THE COMMISSIONER: I don't think Dr Richards raised this issue. I think it was Associate Professor Ridley who might have expressly mentioned the tension created by some people going into the new building and some people staying in the old.

MR MUSTON: Dr Condon?

THE COMMISSIONER: No - oh, maybe it was. It probably doesn't matter at the moment. I thought it was Associate Professor Ridley. It could have been one of a dozen, but - yes.

MR MUSTON: I think Dr Condon did touch on it.

Q. Well, I'll ask you a question that I think I asked him and he answered. Haematology, just as one of the examples that you gave, as a department that was moved into the new facility, was a department which may not have, at least insofar as it was expressing itself, appeared quite as distressed as others. Would that be fair?
A. Yes, that would be fair.

Q. Now, that deals with the under-resourcing side of the concerns that were held by the medical workforce at Concord, but aligned with that is a sense that there was a separation or isolation from the administration and a perception that there was less autonomy, less access to administration, not being listened to. What do you say was the cause of or contributed to that concern on the part of at least some of the medical workforce at Concord?
A. Prior to COVID, I wasn't aware that there was a sense of separation. We spent a lot of time at Concord. During the COVID pandemic, I think in part - I've reflected on it a lot. I think in part, we were not able to go on site in the hospitals as much as we did previously, because of the restrictions and the fear of people meeting and contributing to a transmission of COVID. They were very difficult times. In addition to that, the district was very involved in the state COVID response and I personally was very involved with that, and I do think that that took me away from the front line.

Q. Take your time. If you need a break at any moment, I'm sure the Commissioner will happily accommodate that.

THE COMMISSIONER: Can we go back to something that you touched on but I think I need to understand a little bit more.

MR MUSTON: Sure.

THE COMMISSIONER: Q. Mr Muston asked you about - for want of a better expression - Dr Cheung's election material. You know what I'm talking about, the document he put out, and you were asked whether you had some concerns about it.
A. Mmm-hmm.

Q. You said you agreed with the sentiment but you did have some concerns of the language?
A. Yes.

Q. Do you remember that exchange?
A. Yes.

Q. Can you just tell me what - it's actually an annexure to your statement, at least in my copy it's H32.4. The document number is [MOH.0010.0393.0001]. Yes, that's it. Do you have a hard copy of this?

A. In front of me? No.

Q. Yes.
A. No.

THE COMMISSIONER: It might be easier if the witness had a hard copy.

MR MUSTON: I'm sure that can be arranged.

THE COMMISSIONER: Thank you.

Q. Please take your time to look through this, but can you tell me which bits - I mean, there are some references to Crown Casino and Dreamworld that might be out there a bit, but in terms of the document itself, can you tell me what it was that gave you that concern in terms of its language? Let's start, page 1. Is there anything on that page that troubled you in terms of what?
A. Not really. I mean --

Q. All right. Next, we've got "Public Service", times are tough for public service. I think that's the unanimous view of every witness that's given evidence so far, but just have a look at that column and tell me if there was anything that concerned you in what Dr Cheung said about public service.
A. In terms of staff wellbeing and the --

Q. Sorry, which paragraph am I looking at there, sorry?
A. Oh, sorry, my apologies.

Q. What does it start with?
A. It's the second column, "Staff Wellbeing", talking about MDOK.

Q. Sorry, okay. Nothing in "Public Service". So "Staff Wellbeing". Which part concerns you there?
A. In relation to discouraging tackling industrial issues.

Q. Just tell me what the paragraph starts with, what are the words?
A.

What the MDOK job description didn't mention is that MDOK was actively

"discouraged" to tackle industrial issues.

Q. That's something you disagree with, I take it?
A. I do. And the last sentence --

Q. Did you ever have a discussion with Associate Professor Cheung about that paragraph, saying, "Winston", you know, "I don't agree with you there, Dr Cheung", or --
A. I did.

Q. You did?
A. Yes. That was in - I can't remember exactly the date, but around March/April 2022. I said, you know, that - we met and we talked about, you know, how we could work together. I indicated that I wanted to work with him, had always --

Q. This is just after he has been elected as the chair of the council?
A. Yes, yes. Had always had a good relationship with the medical staff council, and I reassured him that the wellbeing particularly of our junior medical staff was always front and centre.

MR MUSTON: Can I just interpose with a question around that?

THE COMMISSIONER: Of course you can.

MR MUSTON: It might be a convenient time to do it.

Q. The evidence we've received from Dr Richards was to the effect that a decision was made that the wellness team should not intervene in what were described as "operational matters", or take any role in disputes between staff and the executive beyond supporting everyone involved?
A. Mmm.

Q. Was that a decision that you were involved in?
A. No.

Q. Were you aware that that approach had been taken by the wellness team and the chief wellness officer in respect to what might be regarded as disputes between staff and the executive?
A. I don't know if it was - I'm not aware of the exact context, but I don't necessarily think that means between -

industrial matters aren't necessarily between management and the clinicians; it could be an issue to do with the award.

Q. Other than generally supporting all of the staff of the district who might be involved in a dispute, it wasn't your understanding, was it, that the chief wellness officer or the My District OK team were going to be actively involved in dealing with industrial issues, was it?
A. No, that wasn't the purpose, but they did provide support to junior medical staff and, in fact, I met one time with the AMA to talk about their survey, had the chief wellness officer with us, talking about how we support junior medical staff and particularly in relation to hours worked. So it's not consistent with - that is an industrial matter, hours worked, but I suppose it just depends on how it's framed. Does that make sense?

MR MUSTON: Yes. Sorry, Commissioner, I interrupted you.

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

Q. Was there anything else in relation to staff wellbeing - was that the main point that concerned you?
A. And that action only happened because a problem ended up in a newspaper.

Q. I don't know any background to that, obviously something ended up in --
A. I'm not sure of the context, but we took a lot of action because the issues were raised with us, not because of things being in the paper.

Q. I see. Then Dr Cheung is drawing analogies between the Crown Casino Royal Commission, the Dreamworld coroner's inquiry and the "Commonwealth Parliamentary Workplaces". Did you have any concerns relating to the analogy of those matters with --
A. I thought it was unusual.

Q. All right. By "unusual", should I take from that that whilst there might be some similar principles involved, in terms of at least Dreamworld and maybe the Commonwealth parliament as well, and even Crown, it's dealing with corruption, that it might have been a stretch in terms of what's ultimately being looked at at those three inquiries - was that what was concerning you?

A. Yes.

Q. Next page, "The Problems". Any concerns in relation to what Dr Cheung said regarding underreporting?
A. Not really.

Q. "Public Interest Disclosure"?
A. No.

Q. The "Quality Improvement Systems"?
A. I think the issue with the commentary is that it is very black and white, that there is no reporting, and, in fact, Concord does have a high rate of reporting. Having said that, you don't know what you don't know. But if you look at Concord's reports compared to both other parts of the districts and elsewhere, it didn't stand out as having low reporting rates.

Q. Can we just pause there. I think Associate Professor Cheung told us - my memory is, without going back to the transcript - that this might have been the first time there was actually a contest for who should be the chair of the staff medical council; is that your recollection as well?
A. I wasn't present for the meeting but I understand that was the case.

Q. When there had been prior times for, to your knowledge, the election of a chair to the council, was this - was Associate Professor Cheung's approach a new approach in terms of --
A. Very.

Q. -- putting out a document?
A. Yes.

Q. Okay. All right. Focus on minimum standards?
A. I think, just in the second page of "Quality Improvement Systems", in his language, he talks about reporting used for purposes other than quality improvement, used for reprisal, for cover-up, used to intimidate, bully and harass.

Q. Sorry, which paragraph are you on?
A. Sorry.

Q. Can you just give me the first words of it?
A. It's the sixth paragraph, saying "At Concord,

reporting may be used."

Q. "Reporting may be used". I see. Okay. Your concern about that specifically was?
A. The impression given that we were covering up incidents.

Q. You didn't think that was fair or accurate?
A. Correct.

Q. Anything else on that page and in relation to problems with training?
A. The comment on "Focus on minimum standards", that we don't have a high performance unit.

Q. Again, I'm sorry, which paragraph?
A. Sorry.

Q. What does that start with?
A. The second column, commencing with, "At Concord we don't have a High Performance Unit."

Q. Yes, I see that.
A. So we do have structures in place to support performance and to report activity data but also performance data.

Q. This is structures in place even if it's not labelled a high performance unit; is that what you mean?
A. Correct, yes.

Q. "Problems with training"?
A. The commentary about mandatory training generally --

Q. "Contrast this", that paragraph?
A. Yes:

Contrast this with Mandatory Training at Concord. ... established to address minimum standards. ... no high performance intention to achieve excellence.

I disagree with that. We --

Q. Is that for the same reason as the previous discussion?
A. Yes. But also the next paragraph in:

Instead, mandatory training at Concord was set up with the wrong intentions. ... as a tick-a-box.

It's not. Mandatory training is something that happens across all of NSW Health. It is reviewed on a regular basis, what is mandatory, and it's linked to particular policies, models of care, et cetera, and with 170,000 staff, it is important to say, you know, some training you really need to do - for example, advanced life support, you know, particular clinicians have to do that if they're going to be able and they've got to continue to update their knowledge. So it is about setting standards for excellence, not a minimum standard.

Q. All right. And over the page?
A. "Underinvestment".

Q. Yes.
A. Because it gives an impression that the hospital and the district have not looked to increase the investment at Concord, but our funding model is such that, you know, the funding that we get for the district is allocated as per a formula that is used by the Ministry of Health. So there was no intention - this gives an intention, was my belief, how I read this and --

Q. You don't like the language, "Concord has allowed underinvestment", I take it?
A. Correct.

Q. In the sense that, at least to a significant degree, even if you're, for want of a better word, lobbying for more money for your district or for this particular facility within your district, in the end, you get what you're given?
A. That's correct, and I would say that I and the district lobbied hard for resources for Sydney Local Health District and for Concord hospital. But at the end of the day, we have to manage with what we have.

Q. "Intimidation, Bullying and Harassment"?
A. I agree with the sentiment that people are concerned about that, but again, I think it gives an impression that we walk away from concerns of bullying and harassment. We take them very seriously.

Q. And you don't agree with that --
A. I don't.

Q. You don't agree with that sentiment, at least?
A. I don't agree with that sentiment, no.

Q. Then I think Dr Cheung has referred to some other inquiries, a WorkCover inquiry, a "Public Service Commission Action Plan" and "Emergency Services Agencies Inquiry", that don't directly relate, I don't think, to Concord. Did you have any issues with any of that?
A. No.

Q. Then there's "COVID-19". Were there any concerns you had in what --
A. I think again the language used gives a sense that - I actually agree, it was a really traumatic time. I think we all have post traumatic stress from COVID, and it did take a toll. He uses a war-like analogy in relation to that, and the way that this was read by myself and by others is that the needs of staff were not considered in the response, when my belief - and I think we have strong evidence to support that - is the wellbeing of staff was foremost in our thoughts and in our actions.

Q. Anything else in relation to that page, page 8 at the top?
A. I think it's just the language, and no-one was told "We have to obey the ministry". We were - sorry, that's the third paragraph on page 8. That starts:

> *"It was too risky to allow visitors," we were told. "It was too hard." "We have to obey the ministry."*

It was never said in that way, I can absolutely say that. But we were in a very difficult time and it was very difficult for families.

MR MUSTON: Could I just ask a question in relation to that?

THE COMMISSIONER: Of course you can, yes.

MR MUSTON: Q. When you say you are certain that it was never said in that way - that is, "We have to obey the

ministry" - are you making the point that it was never said by you in that way?
A. It was definitely never said by me and I can't imagine - I've never been in a meeting, I've never witnessed anyone saying that.

Q. But the position is, isn't it, that insofar as executive at the hospital might have been engaging with the medical workforce during that COVID period, it's possible that they might have expressed themselves in that way?
A. It's possible but I had never heard that statement prior to reading this nomination document. It had never been raised with me.

Q. Having read it, did you follow up with executive at the hospital as to whether or not anyone might have used that phrase at any point in time?
A. I actually did.

Q. Yes, with who?
A. With Genevieve Wallace, who was the general manager of Concord at the time.

Q. What did she tell you?
A. She said that they talked about the rationale for the restrictions, but it wasn't about the ministry, it was around what we needed to do to keep families safe and our staff safe. We were trying to avoid transmission amongst - from the community into the hospital. Hospitals have very vulnerable patients and what we do know is that, during that period, some of the outbreaks that we had in hospitals across New South Wales were actually through visitors coming in to the hospital.

Q. Was there, at that time, any ministry policy around --
A. There was.

Q. -- visitors?
A. Yes, there was ministry policy.

Q. And that policy provided that certain things could and couldn't happen?
A. Yes, yes, and it had the rationale for that.

Q. And there was an obligation, at least as you and no doubt the executive at the hospital perceived it, to comply with that policy directive?

A. Yes.

Q. From the ministry?
A. Yes.

THE COMMISSIONER: Q. It probably doesn't need to be said, but those procedures, protocols, rules, whatever we call them, weren't for Concord hospital only; they were for hospitals across the board, right?
A. The whole of the state.

Q. Anything else on that page, page 8, that concerned you?
A. No.

Q. Then I think on page 9 we commence with "The Change", and there's a column and a bit on "Living with COVID". Was there anything that troubled you?
A. Yes. Would you mind if we go back to page 8?

Q. Yes, of course.
A. The last three paragraphs on that page:

> *The consequence of chronic underinvestment [is] laid bare for all who came to ICU to see. But not the public. The public could not see.*
>
> *The staff prevented from speaking publicly. Prevented from sharing their stories. Prevented from sharing their concerns, prevented from sharing their pain.*
>
> *They cannot be silenced anymore.*

I have nothing that has been shared with me that indicates that staff were prevented from expressing their concerns.

MR MUSTON: In relation to that, if I could just ask a question --

THE COMMISSIONER: Yes, you can. You don't need to keep asking permission. You know that.

MR MUSTON: I don't want to interrupt you.

THE COMMISSIONER: There is no hierarchy here, not much of

one.

MR MUSTON: You have the high ground, literally.

THE COMMISSIONER: I do. But not if we were standing on the same floor, I wouldn't.

MR MUSTON: Q. Did you make any inquiries of Dr Cheung as to what lay behind those concerns or the sentiments that are reflected in those paragraphs?
A. I did.

Q. At the time?
A. Yes.

Q. What did he tell you?
A. He said he couldn't speak to me about it because of confidentiality.

Q. That is to say, because the concerns that had been raised with him --
A. Yes.

Q. -- as a prospective chair of the medical staff council, had been raised with him in confidence?
A. Yes.

Q. Is it your experience that that's not an uncommon feature of the medical workforce and perhaps the health workforce generally, that there is reporting that happens in that confidential way with people who are seen as safe and trusted recipients of the information, and then there's the reporting that occurs through more formal channels?
A. That's correct, and it makes it very difficult for us to then address it. So the ministry have set up a range of different mechanisms outside of the district - not just our district but across the districts - to enable staff who have concerns to be able to escalate them to the ministry.

There's a JMO - we call it a hotline, but that is not the name, where the JMOs can ring specifically. People can write directly to the ministry. For these things to be investigated, it is really hard without any particulars, particularly in a hospital like Concord that has, you know, if you add the VMOs, around 3,000 staff, knowing where you can start without looking like it's a witch-hunt. There are over 90 departments at Concord, so it's really hard to

investigate something if you don't know what the detail is.

Q. In this case, though, it could be narrowed down at least to the intensive care department --
A. Yes.

Q. -- that is to say, the concerns that had been, it is said by Dr Cheung, expressed?
A. Mmm-hmm.

Q. And the fact that those concerns had not been particularised or made the subject of any formal complaints or grievance process did not lead you to conclude, did it, that the concerns were not genuinely felt by those who might have shared them with Dr Cheung?
A. Yes, and I spoke to the head of intensive care around that time - I can't remember what date - Mark Kol - to ask what was happening, are there any concerns, is there anything that I need to do?

There were concerns about the pressures on ICU across every ICU in New South Wales, and we did a lot of work to try and protect the ICU and make it fit for purpose. So our engineering staff put up, what do you call it, little walls between the beds to try and isolate patients. It was hard to develop a new ICU at that time. But we did make a lot of efforts to do that. There were also --

THE COMMISSIONER: Q. This is driven by COVID, I assume?
A. Correct, yes.

Q. Thank you. Sorry, I interrupted.
A. And we looked at the staffing, because a lot of staff were being furloughed at this time, and we developed a model with the ministry about making sure that when there were shortages of staff in the ICU - and this was at a time even with recruitment activities that everyone was trying to get staff - that we had a model that staff on the wards, who had had experience in ICU previously but were now working in specialty areas or who had advanced life support skills, were moved into the ICU to assist to support them.

MR MUSTON: Q. In relation to those staff with the advanced life support skills, amongst them were nurses who, whilst they had those skills, had little to no experience in ICU --
A. Some of them; that's correct, yes.

Q. And that was - as needs must during the pandemic, that was what --
A. That's right, and I understand the concerns, but the alternative would have been not to accept patients from the emergency department or wards into intensive care, because we recognised we needed staffing, but we tried to put in models that would assist. We also - at that time, there was a reduction in elective surgery so we moved anaesthetic nurses and others from operating theatres into ICU and emergency department, because they had critical care experience.

Q. You haven't raised it, so I assume this is the case, but it would not have been inaccurate for Dr Cheung to have suggested that nurses in ICU who had been seconded from other departments often had had little time in ICU prior to that?
A. Some. Not all. Some had had extensive experience in ICU but had chosen to go into particular sub-specialties.

Q. And some, although having the advanced lifesaving training, had not nursed in a complex ICU unit before?
A. Correct.

Q. But all of them, as Dr Cheung says, were willing to do their best and work their hardest in a difficult situation?
A. People were amazing during that time. There was huge goodwill and people were provided with a lot of support. So my issue is a lack of context. It gives an impression, to me, and it might be a wrong impression, that he was saying that what we had done was the wrong thing.

Q. Just coming back to page 8, when we were talking about the paragraph, the penultimate paragraph in that second column, where there's a reference to staff being prevented from speaking publicly and sharing their views, that's not something that you did, but --
A. No.

Q. -- it having been raised, I think you told us, with Dr Cheung confidentially, you couldn't be satisfied, could you, that it didn't actually happen?
A. No.

MR MUSTON: I'm sorry, Commissioner, did you have any further questions about this document?

THE COMMISSIONER: Q. So page 9 of the document sets out, I think, some expectations and hopes about what will happen in relation to living with COVID, about opening up, what the community wants, expectations regarding elective surgery, operational levels, comments made that living with COVID can't be achieved at current levels of resourcing and a comment about political leaders, and then, on the right-hand side, about the new building, et cetera. Is there anything in that section that caused you concern?
A. My interpretation, which could be wrong, was that --

Q. Well, it's just your opinion, so yes.
A. He is giving an impression that we weren't doing anything to support that COVID recovery. In fact, in terms of recovery from surgery, there were, you know, plans about what we would do to recover after we ceased elective surgery during that time.

Q. Is there anything specific about - when you say "you", I'm assuming the LHD. To me, I get the impression - and I could be wrong, too - that the complaint is more about resourcing, which is more from treasury or politicians, than anything else?
A. We actually did get additional funds, Concord got additional funds during that time, I can't remember exactly what it was, but it was substantial. Our district, in fact, because of the multitude of responses around COVID, was given substantial additional funding. Our staffing increased from a base of around 12,500 to 16,000 staff during that time, and that included both in the hospitals but also in the various COVID responses. So additional resource was given, but there were challenges.

Q. Leaving that aside, the commentary, "Our political leaders", and "Health care spending", et cetera, do you agree that seems more directed at - well, that doesn't seem directed at management of the LHD; do you agree with that?
A. Oh, yes.

Q. It seems more directed at Macquarie Street --
A. Yes.

Q. -- or maybe Canberra, and maybe both. "Medical Staff Council Reform", there are some comments about some aspirations for the council in those, what is it, five bullet points. Is there anything there that caused you

concern? Put to side for a moment, while you consider that or answer it, the various draft terms of reference that came later on, but in terms of this document, those bullet points about best interests of the public, protect health, et cetera, was anything that caused you concern there?
A. I have no problem with those, but I do have a problem with the medical staff council "must be independent, incorruptible and free from external influence."

Q. What's the concern there?
A. One is it's very hard for the medical staff council to be independent when it's a structure within the district under the by-laws. It gives a false sense that it can just operate over to the side when its purpose is to provide advice and --

Q. Advice, yes.
A. So - yes.

Q. I mean, I suppose you could read that as if the essential function of a medical staff council is to give advice to people or management, such as yourself, it would do so at least independently itself and uninfluenced by others.
A. Mmm.

Q. To that extent, "independent" is all right, isn't it?
A. Yes, if you put it that way. I think the wording is --

Q. Your concern is that it's not independent from the hospital?
A. No.

Q. Is that --
A. Yes. And I think the statement about "it must be incorruptible" - and again, it appears to me, and maybe wrongly, that that is - it gives a sense that other people are corruptible, which I think is unfortunate.

Q. I suppose, though, you could read it, if we're just looking at the text, which is all I've got at the moment, that it's just a statement that a staff council should be incorruptible, without drawing aspersions on anyone else or any other body?
A. Yes, I think if you take it separately in that context. If you take it as a whole you might have

a different feeling.

Q. The same about external influence. Just of itself there's nothing wrong --
A. Of itself, no.

Q. -- with saying, "We should be free from external influence"?
A. Mmm. I mean --

MR MUSTON: Q. Another way for it might be simply to interpret it as a desire that the medical staff council be free and comfortable in giving frank and fearless advice to the executive even when that advice differs from or suggests a departure from a decision that has been made by the executive?
A. I would have been very happy with that wording. Could I go to the top of that column --

THE COMMISSIONER: Q. Yes.
A. -- where it says:

> *At Concord we will soon be operationalising a new hospital building. There was no agreement with the community or staff to spend hundreds of millions of taxpayer dollars on a new hospital, but not maintain hospital operations, and not improve on them.*

Q. Yes.
A. I disagree with that.

Q. Which part do you disagree with?
A. That - in terms of "no agreement with the community or staff", you know, the community as a whole and the staff as a whole were very keen to have a redevelopment and the ministry did provide additional funding for staff for the wards that were being moved into the redevelopment. So there were funds to go with that.

Q. I read that paragraph as not being - suggesting that there wasn't community or staff agreement relating to a new hospital, but there was no agreement that if we had this new hospital, it must be maintained - the hospital operations must be maintained, and we need staff and departments provided with the additional health care

resourcing?
A. Yes, and it gives an impression that that wasn't happening, when it was.

Q. And you disagree with that?
A. I disagree with that, yes.

Q. Anything in relation to the topic of "Priorities", which starts at page 9 and then goes down on page 10?
A. On page 10, the first sentence:

> *We are in the best position to decide the priorities.*
>
> *The people who manage the hospital finances do not look after patients. We cannot expect them to know what the community expects ... Their role is to facilitate the resourcing of the community's healthcare priorities, not to determine them.*

Under the health care Act, the role of the district and the facilities is, in fact, to make sure that we're not only looking at the finances but we're making sure that we provide high-quality clinical care to the community, and the medical staff council alone can't determine the priorities, it has to be in discussion. It would be like having 170,000 staff in NSW Health determining the priorities. We have to balance them.

Q. You tell me if you disagree. I tend to read that paragraph as more, perhaps not a particularly precise way and not looking at the Act, of saying it's the doctors and nurses that look after patients and we need a say; is that what --
A. I totally agree they need a say, and if it was that wording, I would have been happy with that wording.

MR MUSTON: Q. Is it possible, though, that the wording that's included there is reflective of the sentiment, at least amongst some of the medical staff at Concord at that time, that they weren't getting a say, they didn't feel like they were being listened to?
A. Yes, I think that's correct.

MR MUSTON: Sorry, Commissioner, please continue.

THE COMMISSIONER: Q. Anything else in that section or in - then we've got the heading "Culture of Denial and Silence"?
A. Just above that one, if you don't mind --

Q. Yes, please.
A. -- where it says:

There may be hundreds of priorities.
They all must be addressed.

Q. Yes.
A. To me, it's really unrealistic. It's not possible to address everyone's priorities. I'd love to. That would make me very happy. But the fact is we do have to have that balance and unfortunately, that means some people will be unhappy, and I think without more resources it's difficult, and even with more resources, it's never going to meet everyone's priorities.

MR MUSTON: Q. Doesn't that have to be read, though, in the context of the paragraph immediately above it, which points to what was at least being proposed was the medical staff council identifying all the priorities and not just a chosen few and presenting them at the management at Concord to resolve? Is it not possible that the phrase that "all of them must be addressed" is really a reference to all of them must be considered and balanced against one another in that exercise which, as managers, the executive must perform in deciding how to distribute resources across the system?
A. Yes.

THE COMMISSIONER: Q. That's another way of reading it, I'm sure. "Culture of Denial and Silence"?
A. I think it reflects how Winston felt.

Q. "Intimidation, Bullying and Harassment"?
A. So in here, Winston's calling for a parliamentary inquiry into bullying. I'm not sure how to comment on that. It's not something that we could address.

MR MUSTON: Q. But bullying and harassment had been an issue at Concord, though, hadn't it, within some - or at least within one department?
A. Yes, and between staff within departments.

Q. So it was an issue which, at least as was being expressed in this document, Dr Cheung did not feel had been adequately dealt with?
A. Yes, and when I met with him, I asked what we could do. He wanted a parliamentary inquiry. I said, "It's not within my gift to give." I asked for other suggestions on what we could do, and he said that was my job.

THE COMMISSIONER: Q. Anything else in the balance of this document relating to the topics of quality, education, research, et cetera - was there anything else that concerned you, or on the last page where there's a history given of Concord?
A. In terms of research, the quagmire of bureaucracy, there has been a huge amount done to support research across the district and in particular at Concord. So calling it a "quagmire", without, again, being clear what that refers to, made it difficult for me to act.

Q. When you discussed this document with Associate Professor Cheung, did he say to you that some of its content was informed by discussions he'd had with colleagues?
A. Yes.

Q. Anything else in the document that concerned you?
A. Not really. I mean, Concord does have a very proud history and the district has continued to support that.

THE COMMISSIONER: Thank you.

Sorry, I interrupted you a long time ago and you probably can't remember where you were up to.

MR MUSTON: No, I can.

Q. In relation to the concerns that were being expressed by Dr Cheung in that document, you had no reason to think, did you, that they were - well, put it the other way, did you have any reason to think that they weren't genuine concerns that he held?
A. No, which is why I met with him to see what we could do together.

Q. The medical staff at Concord are an intelligent and independent bunch, I assume?
A. Yes, they're great.

Q. And in making decisions about whether or not to elect a chair of their medical staff council, you would have been confident that they all would have exercised their own independent judgment, based on their own --
A. Yes.

Q. -- personal experiences at the hospital in the lead-up to that election?
A. Yes.

Q. And to the extent that you've identified some aspects of Dr Cheung's nomination document that you think you don't agree with, or you don't agree with the way that they're expressed, you don't suggest, do you, that in making a decision to elect Dr Cheung as their medical staff council chair, that any of the medical staff at Concord were in any way duped or lured into it by anything that had been said in that document that wasn't expressed in the way that you think it ought to have been expressed?
A. No.

Q. When Dr Cheung was elected by a comfortable majority of his colleagues as the chair of the medical staff council, did you consider that that gave some indication that the concerns which were being expressed in his nomination document were more widely held, not necessarily uniformly, but more widely held?
A. Yes.

Q. Did you think that that was an issue that required serious attention?
A. Yes.

Q. What steps did you take to try and address with the medical staff council, and the medical staff at Concord more generally, the concerns which, rightly or wrongly, they genuinely held about the way Concord was being run and the way in which they were interacting with the executive?
A. Yes, so quite a number of different ways. One was to try and form a relationship with Winston, with Dr Cheung, but that was difficult, and particularly in the context of COVID and time. We attended - I attended - as many medical staff council meetings as I could during that time. Most of them were online because of the COVID restrictions, which I do feel gave a sense of distance. There were also meetings with the facility, with heads of department, with

clinical directors, both by myself but also various members of the executive, to try to get to the bottom of the issues and address them.

The management team, including the director of medical services, the general manager, the director of medical services for the district, and at times myself, would go to the medical staff council to report back on what we were doing to address the concerns. But it was difficult to get a handle on what else we needed to do.

During that whole period of time there were sort of issues in relation to the management of COVID which we worked through with the clinicians. An example would be that there were real concerns around resourcing and residential aged care facilities, so we set up with the head of aged care rehabilitation a task force to deal with residential aged care, because that was raised as a concern and the resources required. We put in additional resources.

At one point we were meeting weekly to address that particular concern. So we tried to address each set of concerns that we were able to tangibly address as they arose. It was difficult with those things that are less tangible.

Q. In relation to the concerns, one of the concerns that was being expressed was a fear that those who spoke out about their concerns would face reprisals?
A. Mmm-hmm.

Q. What was done to try and address that concern, accepting it's a difficult one if you don't think it's the fact, but it's nevertheless a genuine concern that the workforce held?
A. It wasn't necessarily about not thinking it's a fact but knowing how to address it if you don't know - it's, like, you don't know what you don't know. We gave, at the medical staff council meetings, at department head meetings, at the clinical council within the facility, a range of avenues that people could go to, that bypassed the people that they might fear would, you know, make reprisals.

Q. Are you aware that at one of the medical staff council meetings, Dr Cheung asked Dr Wallace if she or the district

would confirm in writing that there would be no reprisals for people who spoke out in relation to the concerns that they had?
A. Yes, I am aware.

Q. And were you present at that meeting?
A. No, I was not.

Q. You've read the minutes of that meeting?
A. I have, yes.

Q. Did you read the minutes of that meeting at the time?
A. No, I didn't. I was unfortunately preoccupied with other matters.

Q. You would be aware, having read the minutes, that Dr Wallace did not embrace the idea that a written confirmation of the fact that there would be no reprisals for those who spoke out would be useful - that is to say, she said, "Why would we give you that. If you don't trust us, what's a written piece of paper going to change, to change that"?
A. Mmm.

Q. Do you think, reflecting on it, that in circumstances where, as chair of the medical staff council representing a group of people who held that concern, that refusing to provide a written confirmation that there would be no repercussions for those who spoke out with their concerns might have inflamed the situation?
A. I think in hindsight, it might have been good to do that.

Q. I gather from the answer you gave a moment ago that the possibility of a written confirmation of the fact that there would be no reprisals for those who spoke out was not something that Dr Wallace raised with you?
A. No - not that I recall.

Q. You tell us in paragraph 116 of your concern that from an early stage of Dr Cheung's tenure as chair the medical staff council conducted itself as though an oversight body. Could you just explain to us what you mean by "oversight body" in that paragraph?
A. The impression that was formed by myself and also by other members of the executive --

Q. Just pausing there, who were the other members of the executive who --
A. So Dr Hallahan, Genevieve Wallace, when she was the general manager of Concord, and then, later, Joseph Jewitt who was then the acting general manager. They felt that the conversations - and I was not present for all of the conversations - were becoming more and more adversarial and more directive.

I think it's very important that medical staff councils are able to ask questions, to seek information, but the way in which that was being done made the - I was informed, when I wasn't there, but in some of the conversation with myself, it was very directive in its approach. So it wasn't just about providing feedback; it was saying, "You must do this", and "If you haven't done that, then you have basically failed."

Q. So just in terms of the process, were there meetings happening at an executive level between yourself, Dr Hallahan and - is it Dr Wallace or Ms Wallace?
A. Dr Wallace.

Q. -- Dr Wallace, in which they conveyed to you what had happened during medical staff council meetings?
A. Yes, there are many meetings that happen within local health districts, operational meetings, meetings about Concord hospital. There is a monthly executive meeting with the executive of the district and the executive of Concord hospital, as well as more informal meetings on a more regular basis.

Q. And through those various avenues, would it be fair to characterise the situation as one in which Dr Hallahan, Dr Wallace, with the assistance of yourself, were looking at ways to deal with the Concord medical staff council situation?
A. And looking at actions that needed to be taken to address the concerns.

Q. Did you explore with Dr Hallahan and Dr Wallace the possibility that the way that they were engaging with the medical staff council might have been adding to the adversarial nature of the relationship which was developing?
A. No, I didn't.

Q. Coming back to the concept of an oversight body, other than to the extent that Dr Hallahan and Dr Wallace were conveying to you that, at least as they understood it, the medical staff council were making demands which needed to be met, did you have any reason to believe that the medical staff council at Concord was doing anything other than seeking to express its views about the sorts of matters that the medical staff council might usefully express views about, namely, concerns that it had in relation to operations of the hospital, ways in which it thought things could be improved, et cetera?
A. As I indicated, some of the meetings that I went to myself, the impression that I formed was that, despite members of the executive, the general manager of the hospital providing feedback in relation to concerns that had been raised, was that those actions were not adequate, and it was hard to work out what else needed to happen other than being told they were not adequate. And we did try, when concerns were raised about finances, presentations were provided to help understand the detail of the financial reports of the district, and that was both by the director of finance at Concord hospital, I myself also gave a presentation to explain how funding is allocated, how we negotiate for the service agreements, and also later the director of finance for the district also provided a presentation and clarification. So we did try to address the concerns. It's clear that we did not do that to the extent that we should have.

Q. A number of the concerns that were being expressed during the meetings were concerns that were longstanding on the part of the staff at Concord - that is to say, that they had been asking for changes or suggesting that changes could or should be made for quite a long time, in some cases, without those suggestions being taken up. I'm not saying that's an improper thing, but that's just as a fact; is that correct?
A. That's right, and where that was raised with us, if there was a valid reason we would give that reason, and I think that that presented in a defensive way, because we were trying to explain, and I think the attempt to explain was seen in a negative light.

Q. You have raised, in your statement, the various iterations, and the correction you gave this morning, the various iterations of the terms of reference of the medical staff council that were being proffered by Dr Cheung.

I think you tell us in paragraph 113(b) that the draft terms of reference that he put forward was something that stood out to you as reflecting a change in approach by the medical staff council - that is, an increasingly adversarial approach by the medical staff council at Concord?
A. Yes.

Q. Could I just go to those documents. If we could go to them chronologically, the first one is, chronologically, at least, an attachment to your statement at tab 6, which is [MOH.0010.0403.0001]. You tell us in paragraph 113(b) of your statement that, as you apprehended it, what these revised terms of reference contemplated was an alternate governance structure for the LHD?
A. Correct.

Q. Could you explain what you mean, by reference, if possible, to the draft terms of reference, being the 25 May 2022 version of them - the one up on the screen and hopefully in front of you - what it was about them that you understood to be proposing an alternate governance structure?
A. Sorry, I'm just trying to find it. My apologies. I can't find it. Found it. Sorry. Thank you. Apologies.

Q. No, no, take your time.
A. So the concerns about the terms of reference related in particular around the establishment of a range of subcommittees that included redevelopment, workforce culture, industrial relations, consumer engagement, quality and safety, education and research.

That is a duplication of structures within the district. I did go to a medical staff council meeting to try to explain how that duplicated existing structures within the district and invited any members of the medical staff council to join any of those existing committees, because it would cause confusion having a second set of committees that replicated the operational functions of the district.

Q. It had the scope to cause confusion, but it wasn't being proposed, was it, that the subcommittees of the - proposed subcommittees of the medical staff council do anything other than consider the particular issues with a view to informing the chair and the medical staff council

generally of their thinking in relation to those matters for the purpose of providing advice to the executive in the manner broadly contemplated by the by-laws?
A. That's unclear to me.

Q. It wasn't clear to you that they did contemplate anything more than that, though, was it?
A. In the functions of the medical staff council and the way in which the medical staff council was running the meetings, it gave an impression that this was more than that.

Q. The medical staff council had, by that stage, reached a point where they had a range of concerns of the type that we've already gone through?
A. Yes.

Q. And is it not possible that the subcommittees that were proposed were merely a way of enabling the medical staff council to delegate to particular members or groups of its membership responsibility for coming up with the medical staff council's position or thinking in relation to each of those individual issues?
A. That wasn't the impression that I formed, and it would - from where I sat, would have been better for them to join the existing - if they wanted to change process, being part of the decision-making in those existing committees would have been of more assistance.

Q. Accepting that that's probably right in terms of the governance structure of the district, did you perceive or consider that preventing the medical staff council from delegating to its membership responsibility for thinking around the concerns that they held might have been seen as an attempt to stop them from thinking about those concerns and expressing their views in relation to the concerns that they had at that time?
A. I didn't at the time. In hindsight, I can see that that might be the case.

Q. The meeting that you attended where the issue of the subcommittees was raised resulted in the subcommittees being dropped from the proposed terms of reference by Dr Cheung?
A. Yes, and I thanked Dr Cheung for doing that.

MR MUSTON: I'm about to move to another document.

I might - it's 11:28:40, instead of moving to that document and then having everyone walk outside --

THE COMMISSIONER: We will take the adjournment now and we'll adjourn until 11.50.

SHORT ADJOURNMENT

THE COMMISSIONER: Yes, go ahead, Mr Muston.

MR MUSTON: I was going to take the witness next to the version of the terms of reference which are attached to Dr Cheung's statement.

THE COMMISSIONER: Are these the March ones?

MR MUSTON: Yes. I'll just find them. They are at tab H7.12.14 of Dr Cheung's statement. They're [SCI.0012.0041.0001]. I'll just see if we've got a hard copy for the witness. Volume 1 of Dr Cheung's exhibits.

Q. If I could just ask you to have a look at them, is there any particular aspect of that document which you regard as proposing an alternate governance structure for the LHD?
A. The section under "Function", on page 4 of 9, when it has "Issues for which advice might be provided may include but are not limited to", those particular things in and of themselves are fine, however, they're taken from the by-laws and relate to the function of the board, and so the interpretation that I had at the time was that the medical staff council, through Dr Cheung, was aiming to replicate the functions of the board.

Q. But you accept, reading it now, do you, that all they were - all, at least in terms of the words on the page suggest is that the medical staff council were wishing to provide advice to the executive on those matters which included the matters which actual decisions were going to be made about by the board?
A. Yes, if you take the words on the page in that way, yes.

Q. But there's certainly nothing in the terms of reference which suggests that the medical staff council, through this draft document, was seeking to take on a decision-making role, is there?

A. Not in the words themselves.

Q. Is there anything else about the document which gave that impression?
A. The context that sat around it.

Q. The context being what the - what is that context?
A. Was the way in which the medical staff council and Dr Cheung were functioning at that time.

THE COMMISSIONER: I think I would need some further explanation to understand that.

Were you going to ask some questions about that?

MR MUSTON: I was going to.

THE COMMISSIONER: I will leave it with you.

MR MUSTON: Q. Could we go to tab 5 of your bundle. Just keep the Dr Cheung bundle there, I'll come to another document in a moment. That's a letter dated 7 May 2022 from Dr Cheung, in his capacity as the chair of the medical staff council, to Dr Wallace, in her capacity as the general manager of Concord hospital. Just going through that, is there anything about that letter which you regard as informing the context that you've just told us about?
A. No, not in itself.

Q. In essence, it was doing nothing more than raising issues which were appropriately the subject of consideration by the medical staff council and requesting some further information from, in that case, Dr Wallace?
A. And normally the issues around knowing how many shifts are currently not staffed, et cetera, is usually a matter for the sort of nursing structures within the organisation, and that includes the nurses and midwives association, the NSW Nurses and Midwives' Association, so there were concerns that the medical staff council, although, you know, appropriately raising concerns about nursing, were actually going into an area that is covered by other parts of the structure.

Q. Whilst covered by other parts, to the extent that the medical staff council might feel that issues around nursing impact on their ability to deliver good care, it's a matter that they're entitled and should appropriately raise

through the medical staff council?
A. Yes. But I think getting down to, you know, what are the number of shifts, et cetera, is probably a level of detail that is unusual for a medical staff council.

Q. Whilst unusual, in the context of a medical staff council which had, through its election of Dr Cheung, embraced collectively the concern that they weren't being sufficiently engaged with by the executive, responding to those sorts of questions could only have improved that situation, couldn't it?
A. Yes, and my understanding is that at the next medical staff council meeting, there were discussions in relation to the questions raised by Dr Cheung.

MR MUSTON: So just for the benefit of the transcript - operator, we don't need that document brought up right now - that was [MOH.0010.0394.0001].

Q. Could I ask you then to go to tab 7 in your bundle, which is [MOH.0010.0395.0001]. That's a letter of 16 June 2022 from Dr Cheung, in his capacity as chair of the medical staff council, to Dr Wallace, as general manager of the hospital. Is there anything about that letter which you consider informs the context that you referred to a moment ago and casts the terms of reference being put forward in any particular light or a different light to that which the words might suggest?
A. So on page 2 of 4, under "Mandatory Training", despite the conversation that we'd had about not setting up additional subcommittees, an agreement not to do that, this again contemplates an education subcommittee, when the preference would have been for that to be incorporated into the existing education committees of the facility.

Q. But the concern that was being expressed there was that the medical staff council, and from that are we to infer the medical workforce at Concord, did not feel that it had not been involved in the process of approving mandatory training and it felt that it wanted to be?
A. It's not the role of the medical staff council to approve mandatory training, certainly to give advice in relation to concerns about training that may or may not be appropriate, and there is a process for being able to sort of escalate those concerns. The majority of the mandatory training is set at a state level for particular groups of staff.

Q. But nothing in those paragraphs there under the heading "Mandatory Training", though, suggests that the medical staff council wanted the right to approve or any right of veto in respect of the mandatory training; is that --
A. So the last sentence says:

> *The major concern is that the [medical staff council] has not been involved in the process of developing or approving --*

medical staff training.

Q. So the concern was not wanting a right of veto, but they wanted to be involved in the process?
A. I was happy for them to be involved but not - it's not the place of the medical staff council to approve mandatory training.

Q. So the approval of - what you perceived there to be a desire to be involved in the approval of mandatory training was one piece of context that informed your understanding of the terms of reference. Reading on, is there anything else in this letter which is an important part of that context?
A. I thought it was good that he fed back the reassurances that there would be no reprisals taken against staff.

Q. He informs Dr Wallace in that letter, though, while we're on that topic, that were still many staff who continued to fear reprisals and were still unwilling to report safety issues. Was that a concern that was dealt with or responded to in any particular way by Dr Wallace or anyone else within the executive, to your knowledge?
A. My recollection - again, it could be wrong - was that it was discussed, again at the medical staff council, and a commitment given that there would be no reprisals, but discussed a way in which those concerns could be escalated in the appropriate manner, is my understanding.

Q. I see there in the next paragraph immediately beneath that, "We think a reasonable step" picks up again this issue about providing an open letter encouraging staff to report things and confirming that reprisals will not be taken. Was this letter - as in, the one that we're looking

at now behind tab 7 - brought to your attention at the time that it was received by Dr Wallace?
A. I'm not sure. I was actually on leave at this time. I had COVID myself, so I - my recollection is a little vague, so my apologies.

Q. If the letter wasn't received by you, which I gather is a possibility, it stands to reason, doesn't it, that it would not have informed any part of the context against which you came to construe the terms of reference when they were received by you?
A. Mmm.

THE COMMISSIONER: I'm just wondering if you go to the next tab, I don't know whether - there's an email, the first email is Dr Hallahan to Dr Anderson of 23 June, where --

MR MUSTON: You're quite right.

THE COMMISSIONER: -- there's a reference to "last letter attached". I'm just wondering if that's the letter you are talking about.

THE WITNESS: Yes, that makes sense.

THE COMMISSIONER: Q. There is a chance it is, anyway.
A. I think it is, yes.

Q. That email is a week after Associate Professor Cheung has sent the 16 June letter to Dr Wallace. There is a fair inference you could draw that it is this letter?
A. Yes.

MR MUSTON: I was about to come to that document, so perhaps, operator, if we could bring up [MOH.0010.0397.0001].

Q. As the Commissioner has pointed out, the email at the foot of it from Dr Hallahan to you of 23 June 2022, is that an email that you recall receiving?
A. I do now, yes.

Q. It suggests that the letter that we've just been through probably was forwarded to you at that time?
A. Yes.

Q. Do you see Dr Hallahan, in that letter, characterises

the letter as containing a series of demands - just in the first or second line of his email?
A. Yes. Mmm-hmm.

Q. If we look back at the letter - having read it, do you recall whether you shared his view that it reflected a series of demands from the medical staff council?
A. Not a series of demands, but certainly I think the intention in relation to the approval function of the medical staff council. But also, you know, on reading this, the issue about having a summit with the emergency department, that was something that was put, and there were concerns by the emergency department and by Dr Philip Visser, who was the head of the emergency department, that that would exacerbate issues rather than solving them.

Q. I think at that time, though, those concerns, if we look at it chronologically, might not have been expressed at the time that this letter was sent. We can work through that if you want to, but just looking at that emergency department summit, it was the case that there were serious cultural problems within the emergency department at Concord at that time --
A. Yes.

Q. -- is that correct? And what was being proposed was a constructive and collegial meeting to identify the problems and allow those present to think about potential solutions?
A. Yes, except the head of the department felt that the timing was problematic.

THE COMMISSIONER: Q. I can see also in Dr Hallahan's email to you, he's set out his opinion about the proposed terms of reference as having "overlapping clinical council and board roles and responsibilities". That was obviously his view at the time?
A. Yes.

Q. I think when he gave evidence he accepted that at least the text of the terms of reference probably didn't support that there was an attempt at usurping the role of the board, and I think that's probably something you agree, at least in the text of the terms of reference?
A. Yes, and I think - you know, the value of hindsight, looking back, I think there was a lot happening at this time.

Q. Should I take from this email and perhaps other discussions that - could it have been Dr - this isn't a criticism, just an expression of their opinion. Could it have been Dr Hallahan and Dr Wallace that put it in your mind that Associate Professor Cheung and the staff council were attempting to usurp board roles when, in fact, at least the document being produced, wasn't supportive of that? Is that a possibility?
A. I think that context might be fair enough, but I think it's really difficult to say what was in the minds of everyone, including myself, unfortunately, at that time, and I have to admit I had a --

Q. Well, save for this email gives an indication of what was in Dr Hallahan's mind about the terms of reference, yes.
A. Yes.

MR MUSTON: Maybe to clear up one issue, if we could jump forward to tab 9, which is [MOH.0010.0398.0001].

THE COMMISSIONER: These were the minutes that I think you were referring to before the break.

MR MUSTON: Yes.

Q. So we get the chronology right, these would appear to be minutes of a meeting which occurred after the letter of 16 June 2022?
A. Yes.

Q. The letter we've just been looking at at tab 7, which contains a reference to the mandatory training and the emergency department summit --
A. Yes.

Q. -- and, sorry, 5, the reporting of safety issues for fear of reprisal - that letter seems to have preceded the meeting, the minutes of which occur behind tab 9?
A. Yes.

Q. Would you agree with that chronology?
A. (Witness nods).

Q. If we just go to those minutes, commencing on page 5, do you see the first of the issues in the letter is

addressed, namely, the pathways that clinicians should follow if they want resources or changes to services to be considered by the executive?
A. Yes.

Q. That doesn't seem to be expressed in a way that is particularly troubling or indicative of a demand, reasonable or otherwise, being made by the medical staff council, does it?
A. Oh, that's correct, yes.

Q. You see at 3(b) there we've got raised the concern which again was reflected in the letter about some ambiguity around the escalation process if requests were rejected at a local level, and how that was to be dealt with?
A. Mmm-hmm.

Q. It's not unreasonable for the medical staff council to want to have an understanding about how requests that they might make to management, if rejected, can be escalated if they feel it requires further consideration?
A. Not at all.

Q. And Dr Hallahan indicated that the medical staff council chair should write to the - sorry, to you, "TA" --
A. That's me.

Q. -- directly in relation to that issue. But that again isn't an unreasonable thing for a medical staff council to be addressing in the context of the ordinary operations of such a beast, is it?
A. No.

Q. Turning over to the next page there, 0006, do you see at point (d) "Mandatory training", there's a discussion of that issue around training and what has been expressed in the meeting, it would seem perhaps better than expressed in the letter, was a desire that the medical staff would like to have a greater voice in the development of teaching and training? Do you agree with that?
A. Yes.

Q. You received those minutes by email, I gather, from what appears on the first page behind that tab?
A. Mmm-hmm.

Q. Do you have a recollection of reading them at the time?
A. I would have, yes, but do I recall when I read it? Apologies, I don't.

Q. But there's nothing about what was said under that heading of "Mandatory training", which would have led you to feel concerned that the medical staff council was seeking to impose itself on issues which were not appropriate?
A. No, I think the wording in the minutes is consistent with what I would think was the role of the medical staff council.

Q. And then we have under the heading (e) "Safety issues and fear of retribution", an issue that we don't need to traverse, but the request for written confirmation that there wouldn't be any reprisals, and that's left where we see it being left at the end, namely, that the executive would take it on notice.
A. Yes.

Q. Reflecting on it now, do you have a recollection of having had any thoughts around that particular issue at the time that you received and read the minutes?
A. I really don't recall.

Q. Let's move on to the ED summit, which appears immediately beneath that. There was, it would appear, some discussion of what was proposed. Dr Hallahan seems to have asked who was to be involved, and Dr Cheung has explained it would involve JMOs and senior medical officers. Do you see there on page 7, at about point 4 on the page, there's a reference to a contribution made by P Visser?
A. Visser, mmm-hmm.

Q. I gather from what appears in parentheses next to his name that he was the head of the emergency department at that time?
A. That's correct.

Q. So earlier when you were referring to Dr Visser's concerns around this proposal, just to put it at least in chronology, it doesn't appear from what appears in those minutes that he was expressing concerns about it at that time?
A. I mean, he does say that he will discuss it with

a group of specialists in ED to determine if they're prepared to engage, and sees it as well intended at rebuilding relationships, but unsure if they're prepared to engage at that time, and he would take it to the consultants' meeting.

My understanding is that discussions that were had subsequent to this meeting, because he was privy to issues within the emergency department - my understanding is he didn't want those aired in a general meeting and felt uncomfortable.

Q. But just to put the earlier letter into its chronology, a proposal was put by Dr Cheung in his letter that there be a forum to discuss some of the cultural problems within the emergency department?
A. Mmm-hmm.

Q. That proposal was then raised at a meeting of the medical staff council. It was discussed in the way that we see here and identified by the then head of the department as a well-intentioned idea to refocus and rebuild relationships, but one which required consideration and input from members of the staff within the emergency department before a decision was made to go ahead with it.
A. Yes.

Q. That decision, as you've told us, was ultimately made by Dr Visser that, at that particular point in time, it would not be, he felt, a productive way of dealing with some of those cultural issues?
A. Yes, and I supported that decision.

Q. And there's no suggestion, is there, that that decision was not also accepted by the medical staff council at the time?
A. There were subsequent conversations. Winston wanted to proceed with that forum and he was asked not to.

Q. But it didn't proceed?
A. It didn't proceed.

Q. And there was no attempt to insist on it happening over the objection of others, for example?
A. No.

Q. In fact, I think if we turn over to tab 10, which is

[MOH.0010.0399.0001] --
A. Yes.

Q. -- that seems to be another set of minutes from the next meeting. Just pausing there, on the first page, the email seems to have been forwarded by or sent by Genevieve Wallace to a Lorna Arkell. Who is Lorna Arkell in the ecosystem?
A. It was Genevieve's executive assistant.

Q. Turn over to page 5 of that document. Do you see there's the next discussion, it would seem, by the medical staff council of the emergency department summit proposal?
A. Mmm-hmm.

Q. It doesn't appear from that that there was any real dissent by Dr Cheung or anyone else, at least at that meeting, from the view being expressed by Dr Visser in relation to the desirability of postponing a summit like that to some later time?
A. That's correct. And I explained that it had been a very challenging time for the ED, particularly with the pressures of COVID.

Q. Just having worked through all of that and bringing it back to the context of the terms of reference, none of what appears in the minutes and the correspondence between Dr Cheung and Dr Wallace, at least, really suggests that the medical staff council was seeking to take a greater role than what might ordinarily be expected of a body like that within the health system, did it?
A. If you go from the minutes, yes.

Q. Ultimately, the minutes are what are most important, aren't they, because they reflect what the medical staff council as a body is doing in terms of making decisions and seeking information?
A. Yes, and - but what they don't sometimes convey is the language and tone that are used in those meetings and what was conveyed to me was an increasing sense of irritation, that the management of the facility and district were not performing adequately.

Q. Who conveyed that to you?
A. That was conveyed both in meetings that I attended but they were small in number, but primarily from the facility and district executive who attended.

Q. So it was by Dr Hallahan and Dr Wallace?
A. Yes, and later Joseph Jewitt, who was the acting general manager.

Q. So at least in those early stages when Dr Wallace was still part of the furniture at Concord, they were conveying to you that, at least as they --
A. Perceived it.

Q. -- perceived it, the meetings were indicative of an unhappiness on the part of the workforce with the way in which executive was dealing with things?
A. Yes.

THE COMMISSIONER: Q. I understand what you're probably meaning to convey when you said that the minutes don't convey the tone that's used. By that, should I take it that some of the people recorded as talking in the minutes are doing so with a fair amount of passion from time to time?
A. Yes.

Q. "Language", though, what do you mean by that? I assume they're not swearing or --
A. Oh, no, definitely not.

Q. So what's the point you wanted me to take from "language", or is it really tone is what you meant?
A. It was tone and a sense of being directed and unsatisfied.

THE COMMISSIONER: All right.

MR MUSTON: Q. Just exploring that, whilst tone might convey a sense of frustration --
A. Mmm.

Q. -- and anger, perhaps --
A. Mmm.

Q. -- tone, in and of itself, is not going to convert something which is not a direction into a direction, is it, or a demand?
A. It's hard to give an example, but --

Q. Very hard, I'd suggest, because it can't?

A. I think the way in which you ask a question can give an impression of a direction. The language that you use can do that.

Q. Put another way, there's no - to the extent that the minutes, accepting they don't convey tone, they do represent, one is entitled to assume, an accurate reflection of the mood of the meeting in what was being said and what was being sought. Would that be right?
A. Generally, yes.

Q. And there's nothing in the minutes of the meetings that conveys any sort of demands, is there?
A. I can't say without going through them in great detail to find you particular examples.

Q. To the extent that anything might have been expressed in a tone that made it sound more like a request than a demand, it was really requests for information, not requests for any particular step or action to be - or decision to be made?
A. If you go to some of the later minutes where there's actually recording of those minutes --

Q. Just for present purposes, I just want to try and stick with the ones we've got at this point in time, if that's okay.
A. What I've read today, because I haven't refreshed my memory on it, then I would agree with your statement.

Q. So if we could go back to tab 8, and that's [MOH.0010.0397.0001], if you turn over to the second page of that email, do you see Dr Hallahan's characterisation of it was that the meeting was principally Winston - that's Dr Cheung - "trying to put Gen" - that's Dr Wallace, and to a lesser extent himself, on the spot. Do you see that?
A. Yes.

Q. Reading the minutes of that meeting, that's not really an entirely fair characterisation of what transpired, is it?
A. So my understanding is that is a different set of minutes, isn't it? The 23rd. Sorry.

Q. I'm sorry, you're right.
A. Yes, that's a reflection of the same minutes. Yes,

apologies. I hadn't - so the - at the time he would have written this would have been immediately following that meeting. The minutes of that meeting come out approximately a month later, and that's what I mean. I wasn't present for that meeting, but he came away from the meeting with that impression. Unfortunately I can't assume to know exactly what he was referring to because I wasn't present, but certainly the minutes don't reflect the sentiment that he felt, and I don't know how he felt other than what he said.

Q. So undoubtedly what he said in his email was reflective of the way he felt about his experience of that meeting?
A. Mmm-hmm.

Q. But is it possible that his experience of the meeting and what he might have felt about it is not necessarily the most objective view of actually what had transpired at the meeting?
A. I can't speak for him.

THE COMMISSIONER: I think - I mean, personally I would interpret it as - there's a whole range of issues raised at this meeting. I would take what Dr Hallahan has said in the email to be principally reflecting the topic of safety issues and fear of retribution, and I would take, unless I'm corrected, "put Gen on the spot", to relate probably to the request by Associate Professor Cheung for a written confirmation about no reprisals, for which the initial response was, "If you don't trust the executive, then a memo is unlikely to change that", but with the professor then saying, "Well, it's a symbolic gesture", and then it being left with "We'll take it on notice". I would suspect that - so it's not a question for you, I'm just making transparent my thought processes in case it's helpful to anyone. I think that's probably what it relates to, and that may well have been the most significant thing to Dr Hallahan when he's reflected on that meeting.

MR MUSTON: Q. By that point, do you have a sense, or did you get the sense from reading that email, that Dr Hallahan felt that the relationship between the executive and the medical staff council at Concord had become a little bit combative?
A. Yes.

Q. Did you reflect at that time on the possibility that the way in which the executive - by which I don't mean you personally but the broader executive team - were engaging with the medical staff council at Concord might have been contributing to the combative nature of that relationship to the extent it was combative?
A. At the time, my thinking was if we were able to demonstrate what we were doing in response to the concerns, that that would decrease the tensions, and I probably wrongly assumed that the general fatigue that everyone had at this time was contributing to that increased tension.

Q. If we move forward to 12 October 2022, Dr Cheung sent his letter to Mr Ajaka, which we find in tab 1 of the folder that you have in front of you, not the small one, but the larger one.

MR MUSTON: For your benefit, Commissioner, it's H7.12.1, and for the benefit of the operator, it's [SCI.0012.0108.0001].

THE WITNESS: I'm sorry, I'm not sure which.

MR MUSTON: Q. Sorry, I think the larger folder --
A. This one?

Q. There should be a tab there that says H7.12.1. Whilst I think the answer you gave a moment ago was that you were hopeful that by conveying to the medical staff council what was being done you would resolve some of their concerns --
A. Yes.

Q. -- was it clear to you when this letter was sent and received that those efforts, at least up to that point, had not resolved the concerns of the medical staff council --
A. Yes.

Q. -- at Concord? Did you have any reason to think that the letter sent by Dr Cheung didn't reflect the concerns of the broader medical staff council at Concord - that is to say, as opposed to just Dr Cheung's own personal feelings about the topic?
A. No, and he was communicated with pretty promptly about arranging a meeting to discuss his concerns.

Q. Can I take you to paragraph 120 of your statement. At least on the chronology, as I understand it, the first

communication with Dr Cheung after he had sent that letter was a telephone call that you refer to of the following day, in paragraph 120?
A. Yes.

Q. You had been informed by Mr Ajaka that Dr Cheung had made attempts to obtain some contact details of him and to ensure that he - that is, Mr Ajaka - had received the letter?
A. Yes.

Q. You conveyed to Dr Cheung that his behaviour in doing that was inappropriate. What was inappropriate about his behaviour in seeking to obtain contact details for the chair of the local health district?
A. It wasn't the trying to obtain the contact details; it was contacting Mr Ajaka's previous employers and also to them expressing concern about Concord, and they contacted Mr Ajaka, who contacted me and asked me to contact Winston and say, "That is not the way to communicate", and to get him to go through the normal processes, and that included to Nerida Bransby, who is the secretariat for the board.

THE COMMISSIONER: Q. I may have misunderstood this part of your statement. The reference to "previous employers" - and then it says "including Parliament House", previous employers is who?
A. So Mr Ajaka was the president at the parliament, and so Dr Cheung contacted the office of the president of the parliament - sorry, I'm probably not using the right terminology, but there's a unit in parliament and Mr Ajaka was previously the president of the parliament and had that unit, and that unit was contacted by Dr Cheung. That was what he was --

Q. To seek his contact details?
A. To seek his contact details and also share his concerns in relation to Concord.

MR MUSTON: Q. What you tell us in the statement is that those attempts had been made to ensure that Mr Ajaka had received the letter and obtain the contact details. Do you say now that, in addition to what you have told us in the statement, that Dr Cheung was sharing with the administrative person who he might have contacted in a department at parliament his particular concerns around Concord hospital?

A. Yes.

Q. In your discussion with Mr Ajaka --

THE COMMISSIONER: I don't think Associate Professor Cheung has had that put to him for his response, so we might need to make a note for procedural fairness reasons about that.

MR MUSTON: Q. In your discussion with Mr Ajaka, was there any discussion between the two of you about the possibility that Mr Ajaka might ring Dr Cheung and confirm that the letter had been received and that something would be done about it?
A. He asked me to do that and, in addition to saying there was a better way to approach Mr Ajaka, I indicated to him that he did have the letter.

Q. In the context of Dr Cheung's concerns around not being listened to and fearing reprisals for speaking out, did it occur - did you reflect at the time on the possibility that chastening him for seeking contact details of the person he was wanting to get in touch with, namely, the board chair, might have exacerbated those concerns?
A. Not at the time, because I did say in the conversation that we take his concerns seriously, that we would organise a meeting as quickly as we could to discuss those concerns.

Q. The aspect of the conversation which I'm exploring, though, is that in which you've conveyed to him your belief that his behaviour in reaching out to Mr Ajaka or seeking the contact details of Mr Ajaka was inappropriate?
A. Yes, because that's what I was asked to do.

Q. But did you personally think it was inappropriate at the time, or is it just that Mr Ajaka felt it was inappropriate and he asked you to convey that?
A. The normal process would be to contact Nerida, which is not what he did. He went to the board chair's previous employer and I would suggest that is --

THE COMMISSIONER: Q. Sorry, just on that, so Mr Ajaka was the president of the legislative council.
A. Yes, apologies.

Q. Professor Cheung has had, what, a discussion with someone within that office, has he?

A. Yes.

Q. And how has that come to your attention?
A. Through Mr Ajaka.

Q. Right. So the extent of your knowledge in relation to what may or may not have been said by the associate professor to someone within the office of the president of the legislative council has been reported to you by Mr Ajaka himself; correct?
A. Correct.

MR MUSTON: By that stage, it's third-hand.

THE COMMISSIONER: Yes.

THE WITNESS: Sorry.

THE COMMISSIONER: No, no, that's all right.

MR MUSTON: Q. I'll come back to the question. Particularly in that context where you didn't really know what had been said by Dr Cheung --

THE COMMISSIONER: Sorry to interrupt. Sorry to interrupt.

Q. For all you know, I suppose, in fairness, we don't know whether, whoever it was within the office of the president of the legislative council may have asked Associate Professor Cheung what was the reason he was calling, and he may well have answered that by saying, "Well, I'm calling for this reason" --
A. He may have.

Q. -- "related to Concord hospital"?
A. Yes.

MR MUSTON: Q. Did you reflect at the time on the possibility that indicating to Dr Cheung that he was engaging in behaviour which was inappropriate in reaching out to Mr Ajaka might have exacerbated his concerns about not being listened to on the one hand and a threat of reprisal for speaking up?
A. I didn't see it at the time as a threat of reprisal. I did indicate that we took Dr Cheung's concerns very seriously. You know, I apologise if he felt that it was

a reprisal, that wasn't the intention, but I was asked to indicate that calling his previous employer was not appropriate.

Q. I'll come back to a question I asked you a moment ago. Whilst Mr Ajaka might have been irritated by that intrusion into his previous employer, was it your view at the time that that was really inappropriate?
A. It's unusual.

Q. I'll ask the question again. Was it your view at the time, whatever Mr Ajaka might have thought, that reaching out to former employers of Mr Ajaka in an attempt to find his contact details was really inappropriate?
A. I felt it was inappropriate at the time.

THE COMMISSIONER: Q. Do you know what details are available for someone like the chair of the medical staff council in relation to contacting the board? Do they have access to emails or phone numbers?
A. They have access to emails. Most of the contact is through Nerida, and Winston previously used those avenues, so I knew he was familiar with them.

MR MUSTON: Q. I think, in fact, shortly after this exchange you told him what those mechanisms were in the document which is H7.12.2, and it's [SCI.0012.0069.0001]. That's in the Dr Cheung bundle.
A. Would you mind repeating the number?

Q. Sorry, I might have given you a bum steer there.
A. I've got that. Yes, I've got that.

THE COMMISSIONER: Q. Where it says that you were contacted by Mr Ajaka, the board chair, who informed you that Associate Professor Cheung had made several attempts to contact him to ensure he's received a letter, and to obtain his mobile number - Mr Ajaka, I take it, had made no attempt to return those attempts by - he wanted you to respond?
A. Yes.

MR MUSTON: Q. I'm sorry, I've led you astray. It is tab 11 in your folder, I think, which is [MOH.0010.0400.0001]. That's the letter that you sent, it would seem, several days later to Dr Cheung.
A. On the 13th - the 18th, the day --

Q. It looks like 18 October 2022, just looking at the document. Do you have that document there?
A. Oh, yes.

Q. It appears to have been sent on the 18th, but refers back, as you can see in the first paragraph, to the conversation of the 13th. Then if we turn over to page 2 of that document, it seems to be a screenshot which includes, with the helpful red box in the bottom right-hand corner --
A. The email address.

Q. -- what seems to be a generic email address for the local health district board?
A. The board, yes.

Q. In response to or as a reaction to the letter that Dr Cheung had sent to Mr Ajaka, a summary of Dr Cheung's concerns was prepared. You tell us about that in paragraph 121 of your statement.
A. Yes. That was a - I was on leave at the time.

Q. Who prepared that summary?
A. Genevieve Wallace with the assistance, I think, of Joseph Jewitt, I think. I'm not sure exactly because I wasn't there.

Q. So in relation to the concerns, many of the concerns that were being expressed by Dr Cheung in his letter, they related directly to the way in which executive at the hospital was engaging with its staff, medical staff?
A. Mmm-hmm.

Q. And so this document that was provided to the board was, as it were, Dr Wallace's side of that story?
A. Yes.

Q. But would you accept that that's possibly a somewhat one-sided view of the situation as it was panning out at the hospital?
A. I think we had both sides of the - we had the letter from Dr Cheung and the - I'm assuming the board chair and the acting chief executive asked Genevieve for a response to the concerns raised, which would be a fairly normal thing to do.

Q. In the response that was provided, there's reference to the "People Matter" survey, but there doesn't appear to be any reference to the information which had been gathered by Dr Richards and her wellness team in relation to staff morale and the issues which were causing concern at Concord?
A. So that wellness survey, as I indicated, isn't routinely given to the executive. So Genevieve wouldn't have had access to that, is my understanding.

Q. Would it have been something that she could have asked for?
A. She may have. I can't answer that.

Q. Do you think, reflecting on it, that granular information about some of the concerns that were held by members of the medical staff at Concord hospital might have been useful to the board in assessing complaints made by Dr Cheung?
A. I think in hindsight it could have been very helpful, mmm.

Q. Would you agree that the summary that was prepared by Dr Wallace and provided to the board really suggests there's no problems at all at Concord?
A. I'm just trying to find the document.

Q. It's behind tab 12 in your bundle. Sorry, I have jumped there without telling you where it is or telling the operator where it is. It's [MOH.0010.0416.0001]. Do you have that document?
A. Yes.

Q. Looking at the first - just, for example, the first bullet point under the heading "Staff Morale", a reference to there being no specifics and it's therefore very hard to comment on the allegation, but the suggestion is high-level workforce data does not indicate a significant issue at Concord --
A. Yes.

Q. You, as the chief executive of the organisation, had an appreciation of the problems at Concord --
A. Yes.

Q. -- insofar as staff morale was concerned. The chief wellness officer had a comfortable appreciation of the

problems at Concord insofar as staff morale were concerned. Was there any reason why someone in the position of Dr Wallace ought not to have had at least some awareness of those same problems that had obviously filtered their way up to higher echelons within the executive?
A. I think it's fair enough to say that - I mean, what she does say is it's hard to comment on the allegation. The workforce data, in terms of turnover - because I think it goes more than just saying there's a staff morale issue; it was saying that the turnover rate at Concord was significantly greater than other places. I think this is one of the problems when you use just the data to - when you're reviewing the data rather than the feel, the vibe.

Q. Is your point there that merely relying on the data can create something of a false impression and not necessarily --
A. Yes.

Q. That's perhaps not the best phrase to use, using just the raw data, relying on that sometimes actually fails to accurately or really in any way assess or measure what the real position on the ground is?
A. I think we would agree that data plus commentary is usually the best.

Q. So, for example, if we go over to the second page there, where there's issues, "Concern Raised: Intimidation and bullying by managers", the first bullet point there refers to complaints which were made, and the way in which they were dealt with, predominantly dismissed.
A. I don't - it depends what you mean "dismissed".

Q. Well, not substantiated?
A. Not substantiated.

Q. I think we have a reference to the HETI accreditation?
A. Yes.

Q. Just insofar as that HETI accreditation is concerned, that's not something which is likely to have unearthed the significant concerns which were being expressed by way of intimidation and bullying, at least in a way which is reflected in any sort of statistics, is it?
A. Not in the statistics, but the JMOs were specifically asked by - independently by the HETI, who aren't part of us, they're separate, and I think they did attempt to gain

an understanding of whether there were concerns, particularly with the junior medical staff, by asking those questions.

Q. You've told us elsewhere in your statement about an independent review that was undertaken of the emergency department in April 2018 by some people from Alfred Health?
A. Yes.

Q. That review concluded that there was, in fact, a significant concern within the emergency department arising out of a culture of intimidation and bullying by a small group of staff specialists who held senior roles within the emergency department and had done so for a long time; do you recall that?
A. Yes.

Q. And it reported an obvious level of anxiety from staff, including staff specialists, registrars, HMOs and nurses around discussing that matter?
A. Yes.

Q. I accept you didn't prepare this document, but do you think, insofar as it touched on the concerns raised around intimidation and bullying, it might have been helpful for the board to have been informed of that fact?
A. They were aware of the cultural review in the emergency department, but no, it wasn't linked to that document.

Q. This document, the summary document, that we're looking at was not provided, presumably, to the staff of the medical staff council at Concord; it was just a memo to the board?
A. That's my understanding.

THE COMMISSIONER: Q. Do you think I have to be careful about data like percentages of resignations or retention rates in a sector as big as the New South Wales public health system in the sense that it's not quite like other industries where people, if there's a morale problem in a small firm, might have lots of different firms they could move to, I suppose doctors and nurses have - I guess they could leave the public system and go and work privately, but would you agree that mere percentages of retention or resignation alone don't mean that there might not be a morale problem in a particular hospital or a particular

site?
A. Yes, if you use the data by itself, yes.

THE COMMISSIONER: Thanks.

MR MUSTON: Q. In terms of this summary that was provided to the board by Dr Wallace, to the extent that it seems to convey the strong impression that there is no problem at Concord, does that potentially suggest that concerns held by the medical staff council that they weren't being listened to might have had something in it?
A. If you take it by itself, yes, but I think part of it is also about action and significant action was taken in relation to concerns expressed by the medical staff, including recruitment. So, you know, significant increase in junior medical staff, senior medical staff over this time is just one example.

Q. So in response to Dr Cheung's letter to the board, a meeting was arranged between yourself, Dr Cheung, Mr Ajaka and Dr Sammut on 15 November 2022?
A. Yes.

Q. Just in relation to that, why was that meeting proposed instead of, say, members of the medical workforce, who were expressing concerns or felt concerns, given an opportunity to raise these issues in front of the board?
A. The - it was felt that we needed to respond quickly to Professor Cheung and he asked for a meeting, so we met with him, and then there was a series of meetings subsequent to that.

Q. But that initial meeting with Dr Cheung didn't involve Mr Ajaka, Dr Sammut or yourself extending an invitation to Dr Cheung to come and speak to the board about his concerns, did it?
A. No. The board chair felt that in the first instance, Dr Sammut, who is one of the board members and himself and I should meet with Winston.

Q. Did the board chair express to you any reasons for not suggesting, as Dr Cheung seemed to desire, that he be given an opportunity, and perhaps some of his colleagues who were feeling these concerns at Concord, be given an opportunity to share those concerns which they felt had not been heard, with the board?
A. I can't recall the exact sort of wording around

organising that, other than - and maybe it was sort of the distance as well, because Mr Ajaka was overseas and we wanted to meet with Winston as soon as he and I both returned from leave.

Q. So the meeting on 15 November, was it an in-person meeting?
A. Yes.

Q. So Mr Ajaka had been overseas, as had you?
A. He was overseas when we received the letter. He came back, and I was overseas I think until the 13th, and the meeting was organised before --

Q. As soon as you were back?
A. Yes.

Q. You had the meeting on the 15th and at that meeting you tell us there was some discussion about Dr Cheung attending a meeting of the clinical quality council. Do you recall that?
A. Yes.

Q. What was at least your understanding of what the purpose behind Dr Cheung attending a meeting of the clinical quality council was?
A. My understanding at the time of that meeting was that at the meeting with Mr Ajaka, Dr Sammut and myself, Dr Cheung expressed concern that there were not appropriate safety and quality processes within the district. He asked about them. We explained about the clinical councils that sit at a facility level, the clinical quality councils that sit at a district level, the nature of the reports that they get, et cetera, and he was invited to be a member of the clinical quality council, particularly so he could understand what was discussed, how those safety data were reviewed by the council, how ims+ were reviewed. So in part, it was felt that that would help to inform Dr Cheung and, you know, that was the primary purpose.

MR MUSTON: I note the time, Commissioner.

THE COMMISSIONER: Yes. We'll adjourn until 2 o'clock.

MR CHENEY: Commissioner, could I just raise this, I think my friend's aware of this, but Mr Griffiths, the next witness, is unavailable tomorrow, so I just wanted to be

sure that we --

MR MUSTON: We will get to Mr Griffiths, but Mr Minns can probably be excused until tomorrow.

THE COMMISSIONER: Well, I think he's just heard that. Our apologies for you coming along.

All right. So we'll adjourn until 2 and let's excuse Mr Minns now so that he doesn't sit around, and we'll have him at 10 o'clock tomorrow, I imagine, and it may be we finish before 4 today, but if we do, we do. We'll just leave it at that. Adjourn until 2, thanks.

LUNCHEON ADJOURNMENT

THE COMMISSIONER: Yes, Mr Muston.

MR MUSTON: Q. I think, Dr Anderson, you had just told us about the purposes for which it was suggested that Dr Cheung might attend the meeting of the clinical quality council.
A. Yes.

Q. I think if you go to the larger of the two folders in front of you there, there's a tab H7.12.4, which is [SCI.0012.0113.0001]?
A. Yes.

Q. Do you recognise that as your letter to Dr Cheung of 16 December 2022?
A. Yes.

Q. In which, at the end, if you turn over to the second page, you suggest that, to reassure him of the strong governance processes in place, he was invited to attend the clinical quality council?
A. Yes.

Q. Would you go over to the next - two tabs forward, to H7.12.6. In fact, maybe an easier way to deal with it is if you go forward to tab H7.12.7, which is [SCI.0012.0071.0001]?
A. Yes.

Q. That's an email - just perhaps start on the second page of that email, and working backwards, in the way that

they sometimes are unhelpfully set out?
A. Yes.

Q. Do you see that's an email from Dr Cheung to Dr Sammut?
A. Yes.

Q. In which he refers to the invitation to attend the clinical quality council and makes a request that he and a number of his colleagues at Concord be given an opportunity to make brief presentations about their concerns?
A. Yes.

Q. If you then go back to the first page of that document, the 1 February 2023 email from Dr Sammut to Dr Cheung, you see that Dr Cheung's request to have his colleagues attend and make those presentations is refused.
A. Yes.

Q. Were you involved in the decision-making process around whether or not Dr Cheung might be given the opportunity to make a presentation to the clinical quality council and have a number of his colleagues attend and make brief presentations of the type suggested?
A. Yes.

Q. What was the reason for refusing to afford them the opportunity to do that, or your reason, at least?
A. Yes, thank you. The agenda for the clinical quality council is sort of set in advance, and it has a number of functions, which is looking at quality data across the district, serious ims+, et cetera, and as Dr Sammut says, that when Dr Cheung was invited to be a member of that meeting, it was first to provide him with a better understanding of the systems that were in place within the district.

He hadn't been to a clinical quality council previously, and there are a number of presentations, they had already been organised for the next meeting, and he was invited to attend a meeting to understand the clinical quality council, and that normally, in the first instance, there would be a draft presentation, we would have some understanding of the content. The meeting runs for about an hour and a half, so what was proposed, although it was an hour, I think in reality it was felt that it would take

up the entire meeting, and so I emailed Dr Cheung, I think the next day - I can't remember exactly - inviting him and those clinicians to meet with me and Dr Sammut to go through their concerns.

Q. Just in terms of the email the next day, could you go to tab H7.12.8, which is [SCI.0012.0074.0001]?
A. Yes.

Q. You'll see if we scroll down - just to that point there is great - that's an email from Dr Cheung to Dr Sammut of 2 February 2023, in which Dr Cheung provides his response to Dr Sammut's email. You'll see again he makes clear in the last - in the second paragraph, that at least insofar as he is concerned, the concerns and issues that he and his colleagues had had been raised locally without any significant progress having been made?
A. Yes.

Q. Do you see again the reference to the fear of reprisals for raising concerns at the local level?
A. Yes.

Q. Which was the reason he tells us, or you understood, did you, for him having written his letter to the board?
A. Yes.

Q. So you understood at that point that Dr Cheung found - he and his colleagues found themselves in a position where they felt that they were not being heard or listened to by the executive, at least at the local level?
A. Yes.

Q. They had reached out to the board in an attempt to convey their genuine concerns to the board?
A. Yes.

Q. That request had been rebuffed with a suggestion that, instead, Dr Cheung might attend the clinical quality council?
A. So a meeting - he was invited and we had the meeting with two of the board members, with John Ajaka and Dr Sammut and myself, in the first instance, and then he was invited to come to the clinical quality council, and he wasn't rebuffed - well, my interpretation was that we weren't rebuffing him; we were giving him an opportunity to meet with John Sammut and myself and the various

departments, so it was a very public forum, so - to air their concerns.

Q. But this is down the track. I'm just trying to step us through this process. The public forum that you speak of is something that came a little bit later, I think, in that chronology - that is, each of the different departments coming?
A. Yes, my understanding is that it was pretty close to that time that I emailed Dr Cheung inviting him to meet with us.

Q. It was clear, though, from Dr Cheung's initial email, that he at least understood that his attendance at the clinical quality council was to afford him an opportunity, him and his colleagues an opportunity, to raise the concerns that they had been wanting to raise with the board?
A. That's not my understanding from the meeting that we had, and --

Q. My question to you is: was it clear from you to Dr Cheung's email of 1 February that that was at least his understanding of where things sat after the meeting?
A. Yes.

Q. So Dr Cheung had reached out, through his letter, and sought to address the board with his concerns?
A. Yes.

Q. And a meeting had been held between yourself, Dr Sammut and Dr Cheung, where it was indicated that that would not be appropriate - that is, meeting with the entire board and sharing the concerns with them?
A. It wasn't put to him that it wasn't appropriate. It was put to him that the board chair wanted to meet with him, with John Sammut and myself, not that it was inappropriate to meet with the board.

Q. But the meeting in which the clinical quality council was raised was a meeting --
A. With John Sammut, John Ajaka and myself.

Q. And at that meeting, whilst people walked away from it with different views, Dr Cheung at least felt that instead of presenting his problems to the board, the suggestion was that they all be presented to the clinical quality council.

Now, I accept you take a different view of what happened at the meeting, but that was Dr Cheung's understanding?
A. That's his understanding. I'd just like to emphasise that I did also write to him after the meeting with John Ajaka, John Sammut, indicating what was our understanding of the outcome, and that was before this letter.

Q. Having sought to facilitate a situation in which his concerns could be shared with the clinical quality council, that attempt was again rebuffed?
A. An alternate opportunity was provided.

Q. But principal amongst the concerns that the medical staff council had were a concern about the way in which the executive had performed?
A. At that stage it was primarily the executive at Concord, is my understanding.

Q. What I want to suggest is by refusing to enable Dr Cheung, as he'd suggested, to present those concerns to the clinical quality council, that could only have reinforced his view, at least, that the medical staff council at Concord were not being listened to?
A. In hindsight, I think I would agree with that. In hindsight, I think it would have been good for him to present to the board.

Q. Again, having regard to the nature of the concerns that Dr Cheung was raising on behalf of his colleagues, the repeated reference by Dr Sammut to the need to provide verifiable evidence before steps could be taken to deal with those concerns was not, I suggest, entirely helpful?
A. I think it was trying to understand some of the specific concerns and evidence to support those.

Q. I think if we turn over now to H7.12.9, which is [SCI.0012.0073.0001], we will find the email that you were alluding to a moment ago, an email from you of 2 February 2023 to Dr Cheung, copied in to Dr Sammut and Dr Hallahan, in which, at the top of page 2, we see your offer of a meeting with the clinicians, with Dr Sammut, Dr Hallahan and yourself?
A. Yes.

Q. That meeting occurred, I take it?
A. Yes.

Q. At that meeting, presentations were made by members of the medical staff at Concord hospital?
A. Yes.

Q. Have you had an opportunity to review the documents which appear behind tabs 10 and 11 of Dr Cheung's statement? They don't need to be brought up but for the benefit of the record, they're [SCI.0012.0164.0001] and [SCI.0012.0076.0001]. Do you see one of them's styled as annexure J and the other one as annexure K?
A. Yes.

Q. In the course of preparing your evidence, did you have an opportunity to review those documents?
A. These particular ones, no, but they spoke to this. I don't recall getting a copy.

Q. No, my question was going to be: to the best of your recollection, do those two documents, as Dr Cheung has suggested, reflect accurately what at least those two of his colleagues shared with you, Dr Sammut and Dr Hallahan during the course of the meeting?
A. Generally. I can't say specifically, but that was generally what was raised.

Q. The tenor of their concerns that they were expressing?
A. Yes.

Q. Can I ask you to turn over to H7.12.15, which is [SCI.0012.0079.0001], and if you go to the end of that - sorry, I'll see if you have that document.
A. Sorry, could you repeat it again?

Q. Yes, of course. Tab H7.12.15 --
A. Yes.

Q. -- which is a letter addressed to Dr Cheung?
A. Mmm-hmm.

Q. If we turn over to the fourth page of it, you'll see it would appear to be from you, dated 21 April 2023?
A. Yes.

Q. So is this right, at around the same time as the meeting with yourself, Dr Cheung, Dr Sammut and Dr Hallahan in which the concerns were being expressed, you had

a separate meeting with Dr Cheung and Dr Hallahan to discuss the terms of reference again?
A. I think that was a couple of months later, but yes.

Q. The documents will tell us what the dates are,
A. Sorry.

Q. No, no, you could quite well be right.
A. Mmm.

Q. So you attended a meeting in April of 2023 with Dr Cheung and Dr Hallahan to discuss the terms of reference?
A. Yes.

Q. And I gather that the terms of reference that you were talking about at that point were that later document in time, being the 3 March 2023 draft --
A. Yes, that's correct.

Q. -- that did not include the subcommittees?
A. Yes.

Q. The letter goes on to express a range of reasons why it was perceived that the proposed terms of reference were inconsistent with the by-laws?
A. Yes.

Q. Can I suggest that the tone of that letter, insofar as it did that, is a little bit legalistic and formal in its approach?
A. I would agree in hindsight. At the time, I thought it was appropriate given we'd been talking about the terms of reference for nearly 12 months.

Q. And as part of these discussions, or certainly as part of the discussions during this meeting, was there ever an occasion when you said to - you or Dr Hallahan said to Dr Cheung, to the best of your recollection, "Let's just put the terms of reference and the by-laws to one side for a moment and work out what is it exactly you're trying to achieve here for the medical staff council and see if there's a way we can do that for you"?
A. My recollection is that I indicated that I wanted to work with Dr Cheung and that Andrew could work with him on a terms of reference that were suitable for the by-laws and met his needs.

Q. But your position in relation to the terms of reference was that, whilst Andrew could work with him, the Concord medical staff council would be using the same terms of reference as every other medical staff council, wasn't it?
A. That would be the normal way. I do have a broad view of medical matters and if you note in the minutes of the various medical staff council meetings, I - when I was present, I never pulled up the medical staff council for talking about issues in the broader sense, but I agree that the letter, as it stands, is quite legalistic.

Q. But my question was, in terms of the approach that you were taking to the terms of reference, it was your position, was it not, that the Concord medical staff council would be using the same terms of reference as every other medical staff council within your district?
A. My understanding across the state, because they're based on the model by-laws linked to the Act.

Q. And that was what you had expressed previously in an email, I think, to Dr Hallahan?
A. Yes.

Q. That is, that that was the way it was going to be, and that was the position that you adopted in your discussions with Dr Cheung, I want to suggest?
A. Yes.

Q. At the conclusion of the meeting - or at the conclusion of the letter, I should say, you refer to his attempts to deviate from the usual by-laws as being simply unacceptable. Do you see that on page 3?
A. Yes. Mmm-hmm.

Q. Do you agree that characterising his behaviour in that way in a letter like this perhaps had the capacity to exacerbate the combative relationship which had come to exist between Dr Cheung and his medical staff council colleagues and the executive?
A. I do now, yes.

Q. And is it the case that at the end of the meeting when you handed him a copy - or at the time you handed him a copy of this letter, you also handed him a copy of the code of conduct?

A. Yes, that's correct.

Q. And at the end of the letter there's a reference to the fact that as an employee of the Sydney Local Health District, he is required to abide by that code of conduct and failure to do so would give rise to disciplinary action?
A. Yes.

Q. Do you see that, in the context of the relationship which had developed between Dr Cheung, the medical staff council and the executive at that time, that dealing with him in that way - that is to say, referring to the prospect of a disciplinary action and handing him a code of conduct - the code of conduct might have been seen as somewhat threatening to Dr Cheung?
A. Yes, it was unhelpful.

Q. Could I ask you to turn forward to tab H7.12.19.

THE COMMISSIONER: Q. Did you draft the letter, Dr Anderson?
A. No, I did not.

Q. Was it a collaboration?
A. Yes, it was.

Q. Who drafted it with you?
A. Dr Hallahan came to me with a first draft, and I then sought advice from the Ministry of Health legal branch, hence why --

Q. That's about the stuff concerning the by-laws; is that the legal advice?
A. Yes, because - you know, as I said, in hindsight, I might have done it differently, but at the time, because it's the by-laws and it's linked to the Act, I thought going to legal branch was the appropriate mechanism to clarify what I thought was a legal matter, because it's not - you know, I'm not a lawyer, so my interpretation was that we were expected to function according to the Health Services Act and to the by-laws, and part of my obligation as a chief executive - and in fact, we do an attestation each year that says that we have made sure that the health service operates in accordance with the Health Services Act and the by-laws.

Q. Yes. Other than any input that may have fallen out through that advice you received, was the final version of this letter substantially similar to the draft that Dr Hallahan had prepared?
A. There were similarities, but it's not exactly the same.

Q. What about the paragraphs that Mr Muston took you to at the end of the letter about reminding Associate Professor Cheung that he's an employee and he's got obligations and that could give rise to disciplinary action - was that in the draft?
A. I can't recall, I'm sorry.

THE COMMISSIONER: Okay.

MR MUSTON: Q. Can we go forward to H7.12.19 in your folder?
A. Nineteen?

Q. Nineteen --
A. Yes.

Q. -- which is [SCI.0012.0008.0001]?
A. Yes.

Q. Do you see that? That's an email exchange. If you turn all the way through to the end of it at page 4, you see there's an email from Dr Hallahan to Dr Cheung enclosing a revised version or providing a revised version of a terms of reference?
A. Is that 21 April?

Q. An email of 21 April 2023 from Dr Hallahan to Dr Cheung, copied to you, on page 4 of the document, at the very back.
A. From Andrew to Winston, with a copy to me, yes.

Q. That email set out or provided when might be described as the same terms of reference, an acceptable terms of reference insofar as Dr Hallahan and yourself were concerned?
A. Consistent with the by-laws, yes.

Q. If we go forward, then, to page 3, you see, on 1 May 2023, Dr Cheung's sent an email to Dr Hallahan seeking some information, making some inquiries about --

A. Yes.

Q. -- the terms of reference and wanting to make sure there's no ambiguity so he can report back to his medical staff council?
A. Yes.

Q. At the top of that page, page 3, Dr Hallahan says "Thanks. I'll seek advice and come back to you"?
A. Yes.

Q. And then we turn back to page 1, there's an email of 5 May from Dr Cheung to yourself?
A. Yes.

Q. Which sets out, in effect, the chronology and indicates that Dr Cheung is awaiting a formal response from Dr Hallahan?
A. Yes.

Q. Are you aware of whether Dr Hallahan ever sent a response to that email?
A. No, I'm not.

Q. Having regard to the queries that were being raised by Dr Cheung in the 1 May email on page 3, it would have been constructive if he had, would you not agree?
A. It would have been helpful.

Q. I think you tell us in paragraph 131 of your statement that from that point on you didn't have any further involvement in the terms of reference issue?
A. No.

MR MUSTON: Could I ask, just as an aside, the operator to bring up [SCI.0012.0160.0001], and scroll up to the top of that document.

Q. Dr Anderson, is that a document that you're familiar with?
A. I wasn't until the other day.

Q. So you don't know what the origin of this document is or who created it?
A. No, I don't.

Q. Could I ask that we scroll down to the second page.

To the extent that the complaining "about resource limitations and constraints rather than striving to work creatively within available resources and looking for innovative solutions" in that highlighted portion is described as "below the line behaviour", would you agree that that's unhelpful to be putting that forward as a core value or behaviour of the health district?
A. I think it's unhelpful. I wouldn't have worded it in that way, but I don't know the context in which it was developed.

THE COMMISSIONER: Q. On the first page of the document there's a contact. Who is that, do you know?
A. I think she was - she's a workforce manager, and I think was at Concord at that particular time.

Q. But you don't know whether that person had any role in drafting this?
A. No.

Q. As distinct from being the contact?
A. No, and I've never seen the document used. And as the chief executive, there are many documents that I don't see, but I'm not familiar with it, I'm sorry.

MR MUSTON: Q. Did Dr Hallahan tell you that during the course of the medical staff council meeting, Dr Cheung raised this document with him in a slightly aggravated way?
A. I don't know if my recollection is coloured by the other day, because that was the first time that I recall hearing that, but I might have heard it previously.

Q. As you would have heard the other day, Dr Hallahan made a disciplinary complaint against Dr Cheung arising out of the meeting at which, amongst other things, that document was discussed. At the time that the disciplinary complaint was made by Dr Hallahan, did you discuss that with him - that is to say, before he made it?
A. No, and my understanding is it wasn't a disciplinary complaint.

Q. A workforce grievance?
A. I understand he made a workplace grievance, and no, I wasn't aware about it before, but I was after.

THE COMMISSIONER: Q. Can I just, sorry to interrupt, otherwise I'll forget, slightly off topic, but back at the

document still on the screen, if we could go to the second page and the bit that's highlighted that Mr Muston asked you about, you've explained to me you weren't aware of this document until this Inquiry. Do I take from your answer that - do you think sitting in the witness box now, had this document been brought to your attention, you might have suggested a different wording --
A. I definitely would have.

Q. Yes, okay, and I take it that different wording might have suggested - forgetting what the exact wording would have been, but it would have clarified that complaints that are bona fide and genuine are matters that, in fact, management encourages to be made, without any repercussions?
A. Absolutely.

THE COMMISSIONER: All right.

MR MUSTON: Q. On the medical staff meeting of 29 June 2023, a vote of no confidence in yourself as chief executive was passed by the medical staff council at Concord?
A. Yes.

Q. In paragraph 134 of your statement, you tell us that you remain uncertain as to the precise allegations asserted by Associate Professor Cheung --
A. Yes.

Q. -- which led to that? The complaints and concerns of the medical staff council were expressed with reasonable clarity in the letter of 12 October 2022 to the board, weren't they?
A. In relation to Concord hospital, but I didn't feel, and still don't feel, it was specific to myself, even though I was the chief executive. So it's hard to respond to all of those issues when we felt we were responding to the concerns that were being raised.

Q. But a number of the concerns - I think we've already traversed this, but a number of the concerns raised are not necessarily amenable to precise allegations or the delivery of specific particulars; would you agree with that?
A. Yes.

Q. And I guess to the extent that he and those who voted

in favour of that motion were acutely feeling those concerns and feeling that they had not been addressed by the district, did you appreciate at that time that that was what underpinned their vote of no confidence?
A. Yes.

THE COMMISSIONER: When I unhelpfully interrupted you about the document still on the screen, you were discussing with Dr Anderson the grievance complaint. Did I take you off track for that?

MR MUSTON: You may have.

Q. I think you told us in relation to that that you were not aware of the fact that the grievance complaint had been lodged before it was lodged?
A. Correct.

Q. But you did become aware after the event?
A. Yes.

Q. What did you do in relation to that grievance complaint after it was brought to your attention that it had been made?
A. It was being dealt with by workforce and it would have been inappropriate for me to have done anything about it. It needed to go through its process. I would not normally - it is not what I should be doing, is to interfere with any process like that.

Q. At the time, cognisant of Dr Cheung and his colleagues' concern that those who spoke out would face reprisals, did you think the lodging of a workplace grievance against him was something that was helpful? I know you didn't lodge it, but did you think about it?
A. I think it is difficult to comment. I wasn't in the meeting where that occurred and whether you're management, clinicians, environmental staff, everyone has a right to feel how they feel, so I didn't see it was my place to give a commentary on that.

Q. Did you explore with Dr Hallahan --
A. I didn't think it was my place to do that, because then I would be getting into a pseudo investigation of the matter, which I didn't think was appropriate.

THE COMMISSIONER: Q. Accepting you didn't know about

the grievance complaint that Dr Hallahan instigated against Professor Cheung, prior to that, or at any stage, did Dr Hallahan speak to you and say he had been to a meeting of the council and he was unhappy about being interrupted and about rudeness at that meeting?
A. I don't recall him mentioning it, but other people, clinicians, who were present said to me that they felt very uncomfortable in the way that he'd been treated.

MR MUSTON: Q. Coming back to the vote of no confidence and what you understood likely underpinned it, did it occur to you at that point that perhaps the executive, at least at the hospital, had not been engaging with the medical staff at Concord in a manner which was optimum and might have assisted to alleviate the concerns that the medical staff had?
A. Yes, I think anyone who has had a vote of no confidence in them would be reflecting on what might have been.

Q. As part of that process of reflection, what did you and other members of the executive do?
A. Had discussions with the Ministry of Health, who arranged for ProActive ReSolutions - they went through a tender process and had ProActive ReSolutions come to undertake an intervention, which I think was partially successful, and that involved a listening, having an independent group listen to the concerns and then attempt to improve the communication.

Q. Were you involved in that process?
A. Some of it.

Q. What was your involvement?
A. The main part that I was involved in was in relation to radiology. I did think that I might get invited to some of the other working groups to hear their concerns once they'd been aired with ProActive ReSolutions, but the radiology was the only one I was invited to.

Q. Did part of that process involve, at least to your understanding, ProActive ReSolutions making any sort of assessment of what the root causes of the breakdown in the relationship between the staff at Concord and the executive of both the hospital and the district might have been?
A. There was no formal report as such, but an action plan that was developed with - by ProActive in partnership with

the clinicians, that the district - that the general manager in particular, he attended many of those workshops, he was invited to them, and I think that the general feeling was that it was a breakdown of communication, primarily, and that by going through a process of listening to the clinicians, working out what are the actions, documenting those actions and taking them back, that that would assist in the resolution of the issues.

Q. Did anyone ever share with you - when I say "anyone", that is anyone from ProActive ReSolutions or anyone else share with you - their views about where that breakdown had occurred, the communication breakdown, or why it had occurred?
A. At a general level in relation to communication, if I look at the radiology, it was particularly about being clearer about what actions are being taken and actions that aren't, giving clearer rationale for those actions not being taken. We had two workshops with radiology, and again, an action plan was developed from that and a second meeting - one was in September 2023 and another was in February '24, and the feedback I had was - from Mr McDonald was that he also thought that the second meeting was really positive and that issues overall had improved.

Q. Just in terms of being a bit clearer about what was going to happen and what wasn't going to happen within radiology, for example, could I ask you to go back to tab H7.12.11 of the Dr Cheung folder, which is annexure K of his statement, [SCI.0012.0076.0001]?
A. H7?

Q. H7.12.11.
A. Mmm-hmm.

Q. At the top of that document, hopefully, it says "Annexure K"?
A. Yes.

Q. I just want to ask, in terms of some of the complaints or concerns that had been aired by radiology, accepting that this is before this ProActive ReSolutions process, but could I take you down to the paragraph commencing, "It's not just the cuts in resources"? Do you see that paragraph about four from the top?

A. Yes.

Q. Then there's a reference to "Teresa", which I assume is a reference to you --
A. That must be me.

Q. -- having taken several millions dollars from radiology trust funds because you were convinced that the vascular surgeons would leave without decent equipment; did you understand what that concern related to?
A. I definitely don't understand that.

Q. The next concern, "virtually every major imaging equipment in the last decade has been replaced beyond its end of life." Did you understand what Dr Ridley was --
A. I understand what he's saying. I don't agree with it.

Q. In what way do you not agree with it?
A. Because we have replaced significant amounts of medical imaging equipment at Concord hospital. By "end of life", having seen Dr Ridley's testimony, he's referring to capital sensitivity, which is different to end of life. Capital sensitivity is terminology that relates to Medicare and for private patients, Medicare - you don't get reimbursed once a piece of equipment reaches a certain age, but that equipment may be still very functional. The equipment is assessed by our biomedical team and it also - the majority of that equipment is under maintenance contracts. So it's not obsolete.

In the public health system, we do try to use equipment to that point because of the limited resources that we have, but, as I said, significant equipment has been replaced at Concord hospital over the last, you know, even the last six or seven years, and that includes mammography, fluoroscopy, CT and obviously - the first MRI's been replaced; we're hoping to have a second MRI.

Q. Just dealing with the proposition that if we read Dr Ridley's statement there, where he refers to "end of life", as a reference to the sensitivity rules that are engaged by Medicare --
A. Yes.

Q. -- would he be correct in his assertion that at least a significant portion of the major imaging equipment had been replaced beyond its end of life in that sense - that

is --
A. I haven't got the figures in front of me, but it's not the majority, no. The majority is around that time.

Q. If we go down a couple of sentences, do you see there's a sentence commencing:

When the imaging stream decided not to replace the mammo unit the MSC got involved.

A. Yes.

Q. "Mammo unit", I take it, is the mammography unit?
A. Yes.

Q. There's a reference to you having readily agreed that women's imaging was an important service at Concord?
A. Yes.

Q. Is that something you remember agreeing with?
A. Definitely, yes.

Q. He then suggests that, despite that support, it took another seven years to replace the already obsolete equipment?
A. I don't agree with that statement.

Q. Why not?
A. Because it is giving an impression that it was seven years past the capital sensitivity, and that's not my understanding. I will have to look at - take it on notice, but that's not my understanding.

Q. At the time that you had this discussion with him, which was that initial meeting between yourself, Dr Cheung, Dr Sammut and Mr Ajaka, when the various members of the Concord workforce addressed you, did you engage with those propositions then and seek to get to the bottom of what the --
A. I don't recall him - I do recall him indicating that equipment was purchased past end of life. I don't recall him saying mammography was seven years past its useful life.

Q. It's possible that he said it and you can't recall?
A. It's possible but I - it is something that I think

I would recall.

Q. The next little issue he raises there relates to the second MRI?
A. Yes.

Q. I'll come to the documents that you've given us in a minute, but he makes the point it's more than seven years since you had agreed to the need for a second MRI at Concord. Just pausing there --
A. That's correct.

Q. And it's six years since the ministry endorsed the procurement; is that correct?
A. That's not correct.

Q. Four years since Genevieve, who I assume is a reference to Dr Wallace, told the medical staff council that the second MRI would be operational within six to 12 months, do you know one way or the other whether that's the case?
A. No, sorry. And I don't recall that being mentioned in the meeting, but it could have.

Q. Still, as he points out, still no sign of the second MRI, despite the extensively discussed impacts of the inadequate capacity. The first point, as at that point in time it's correct to say, isn't it, that there was not a second MRI yet in the building at Concord?
A. Definitely. Definitely, yes.

Q. And would it be right to say that the radiology department had been extensively advocating the need for it, based on what at least they perceived to be the impacts of the inadequate capacity?
A. Yes, I would agree.

THE COMMISSIONER: This is not a question for you, Dr Anderson, but there might be some significance that this document says it's four years since Genevieve told the staff council the second MRI would be operational in six to 12 months, and I don't have anyone saying to me or this Inquiry that's not right.

MR MUSTON: No.

THE COMMISSIONER: Okay. Sorry, when I say, "That's not

right", that wasn't said is what I mean.

MR MUSTON: Yes, that's exactly the position.

Q. Could I ask you to go back, finally, to your own statement folder there, the smaller of the folders in front of you hopefully, behind tab 1.
A. Tab 1?

Q. Yes, which is document [MOH.0010.0404.0001].
A. Yes.

Q. If you turn to page 3 in that little bundle, you see there's a "Health In Brief For Major Procurement Committee SLHD" which appears to be --
A. That's me, yes.

Q. -- your recommendation that the second MRI scanner be procured for Concord. That was a document you signed on 18 November 2016?
A. Correct.

Q. If we go back to the emails which immediately precede that in the bundle, we see an email just starting on page 1, at the very foot of that page, from Pravindra Singh to Tim Sinclair?
A. Yes.

Q. Just pausing there, who is Pravindra Singh?
A. He was the acting manager for the business case unit in the --

Q. The business case unit did what at the LHD?
A. So one of the concerns previously - this was back in 2018 - that clinicians had is that they didn't have time to prepare business cases without support, so we developed a business case unit in the finance department and capital assets team to assist clinicians with business cases.

Q. And who's Mr Sinclair?
A. He was the general manager at the time.

Q. At Concord?
A. At Concord. Oh, wait a minute. Yes, I think he was still at that - I'll have to check, take it on notice. He was the general manager of Concord hospital and through a competitive recruitment process was appointed as director

of operations for the district around that time.

Q. Just looking at the email there, of 15 February 2018, if we turn over to the second page, it contains a draft or it purports to attach a draft business case and brief. Do you have any explanation or are you able to provide any explanation as to why it took 18 months from signing the major procurement committee SLHD document to preparation of the draft business case?
A. My understanding was that there were challenges in getting the data to support the business case.

Q. What data?
A. It would have been a range of activity data on utilisation of the existing MRI, case mix of patients coming through the radiology department, et cetera.

Q. Just looking --

THE COMMISSIONER: Q. Is this different data than what is in the November 2016, "Health In Brief Major Procurement" document that Mr Muston was asking you about regarding, if we go back to it - it's on page 3 of this chain - the key issues:

Concord hospital currently has one --

what does "3T" mean?
A. 3T is the nature of the MRI:

Q.

... one 3T MRI unit and scans approximately 5 000 patients per year, of which 80% are billable. The scanner operates 65 hours per week ...

et cetera. "Current wait times", et cetera, et cetera, there's additional data that is needed, is there?
A. Yes, correct.

Q. Which would be what?
A. So at that time, I did not get this document because it was a draft, and so it was still being developed between the general manager of Concord, the business unit and the radiology department.

Q. I'm still not sure I understand why it would take 18 months. It's not a criticism of you. Are you able to help us?
A. I don't, but I did ask when they were raising the issue of the MRI. I don't go back to every facility, I have to say, and say, "Where are you up to?"

Q. No, but this is obviously - this is, one, an expensive piece of kit, and obviously an important machine, thought to be needed for providing health care in the district and at the hospital?
A. Yes.

Q. It seems a long time to get the data ready?
A. It was, my understanding, very challenging to get the data, but I also think - and I'm surmising at the moment - that part of it was also we were in the middle of discussing the redevelopment of Concord hospital.

Remember, we were looking to do a very big redevelopment, we only received enough money to do part of that redevelopment, and there were questions being raised about whether or not the second MRI would fit in the existing radiology department if the redevelopment did not occur. So there were discussions. It's a very constrained environment, and it's right next to --

Q. I think you mean literally fit inside, do you?
A. Physical, yes. Unfortunately it isn't the Tardis, and so there's a constrained footprint. Nuclear medicine is right next to it. There were thoughts, when we did have the stage 1 of the redevelopment being planned whether or not some of nuclear medicine could go into part of the stage 1 redevelopment and free up space, but it was determined, in partnership with Health Infrastructure, that that would not be feasible.

MR MUSTON: Q. It wouldn't appear, based on the grievances and concerns being expressed by radiology, to at least the executive at the hospital, and subsequently to you, that the radiology department was told, "We're not going to action the MRI until we've made a decision about which part of the hospital we want to put it in"?
A. My understanding is - I didn't go to all of the user group meetings for the redevelopment. I was on the overarching executive steering committee, but it is my understanding that those discussions were being had at the

radiology department level.

Q. But insofar as those discussions might have touched on the issue of whether the procurement of a second MRI would proceed as had been proposed or would instead be put on ice pending decisions around the redevelopment, you don't know one way or the other what was said, if anything, about that; would that be correct?
A. No. My understanding is that people were informed, were part of that decision-making.

Q. So that in an earlier answer you indicated that you were - or someone within the LHD was awaiting some information about activity data and the like for the purposes of preparing the business case?
A. That's right, for the MRI, second MRI, yes.

Q. And who was that information to be provided by, as you understood it?
A. By the - my understanding was by the radiology department, the head of radiology.

Q. And so you attribute the 18-month delay in preparing the draft business plan to that, in part?
A. The - yes, in that process. I think there were more - there's more correspondence in relation to that. I don't have it all, but I understand there is.

Q. If we look at the email on page 2 of the document that we were looking at a moment ago, you can see it refers to some discussions, and then ultimately do you see it says:

> *Currently we are waiting for the approved location plan/drawing for the additional MRI. We will finalise the Business Case financial information upon receipt of plan/drawing and estimated Capital Works cost.*

Would it be fair to infer from that that to the extent activity data and the like was to be provided by the radiologists or the radiology department, that information had been provided and what was being waited for at that point was some approval location plan drawings?
A. In that email, yes. There are other email correspondence that indicate that there was data that was being waited for as well.

Q. But looking at the draft business case that has been prepared, which commences at page 5, it doesn't appear as though there's any outstanding data beyond the capital works costs. Flick through it, but it seems the outstanding data which is being sought is that which is underlined and in red within the document?
A. Normally - sorry. Normally, a business case would have more activity data than is in this particular business case. Having said that, as I said, this never came to me because it wasn't complete.

Q. At least based on the email chain that we can see here that you've provided us with, it doesn't appear as though there was, as at 15 February 2018, any further information that was being sought from the radiology department that had not been provided. Would you agree that that's at least a fair reading of these emails?
A. If you just look at that email, yes.

Q. And do you have any explanation as to why a further five years later, the MRI's still not there?
A. Two years later, in terms of the 2018.

Q. Well, but the MRI is not in place yet, is it?
A. No.

THE COMMISSIONER: Q. The business case, if you look at it at page 13 - tell me if I'm missing something - it says under "Issues", "we've got a single MRI at Concord." Second bullet point on that page says, in breakdowns, we've got to send patients to the RPA, during breakdowns, our revenue is compromised and the current wait times with one machine for an outpatient scan is 8 to 10 weeks, with inpatients waiting up to 48 hours. Is there much more that is needed to indicate by way of data that the second machine was needed? That seems like a comprehensive case for a second machine to me, or am I missing something?
A. It's a very expensive piece of equipment, around $4 million.

Q. I know. I recognise that, yes.
A. And many hospitals across New South Wales only have one MRI. So we are required to have certain levels of detail.

Q. That's a different issue, though - that other

hospitals might have had one doesn't mean - there might be sufficient demand in those hospitals as well for a second machine?
A. Yes.

Q. If funds were available?
A. Mmm.

Q. All I'm asking you - and feel free to tell me why I'm wrong - that at least under those bullet points that I've just mentioned, that seems like a strong case, to me --
A. Yes, and the --

Q. -- for a second machine? And leave aside that it costs $4 million, because I get that and the money has to be found somewhere, I understand that.
A. Yes. So it's not within the district's ability to just purchase an MRI. You need to submit to the ministry, and they require a certain standard for the business case with more activity data. You know, I've supported the concept and the principle of having an MRI. The issue is getting the documentation to be able to get the approvals to be able to purchase it.

Q. Okay. So whatever extra data is needed, the fact that the current machine is used by 5,000 patients a year, if it breaks down, people have got to be sent to the RPA, if it breaks down we lose revenue, and with one machine, people have got to wait 8 to 10 weeks, or if they're inpatients, 48 hours, is not enough data for the ministry?
A. No.

THE COMMISSIONER: All right. Okay.

MR MUSTON: Q. It would seem from the emails that I've just taken you through, though, that the only piece of data that was outstanding as at February 2018 was some plans and some information about the costings of the capital works that would be required to make space for this second piece of equipment?
A. As I said, my understanding is - and I don't have the emails in front of me - that there was other data that was being requested. But I don't have that in front of me.

Q. To the extent that we have to go on what's in front of us, the plans and the costing of the capital works was not information which was to be provided by the radiology

department, was it?
A. The capital plans required the radiology department to work with capital works to come up with a solution. So engineering can't do that by themselves, they need to talk about the work flows, the way - the processes. So it's unclear from this email about where that process was up to.

Q. Do you have any reason to think that it was the radiologists and decisions about the location of the machine or the work flows within that department that were the cause of the delay - that is to say, the five or so years that it then took between 2018 and 2023 to finalise the business case?
A. I can't say. I don't know.

Q. If responsibility for that delay didn't rest with the radiology department or any failure on the part of the radiologists to provide information, you can understand why that delay might have contributed to their distress when it came to 2023?
A. Yes.

Q. And the MRI had still not arrived?
A. I think it's again important to understand the context. So at the end of 2019 you will recall the bushfires that occurred in New South Wales. Concord was really affected by that, having one of the two burns units --

Q. I don't doubt that, but that's still almost two years after the draft business case had been prepared?
A. And then we had three years of COVID, where I have to say the attention of the district was on a whole range of strategies to assist with the NSW Health response and the priority at that time was keeping patients safe. So the MRI was not front of mind for myself during that period of time.

THE COMMISSIONER: Q. I shouldn't understand that as meaning that scans aren't important for patient safety, if scans are needed, but you mean keeping people safe in relation to the virus?
A. In relation to COVID. The district was very involved in the NSW Health response. That included the setting up of screening at the airports, domestic and international; the setting up of the police-managed quarantine program; as well as the NSW Health special health accommodation for

people who had COVID or were at risk of having COVID; and also the establishment of the very large vaccination program.

MR MUSTON: Q. So is your point that those working within the district and the executive were, during the period of time when this MRI business case was in the process of being prepared, also distracted by a range of other important operational matters?
A. Very much so.

Q. And that distraction on the part of the members of the executive who might have been involved in the development of the business plan and those within the health district head office, as it were, involved in the development of the business plan, might have contributed to a delay by them in bringing it to fruition?
A. Yes, I think there were contributions all round.

Q. So to the extent that in paragraph 83 of your statement you tell us that the business case was to be prepared by the radiology department, with the support of the facility executive, for provision to the Ministry of Health, do we take it from what we have seen in those emails that the process of preparing the business case actually rested with the business case unit --
A. The responsibility --

Q. -- informed by the radiologists?
A. My apologies.

Q. Would that be right? Responsibility for the process of preparing the business case rested with the business case unit, informed by the radiology department providing the information that was required?
A. The normal process is that the business case is owned by the department and the business case unit provided support.

Q. And to the extent that in paragraph 84 you tell us there was an extended delay in the radiology department providing the relevant information for the finalisation of the business case --
A. That is one of the contributors.

Q. One of the contributors, but having regard to what you've just told us about, the various other pressures that

were brought to bear upon others within the district, you're not seeking to convey through that paragraph that it was the radiology department and a failure by that department to provide information which is the reason that it took and has taken almost seven years from the initial 2016 approval of the process to now, and we still don't have an MRI, a second MRI at Concord?
A. That's correct.

THE COMMISSIONER: Q. Forgive me for not understanding, perhaps, something you've said before, but specifically, in 84 when you talk about the extended delay in the radiology department providing the "relevant information", precisely what should I understand to be the relevant information, though?
A. It was information in relation to number of scans, types of scans, et cetera.

Q. So the number of scans that might be performed on the new machine?
A. That were being performed on the current machine and then --

Q. Don't we know that it's 5,000?
A. I wasn't involved in the development of it, so that --

Q. Feel free to say where you've said "relevant information" in that paragraph you're not precisely sure.
A. I'm not precisely sure because I was not involved at that point.

MR MUSTON: Q. Just quickly, at paragraph 86 you tell us about the process whereby procurement of the MRI was approved and then the procurement was cancelled as a result of some discussions that you'd had with Mr McDonald.
A. That's correct.

Q. Can I ask, did you have any discussions with members of the radiology department before you cancelled the procurement of the second MRI, or did you rely on Mr McDonald's judgment about that matter?
A. I relied on Mr McDonald's judgment. I discussed it with the ministry and the view was that we should cease that procurement, which was consistent with NSW Procurement policy.

We'd gone to a panel - I didn't personally, I don't do

that myself - and that was approved by the department head with the clinical director. But we determined that we did not want to escalate the issues further, so we ceased that process. I communicated it to our head of procurement. So I didn't have the conversation with the company myself - I don't talk to companies - and we then determined, with the chief procurement officer, myself, for NSW Health, that what we should do is go through a tender process, which different to what we've agreed previously.

In my previous evidence I talked about that NSW Health has had procurement reform, there are concerns about the amount of time it takes to procure equipment because of the tender process, et cetera, so the panel has a series of equipment from different vendors that have gone through a tender process but at a state level, and then you can select from that panel, which is what was procured, what was being procured, but we went to HealthShare and said could they oversee a tender process, which they did, with the radiology department.

Q. That last bit was the big and important change as between the first process and the second, wasn't it, though, that the radiology department, a group of people who were feeling a bit disenfranchised because they felt they hadn't been consulted with about important decisions, were consulted with about which particular type of MRI should be bought for them to use in their facility?
A. Yes, and it was the same piece of equipment that was ordered in the first place.

Q. I think there might be some suggestion that it has a different power, but we can - little turns on that.
A. It's the same piece of equipment.

Q. But the fact is the first procurement process which was cancelled did not involve consultation - would you accept did not involve adequate consultation with the members of the radiology department who had been expressing a strong desire to be consulted with in relation to decisions relating to their unit within Concord hospital?
A. Yes.

Q. Including, for example, which type of MRI machine to buy?
A. Yes, but they had also expressed concern in previous tender processes about how time consuming that process was,

so, you know, in hindsight, we could have gone through the tender process. Having said that, NSW Health procurement reform was aimed at reducing the amount of time clinicians had to spend on what was seen as administrative activities rather than provision of clinical services, so --

Q. A middle path could have been to sit down with them and say, "We could get this one quickly through these more efficient processes. Alternatively, we can go to a tender process if you're not happy with this particular type of machine, as you've told us before those tender processes can drag on a bit. What would you like to do?"
A. In hindsight, could have done that.

Q. Last point. In paragraph 88 you make an observation about what you understand to be the way in which some concerns Associate Professor Ridley had were reported back to the medical staff council and the impression that that might have created. Do you see that --
A. Yes.

Q. -- the last sentence? Were you present during that meeting?
A. 29 February? Oh, yes, 29 February, yes. That was the second workshop.

Q. Were you present during the medical staff council meeting? We might be at cross-purposes, you see you say in the last sentence that you were present during the workshop, Associate Professor Ridley expressed some discontent, which you've suggested was reported back to the medical staff council in a way which created the impression that the entire department was unhappy. Do you see that?
A. I can't recall if I was there or it was reported to me.

Q. But as you sit there now, you don't know what was said to the medical staff council about Associate Professor Ridley's concerns, do you, really?
A. No, I can't remember.

Q. Why did you include that sentence in your statement? What were you seeking to convey through it?
A. So in the ProActive ReSolutions meeting, there were other members of the radiology department present. Dr Ridley - they indicate that they were happy with the process. He indicated that he was not. They indicated

that although it wasn't an ideal solution, ie, we're in a physically constrained environment, they wanted to go ahead with the second MRI, and the compromise, in terms of the layout of the second MRI suite, the director or head of department for nuclear medicine had given up additional space to make the MRI fit in better, and although everyone said, you know, "It's still constrained, it's not perfect", they wanted to go ahead.

My understanding is, at the next medical staff council meeting, that Dr Ridley indicated that the department was unhappy, which is not consistent with the discussion that we'd had in the ProActive ReSolutions workshop.

Q. But you weren't present at the medical staff council meeting at which Dr Ridley's views were expressed in some way?
A. No, but I - I think if we were to go to the minutes, we would see that he expressed his concern.

MR MUSTON: I've got no further questions for this witness, Commissioner.

THE COMMISSIONER: Thank you.

Mr Cheney, do you have any questions?

MR CHENEY: No, Commissioner.

THE COMMISSIONER: Thank you very much for your time, Dr Anderson. We're very grateful.

THE WITNESS: Thank you.

THE COMMISSIONER: You are excused.

THE WITNESS: Thank you very much.

<THE WITNESS WITHDREW

MR GLOVER: That brings us to Mr Griffiths.

THE COMMISSIONER: Yes.

<RICHARD RONALD GRIFFITHS, sworn: [3.22pm]

<EXAMINATION BY MR GLOVER:

MR GLOVER: Q. Can you tell us your full name, please?
A. Yes, Richard Ronald Griffiths.

Q. You're the executive director workforce planning and talent development within the ministry?
A. I am.

Q. You've been in that role since about January 2019; correct?
A. Correct.

Q. And to assist the Commission in its work, you've made two statements, the first dated 16 July 2024?
A. Yes.

Q. And that's [MOH.0011.0022.0001]. Do you have a copy with you there?
A. I do.

Q. There are some screens either to your right, opposite you, or feel free to use your hard copy. I understand there's an adjustment you wish to make to the table in paragraph 101 of your statement?
A. That's right. There was - for the PMES survey, there was some data that didn't come through, in the printer.

Q. You've provided the Commission with a full copy of that table, which is, for the benefit of the transcript, [MOH.0010.0457.0001]. Subject to that adjustment, have you had a chance to read through your 16 July statement before giving your evidence again this afternoon?
A. I have.

Q. And are you satisfied that it's true and correct to the best of your knowledge and belief?
A. Yes, I am.

Q. And you've made a second statement dated 2 August 2024?
A. Mmm-hmm.

Q. Correct?
A. Correct.

Q. That's [MOH.0011.0039.0001]. Have you had a chance to review that statement again before giving your evidence this afternoon?
A. I have, yes.

Q. And are you satisfied that that statement is true and correct to the best of your knowledge and belief?
A. Yes, I am.

Q. I might just start with exploring a little bit about your branch and your role and we might do it by reference to your CV, which is [MOH.0010.0280.0001]. Do you see there in the third paragraph under "Current role", "The Branch is responsible for" - do you see that?
A. I do, yes.

Q. I'm not going to ask you about all of it, but the first area of responsibility you describe is strategic workforce planning.
A. (Witness nods).

Q. What is involved in that function?
A. So as it implies, there's obviously layers of workforce planning across the health system. The ministry's role in workforce planning is looking at the system as a whole and coming up with strategies that will benefit the whole system, and that's the responsibility of my branch, is to guide the system in terms of its strategic workforce planning.

Q. What are the other layers?
A. There's local, there's operational workforce planning, there's tactical workforce planning, which - tactical is fairly short-term supply challenges because of an event. Operational is at the local health district level where they need to operationalise the plans for the ministry, for the health system.

Q. Does tactical sit at the local level or at the ministry level in that --
A. It can be both, yes.

Q. Amongst those layers in your first answer you described the ministry's role as coming up with strategies that benefit the whole system. Does it take into account the work of the other layers in doing that?

A. Yes, it does.

Q. How?
A. So it's really looking at - well, if you take it back to the local health district levels, they can't really control pipeline, whereas the ministry is operating at a level that it can influence pipeline. So it's bringing some of that planning from the local level to lift it up, to see how the system can support some of those supply strategies. So it's - yeah, I'll just probably --

Q. As part of that, does the ministry perspective enable it to identify trends that might be looming on the horizon?
A. Correct. So my branch also has responsibility for workforce reporting, workforce analytics and insights, so we monitor the workforce right across the state, including the performance of local health districts in terms of the workforce, so that we can identify some of those trends that are beginning to emerge across the health system and we take that to various forums to see if there's something we need to do to address an emerging trend.

So it does, it has the - the ministry's branch, or my branch, has that helicopter view of the health system so we can actually assist the organisation with its workforce planning.

Q. We'll come back to some of those functions and features in a moment. The second one I wanted to ask you about is the next that appears in that same sentence "operational workforce supply strategies". In an earlier answer, you referred to the fact that LHDs may not have the ability to influence pipeline whereas ministry can. Is that the function that I've just drawn your attention to?
A. No, not really. Operational workforce supply strategies is - yes, there may be, for whatever reason, difficulties supplying to various areas throughout the state. I have a unit in my branch that has been established to look at deploying workforce to some of those areas where there's ongoing challenges to supply, and so we deploy nurses, allied health for between two and 13 weeks while those organisations can actually continue to recruit to some of those areas.

Q. Can you give us a practical example of when your team has done that in recent times?
A. Well, it's occurring all the time. At the moment

we've got about 100 FTE or so out on deployment. So they register with us as an agency, effectively, and we deploy them across the state. But we also move internal workforce around. So at the, for example, bushfire period in 2019, we called on the local health districts to assist with supply and we deployed metro health workers into those bushfire-affected areas, both as fatigue relief but also as supply, because we had some of our own staff affected by the bushfires.

Q. So it provides assistance in addressing difficult to fill positions but also providing surge capacity in the event of, for example, natural disasters?
A. Correct. Yes, with an ultimate aim, really, of trying to bring down the use of agency where we can. So there's some areas that would rely on agency in those scenarios and we're trying to fill that so we don't have to rely on the agencies to the degree that we perhaps have in the past.

Q. The next function I wanted to ask you about is just beyond halfway down the paragraph, "Workforce governance connection with professional workforce bodies, including registration authorities and medical colleges"?
A. Yes.

Q. Can you just describe that function for us?
A. So my branch is the connection between the Commonwealth Department of Health, the workforce areas of the Commonwealth Department of Health, and the New South Wales health system, and also Ahpra and some of the boards. So we liaise - where there's, you know, proposals from a board to change a process, that will come through my branch and we actually - we send information out to our system gather it and respond on behalf of the health system.

Q. What about the engagement --

THE COMMISSIONER: You're both going to have to forgive me for interrupting and just going back to a previous topic, but I'm just interested in this.

Q. The unit in your branch that was established, you told us, to look at deploying workforce to areas where there's ongoing challenges, how long ago was that unit established?
A. So we actually established it as part of the pandemic response - well, no, sorry, part of the bushfire response.

It carried over to the pandemic.

Q. So just before the pandemic?
A. Yes. It carried across into the pandemic and then it - so it sat within the pandemic response unit at that time, and then it transitioned across into my branch formally and we've just made it permanent.

Q. And is the hope that it will expand beyond the 100 FTE?
A. Yes.

Q. So that it becomes a bigger workforce, if you like, to lower the numbers of agency staff used?
A. That's right. We've just had approval to upscale to 400 FTE.

Q. Okay. So that's an ongoing process at the moment?
A. Correct. Predominantly nursing and allied health.

THE COMMISSIONER: Thank you.

MR GLOVER: Q. Are those 400 FTE envisaged to be employees with NSW Health?
A. They will be, yes. And so out of the 100 that we've got at the moment, there's a mix of engagement arrangements, so we've got some that are permanent, full-time workforce, and we've got others on a more casualised arrangement.

Q. This is the workforce that sits within this cohort of people who can be deployed wherever they may need it by your branch?
A. Yes, and there's a bit of a - as I said, there is a mix, and that's because there's particular employees who like that casualised arrangement, and there's others who want more certainty. So we offer both.

Q. And I think you said primarily it's nursing and allied health staff?
A. At this stage, yes.

Q. Is there scope or ambition to expand it into the medical workforce?
A. There is, yes.

THE COMMISSIONER: Q. I assume the fact that it's been

expanded from 100 to 400 FTE is an indication that it's at least been as successful as hoped so far?
A. Yes, it has been - it's been very successful.

Q. Tell me if it has exceeded expectations as well.
A. I think it has exceeded expectations and there's been very good response from the local health districts who are the customers of that service. But we are scoping how we might run a similar type of service for medical locums as well.

MR GLOVER: Q. Is that what you refer to in your statement as work being done to investigate a NSW Health --
A. Yes, that is.

Q. -- for want of a better term, locum agency?
A. Correct, yes.

Q. We might come back to that if time permits. The last part of the role of your unit that I wanted to explore with you this afternoon is collaboration with Commonwealth and state jurisdiction on workforce programs. Can you just describe that function, please? It's the very last one in that third paragraph.
A. So the Commonwealth Department of Health has a workforce branch and it will propose nation-wide programs from time to time, where there might be priorities or we need to incentivise people into certain classifications, and we work with that unit to roll it out across the state. That unit also is responsible for the national workforce modelling, and so we work quite closely with that unit and translate its work into our modelling.

Q. Firstly, how, in a practical way, does your unit work with the Commonwealth unit on the national workforce modelling?
A. We use the modelling information - well, going back a step, we work collaboratively with that unit around what should be prioritised for modelling, and then we pick up that data and we bring that into our modelling itself. So it's one of our data sources for our own workforce modelling.

Q. And does your unit provide inputs to the Commonwealth department for the purpose of its work?
A. It has its own methodology and gathers its own data, but we certainly talk about that methodology with the

Commonwealth.

Q. Can I take you to your 16 July statement, please, and we'll start at paragraph 16. In paragraph 16 through to about paragraph 28 you describe a range of data categories that the ministry collects and analyses?
A. Mmm.

Q. I won't take you through each of them in the interests of time, but what I want to explore with you is, having gone through the process of collecting and then analysing it, how, in a practical way, does your team use that in planning and projecting workforce demands, needs, across the spectrum of NSW Health staff?
A. So probably in two ways. We report very regularly to the system on its workforce performance, and that can highlight emerging areas of need in the workforce that my team may pick up. If it's a localised issue that we're spotting, we will raise that with the local health district to see if it's something that might be beginning as an issue there but might spread to the state level.

Q. Just pausing there, are you able to assist us with a practical example of what that might occur?
A. Well, we might - just hypothetically, we might spot a spike in agency use in a regional local health district that's over and above what has been a typical trend, which might indicate a supply challenge. And if it's in a particular discipline, we might look, then, to see if that's going to be something that would be replicated across the state, and, if so, we would work - we would bring that to the directors of people and culture meeting, which is a monthly meeting, and we'll look at whether or not we need to tackle that issue as a statewide issue, and then, if so, my branch would then pick that up as a piece of work and engage with the local health districts in coming about the solution.

Q. Will you also engage with the particular district where that red flag has popped up?
A. Oh, yes. Yes, of course. I mean, that would be the first point of inquiry. So another example, I won't name the districts, but we've had cause to look into a trend in a local health district where we were seeing some odd trends against activity, so workforce growth against activity, and so we needed to do a bit of a dive.

Q. Just pausing there, more staff but not a commensurate expected rise in activity; is that what you mean?
A. Not necessarily just more staff, because staff workforce growth in areas where there may not have been activity, but activity growth in other parts of the district. So it just - it caused us to do a little bit of a deep dive into its workforce and what seemed to be developing as a bit of a pattern. So for that you have to work very closely with the local health district to understand the way that they're managing their activity and the way that they're rostering and managing that workforce.

Q. The example that you've just described, what might that tell you as part of the system management about the function of that particular LHD?
A. Well, in that particular example, it showed that there might have been some workforce challenges in those smaller hospitals, and as a result, the activity was transferred to the larger hospital, but hasn't transferred back.

Q. And is part of the role of your team to work with the local health district to assist them to ameliorate those types of issues?
A. Correct. Correct, yes. So that's one way that my workforce picks up that data - my team, sorry, picks up that data. The other is that we look at it. When we go about renewing and refreshing the overall health workforce plan, we do a full analysis of the workforce trend over the preceding period to see if there's areas of specialisation; for example, that might need a particular area of focus.

There's probably a third, really, which we will both see in data, but we'll also have feedback from different disciplines, that there may be emerging issues, and some of that, of course, can come through industrial associations as approaches to the ministry, that might require us to prepare a particular discipline workforce plan. So, for example, psychiatry was an emerging area of challenge and we've had to develop a psychiatry workforce plan in 2020.

Q. In that answer you referred to doing a full analysis of the workforce over a particular period. How often is that type of analysis undertaken?
A. Well, the health workforce plan is structured over horizons, and so we've developed our last workforce plan from 2022 to 2032 with three time horizons, so we'll be doing that again the next year, the full analysis over the

preceding three years.

Q. Ongoing monitoring and review?
A. With ongoing monitoring, yes.

Q. It's a constant process, I take it.
A. It's a bit like painting the Harbour Bridge.

Q. Can I just ask you about a couple of particular examples that you go to. In paragraph 24 you refer to locum engagement?
A. Yes.

Q. You tell us that a recent trend has been the increase in the use of locums, although you point out that it's still a relatively small component of the overall workforce.
A. Mmm.

Q. Has your team undertaken any analysis to seek to understand why the use of locums has increased over the past four years, I think, in your time frame?
A. Yes, we have.

Q. What has it discovered?
A. Well, in terms of causal factors, there's probably a little bit of a national issue that's contributing to it as well. What we found during the pandemic is that the pandemic disrupted our supply in terms of the international workforce, that would fill some of our holes, and so it built an additional reliance on to medical locum agencies. That has resulted in a supply/demand tension and the result is higher prices in terms of prices being demanded by locums and locum agencies. So we know that to tackle that, there needs to be some national approach.

What we are finding, though, is, because of that being a fairly attractive employment proposition for particularly younger doctors who are prevocational training, that there's a bit of a propensity now for doctors to have what we're sort of seeing as a bit of a gap year to go and locum for a period. There's some advantages in them doing that, by the way, because it does give them exposure to a broader number of hospitals than they would otherwise have exposure to had they stayed with their specialty training in metro Sydney, for example. But it is fuelling the supply/demand challenge at the moment. And so we've got to reverse that

as a trend, which is a very difficult thing to do when it's a national market. It's not just a NSW Health market.

Q. So although the component of the overall workforce that is made up by locum doctors is relatively small, that trend is presenting challenges to the delivery of care in the system, is it?
A. Well, it's not so much delivering challenge to care in the system, we're still supplying doctors. It's the way that they're engaged that might vary across the system, and it's the price point. So at the moment it's the price point that's causing us some issue. They're still sitting at about less than 1 per cent of the workforce, so it's not like it's a dominant workforce at the moment. It's our important back-up workforce that we can't do without. It provides us that agility to very rapidly scale up and scale down when we need to. But the price point is the challenge, and if it continues as it is, you know, it's quite a - it's a substantial cost at the moment to rural, predominantly rural local health districts.

Q. And in paragraph 66 of your statement, you tell us that there's some work being done on a national approach to this issue. Are you familiar with that work and where it's up to?
A. I am familiar with that work because that's being coordinated through the national Health Workforce Taskforce that my branch is hosting the secretariat. So I do have a couple of teams in my branch that are working with the states on that national work. At the moment, that's really scoping work. It's to try and get an idea of what the price point is looking like and the engagement methods, what they're looking like in the different states.

Q. Through that work, I take it from your earlier answers, you've come to the view that this is not a problem confined to New South Wales?
A. No, it's absolutely not just New South Wales.

THE COMMISSIONER: Q. Is it a bigger problem in New South Wales than other states?
A. No. No. In fact, some of the other states may not have the drawcard that we do in New South Wales. We've got - we're quite lucky in that we are still considered a desirable employer for medical.

MR GLOVER: Q. Can I ask you about --

THE COMMISSIONER: Q. That drawcard, what should I understand you to mean specifically in relation to that? What is the drawcard?
A. Doctors still like to train in New South Wales. I think --

Q. It's the large public teaching hospitals, is it?
A. It's the large public system. You get exposure to more things in New South Wales, particularly than you would in smaller jurisdictions. So there is still something that, thankfully, draws people to our state.

MR GLOVER: Q. Can I take you to paragraph 25, please?
A. Twenty-five?

Q. Twenty-five . This picks up something you mentioned in your last answer.
A. Mmm.

Q. There you tell us that the ministry analyses data on employment mix to determine how the NSW Health workforce is employed and to identify trends such as increasing casualisation of the workforce.
A. Mmm.

Q. Tell us what that issue is.
A. Well, there's a couple of things there. There's growing trends in terms of younger generations preferring casualised arrangements, and that is playing out particularly in medicine, as I said, that gap year concept, before they've put down roots. Young doctors, in particular, are finding that sort of casualised work very attractive. But it is also moving across into other disciplines, other corporate workforces, that we do see casualised arrangements as more attractive, particularly as Millennials and the Gen Z generations come through the workforce.

Q. And in your most recent statement you annex a Deloitte study about that particular feature of the workforce?
A. Correct, yes.

Q. What challenges does that shift in expectation of young workers present?
A. Well, I think it's almost more a problem for perception rather than what it presents in terms of the

operations of the health system. There are certainly some advantages in continuity of workforce, but I think the bigger challenge is perception, particularly from both longstanding clinicians but also the public, around stabilised workforces in health. I think we've got time to adjust to it. They're progressively making their way into the workforce. But I don't think it's as big a problem as what people perceive it to be at the moment.

Q. When you say you think it's more a problem for perception, what is the perception that you have in mind?
A. I think people judge success in terms of workforces by the amount of permanent workforce that you've got. Now, we have about 75 per cent - I've got the figures in my statement. I think it's about 78 per cent or something, permanent, then you've got a mix of temporary workforce, and then you've got a casualised workforce that does also include agency, and that's about 5 per cent.

A lot of people perceive the bigger the permanent number, the better, but it doesn't necessarily mean that that's any safer, but I think there is a perception that if you don't have that permanent workforce, then you might not be doing something right.

Q. Is that the issue that you refer us to, in paragraph 147(e) of your statement, as one of the challenges faced by the system in addressing training and workforce attraction and retention - that is, a misconception that permanent workforce is the optimal employment condition?
A. Yes, and I think - so, yes, I think as a system we need to adjust our indicators of success to account for the changing workforce demographic.

Q. What change do you consider to be necessary in that respect?
A. Well, I think the change in perception. So from my branch perspective, I think we will need to really clearly enunciate what we would see as success in the workforce, in the workforce model and the workforce design, so that both clinicians but also members of the public can understand that that's not a failure if you don't have 75 per cent of your workforce as permanent. I think it's reassuring the public as well that, regardless of the mix, the services can be provided safely.

Q. Can I take you ahead to paragraph 28?
A. Yes.

Q. Here you tell us that the ministry gathers data on attrition and measures retention.
A. Mmm.

Q. What does one take from an analysis of rates of attrition and retention within the system as a sign of the health or otherwise of its workforce?
A. So in terms of our turnover - now, turnover is people who have moved positions, so it's internal churn. Then you've got attrition, which is people who've left your organisation altogether.

Q. Just pausing there, so turnover, if a doctor was a staff specialist but became a VMO, would that be reflected in a turnover stat but not an attrition stat - those definitions?
A. I'd probably need to just take that on notice. I'm not a hundred per cent sure of that one. I can check that one. But it would be, for example, a registered nurse who works at Lismore Base Hospital and moves to Grafton hospital, that would be in the turnover stats. But that would not be reported as attrition, because that person remains in the health system. And the reason that I was unclear about the VMO was that's not through payroll, so - they're paid differently so I might just need to check.

Q. It might have something to do with how the statistics are collected; is that what you mean?
A. Beg your pardon?

Q. It might have something to do with how those statistics are collected within the system -- -
A. Yes.

Q. -- is that what you're referring to?
A. Yes. So in terms of attrition, we're sitting at about 6.6 per cent; turnover, about 13. If you look at industry average, most organisations would love to have an attrition rate of 6.6 per cent. That's pretty stable. Turnover, on average, is - well, in the public sector is about 18 per cent. So we're sitting below. But as I said, attrition, 6.6 per cent, is significantly below what most organisations would experience.

THE COMMISSIONER: Q. What do you mean by "industry average"?
A. So AHRI - I've annexed to my statement an AHRI report. They actually collect quarterly reports on business and business turnover and they report industry average for public sector as 18 per cent turnover.

Q. Beyond health, though?
A. Yes. Yes, broader public system. So I think in summary - I think we're doing pretty well in health. We've got a fairly stable workforce. We don't lose a lot of workforce. Certainly not at the rate that I think people seem to be under the impression that we do. 6.6 per cent is not a significant number.

MR GLOVER: Q. Is there, though, a limitation to the utility of attrition and --
A. Oh, of course.

Q. -- turnover stats in measuring the health of a workforce?
A. Of course. Because one loss of a workforce in a very small facility is felt, of course. So we don't use that to counter challenges that are being experienced in our hospitals, but we do look at the overall health of the workforce.

Q. Can I take you to ahead to paragraph 33, please. There you tell us that the ministry relies on the government-wide PMES, that might be described as the "People Matter" survey?
A. Correct.

Q. Then in paragraph 146 - I'm sorry, Mr Griffiths, bear with me just a moment, I've lost my place. So 146(e):

> *Limitations of a one size fits all PMES measuring tool.*

A. Mmm-hmm.

Q. What's the particular limitation that you are drawing attention to in 146(e)?
A. Well, when you're running an organisation the size of the public service, there's only so many questions you can allow each portfolio of the government to ask. It's already a lengthy survey. We do have the opportunity to

ask some health-specific questions and we ask about 10 of those. I'd love to ask a lot more, but it's a statewide survey. So we do collect some very localised health information, but it's limited to those questions.

Q. When you refer to localised health information, is that through the 10 questions that can be added?
A. Correct, yes. We also had an arrangement with the vendor that we analyse some additional questions and have a culture index created.

Q. I might come to that directly. If you go to paragraph 97, please, in this passage of the statement - I'll come to the culture index or score in a moment - you tell us that in 2011, 2013 and 2015, there was a unique survey to NSW Health?
A. Yes.

Q. Is there a particular reason why there is no longer a unique survey to NSW Health?
A. Well, it really replicated the PMES to a degree. We did have that additional index in the culture index, but at the time, it was something that was expected to run across health as well, as in the PMES, so we looked to see how we could utilise the PMES in its place.

Q. And that having now been in the system for some nine years following, does the PMES replicate satisfactorily what was previously a NSW Health specific survey?
A. Yes, I think so, yes. I was in the system at the time, and the reports that we get through the PMES, with our health questions, provide us the indices that I've mentioned, the engagement and the culture index, and for us, that was important to trend that information from 2011, so I think it does give us some utility.

Q. If we scroll down, we will see there a table at paragraph 101. This is the table that has been updated.

MR GLOVER: Commissioner, if your copy of the statement looks like mine, some of these numbers will be cut off, but there's the revised table on the screen.

THE COMMISSIONER: No, mine looks like that.

MR GLOVER: You've been favoured with an updated version.

THE COMMISSIONER: I think mine already looks like that, yes. Thanks.

MR GLOVER: Q. What is the culture index measuring?
A. There's a range of questions that are utilised to develop a reflection on the culture of the organisation. I don't have the questions at hand. They're consolidated to come up with an index that gives a bit of an indication around the general culture in the organisation.

Q. When you say "an index around the general culture in the organisation", what are we measuring? What is it designed to tell one, if one says, "Well, the culture index in 2023 was 61 per cent"?
A. The general sense of satisfaction with the organisation.

Q. From its workforce?
A. From the workforce, yes.

Q. Can I take you to paragraph 42, please. Here you introduce the concept of workforce modelling. Can you just describe in general terms what is involved in the concept of workforce modelling?
A. Sure. Well, at a very high level, we look at the existing workforce stock and we then overlay that with what we see as the input - so what's coming through in terms of academic pipeline - and then factor in anticipated exits, and that gives you a little bit of an indication of what the stock will look like over the forward years.

Then we also factor in demand and how demand will change over time. We do that in a - we look at a number of different datasets. We work with our colleagues in system, information and analytics to gather that information, as well as we consult quite extensively during the period of analysis to get a sense of models of care change and whether or not there's going to be significant changes to the way that we do business, and then we pull that together as an analysis to see what we might need to do in terms of supply.

Q. Is this done at a system level or does it become more granular than that?
A. No, it's - well, it's done at the system level. If I look at the nursing and midwifery modelling, for example, we've just done the system modelling, and what we're doing

now is moving to local health districts to give local - to do some local modelling with them. So in nursing it's sort of done at both levels.

Q. Do I take it from that that similar modelling for the medical workforce is limited to system-wide approach?
A. We model medical both on overall supply but then we focus more on specialties and we do keep that at system level.

Q. So how, then, does a particular LHD utilise the system-wide modelling in its own planning purposes?
A. So when we do the modelling, we look at the supply across the local health districts and we map that out. We then release that modelling to local health districts for incorporation into their own workforce planning. So they have an idea of the supply in their regions and what to expect in terms of statewide changes to supply across those specialties.

Q. So in mapping future workforce at a system level, it descends, does it, to workforce that would be available in each of the LHDs?
A. For medical, not so much to what I think you're suggesting. Nursing, yes. Nursing we will go to quite granular detail with the local health districts. For medical, we keep it at the system level, encouraging local health districts, though, to look at those specialties that are in demand, to incorporate those into their local workforce plans.

Q. And how, as a practical matter, do they do that, to your understanding?
A. Sorry, can you say that again?

Q. How, as a practical matter, do they do that, to your understanding?
A. From my understanding, when I've met with local health district directors of people and culture, they - well, they really look at it quite - if I think of one of the local health districts who has done it quite well, it's probably one of the western districts. They actually translated a lot of that information into their own health workforce plan or their local health district workforce plan.

The problem with medical specialties though, as you know - or as you would have heard - is a lot of that - it's

a difficult market to influence at those local levels, and so we would really need local health districts to be working with us to see how we can assist around some of those specialty training positions.

Local health districts develop and create training positions, but we need to give them some guidance around some of the areas that are in demand in terms of supply.

Q. Is there then a difference on the one hand between modelling of future workforce and planning future workforces within the individual LHDs?
A. Sorry, I don't understand the question.

Q. That's probably because it was a bad one. When you are modelling --

THE COMMISSIONER: I don't understand it either, if that helps.

MR GLOVER: No, that's fair. I did say it was bad.

Q. When you are modelling the medical workforce at a system level, and then you tell us that it is then utilised by the local LHDs in their planning, in answering that question you drew a distinction between the medical and the nursing workforces in the sense that it is hard to influence the medical workforce. Is it the case, then, that the modelling looks at the workforce as a whole, but the planning phase is where the LHD will pick up and run with what it needs to do to attract the workforce to that particular area?
A. Correct, yes.

Q. Does the ministry provide support to the LHDs in doing that?
A. Guidance. Yes.

Q. In what form?
A. When you say "support", it sort of implies there might be dollars there, which may not necessarily flow, but --

Q. Or in kind?
A. Yeah - well, perhaps, but it's more guidance around what to focus on and how to do it. So we can give them some higher-level guidance around - you know, for example, if they're looking at trying to focus on some disciplines

that are in oversupply, we probably guide them away from that, unless there's a genuine demand need in their district for a particular service, and perhaps focus on an area that is more relevant to their service need.

Q. In paragraph 42, you tell us that analysing, forecasting and managing the workforce supply is complex due to the number of stakeholders involved.
A. Mmm.

Q. As part of this system-wide modelling process, does your team engage with those various stakeholders?
A. Yes, they do, yes.

Q. Who are they?
A. Well, there's quite a number. So obviously there's Commonwealth, in terms of the Department of Health, department of ageing. There's various colleges, so medical colleges, other professional colleges, industrial associations, health agencies, insurance companies, private operators. We go quite wide so that we get a pretty good understanding of supply and demand.

Q. In terms of the colleges and other training institutions, do you agree that as part of a comprehensive workforce plan, looking at the numbers of clinicians to be trained and where they might be trained is an important part?
A. Absolutely. And I know I didn't say "education providers", so thank you for prompting. Yes, absolutely. And if I can give you an example --

Q. Please do.
A. -- of that, from time to time when vice-chancellors might be appointed at universities, they do like to come and meet with the health minister, and we will usually accompany them on that visit. In one of those engagements, one of the vice-chancellors suggested he was going to have a look at rallying for some additional Commonwealth supported places in a discipline. It was an allied health discipline. It was one of the ones that wasn't necessarily in supply challenge, it was quite adequately supplied, which was a great opportunity for us to say, "Look, we actually model our workforce and we've got very good allied health modelling on - it's published, and we would really love you to have a look at some of those that we would like to see additional graduates."

So I think I was talking about, at the time, looking at social work and exercise physiologists, from memory, and moving away from something that was possibly popular with school students but really well supplied.

Q. Can I take you, on this topic, ahead to paragraph 59 of your statement.

THE COMMISSIONER: Have you got --

MR GLOVER: I should be finished by 4.30.

THE COMMISSIONER: Do you want to keep going until 4.30?

MR GLOVER: Yes. Mr Griffiths is unable to be here tomorrow. I'll try to finish it by then.

THE COMMISSIONER: Of course. Yes, keep going.

MR GLOVER: Q. Paragraph 59. Just down to 59, operator? Thank you. This is part your statement where you address workforce maldistribution.
A. Mmm.

Q. In this paragraph, you highlight that which we've heard elsewhere about the metro-focused nature of specialty medical training.
A. Mmm.

Q. In the last sentence you tell us that NSW Health continues to work with stakeholders to encourage training in regional and rural locations. Can you just tell us a little bit more about that work, as you understand it?
A. So we've had some really constructive conversations over the last 12 months in particular with medical colleges, for example. We've been engaging very closely with the deans of the various schools. I think there's a growing appetite to support regionalised training and placements. There's obviously a lot of things that we need to consider in increasing training, particularly in those regional areas, and supervision is one that does cause us some difficulties.

But there have been some really constructive conversations over the last 12 months, as I said, not just with colleges but with universities, with TAFE NSW. It's

been quite a good period to sort of ideate with them around how we might address some of the supply challenges in rural New South Wales.

Q. In addressing some of those supply challenges, do you think that one of the functions that can be performed by the centre is really leading the engagement with the specialist medical colleges about some of those accreditation processes that might limit the opportunities to train outside metro areas?
A. Yes, absolutely.

Q. Rather than perhaps it being dealt with at a facility or LHD basis?
A. Yes. It would need to involve both, but yes, that's something that I think we have a good - we're positioned well to facilitate that.

Q. And if there were more training opportunities in rural and regional locations for medical specialists, I take it you would see that as a benefit to the overall sustainability of the workforce in that region?
A. Yes, for sure.

Q. You tell us in paragraphs 51 and following about workforce planning. I've asked you about some of those. But I want to take you to some of the challenges you highlight in paragraph 146. I've dealt with one of them already. You tell us it's challenging in New South Wales to build a full and accurate picture of workforce need against demand and then to properly develop workforce strategies that address emerging workforce needs. What is the particular challenge that you are highlighting in that sentence, the first sentence of paragraph 146?
A. Well, that particular following sentence there is our data picture. There's a lot of data in health. One of the challenges that we have in health is translating that to useful information so it gives us a clear picture of workforce demand.

The reason that it can be so challenging is workforce - particularly specialised workforces - may not be needed or may not be possible to be moved to areas where there's fractional demand. So it's understanding that fractionated demand in some of those small centres and whether there's adequate demand for a service to justify one FTE of a specialised practitioner there. So getting

that picture around what the true demand is in a location is quite difficult, because some of that service is actually provided out of Sydney rather than out of particularly regional New South Wales.

Q. Aside from that example, what is it about data availability, access and governance that present a particular challenge in workforce planning?
A. I think - I think what I was meaning by that paragraph was more along the lines of getting all that data but getting it in a way that's consistent enough to be of use - so our finance data, our activity data, our patient data. It's not necessarily aligned with workforce data, because they are recorded differently.

Q. Is that the issue that you are talking about in subparagraph (a) --
A. It is.

Q. -- the need for manual correlation of multiple datasets?
A. That's right.

Q. Is there work being done by your team to overcome that challenge as to how data in the system is captured and then reported?
A. So we definitely work with our colleague branches to manually correlate, but that is a pretty big exercise and we're one of many data branches that would be impacted.

Q. If there wasn't a need to manually correlate multiple datasets - that is, it was recorded in a consistent way across the system - that would no doubt be of benefit to the work of you and your team?
A. Absolutely, yes.

Q. Are there steps being taken to arrive at that situation?
A. Not that I'm aware of. I'd love that, but I'm not aware of it.

Q. Whilst we're on paragraph 146, in (b) you identify some limitation of the use of important datasets arising from privacy legislation?
A. Mmm.

Q. Can you give us an example?

A. Some of our data is collected for particular purposes, and if we want to use that information in a different way, we're restricted by the privacy legislation.

Q. What might be an example of an important dataset that you would like to use in your work that currently is not available to you?
A. Some of our EEO data, for example, gives us some useful demographic data but it's not necessarily why we would collect it. Similarly, some of the medical information that we collect at the time that we engage our workforce, but we can't necessarily use it in all circumstances.

Q. Forgive me, you said "EEO data"?
A. Yes, the diversity data.

Q. Thank you. Whilst I've got you on that page, if I take you to paragraph 147(a) --
A. Mmm-hmm.

Q. -- this is part of the challenge you've highlighted in addressing training and workforce attraction and retention. You tell us about the multiple sectors and jurisdictions, and in the last sentence you tell us that it's not possible for NSW Health to control its medical workforce pipeline to address predicted demand, no doubt because of the roles played by those other stakeholders?
A. Yes.

Q. But it's possible, isn't it, for NSW Health, as a system, to influence its pipeline?
A. Oh, yes, absolutely.

Q. And does it seek to do so?
A. We do.

Q. In what ways?
A. Well, we work - for example, we work closely with the Commonwealth around what we're seeing as emerging workforce need. We're not obviously able to control that, but we can advocate for additional particularly Commonwealth supported places, which tends to be a pretty attractive pathway for domestic students.

Q. What about after those students have undertaken their medical degrees? Are there levers that NSW Health can pull

to influence its pipeline of workforce?
A. Yes. We are working - as I said, we've had some really good constructive conversations with colleges over the recent 12 months around the specialist pipelines, and while we fund those training places, there are some challenges in terms of the requirements that are required to be met from colleges from an accreditation perspective. So mainly supervision is the challenging one for us, and obviously activity. But we are really seeing some shift in the relationship with medical colleges, so I'm pretty confident that, moving forward, I think we'll have a pretty constructive dialogue around workforce need.

Q. Is that engagement with the colleges - I think I asked you whether it would be better driven by the ministry than the individual LHDs earlier?
A. Yes.

Q. But is it a coordinated effort across the various specialist colleges?
A. I think it needs to be. And I do think the ministry is positioned well to be the conduit for that conversation, but it's important that the whole system does engage in the conversation. In recent times where we've had some good dialogue, it's highlighting that I think there's appetite in colleges to consider different ways, for example, of supervision that I think we'll be able to work with. So an example is the intensive care college with virtual supervision. So I think that's exciting. I think it's going to be a much more constructive dialogue moving forward.

Q. We've spoken a little about the pipeline of medical workforce. Are there particular challenges faced by the system in its pipeline of its nursing and midwifery workforce.
A. Sorry, are there --

Q. Are there any particular challenges associated with the NSW Health pipeline of nursing and midwifery workforce
A. So registered nursing, in terms of supply, is looking like supply will meet our demand projections. That's at a state level. That's not accounting for maldistribution. So there will always be some local challenges for supply in different local health districts.

Midwifery is a different story. There are real

challenges with midwifery supply. We would need to significantly increase the pipeline of midwifery to meet demand, and so it is also important, then, that we do look at local demand to understand where some of those - because it doesn't account for the maldistribution, to really get a picture of what's it going to look like at particularly regional local health districts.

In terms of enrolled nursing, we also need to - we would need to increase the pipeline in enrolled nursing, because the current pipeline is not going to meet projected demand.

Q. And in the case of midwifery and enrolled nurses, are they challenges that NSW Health has the ability to influence, if not control?
A. Yes, and there's some good work occurring in that space. So from midwifery, while we still have a lot of work to do, NAMO, the Nursing and Midwifery Office, offer a mid-start grad - sorry, a grad start, and I'll get them mixed up.

Mid-start is for registered nurses transitioning across into midwifery, which is helping with the New South Wales position. Other states don't do that, so I think that's a really, really sensible strategy from our nursing counterparts.

Enrolled nursing, we've had some very good conversations with TAFE NSW and they're very interested and have started work around some additional regional places for enrolled nurses. So we are commencing work on some of the solutions. We're not just reporting it and leaving it.

Q. What about allied health workforce? Are there challenges in pipeline of allied health workforce?
A. There are. The NDIS is causing some challenges in terms of supply across the allied health disciplines. So there are a range of those where work does need to be done to improve the pipeline. So, you know, there are examples where we've identified some critical - small but critical workforces in the allied health area that we've put some funding into to try and increase training of existing allied health practitioners into some of those specialty areas.

But we're also using our modelling information, as

I mentioned before, to really try and influence universities around courses on offer, because we do still have in Australia some courses in allied health that turn out too - you know, graduates and it's - I don't like really using the term "oversupply", but there's adequate graduates. And some of the areas, particularly in the areas where we would like to see some emerging practice, we need to build some of those pipelines. So I'd like the universities to really consider our modelling information so that we know that we're getting some pipeline into some of those areas.

Q. I take it, for that purpose, the modelling information is shared with those institutions?
A. It is. They are. We write to the universities and share our modelling information.

Q. Is it shared with any other stakeholder in the system?
A. Yes, we write quite widely, really. We send that out to universities. We send it to local health districts. In the case of medicine, we send it out to medical colleges. So we share with those stakeholders that we think are going to be able to influence our pipeline.

Q. Does that extend to industry bodies, unions, for example?
A. I'd have to take that on notice. I'm just not sure.

Q. All right. Is one of the levers that NSW Health can pull to influence its pipeline the establishment of incentives in the system?
A. Mmm-hmm. Mmm-hmm.

Q. And you tell us about a number of them in paragraphs 86 and 87 of your statement. Mercifully for everybody, I'm not to going to take you through each of them, but what I would ask you is what work, if any, is done to assess whether these incentives are having their intended effect, either by attracting new employees or retaining existing ones in areas of need?
A. Well, I'll speak very specifically about the Rural Health Workforce Incentive Scheme, which - that was a collaborative scheme that came about because of emerging issues, pre-pandemic, in rural New South Wales and was exacerbated by the pandemic.

In terms of the way we constructed that scheme and we

monitor that scheme, we looked at areas of rurality that, using the Modified Monash Model, classified MM3 to MM7, which is fairly remote. So MM3 is sort of fairly large-sized regional towns like Dubbo, through to very, very remote areas, and we've scaled that scheme on the basis of rurality, so the more difficult, the higher the value of the incentive. And we report that - we actually report that on a weekly basis to sort of monitor trends across local health district movements, but that reporting is designed to ensure that we can see whether or not the scheme is having an impact.

What it's really showing us is that we're seeing a lot more stability in the rural workforce now. So one of the indicators of success for that scheme was retention. So while we obviously wanted to attract people, we were seeing some lowering retention rates, at the back end of the pandemic, which has now - we've arrested that sort of trend and, in fact, it's trending positively upward again. So those sort of - when we develop a scheme, we try and build a success indicator so that we can see whether it's met its intention.

Q. Although perhaps not as frequently reviewed as that example --
A. Yes.

Q. -- was similar things - similar work done in relation to each of the incentive schemes that you've set out in your statement?
A. So yes, but certainly not weekly, as that one is. The tertiary health subsidies, for example, we're reporting those every fortnight, I think, and that's a government commitment, so the government's very interested in how we're tracking with that and that has seen - we've now given out the full set of subsidies for this year.

Q. When you say that the success of these initiatives are reported, reported to whom?
A. For the subsidies, do you mean?

Q. Yes.
A. So reported up through to the ministry executive but also through to the minister's office, in that case.

Q. Finally, I just want to ask you about something you refer to in your 2 August statement. It's the topic of

vacancy data. In paragraph 6 and following you issue a caution about the utility of vacancy data.
A. Mmm.

Q. In paragraph 4 you tell us that the ministry collects that data from time to time. How frequently does the ministry collect the data on medical workforce vacancies?
A. For medical workforce vacancies it's really collected fairly infrequently. We've collected it just a few weeks ago. Prior to that, it would have been last year that we last collected that data. It's really as needed. If we think there's some information coming from the system that is suggesting there's an issue with our supply, then we'll go about gathering that data. The reason we don't do it too frequently is it's very manual and it is an impost for the local health districts to have to manually gather that information.

Q. When it is gathered, though, what are you - you and your team - looking for when you analyse vacancy data across the system?
A. Well, which specialties are in supply challenge. If there's a - if it has come about because of some suggestion from the system that there's an area that is of particular concern or worry, then we will obviously look for those areas to see if there's a need to, as a system, address something that might be coming about.

So an example would be psychiatry. We collected that information recently because there's been focus on some challenges around mental health and in particular the psychiatry workforce.

Q. So what might vacancy data - let's use, for an example, any particular LHD about the psychiatry workforce - tell the system?
A. Well, we really more look at total numbers. I mean, we will look at which local health districts are experiencing particular concern, but we also look at whether or not the workforce has grown or contracted, and if it's grown or contracted in particular areas or across the specialties - sorry, across the staff specialist workforce or is it in the VMO workforce or is it in the junior workforce?

Q. So it's one of the integers that goes into part of your workforce planning and modelling processes?

A. Mmm. There's usually a hypothesis that is considered at the time, so it might be we're seeing we're losing staff specialists to VMOs, you know, and so we'll go to that information to see if there's any validity to that.

Q. And part of the caution you urge on us in your statement is that, if looked at in a stand-alone way, vacancy data might not represent the effectiveness of the system as a whole; correct?
A. That's right, yes.

Q. And to the extent that then vacancy data would be made public, that would be a concern to you, would it?
A. Yes. And for a number of reasons. The first is that I don't think there's a clear understanding around what "vacancy" even means, and we would obviously need to - when we go out in the system asking for vacancy data, we have to put a pretty clear definition around what we're gathering, and I go into some detail in the statement around the variable definitions of "vacancy".

But the reason that I hold a concern about vacancy data just being publicly available is it is not a reflection of the safety or of the effectiveness of the health service; it's routine churn that occurs in every organisation, and if that information is then misunderstood, I think it unnecessarily erodes public confidence in that service.

Q. If it were to be made public, though, both of those matters could be taken into account by explanation or qualifiers accompanying the data; correct?
A. Could be, but I think there's also risk that that information then is taken up and used for a purpose.

THE COMMISSIONER: Q. Do I take it that you would have a concern that if that - that the way that vacancy rates are discussed in the public domain may not have the qualifiers or the explanations that are contained in 6(a) to (c) of your supplementary statement?
A. That's right, Commissioner. But also --

Q. In other words, they'll just be published as vacancies without any indication that there might be someone in that role providing the healthcare services that are needed?
A. Correct. And in some cases, people that fill that role are highly qualified, highly experienced. So it's

really not an issue of safety concern. Yes.

MR GLOVER: Thank you, Mr Griffiths. I have no further questions for this witness.

THE COMMISSIONER: Do you have any questions for Mr Griffiths, Mr Cheney?

MR CHENEY: No, Commissioner. Can I just check that your copy and everybody's copy of the supplementary statement includes the annexure to it that was referred to in the last paragraph, or is that something that is to be provided?

THE COMMISSIONER: What is the annexure?

MR CHENEY: It's a table that collects questions that have been deferred to Mr Griffiths by other witnesses and his responses to it. I'm told it is in the hard copy.

THE COMMISSIONER: Someone's got it. Not me. But I guess it will end up coming to me.

MR GLOVER: It's H5.21.2.1. It's the annexure referred to in paragraph 20 of Mr Griffiths' second statement, which is [MOH.0010.0450.0001]. In that table, Mr Griffiths has very helpfully collected the questions that I think I mainly asked witnesses, where they deferred to him, and given an answer. So I don't need to take him to it.

THE COMMISSIONER: Very good. We do have that. All right. Thank you very much for your time. We're very grateful, Mr Griffiths. You are excused.

THE WITNESS: Thank you.

<THE WITNESS WITHDREW

THE COMMISSIONER: We adjourn until 10 o'clock tomorrow?

MR GLOVER: Thank you.

THE COMMISSIONER: Thank you. We'll adjourn until then.

AT 4.36PM THE SPECIAL COMMISSION OF INQUIRY WAS ADJOURNED TO WEDNESDAY, 7 AUGUST 2024 AT 10AM

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