

**Special Commission of Inquiry
into Healthcare Funding**

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

**At Batemans Bay Soldiers Club
6 Beach Rd, Batemans Bay, NSW, 2536**

Friday, 16 August 2024 at 10am

(Day 048)

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)
Mr Hernan Pintos-Lopez	(Counsel Assisting)

Also present:

Mr Hilbert Chiu for NSW Health

1 THE COMMISSIONER: Good morning, everyone. Yes,
2 Mr Glover.
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4 MR GLOVER: Thank you, Commissioner. This morning the
5 first two witnesses are Ms Hoskins and Mr Clout. They are
6 being called together, and they are in the witness box.
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8 <ELIZABETH HOSKINS, AFFIRMED [10.04 am]
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10 <TERRY CLOUT, SWORN [10.04 am]
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12 <EXAMINATION BY MR MUSTON
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14 MR MUSTON: Ms Hoskins, can you state your full name
15 please.
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17 MS HOSKINS: Elizabeth Maria Hoskins
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19 MR GLOVER: You are the current chair of the board of the
20 Southern NSW Local Health District?
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22 MS HOSKINS: Yes.
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24 MR MUSTON: And you've held that role since 2023?
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26 MS HOSKINS: Yes.
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28 MR GLOVER: And been on the board since 2017; is that
29 right?
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31 MS HOSKINS: Yes.
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33 MR GLOVER: To assist the commission in its work, you have
34 prepared signed a statement dated 2 August 2024, correct?
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36 MS HOSKINS: Yes.
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38 MR GLOVER: Do you have a copy of it there with you?
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40 MS HOSKINS: I do.
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42 MR GLOVER: For the benefit of the transcript, it's
43 MOH.0011.035.0001. Have you read it again before giving
44 your evidence this morning?
45
46 MS HOSKINS: Yes.
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1 MR GLOVER: And you are satisfied it is true and correct?
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3 MS HOSKINS: Yes.
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5 MR GLOVER: Mr Clout, can you tell us your full name,
6 please?
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8 MR CLOUT: Terence James Clout.
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10 MR GLOVER: You are the deputy board chair of the Southern
11 NSW Local Health District, correct?
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13 MR CLOUT: Correct.
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15 MR GLOVER: You have been on the board since 2020?
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17 MR CLOUT: Correct.
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19 MR GLOVER: And been deputy chair, either acting or
20 substantive, since 2022?
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22 MR CLOUT: Correct.
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24 MR GLOVER: And you have also prepared a statement to
25 assist the commission, correct?
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27 MR CLOUT: I have.
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29 MR GLOVER: Dated 6 August. That is MOH.0011.0040.0001.
30 Have you read it again before giving your evidence today?
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32 MR CLOUT: Yes, I have.
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34 MR GLOVER: And you are satisfied that it is true and
35 correct?
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37 MR CLOUT: I am.
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39 MR GLOVER: Just by way of introduction to how this
40 morning will proceed, I will ask you a series of questions
41 about topics referred to in your statement, perhaps others.
42 I might direct the questions to one or other of you. Feel
43 free to pipe up at the end of the answer and add to what
44 one or other of you have said, even if I don't - I will try
45 and direct that to you as well, but if I forget, feel free
46 to interrupt me.
47

1 Mr Clout, we might start with you. Can you tell us a
2 little bit about your background in the health sector
3 generally?
4

5 MR CLOUT: Yes. So I have worked in the public health
6 sector of New South Wales since 1984 in various roles,
7 initially in industrial relations in the Ministry of
8 Health, then in planning, then in director of corporate
9 services at south western Sydney and deputy CEO at
10 Illawarra area health service and CEO there, and then CEO
11 of the Mid North Coast Area Health Service followed by
12 Hunter New England, followed by northern Sydney, followed
13 by south eastern Sydney-Illawarra, and finally at south
14 eastern Sydney, finishing in 2014-15.
15

16 MR GLOVER: And you were also, briefly, acting CE of this
17 district for a short time as well?
18

19 MR CLOUT: Sorry, yes, I was. So for three months
20 from January to March 2020, awaiting the appointment of the
21 current chief executive.
22

23 MR GLOVER: We take it you have seen a lot of changes in
24 the New South Wales health system over those years?
25

26 MR CLOUT: I have.
27

28 MR GLOVER: Can I ask you both briefly about the role of
29 the board in monitoring the performance of the LHD
30 generally? And Ms Hoskins, we might start with you. What
31 do you see to be the board's role in monitoring the
32 performance of the LHD generally?
33

34 MS HOSKINS: The board's function, we refer to the
35 section 28 of the Health Services Act. So the key
36 functions include ensuring that appropriate legal and
37 governance frameworks are in place, strategic planning
38 processes is in place, that we are monitoring performance
39 both financial and operational, that we're seeking the
40 advice of consumers and providers. They would be the key
41 things.
42

43 MR GLOVER: Mr Clout, do you have anything to add?
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45 MR CLOUT: Yeah, I think there are a couple of others as
46 well, which is clearly the culture of the organisation is
47 critically important, and part of the role of the board is

1 to monitor and get a sense of what that culture is, and
2 ensure that it is appropriate. One of the others is to
3 determine the risk appetite for the decisions that are made
4 within the health service. And probably the other one is
5 around ensuring that there are frameworks in place to
6 ensure that the quality of patient safety that is being
7 provided is in accordance with the standards, both
8 nationally and as required under the service agreement.

9
10 MR GLOVER: I might break up some of those features. When
11 you say culture of the organisation is critical, why is
12 that particularly the case in a region like this?

13
14 MR CLOUT: So one of the major issues for this district
15 and other rural areas is ensuring that you can get
16 appropriate qualified staff to staff the facilities and
17 services you're providing. To do that, people won't stay
18 in rural areas in the health sector when they have got
19 opportunities elsewhere, unless they are satisfied that the
20 culture of the organisation they are working in is one they
21 are committed to and aligned to, and, therefore, ensuring
22 that the welfare of staff is foremost, that they're looked
23 after, and that they're listened to is critically
24 important, and that is what forms the culture of the
25 organisation.

26
27 MR GLOVER: Ms Hoskins, do you have anything to add?

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29 MS HOSKINS: I could add to that, yes. I recognised when
30 I joined the board that there were some serious concerns
31 about our culture, and that's a function of the history of
32 this LHD. And I --

33
34 MR GLOVER: Pausing there, what do you mean by "serious
35 concerns about the culture"?

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37 MS HOSKINS: It was clear when I travelled to sites that
38 our staff were unhappy. It was clear in the conversations
39 that I had with them. And that's clearly, you know,
40 obviously a generalisation, but this was a function of
41 multiple changes in leadership, it was a function of a
42 restructure that was started four years or more before it
43 was finally implemented, and it was a function of not
44 having the right person, in my view, in the CE role.

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46 MR GLOVER: And has the redevelopment of that culture been
47 a particular focus since you joined the board?

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MS HOSKINS: Absolutely. To me, it's one of the most critical things the board has a responsibility to monitor.

MR GLOVER: And what steps has the board taken to try and influence that change in culture?

MS HOSKINS: We have - well, you know, I was on the panel that selected the CE. That would be the fundamental thing we have done, but from there we have stood our people in culture committee, we have ensured that there are appropriate plans in place to improve, to work towards improving the culture of the organisation, and they include our cultural framework, and I made reference to that in my statement. We use a framework called Elevate, and there are a number of principles we all work towards, and this is helping us align our goals. It's helping to improve the wellbeing of our people. It's helping - Terry spoke to all the key things, but you know, retention, recruitment, all of those things, culture are a function of that.

MR GLOVER: Mr Clout, in an earlier answer, you also mentioned monitoring the risk appetite of the organisation. What did you mean by that?

MR CLOUT: Well, when you run a health service or when you are governing a health service, and this is an issue for the Ministry of Health as well, you have to make decisions, and those decisions are between - difficult decisions about what you can and can't do with the budget that you've got and availability of staff that you've got. Now, to do that, you've got to work out what are the risks? What are the risks to patient safety and quality, what are the risks to reputation, what are the risks to the financial implications of those decisions you are making?

Now, this health service - I am a fellow of the institute of company directors and also risk management institute and a certified practising risk manager, and I can say to you that the risk structure and framework that this district has in place is quite mature, and it goes both to clinical and to corporate and to all other manners of risk. So the process is looking at what are the risks to patient safety and quality, first of all, and then to delivery of the service agreement, then to the expectations of the community. Balancing those and saying what are the risks?

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2 If something is a high-level risk, the board needs to
3 know about it. The board needs to monitor what decisions
4 are being taken in relation to that and be comfortable with
5 that. It then needs to monitor that there are risk
6 mitigation strategies in place, that they're being dealt
7 with in a timely manner, that they're effective. If not,
8 then further discussion with the executive about what other
9 steps need to be taken to address those risks. And I think
10 that's a process that is quite mature in this district and
11 I think works reasonably well. It doesn't mean, however,
12 that the board can, or the executive can, address every
13 risk that is there. And nor does it say that it is risk
14 averse, but if you are looking at the risk and determining
15 which are the high level risks, where are we falling short,
16 what do we need to do, and monitor that, then you at least
17 know what the risks are and you know what you are doing and
18 can do to address those.

19
20 THE COMMISSIONER: Can I just ask you a question about
21 that, your experience and expertise in risk. I will
22 preface it by saying it doesn't apply to this local health
23 district, but just a hypothetical. Does the board of an
24 LHD have a governance role, in your opinion, if it comes to
25 the board's attention that a huge number of clinicians,
26 let's say a medical staff council, have lost confidence in
27 management? Is that a risk that the board should be
28 involved in actively?

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30 MR CLOUT: Absolutely.

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32 THE COMMISSIONER: Thank you.

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34 MR GLOVER: Why?

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36 MR CLOUT: Well, because clinicians are the hands, the
37 feet, the eyes, the ears, of providing services to patients
38 and the community, and that is the main purpose of a health
39 service. Therefore, if there isn't confidence by the
40 clinicians in the decision-making processes of management
41 and senior management, then they are not going to be
42 passionate about what they're doing. There needs to be a
43 partnership. There needs to be synergy. It doesn't mean
44 they will always agree, at all, because expectations of
45 clinicians are predominantly for their patients, and they
46 should be, but there needs to be a partnership, there needs
47 to be dialogue, there needs to be understanding, there

1 needs to be serious listening.

2

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4 The clinicians need to know that the health service
5 senior executive give serious consideration to what the
6 clinicians are saying. If they think that they are getting
7 serious consideration to what they're saying, they will
8 have confidence in the decision, even if they disagree with
9 them. But without that confidence, you've got a fractured
10 health service, number one. Number two, the executive and
11 the medical staff and the clinical staff will spend a lot
12 of their time dealing with the fact that they don't have
13 confidence rather than dealing with what they are there to
14 do.

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THE COMMISSIONER: And would I be right in thinking that the risks involved in the scenario we have just discussed are multi-faceted in the sense that there is a risk to your workforce if it is unhappy, but there is equally a risk to patients?

MR CLOUT: Absolutely. So from a board perspective, the discontent that a clinical council, senior clinical staff, medical, nursing, allied health have in the district is a risk to patient care. If for none other reason, because they are spending time dealing with that lack of confidence rather than concentrating on the high-quality, safe services to patients.

THE COMMISSIONER: Thank you.

MR GLOVER: Ms Hoskins, do you have anything to add to that topic?

MS HOSKINS: Only to say that my experience with clinicians in our board context is we always have at least one clinician as a board member.

THE COMMISSIONER: Just stopping there, do you think that is a good idea --

MS HOSKINS: Absolutely.

THE COMMISSIONER: -- beyond this LHD? To have, say, a chair of the medical staff council or another senior clinician on a board?

MS HOSKINS: I think it is critically important to have a

1 clinician who is currently working for our service, but
2 I also think it is critical to have others who have history
3 in a clinical space as well.

4
5 THE COMMISSIONER: How do you think it helps other board
6 members?

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8 MS HOSKINS: I think we need to - well, there's two parts
9 to this, in my view. I think it is important that the
10 clinicians understand the business that we are trying to
11 govern, and my experience has been --

12
13 THE COMMISSIONER: They might know what the financial
14 constraints are more clearly than other ones.

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16 MS HOSKINS: Correct. Yep, absolutely. And I think they
17 get a very different picture once they're sitting at a
18 board table and considering, you know, financial
19 sustainability in the other areas that we've got to govern.
20 So I think that's important.

21
22 THE COMMISSIONER: They still may not agree with those
23 financial constraints, but --

24
25 MS HOSKINS: Absolutely, because their imperative is to --

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27 THE COMMISSIONER: Yeah, of course.

28
29 MS HOSKINS: -- to look after members of the community who
30 are unwell or injured. So that is their imperative. It is
31 not to ensure that we are, you know, economically managing
32 our district.

33
34 THE COMMISSIONER: Did I interrupt you? Had you finished?

35
36 MS HOSKINS: No, but I am sorry, you had asked me a
37 question that had two parts and I have only answered one
38 part.

39
40 THE COMMISSIONER: The question really was how does it
41 help the board to have, say, a chair of a medical staff
42 council or senior clinician on it?

43
44 MS HOSKINS: Well, we hear from our clinical council
45 members, and the head of internal medicine came and
46 presented to us recently, too. So we do hear from our
47 clinicians in various forums, including at board meetings.

1 But, of course, it is very important to understand what is
2 concerning them at any particular point in time.

3

4 THE COMMISSIONER: I get the impression the answer is
5 "yes", but to you as a board, do you have either formal or
6 informal get-togethers with senior clinicians at the
7 various sites?

8

9 MS HOSKINS: We do. We have regular medical engagement
10 functions, and board members attend these. We don't
11 require that they do, but we request that some do. And
12 those medical engagement functions, all our medical
13 workforce are invited, as are GPs and others that work in
14 the space across the district.

15

16 THE COMMISSIONER: Thank you.

17

18 MR CLOUT: Can I just add something?

19

20 THE COMMISSIONER: Yes, of course.

21

22 MR CLOUT: I actually don't think that it is important
23 that the medical member of the board be from the medical
24 side of council.

25

26 THE COMMISSIONER: Right. Yep.

27

28 MR CLOUT: I think that they have a particular function
29 and role, and that gives them an avenue, through that, to
30 engage with the senior management and with the board and
31 the healthcare quality committee, et cetera, but I think
32 it's critically important that the senior medical
33 practitioner on the board is available to the board. I'm
34 not a clinician.

35

36 THE COMMISSIONER: Yes.

37

38 MR CLOUT: A lot of experience - no. So I need to have
39 someone who I respect and trust --

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41 THE COMMISSIONER: Yes.

42

43 MR CLOUT: -- who has that medical background knowledge,
44 that I can turn to as a board member and say, "What do you
45 think about that from a clinical perspective? What would
46 your colleagues think about that?" Because they will have
47 that insight and I won't, and that mix of skills on a board

1 is important.

2

3 THE COMMISSIONER: Should I understand your answer to mean
4 that it shouldn't exclude you from being on the board if
5 you happen to be the medical staff council chair --

6

7 MR CLOUT: Absolutely.

8

9 THE COMMISSIONER: -- but it needs to be an appropriate
10 clinician?

11

12 MR CLOUT: Correct.

13

14 MR GLOVER: What about the lines of communication between
15 the medical staff councils across the district and the
16 board? Do you think that those processes can be improved
17 to better support the flow of information, both to the
18 board and then from the board back through the medical
19 workforce?

20

21 MR CLOUT: Do you want to answer that first?

22

23 MS HOSKINS: I think we can always improve communication,
24 would be my response to that. You know, we ensure that we
25 view minutes. We ensure that we have members of the
26 clinical council come to board and speak to us. We are
27 aware that the LHD communicates with our clinical cohort
28 all the time. That doesn't mean that what we're doing is
29 perfect. It doesn't mean that we are hearing from
30 everybody all the time. So my response would be: I'm sure
31 there is improvement for the community.

32

33 MR GLOVER: Would you see benefit perhaps in the medical
34 staff council or councils, should there be more than one in
35 any particular district, being able to present to the board
36 on a quarterly, for example, basis throughout the year?

37

38 MS HOSKINS: They do come to board, yeah.

39

40 THE COMMISSIONER: In this LHD?

41

42 MS HOSKINS: Yes, absolutely. It's not quarterly, and
43 perhaps we could do it more often, but we do hear from
44 them. And I'd add that --

45

46 MR GLOVER: I will let you continue, but do you see there
47 being some benefit in that being a standing feature of the

1 board's operations, to have presentations like that?
2 Whether it be quarterly, half-yearly.

3
4 MS HOSKINS: Yes, and that's what we do.

5
6 MR GLOVER: Set into the processes of the governance of
7 the LHD?

8
9 MS HOSKINS: I was only going to add that a member of the
10 clinical council is now coming to every board meeting when
11 he's available. So we are very open to hear from them at
12 any point in time. At the moment, you know, we do - we do
13 hear from them, you know, a standard format. Whether it be
14 six months or yearly, I can't --

15
16 MR CLOUT: Yeah.

17
18 MS HOSKINS: But they would be welcome to come to the
19 board at any time if they wish.

20
21 MR CLOUT: I suppose a question of stipulation is part of
22 your question. I think it should be stipulated that there
23 should be engagement between both councils and the board
24 regularly, but not stipulate a particular regularity. But
25 the other thing is that there is another forum. The
26 healthcare quality committee of the board is a significant
27 important position for engagement with clinicians, and
28 I think there being clinical leads, clinical councils,
29 heads of departments, medical, allied health and nursing
30 presenting to those, which happens in this district, that
31 is equally important as it is presenting to the board. In
32 fact, that can be a filter for what is the most important
33 thing to present to the board. So what comes up from that
34 committee may well be a trigger, because we have a process
35 by which what happens at those committees of the board, or
36 chairs, then determine at the end of each - sorry, the
37 committee members determine at each meeting what matters
38 need to be raised to the board, and that can be a forum
39 where things come up that that would be a presentation that
40 should be targeted to the board.

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42 MR GLOVER: But those are matters related to delivery of
43 clinical services across the district?

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45 MR CLOUT: They do.

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47 MR GLOVER: Through that committee?

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MR CLOUT: Yes.

MR GLOVER: What about a forum for staff members to raise issues of management and governance? Would that be the appropriate committee or should there be a different avenue?

MR CLOUT: That would not be appropriate committee. I mean, look, these matters could and should be raised through any of those committees, any of the forums, the clinical councils, the medical staff executive council, meetings that we have in hospitals. Wherever those are raised, those forums should be open enough so that people can raise those concerns, and we try to make them that way.

The other thing I would say, though, is that the board's responsibility to a large degree in that is to ensure that there are process frameworks and policies and mechanisms in place for the senior executive at hospitals, at departments, at networks and at the executive level, that those are also forums in which that can happen. That's the first responsibility of the board. The other is then to look at a risk rating basis, which ones are most appropriate to inform the board, to raise concerns for the board and ensure that people who wish to raise those matters with the board can.

MR GLOVER: And I think in your earlier answer, you accept that there should be an avenue for those senior clinicians to engage with the board directly, even though there are other avenues for them to do so as well?

MR CLOUT: Absolutely.

MR GLOVER: Ms Hoskins, one of the functions of the board is to monitor the performance of the CE of the local health district. Is that an important function for the board to have, in your view?

MS HOSKINS: It is an important function in my view. I mean, if we're going to fulfil an appropriate governance role, that includes holding the employer function. And so, yes, I think it's important.

MR GLOVER: Mr Clout, do you agree with that?

1 MR CLOUT: I do. We have to accept that the monitoring
2 function is both from the board and from the secretary of
3 the Ministry of Health. That is an unusual corporate
4 arrangement, but it's the reality and quite appropriate.
5 That's why the performance assessment is done by both on an
6 ongoing basis the chair of the board and on a mandated
7 basis in conjunction with the chair of the board and the
8 secretary of the Ministry of Health.

9
10 MR GLOVER: What would you say to the proposition that
11 there should be a single line of accountability from the CE
12 through to the secretary of NSW Health?

13
14 MR CLOUT: I have worked under that model, and what
15 I found difficult in that circumstances was the lack of
16 expert advice available to me, as a chief executive in a
17 chief executive-governed corporation, to me when I had very
18 difficult decisions to make and they didn't necessarily
19 align with the decisions that would necessarily come from
20 the secretary of the Ministry of Health, and I needed other
21 independent advice and - to soundboard my views, my
22 thoughts and my concerns with. And as a chief executive
23 with the board, particularly with a strong board chair,
24 that was available to me and I found that very, very
25 valuable.

26
27 I think that it is also an avenue for the secretary to
28 have another avenue to go to and say, "Okay, you are
29 dealing with this matter on a much more regular basis than
30 I am, what's your assessment? What are the nuisances that
31 I can't pick up, sitting in Sydney, that I can't pick up in
32 my discussions with a CE?" I think that's valuable to her
33 as well.

34
35 MR GLOVER: Ms Hoskins? I can repeat the proposition if
36 you don't remember what it was, but do you have a response
37 to it?

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39 MS HOSKINS: My view is that we as a board, and I as
40 chair, know more about - much more about - the CE's
41 performance. You know, we monitor that on a daily, weekly,
42 monthly basis. This isn't an activity that we just do once
43 a year, and so my view is that it is an important part of
44 our governance function to hold the performance review of
45 the CE, and I think it would be an inappropriate step to
46 change that line of accountability.

1 MR GLOVER: Ms Hoskins, we have spoken a little about
2 engagement with clinicians. I will ask you some questions
3 about engagement with the community now.

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5 MS HOSKINS: Sure.

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7 MR GLOVER: Is that an important part of the work with an
8 LHD, in your view?

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10 MS HOSKINS: Critically important.

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12 MR GLOVER: Why?

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14 MS HOSKINS: Because all that we do is for the members of
15 our community, so we need to have an understanding, clear
16 understanding, of the areas that are concerning them, and
17 so it is very important.

18
19 MR GLOVER: Mr Clout?

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21 MR CLOUT: I think it is. I think that to a large degree,
22 it's critically important for the chief executive and her
23 executive and senior management to be doing that. It's
24 also critical for the board to ensure that there are
25 frameworks, processes in place for that to occur and that
26 they are effective. But in addition to that, there needs
27 to be avenues by which board members can engage with the
28 community. And when we talk about the community, there is
29 not one community. There are communities. And they are
30 variable. Within a local place, there can be different
31 communities. So there are local council communities, there
32 are individual group communities, there are interest
33 communities.

34
35 It is important that there are frameworks and
36 processes in place to capture that, to provide
37 opportunities for it to be articulated, and to listen to it
38 and to give feedback to it in terms of decisions that are
39 being made that affect them. So I think the board's role
40 is critically important to ensuring those are in place, but
41 then providing other avenues because it may be some of
42 those groups that aren't comfortable with, or dissatisfied
43 with, the engagement we've had with management and want an
44 avenue to have that.

45
46 Now, many of the board participate regularly in those
47 engagement processes, and I think that's valuable for them

1 in terms of getting information, but it's also valuable for
2 the community to understand that they are available to them
3 should they wish to go to them.
4

5 MR GLOVER: In paragraph 13 of your statement, Mr Clout,
6 you tell us there are, and have always been, challenges to
7 an effective and impactful community engagement. What did
8 you mean by that?
9

10 MR CLOUT: It's difficult. It's difficult if you think
11 that the engagement will be with a group and
12 representatives come on to that group, and that somehow
13 they "represent" the community or the communities. It's
14 difficult to get people who are broad in terms of their
15 understanding and interest from a community to be engaged
16 in the processes that are available. That's really
17 difficult. It's really tricky.
18

19 It can then become a situation where people who are
20 representatives consider that they are the representatives
21 and that they should be there forever, and disengaging
22 really engaged members of the community is just as
23 difficult. But then it's difficult to engage on working
24 out what level that engagement is. Because some members of
25 the community understand engagement to mean, "I told you
26 what I thought should happen and you didn't do it, and
27 therefore, you didn't consult, you didn't engage." Now,
28 that might be hypothetical.
29

30 THE COMMISSIONER: That's decision-making, it sounds like.
31

32 MR CLOUT: Yes. So having a dialogue with communities
33 that enables them to accept that there are people who have
34 a responsibility to make decisions, and what they have a
35 right to is to be heard and for the decision-makers to take
36 due consideration of the comments that they make before
37 making decisions and then to feed back to them what the
38 decisions are and what are the implications. That is
39 pretty difficult --
40

41 MR GLOVER: Sorry to interrupt you. That last step is
42 quite an important one, is it not?
43

44 MR CLOUT: It is. Absolutely important.
45

46 MR GLOVER: And you tell me in your own words why you
47 think that last step is an important one in the process?

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MR CLOUT: Because the community needs to know what decisions have been made as the result of the process of consultation.

MR GLOVER: And why those decisions are being made?

MR CLOUT: Yes, they need to know what the rationale was for that decision-making, what the criteria were, what the constraints were, what the rationale was for the making of those decisions. Now, it doesn't necessarily follow that they will agree with either the criteria that is used, construct in which was given, or the decision that was made, but they've got a right to know what they are.

MR GLOVER: And it is inevitable in any consultation process that there will be people who will never agree with the final outcome.

MR CLOUT: Yes.

MR GLOVER: Is the process that you have described an important one to at least foster an understanding as to why that outcome has been arrived at?

MR CLOUT: That's the aim of it, yes. To foster that understanding, or at least to provide them with the information as to what's going to happen.

The other thing that we need to do is - you have asked specifically about community consultation. That, of course, is different from and distinct from consumer consultation.

MR GLOVER: I'll come back to that in just a moment. Ms Hoskins, do you have anything to add to Mr Clout's comments?

MS HOSKINS: I was just going to add that the challenge that is community engagement is the very reason the LHD has invested in a new framework, and this framework is designed to ensure that we hear from a much wider and much more diverse audience. So, to that end, we sought the advice of consultants, and I think I have given you some information in my statement. And the new framework provides for two larger committees aligned with our clusters, so one inland, and one coastal. We sought expressions of interest from

1 people in the - and advertised that widely, so anybody had
2 an opportunity to join these committees.

3
4 They have only recently been stood up, and part of
5 what we - we, the district - will do with these committees
6 is to educate them about the health system, and we will
7 ensure that there is appropriate two-way feedback, and we
8 will continually monitor the success or otherwise of these
9 committees. I attended the first of the inland committee
10 just recently, and these were a very passionate, engaged,
11 diverse group of people. And I was really impressed by
12 that, but that brings its own challenge. So those people
13 need to be educated and steered in a way that can be
14 effective and appropriate.

15
16 MR GLOVER: This piece of work was commenced in
17 about November of last year; was that right?

18
19 MS HOSKINS: Completed in November.

20
21 MR GLOVER: Thank you. I might have brought up on the
22 screen the framework of which you just spoke. It is
23 MOH.0010.0427.0001.

24
25 THE COMMISSIONER: This is in the teal bundle?

26
27 MR GLOVER: It is. It is tab I.26.5.

28
29 Ms Hoskins, we might be able to give you a hard copy
30 rather than have you strain your eyes to that small screen.
31 Mr Clout, hopefully that is close enough for you to be able
32 to see.

33
34 MR CLOUT: It is.

35
36 MR GLOVER: What I want to take you to very briefly is
37 page 11. You will see, Ms Hoskins, at the top of the
38 page there is the code that I just read out. So it is
39 internal page 8, if you are looking in the bottom
40 right-hand corner, 0010 of the doc ID. And here it sets
41 out the principles. And, Ms Hoskins, you were telling us a
42 little about how these were arrived at. Do we take it that
43 what we see on this page is as a result of the work that
44 you have described is a general description of the ideal
45 engagement process?

46
47 MS HOSKINS: Yes.

1
2 MR GLOVER: And I want to just take you to the last few
3 under the heading:

4
5 *Our processes for engagement are*
6 *transparent.*

7
8 The first one:

9
10 *Our engagement is open and honest and sets*
11 *clear expectations. We explain what can*
12 *and cannot be influenced and why.*

13
14 Why is that an important feature of any good community
15 engagement process?

16
17 MS HOSKINS: It is very important, because we're always
18 working with a resource bucket that needs to be managed,
19 and I think often it's the case that our community members
20 don't have an understanding, and it's why I mentioned
21 earlier about health literacy and specifics to the LHD. It
22 would be very important that these people have a good
23 understanding of the challenges we face, and for us at the
24 moment, particularly, it's the financial and workforce
25 challenges.

26
27 THE COMMISSIONER: Mr Clout, anything to add?

28
29 MR CLOUT: I think it is critically important. Different
30 people have different expectations of what health services
31 should be provided, where, and by whom, and to what extent
32 and into what range, and there needs to be a dialogue
33 around what is reasonably able to be provided and
34 reasonably appropriate to be provided. So there needs to
35 be discussions around not just infrastructure.
36 Infrastructure is an end result. It's about what services
37 are needed for a community to have access to; which of
38 those can appropriately be provided as close as possible to
39 where people live, ie, in their community; which of those
40 services we can staff to, to ensure that the staff that are
41 there are appropriate to provide safe and high quality
42 services; and which ones it is going to be far better, just
43 from the point of view of patient safety and quality, for
44 someone to have a process of travelling to, or being
45 provided in a different locality, so that specialist care
46 can be provided when it is needed. Now, that is not well
47 understood by communities and that's not their fault.

1 That's just the reality of it.

2

3 So, when we do our planning, we need to have that
4 dialogue. When we have our engagement with them, we need
5 to be honest about that. We also need to be honest about
6 what resources are available to provide them the
7 infrastructure that the staff that can be employed there
8 can be put in place to provide those services.

9

10 MR GLOVER: Having a frank conversation about the extent
11 and limitations of resources --

12

13 MR CLOUT: Absolutely.

14

15 MR GLOVER: -- to stand up and maintain safe services is
16 important as part of that process? Is that what --

17

18 MR CLOUT: "Sustain" being the most important component of
19 what you have just said, in my view.

20

21 MR GLOVER: Ms Hoskins, do you wish to add to that?

22

23 MS HOSKINS: No. It is just a "yes", is the response to
24 that very important thing.

25

26 MR GLOVER: I take it you are both aware of community
27 concern about the closure of the emergency department in
28 this town. To what extent has the board been kept aware of
29 those issues?

30

31 MS HOSKINS: The Eurobodalla hospital planning has been
32 worked on since, as far as I am aware, 2004, well before
33 our time. So there was extensive community consultation a
34 long time ago. I can't give you precise dates on that, but
35 I have seen the reports that speak to community
36 consultation in 2005 and that there was a - council
37 prepared a report. They were looking at a different model
38 at that time, and they were looking at a private funding
39 model for the Eurobodalla hospital.

40

41 The survey results that I saw as part of that report
42 where the community was surveyed around specific questions,
43 including, "Would you be prepared to travel?" So, "Would
44 you be prepared for two hospitals to become one?" The
45 location wasn't clear at that time. And, "Would you
46 therefore be prepared to travel?" And the clear messaging
47 was, from that time, that two hospitals are becoming one.

1
2 So I, in my time there, we have been briefed around
3 the community consultation events, and certainly when it's
4 become a really hot issue in the district, we are
5 (indistinct - Zoom frozen) and have papers come up to us
6 outlining the community forums that were held, outlining
7 the themes that the community raised, and the district and
8 the Health Infrastructure, because of course they are
9 becoming involved. The response --

10
11 THE COMMISSIONER: This is on the construction of the new
12 hospital?

13
14 MS HOSKINS: Yes, which is --

15
16 THE COMMISSIONER: Which is fine. The question was about
17 the closure of the ED at Batemans Bay, but I am quite happy
18 for you to keep going with this chronology as well, as long
19 as we get to --

20
21 MS HOSKINS: It is simply because they are intrinsically
22 linked.

23
24 THE COMMISSIONER: They are, yes.

25
26 MS HOSKINS: And we would, I am sure, have - should the
27 location have been chosen as Batemans Bay, I am sure we
28 would have the same concerns raised by the community in
29 Moruya.

30
31 I understand that some people feel that they were not
32 consulted, but from the information that has been received
33 by the board and the information that I have reviewed, the
34 community has had plenty of opportunity to ask questions
35 and to speak to their concerns around the closure of the
36 Batemans Bay ED.

37
38 MR GLOVER: Do I take it then that there has been a review
39 of the consultation process around the closure of the ED in
40 Batemans Bay, in particular?

41
42 MS HOSKINS: I'm not aware of any review. I'm aware, as
43 I said, that we have received reports and briefings on the
44 concerns raised from the communities. I'm not aware of any
45 review.

46
47 MR GLOVER: Having reviewed those reports about the

1 process that was undertaken, are you satisfied that it
2 meets the objectives and standards set out in the new
3 Strengthening Community Engagement framework?
4

5 MS HOSKINS: Yes.
6

7 THE COMMISSIONER: Can I ask you, did either of you attend
8 any of the community consultations regarding either the
9 location of the new hospital or the closure of Batemans Bay
10 ED?
11

12 MS HOSKINS: No.
13

14 MR CLOUT: No.
15

16 MR GLOVER: Have you seen examples of where the community
17 has been advised of how their input affected the decision
18 and outcome concerning the closure of the emergency
19 department in Batemans Bay?
20

21 MS HOSKINS: Sorry, could you repeat that question?
22

23 MR GLOVER: Yes. I will approach it in a different way.
24 One of the processes set out at internal page 8, doc ID
25 page 11 of the document that you should have in front of
26 you, and I might have brought back on the screen,
27 MOH.0010.0427.0001 at 0011. It should just be there on the
28 left there for you.
29

30 MR CLOUT: Yes.
31

32 MR GLOVER: If we scroll down, please, operator. Thank
33 you. One of the processes, the third last dot point from
34 the bottom:
35

36 *We advise people how their input affected*
37 *the decision and outcome*
38

39 From your review, and accepting that this is based on a
40 review of things have been reported to you as a board, of
41 course, but from your review of that material, did you come
42 across examples of where that type of process was engaged
43 in?
44

45 MS HOSKINS: I think that input would have critically been
46 well before my time, you know, as far as the decision, as
47 I say, that two hospitals would become one was well before

1 my time. You know, I've seen reports, as I've noted, that
2 speak to that. But I've seen no other evidence that that's
3 the case.

4
5 MR GLOVER: Accepting - I'll rephrase that. You've
6 referred in your answers so far to opportunities for the
7 community to have input on these decisions. What I am
8 trying, perhaps clumsily, to explore with you, is the last
9 step of the process that I explored with Mr Clout a bit
10 earlier was feeding back to the community how their
11 concerns have been taken into account, how the decision has
12 been arrived at, and what steps or measures are in place to
13 address those concerns, should they be something that need
14 to be addressed. Is that in your review of the material
15 that you have come across, examples of that type of work?
16

17 MS HOSKINS: My understanding is that members of our LHD
18 and Health Infrastructure have given that feedback.
19

20 MR GLOVER: And is that understanding drawn from your
21 review of the materials that have been briefed up to court?
22

23 MS HOSKINS: Yes.
24

25 MR GLOVER: Mr Clout, do you want to add?
26

27 MR CLOUT: I think it is very difficult to answer a
28 question specifically about one component of a total
29 construct change. Where decisions have been made in
30 relation to that many years ago, the documents, if you go
31 back, make it clear, even in its conceptual, early
32 conceptual ones, which were shared with the community, and
33 there's evidence of that and even well before my time, but
34 I've seen them, that talks about what would then be in
35 place in the places where the hospital wasn't, and it was
36 clear that did not include emergency department.
37

38 I'm not sure that I have seen specific documents, up
39 until the last couple of years - maybe three years - where
40 it was clear that the discussion around it not having an
41 emergency department was there. The steps that were taken,
42 however, to take into account concerns that were raised
43 were promotion of the concept of an urgent care centre
44 being in Batemans Bay, which is fundamentally important, a
45 thing to put in place in that construct. The advocacy for,
46 which the board supported and the executive were very
47 strong about. Local members were briefed about the

1 community, were briefed about the community health centre
2 and a new community health centre being in place.
3

4 So, were those concerns understood/heard? Yes. Were
5 we aware of them? Yes. Was there a response to them?
6 Yes. And those were: advocacy for those other two
7 services would be there at the point in time, and those
8 have been acted upon and are being put in - well, one of
9 them is already in place and operating, and operating well,
10 I might say, and it will be subject to review on an ongoing
11 basis as to what the needs are and what that shows, both
12 now and into the future and when the new hospital is in
13 place, and decisions will be made at that time as to
14 whether or not the services that can be provided from an
15 urgent care centre need to be modified or changed.
16

17 Example, hours extended or categories of services that
18 can be provided. Those will be the subject of review on an
19 ongoing basis. My view is there has been quite good
20 consultation. I am being satisfied as a board member they
21 have been appropriate, that they are consistent with these
22 principles, and that the concerns that have been raised,
23 which are understandable, have been given due consideration
24 and options looked at to mitigate those concerns.
25

26 THE COMMISSIONER: Accepting, as I do, that whenever there
27 is a decision made about the placement of a large piece of
28 infrastructure like a new hospital, and accepting that
29 because it is located at Moruya, not everyone at
30 Batemans Bay is going to be delighted, and also accepting
31 that a change from having an ED to having a community
32 centre with an urgent care clinic is a change and that not
33 everyone will be happy about that, what is your opinion
34 about how I should understand the petition and the 18,000
35 signatures indicating some form of between dissatisfaction
36 to violent objection to the closure of the Batemans Bay ED?
37

38 I suppose, and I certainly haven't made any findings;
39 whether I need to, I'm not even sure yet. But on one view
40 that - you could say, well, that indicates a large amount
41 of dissatisfaction, given the populations we are talking
42 about. It might also mean that the consultation process
43 wasn't as good or as clear as it could have been. It could
44 mean also that the population, for whatever reasons,
45 because everyone has got busy lives, may not have been
46 engaged as it could have been. I don't know. For both of
47 you, what is your opinion about how you think I should

1 treat that petition and how you perceive it as well?

2

3 MR CLOUT: Commissioner, I think it's all of those things
4 that you have mentioned. It is not one of them. It is
5 always all of those things. But what my advice to you
6 would be --

7

8 THE COMMISSIONER: Yep.

9

10 MR CLOUT: -- that you should take it as a genuine concern
11 that people are unclear about, and worried about, how they
12 will be able to appropriately access those services once
13 the new construct is in place.

14

15 THE COMMISSIONER: Yes.

16

17 MR CLOUT: They wish to raise their worry and concern
18 about that, which is understandable, and that that has to
19 be given due consideration by decision-makers in terms of
20 what other things will be in place, number one, and that
21 how their concerns will be addressed if they arise.

22

23 For example, what are the appropriate ambulance
24 services that are also in place? Because that's a critical
25 part of that exercise as well.

26

27 THE COMMISSIONER: Yes, yes.

28

29 MR CLOUT: What is the construct difference going to be if
30 the new highway is put in place at some point in the
31 future?

32

33 THE COMMISSIONER: Yes.

34

35 MR CLOUT: And, in the meantime, once that new construct
36 is in place, how their concerns are going to be put in
37 place? And I think an appropriate response to that is to
38 say, "Look, we are very aware of those concerns". They are
39 ones we need to know about and monitor as well.

40

41 THE COMMISSIONER: As a board?

42

43 MR CLOUT: As a board, and as a senior executive, and
44 NSW Health and the ambulance service.

45

46 THE COMMISSIONER: Yes.

47

1 MR CLOUT: All of us need to ensure that we - and the PHN
2 by the way, sorry --

3
4 THE COMMISSIONER: Yes.

5
6 MR CLOUT: -- as well. We need to make sure that in this
7 change process, we are clearly monitoring, we are reviewing
8 constantly whether or not it is meeting those needs, and if
9 there are foibles in how that is happening, we need to
10 promptly address those.

11
12 THE COMMISSIONER: Would you like to add anything to that?

13
14 MS HOSKINS: The only thing I would add is that, of
15 course, we need to take learnings from this experience.
16 But I came on to the board not long after SERH was opened,
17 and there was the same concern expressed in 2016.

18
19 THE COMMISSIONER: So that was 2016, and you came on the
20 board in 2017?

21
22 MS HOSKINS: 2017, yes. So there was still a lot of
23 community agitation and angst around the potential closure
24 of Pambula hospital. So I think that in addition to
25 absolutely legitimate concerns by our community members,
26 often probably founded on the basis that they don't have a
27 full understanding of what their health life will look like
28 without an ED, and a full understanding of the fact that we
29 would find it extraordinarily difficult to operate the
30 Batemans Bay ED - it can't be a stand-alone facility,
31 obviously; an ED needs to come with other facilities. But
32 to staff and run that safely and appropriately, as well as
33 the challenge we face to staff and run a new level 4
34 facility for this community would be very, very difficult
35 to do. So those facts could potentially have been better
36 expressed to the community much earlier on.

37
38 The only other thing I would add is I would expect
39 that any time you're going to close a facility, you talk
40 about closing a facility, there will of course be community
41 angst and that is completely understandable.

42
43 THE COMMISSIONER: One of the things that the panel of -
44 no doubt you are aware there was a panel of four doctors
45 yesterday. One of the things that they were of a unanimous
46 view of, and had a unanimous concern of, and I imagine this
47 is a concern for you as board members, too, was that the

1 services that people being told will be available at the
2 new hospital at Moruya will actually be properly planned
3 for and have a workforce ready to deliver those healthcare
4 services. Is that something that is occupying your minds
5 as well?
6

7 MS HOSKINS: It sits as a key risk on our risk register.
8 I absolutely believe that this LHD can do this, provided
9 we're appropriately funded to do so.
10

11 THE COMMISSIONER: Yes.
12

13 MS HOSKINS: And that would be our challenge. It will
14 take a significant investment of funds --
15

16 THE COMMISSIONER: Yes.
17

18 MS HOSKINS: -- and there will have to be capital
19 investment and key work accommodation, and other things as
20 well, to be able to encourage the staff that we need to be
21 able to open that facility at level 4 in (indistinct).
22

23 THE COMMISSIONER: Well, there has been public relations
24 material published about what this hospital will deliver,
25 so no doubt people will make sure that happens.
26

27 MR CLOUT: And I think the challenge, Commissioner, is not
28 so much in the planning. I think the planning is fine and
29 the clinical service planning is fine.
30

31 THE COMMISSIONER: Yes.
32

33 MR CLOUT: The challenge for everyone is going to be
34 ensuring that we have the appropriate range and levels of
35 clinical staff to provide those.
36

37 THE COMMISSIONER: Yes.
38

39 MR CLOUT: And, look, in my experience --
40

41 THE COMMISSIONER: So that's the workforce issue?
42

43 MR CLOUT: -- you cannot and would not open the services
44 at the levels that cannot be appropriately staffed by us.
45 So the timing of the opening of those is going to be
46 totally contingent upon our ability to be able to provide
47 the appropriate levels and range of staffing so that they

1 can be provided safely and appropriately.
2
3 THE COMMISSIONER: Yes.
4
5 MS HOSKINS: If I could add to that, I'm not from a
6 medical background, but I can see that that decision to
7 open day one level 4 was an inappropriate decision.
8
9 THE COMMISSIONER: Why do you say that?
10
11 MS HOSKINS: Because it will be - my understanding is
12 that, and I've seen it --
13
14 THE COMMISSIONER: Was it a decision or a promise?
15
16 MS HOSKINS: Probably both.
17
18 THE COMMISSIONER: Was it a political promise or a
19 decision?
20
21 MS HOSKINS: Is there much difference in that? I'm not
22 sure.
23
24 THE COMMISSIONER: I think there probably is a difference.
25 But, anyway, I interrupted you, you keep going.
26
27 MS HOSKINS: I don't see a difference, whether it's a
28 promise.
29
30 MR CLOUT: From a board point of view, there is probably
31 no difference.
32
33 MS HOSKINS: Yeah, no difference.
34
35 THE COMMISSIONER: Understood. Sorry, I interrupted.
36
37 MS HOSKINS: No. I was just going to say my understanding
38 as far as Goulburn Hospital, which is a level 4, was that
39 it was timed to move to level 4 when it was appropriately
40 staffed. So to do that, you know, on day one, I think
41 presents a challenge. As I said, I believe the LHD can do
42 it, but it presents a challenge.
43
44 THE COMMISSIONER: Yes.
45
46 MR GLOVER: Mr Clout, in an earlier answer, you drew a
47 distinction between community engagement and consumer

1 engagement. Can you just tell us what that distinction is
2 and why it is an important one, in your view?
3

4 MR CLOUT: So it's important because consumer engagement
5 is about dealing with a particular patient and/or their
6 family and carers, and having clear understanding about any
7 concerns that they have in relation to the appropriate care
8 that they, as individuals, are provided. So that's a very
9 particular issue.

10
11 Now, from a governance point of view, we have clear
12 mechanisms to be able to see any concerns that are raised
13 by that. There are a number of patient surveys that are
14 undertaken, carer surveys that are undertaken. We have
15 absolute transparent viewing of that. Any concerns that
16 are raised in relation to those, or learnings that come
17 from those, are known to us and we have an opportunity to
18 indicate whether or not we think they are robust or not
19 and, if not, we continue to monitor those. Again, if those
20 concerns that are raised, the importance of being able to
21 see those - consumer engagement is predominantly an issue
22 for management. It is predominantly an issue for
23 management at a local level and clinicians and management
24 at a local level. However, we need to make sure that there
25 are processes in place to see those, to monitor those, to
26 analyse those, and to identify risks.

27
28 If there are high risks that arise, particularly if
29 they go across time with a similar type of concern, or if
30 they go across facilities and services, then there is a
31 question about saying, "Okay, what is this telling us about
32 our systems and structures?" So those are that things that
33 the healthcare quality committee would see, it is things
34 that the people and culture committee would see, things
35 that the performance committee would see and that the board
36 would see, and it is important for us to see those. We
37 also see board level correspondence coming in from
38 consumers or carers, and we have an opportunity that gives
39 is a very good summary of the issues and the responses, and
40 we have an opportunity at the board meeting to be able to
41 ask questions about those if we, as board, can maybe see
42 things that haven't been seen, or are unclear as to what
43 the response is to it. So I think it is critically
44 important, but it is quite different than community
45 engagement.

46
47 MR GLOVER: Ms Hoskins, do you have anything to add to

1 that?

2

3 MS HOSKINS: Yeah. It absolutely is critically important
4 that we hear from our patients, both the concerns and
5 issues they have, and also the positive experiences they've
6 had, and we make sure that it's not that we hear
7 predominantly about positive experiences. We do monitor
8 closely, as Terry has indicated, through various
9 committees, certainly trends in patient responses.

10

11 One of the things I felt was very important, and there
12 has been great improvement in, is our response rate.
13 I think we all need to be better at using technology to
14 speak to our consumers. That traditional method of asking
15 someone to fill in a piece of paper as they, you know, get
16 home after a hospital visit is no longer appropriate. We
17 are now using a text option, and so we're getting -
18 I couldn't tell you in percentage numbers the increase, but
19 it would be more than 10-fold increase in the responses
20 that we're getting. And I think there's still work to do
21 in that space.

22

23 We - you're not asking this question but as a board,
24 as I say, we monitor trends but we also try and join the
25 dots. And so, I have been very concerned about one
26 particular site. Other board members have, as have members
27 of our LHD. We cross-referenced some consumer feedback
28 with some safety and quality indicators, and that then
29 resulted in discussions and reports to board that then
30 resulted in a review of that particular service clinic,
31 that led to a review of that particular service, and the
32 board and, through the healthcare quality committee, are
33 now monitoring the actions against that review and are
34 seeing appropriate uplift in the areas that we were
35 concerned about.

36

37 MR GLOVER: Can I, Ms Hoskins, take ahead in your
38 statement to paragraph 22, please. Just on the last topic
39 about consultation and engagement there, you referred to
40 engagement with Indigenous community, and in the last
41 sentence, you tell us that:

42

43 *The LHD has made progress in working with*
44 *Indigenous communities ... but we*
45 *acknowledge there is still a significant*
46 *amount of work to be done.*

47

1 Firstly, what is the progress that you are referring to?

2

3 MS HOSKINS: We have, in my time, stood up the Aboriginal
4 Health Governance Committee, I think that's important. We
5 have ensured that we have two Indigenous board members.
6 One, I think you met yesterday, and another who is a
7 current clinician to the LHD. Those factors are important.
8 The Aboriginal Health Directorate has been structured,
9 appropriate people employed. It is now going through a
10 complete reorganisation because there have been many
11 issues, as I understand it, with employing the right people
12 in the right roles.

13

14 We see, regularly, reports around our Closing the Gap
15 performance. We monitor the strategies behind that. We
16 hear regularly from members of our Aboriginal directorate
17 and the work that they are doing around communication with
18 the local communities. So we've come a long way, but it's
19 a very challenging space and I would never say otherwise.
20 I think all of us, you know, in Australia, would be working
21 on trying to improve the lives of our Indigenous people,
22 those that care, for the rest of our lives.

23

24 MR GLOVER: One of the things that the inquiry has been
25 told of, and in this district, is the challenges in
26 recruiting and retaining Aboriginal - an Aboriginal health
27 workforce. Is that something that the board is aware of?

28

29 MS HOSKINS: Absolutely. And --

30

31 MR GLOVER: I'm sorry, you go.

32

33 MS HOSKINS: No, sorry. Just there are a few recent
34 examples that really stood out to me, as far as the lengths
35 our people will go to. We were - we had a presentation
36 from a wonderful member of our Aboriginal cohort recently
37 about a particular project she had been working on, and
38 that's a consultation exercise that has been rolled out
39 with our Indigenous consumers. And she was in a clinical
40 role; she was a nurse on a ward. There were factors that
41 meant she really struggled in that space, and I'm not
42 saying she was discriminated against, but there were
43 various things related to her that meant she struggled in
44 that role. One of our wonderful managers picked that up
45 and moved her into another role that was more suitable for
46 her. I think that sort of nuance is really important in
47 the - for all employment, but particularly in the

1 Indigenous space.

2

3 MR GLOVER: Do you think in delivering services to the
4 Indigenous community within the district there is scope for
5 the LHD to coordinate with Aboriginal Controlled Community
6 Health Organisations and Aboriginal Medical Services?

7

8 MS HOSKINS: Absolutely, and we do. It's not to say that
9 can't be strengthened. Our new director of Aboriginal
10 health is a former chief executive of one of our Aboriginal
11 partner organisations. Our representative from that
12 organisation attends all our Aboriginal health governance
13 committee meetings. We don't have - and this is on the
14 coast. We don't have the same sort of coverage in the
15 inland network, so I think - and I am not entirely sure,
16 actually, whether that is because there has been resistance
17 from the partner organisations or because we're still
18 working very hard to build our directorate, but that will
19 happen in time, I've got no doubt about that.

20

21 MR GLOVER: Can I turn to the issue of funding.

22

23 MR CLOUT: Just before you go to that, may I just say
24 something on that topic?

25

26 MR GLOVER: Please do.

27

28 MR CLOUT: A really good example of the engagement with
29 the Aboriginal community that the health service has
30 undertaken, predominantly the senior executive, but also
31 with Health Infrastructure, is the preparation of the site
32 for the new Eurobodalla hospital. Now, the engagement
33 there has been very, very extensive, and from all feedback
34 that the board has received, exceedingly successful. And
35 I think that if you wanted to look at an example of where
36 that engagement has been really positive and has really
37 worked, it has been extensive not just in the health
38 service but with Health Infrastructure, that would be a
39 really good one to have a look at.

40

41 MR GLOVER: I should have asked you, Mr Clout, before
42 moving on, but in the context of the challenging or
43 constrained financial environment, to which we will come in
44 a moment, do you see there to be opportunities,
45 particularly in delivering care to the Indigenous
46 population, for the LHD to plan and structure its services
47 in combination with those organisations delivering care to

1 those communities, so that to eliminate duplication,
2 cannibalisation of services, and better deliver care to
3 those communities across the region?
4

5 MR CLOUT: Absolutely, and we do, and it needs to
6 continue, and it needs to develop further and, you know,
7 ensure that it is holistic. We've got to remember that the
8 critical thing that needs to be done together in relation
9 to that is health service planning. So health service
10 planning more generally. The Aboriginal communities need
11 to be significantly engaged in that, and I think they are,
12 but there is always room for improvement, and it needs to
13 be ongoing. And they need to be particularly engaged in
14 the provision of specific services for their Aboriginal
15 communities.
16

17 Now, again, when we talk about communities, there is
18 not one Aboriginal community; there are numerous. And part
19 of the structural difficulty in that engagement is a health
20 service understanding and acknowledging the nuances of
21 those sometimes conflicting communities' views about what
22 should be provided and how it is appropriate to provide it.
23

24 MR GLOVER: Is there anything that the system as a whole
25 can do to better support the LHD in that work?
26

27 MR CLOUT: I think that the priority that Susan Pearce -
28 sorry, the health service secretary - has given to
29 Aboriginal health service and provision and planning is
30 absolutely the right approach, and the support that is
31 being provided through her and her staff, through to the
32 LHD, CEs, and so forth, is the appropriate approach and
33 what needs to continue.
34

35 MS HOSKINS: If I could just add, sorry, just to pick up
36 on a point Terry made --
37

38 MR GLOVER: Please do.
39

40 MS HOSKINS: -- about the new Eurobodalla hospital, we are
41 a pilot project for the New South Wales Government
42 architects around their Connecting with Country program,
43 and that is the piece that Terry is speaking to, but from a
44 board I think that - and it speaks to the point about, you
45 know, partnering with others and who is delivering these
46 initiatives. This is a really important one, because this
47 has ensured already that the local Indigenous community are

1 consulted right the way through the process. They're
2 represented on the build committees, and we've seen copies
3 of those minutes. It will result in, we hope, a much more
4 culturally safe environment for the Aboriginal people of
5 this district to receive their health services, and I think
6 that's a very important point. I think they're often - or
7 my understanding is they are often very nervous about
8 healthcare and health provisions, so it is very important
9 that we make sure that the new Eurobodalla hospital meets
10 the needs of our Indigenous people.

11
12 MR GLOVER: Ms Hoskins, can I take you to paragraph 17 of
13 your statement, and there you tell us that the district has
14 had a high unfavourable financial variance to budget for a
15 number of years. Has that been the case since you first
16 joined the board?

17
18 MS HOSKINS: Yes.

19
20 MR GLOVER: And then in paragraph 18, you tell us that the
21 LHD provides information to NSW Health to demonstrate that
22 approximately half of that variance is factors beyond the
23 LHD's control. Can you list some examples of those
24 factors?

25
26 MS HOSKINS: There are two key parts to that. The first
27 is that - you have heard many people speak to the challenge
28 that is the medical locum workforce. As part of our, the
29 LHD's, response to how we reduce our dependence on medical
30 locums, there has been work done around the medical
31 establishment. So that aims to report on what is the
32 optimum medical structure in our particular sites.

33
34 That work shows that even if we have all the right
35 clinicians in the right place at the right time, the amount
36 we receive through ABF funding will not cover those costs.
37 So that, combined with the challenge for us that is our
38 medical locum labour and the fact that we are one of the
39 highest users of premium labour overall, but, in
40 particular, medical locum labour, provide the - well, is
41 the response, really, to that point. It is those two
42 things.

43
44 So it has been recognised at a ministry level that we
45 have this structural cost that we are not going to be able
46 to easily address, because the funding we receive does not
47 meet the cost of running those particular sites.

1
2 THE COMMISSIONER: Can I just ask a question here, it may
3 not necessarily be for either of you. The sentence:

4
5 *These facilities are low volume ...*

6
7 Et cetera, I doubt whether even IHACPA would disagree with
8 you in relation to that, but:

9
10 *The LHD has provided information to*
11 *NSW Health ...*

12
13 Et cetera. Do we have that information?

14
15 MR GLOVER: I don't know. I'll make some inquiries.

16
17 THE COMMISSIONER: Yes, if we don't. And also:

18
19 *The LHD has requested that a change in*
20 *funding ...*

21
22 Do we have that request?

23
24 MR GLOVER: Same answer again.

25
26 THE COMMISSIONER: Yes. Sorry, I should have done this
27 before.

28
29 MR GLOVER: That's all right.

30
31 THE COMMISSIONER: And I notice the term used here is
32 "financially constrained environment" rather than
33 "constrained financial environment". We are going to have
34 to get the acronym right at some change.

35
36 MR GLOVER: We will turn to that in a moment. Before
37 I come to that phrase and what you mean by it, can I take
38 you back just to paragraph 15 of your statement,
39 Ms Hoskins. There you tell us that part of the role of the
40 performance committee is closely monitor the LHD's
41 performance result. And you tell us about the EIPs that
42 have been put in place; these are efficiency improvement
43 plan targets. They are set by ministry, or at least in
44 conjunction with ministry, to attempt to return the
45 financial performance of the district to, ideally, I would
46 suspect, a level zero. Is that right?
47

1 MS HOSKINS: Yeah. I mean, it's a collaboration. I mean,
2 clearly we provide information and reporting on what we
3 believe are achievable efficiency improvement plans and
4 they are then discussed at ministry level. As, you know,
5 is completely understandable, there is often a response
6 requesting that we increase our targets, and it is why
7 I made reference in my statement to the board's view that
8 they be reliable, achievable, and impactful EIPs, because
9 as a board, we don't want the LHD to be committing to EIP
10 targets that they are not able to meet.

11
12 MR GLOVER: Do you think the current targets meet that
13 criteria?

14
15 MS HOSKINS: There are new targets being worked on at the
16 moment, and I participated in a performance meeting with a
17 number of ministry representatives only last week, I think
18 last Friday. So, there is still work to do before what the
19 actual figures are decided, before the targets are decided.

20
21 DR CLARKE: If I can just add to this?

22
23 MR GLOVER: Please do.

24
25 MR CLOUT: In relation to your point about whether or not
26 the expectation is that the EIPs will return us to a
27 balanced budget, I don't think that's the case. I think
28 what they are aimed at doing is what they say: they are
29 where we can make efficiencies. The quantum of them is
30 nothing like what everyone understands would be needed to
31 bring us back to a balanced budget, but the objective of
32 that is to identify areas where we think within our
33 control, we can reduce costs. So I think that everyone
34 understands that's their purpose.

35
36 MR GLOVER: And I take it that the board has identified
37 some of those areas via this process; is that right?

38
39 MS HOSKINS: Absolutely. We look very closely at the EIP
40 reporting through our performance committee and then feed
41 any areas of concern up to the board, absolutely.

42
43 MR GLOVER: But do I take it that, through that work,
44 identifying reasonable efficiency targets will still not be
45 enough to return the budget to balance?

46
47 MS HOSKINS: Correct. It's why our request is that the

1 recognised structural deficit that is present in our
2 district is funded. So then we are on a more even playing
3 field with other LHDs and should - there should be no
4 reason why we can't return to a zero position over a period
5 of time. No-one would request that we do it in one year or
6 even two years, but it would need to be a period of time.

7
8 MR GLOVER: When you use the phrase "recognised structural
9 deficit", what are you referring to?

10
11 MS HOSKINS: I spoke to them a minute ago, but the key
12 things are the fact that low volume sites, the revenue we
13 receive for a low volume site, doesn't go anywhere near to
14 the cost of running those sites. I referenced two of our
15 hospitals. They're classified C2. I don't know a lot
16 about the classification, but I understand it is an
17 nWow-type classification for small hospitals. Those two
18 hospitals are two of the highest cost by type in the state,
19 by a wide margin. And one in particular is by far the
20 leader as far as highest cost in the state.

21
22 MR GLOVER: Mr Clout?

23
24 THE COMMISSIONER: I don't fully understand this, but -
25 and there may be more than two options, but I can only see
26 two at the moment. One is you are hopelessly inefficient
27 and you spend money really badly. But if that's not true,
28 you are just not funded enough.

29
30 MS HOSKINS: Correct.

31
32 MR CLOUT: If I can just add to that. I don't think we're
33 grossly inefficient, but I think there is always
34 efficiencies that can be made.

35
36 THE COMMISSIONER: Of course, yes.

37
38 MR CLOUT: I think the two issues are premium labour cost,
39 which are absolutely what is required to provide the
40 services we are mandated to require. That's number one.

41
42 The other thing is that the period has been very
43 clear, and we have been very clear with the Ministry of
44 Health, that we will not compromise the provision of
45 appropriate safe care to the community in relation to those
46 services we are required to provide. And what that means
47 sometimes is that where there is a mandated service in a

1 hospital, for example, maternity, you can't have maternity
2 that is serviced, you know, four days a week, eight hours a
3 day. It has to be a 24/7 service. The cost of doing that
4 is a standard cost that is required for the medical,
5 nursing and other support services that are provided.
6 However, the volume of deliveries is going to be such that
7 you are never going to generate the revenue from an
8 activity-based funding model that could possibly cover that
9 cost.

10
11 THE COMMISSIONER: I have to say, the evidence we heard at
12 a round table and also in the hearing yesterday from the
13 staff at Cooma hospital, as an example, who seem like
14 excellent people, is that at a minimum, the funding for
15 that hospital is really stretching as to whether you are
16 actually providing fully adequate healthcare to the people
17 that have to attend that hospital.

18
19 MR CLOUT: Certainly the services at Cooma and Moruya are
20 two hospitals that are really good examples of where you
21 are trying to do - provide that required range of services,
22 healthcare services. So they're not ones that we have an
23 option of saying we're not going to do it, the required
24 services, but the costs of providing those, a significant
25 dead weight. That is where that issue about, in our
26 budget, what is recognised structural cost, so that one is
27 one of them, and, of course, the premium labour cost is the
28 other.

29
30 So when you put those together, again, we can't have a
31 shifts where we don't have the appropriate staff. If the
32 only way we can get that is that we have locum staff that
33 are premium labour, nursing staff that are premium agency
34 labour, that's what we've got to do because we cannot have
35 that service being provided unless we have the appropriate
36 levels of staff there.

37
38 MR GLOVER: Is it the case that even if there could be
39 work done to reduce the LHD's need to rely on premium
40 labour, the structural deficiencies of the kind that you
41 have both described would nevertheless remain?

42
43 MR CLOUT: Particularly for those two hospitals, yes.

44
45 MS HOSKINS: Could I try and explain that structural
46 deficit a little better?
47

1 MR GLOVER: Please do.

2
3 MS HOSKINS: As I touched on, part of the work we're doing
4 towards, or the LHD is doing towards reducing our reliance
5 on premium labour is to map out what are the workforce and
6 particularly the medical workforce requirements at each
7 particular site. That is critically the structural
8 deficit, because the report that has been prepared that the
9 board has seen shows that. If we have less reliance on
10 premium medical labour, if we have all the right employed
11 doctors at the right levels, at the right time, we will
12 still have a very significant difference between what we
13 are funded for based on the low volume site and what it
14 will cost.

15
16 The issue were then exacerbated - so medical locum
17 issues in this district are intrinsically linked to that
18 structural deficit, because this district has always been
19 depended on the higher use of premium labour. And there
20 are many factors that go to that, and I am sure you have
21 heard them right across the country as you travel around.
22 So we, as I noted, are one of the highest users of premium
23 labour, and it is a key area that we're working on, but it
24 is recognised that this district has particular challenges,
25 and they are challenges around the ability of our
26 clinicians to make a reasonable income in our district. We
27 don't have large cities. We don't have a tertiary
28 hospital. There are a whole lot of factors. They're the
29 key ones, but there is also some history behind this and
30 link into medical leadership and a whole lot of other
31 factors that speak to the history of the LHD and how far we
32 have come.

33
34 But they - there is recognition at ministry level, and
35 even in the meeting on Friday they have asked for
36 additional reporting around particularly the medical locum
37 cost on a premium basis. So, in other words, what would be
38 the cost if all your doctors were employed versus what you
39 are paying? And so, my hope is that we have been speaking
40 to this for a number of years and we have spoken and
41 written on this issue for a long period of time, but my
42 hope is that the reports that are currently being prepared
43 in this space will mean that we are funded for at least
44 part of this issue, whether it be called "structural
45 deficit" or whether it be called "medical locum issue",
46 that puts on an equal playing field with other LHDs. At
47 the moment, I feel we are so far behind, and that is why

1 I referred to us being the highest in percentage terms
2 variance. Those are the factors that contribute to that.

3
4 MR CLOUT: Another difficulty in attracting and retaining
5 ongoing permanent staff, particularly senior doctors, is
6 that there is exceedingly limited capacity for them to have
7 private practices. There aren't private hospitals. There
8 aren't them setting up - and that's an intrinsic part of a
9 senior doctor's kit bag, is that you have public hospital
10 service, you have private hospital services, you have
11 private practice services. If we - we can't offer that.
12 Now, it is not up to us to offer private health services,
13 but it's not there. And, therefore, people can get that
14 elsewhere and they can come in as locums, and so forth, and
15 do that here, and that's what they tend to do. It is a
16 real difficulty.

17
18 MR GLOVER: In paragraph 20, Ms Hoskins --

19
20 THE COMMISSIONER: I fully accept everything you are
21 saying, I think, in the problems around premium labour.
22 What - and this isn't a finding, it is an observation.
23 What I am struggling with is how your clinicians or even
24 management at Cooma hospital can have IT equipment that
25 takes 40 minutes to turn on for even a week, let alone for
26 months. I mean, I am sure no-one at New South Wales
27 Treasury has a computer that takes 40 minutes to boot up.

28
29 Equally, I am really surprised to hear that patients
30 who happen to live at Cooma might be given dressings that
31 aren't of the quality either needed medically or are
32 different to the dressings that might be provided if you
33 went to a public hospital in the eastern suburbs of Sydney
34 or the inner west. That seems not right.

35
36 MR CLOUT: Well --

37
38 MS HOSKINS: I agree it seems not right and I think those
39 questions are probably better directed at our chief
40 executive, because it's the --

41
42 THE COMMISSIONER: I was just saying it out loud.

43
44 MS HOSKINS: No, no. The computer issue, I was very
45 surprised to hear. I understand that all those computers
46 are arriving soon.

1 THE COMMISSIONER: Yes.

2

3 MS HOSKINS: But I don't know why there was a lag. There
4 could be a reason around funding, or something else, but
5 we're not there..

6

7 THE COMMISSIONER: They could be in the market right now.

8

9 MR CLOUT: Yes.

10

11 MS HOSKINS: We are certainly not aware of any substandard
12 dressings.

13

14 THE COMMISSIONER: Right.

15

16 MR GLOVER: Mr Clout, just going back to an answer a
17 moment ago in terms of the difficulty in attracting and
18 retaining staff. Is another of the difficulties that given
19 the challenges of funding services in your district, and
20 Ms Hoskins' statement refers to the lack of funding to
21 expand services, that those features of the district, along
22 with gaps in the workforce, also present challenges in
23 recruiting and retaining the senior workforce, firstly?

24

25 MR CLOUT: Absolutely.

26

27 MR GLOVER: And the junior workforce?

28

29 MR CLOUT: Yes. Well, in one sense they go together. You
30 have to have the senior workforce, particularly medically,
31 but also in nursing and allied health. You need to have the
32 senior staff there so that you can have the junior doctors
33 and the trainees. There are requirements around the
34 provision of their training. They are quite, as they
35 should be, quite strict and stringent, and you need to have
36 an appropriate and stable senior medical workforce to
37 provide the environment in which that training for junior
38 doctors can take place.

39

40 And, very clearly, if you don't have that, it keeps
41 going on. The next senior doctor you have - "well, sorry,
42 I am interested in training as well. I can get that
43 somewhere else. I can't get that here. Why would I choose
44 here?" So absolutely.

45

46 MR GLOVER: And the inability to attract senior medical
47 workforce in the numbers that you need also then puts an

1 additional burden on the ones that you have in the
2 district, does it not?

3
4 MR CLOUT: That's true. That is why it has been a
5 critical issue to be addressed and has been improving.
6 I think we have employed at least 50 senior doctors this
7 year, this calendar year, which is good. Not enough. And
8 we have to retain them as well, which means creating the
9 appropriate environment when they come.

10
11 So it is a critically important issue. It is a high
12 risk issue, but one that the executive is working really
13 hard to address with the workforce that is here. But you
14 are absolutely right. It is, in a sense, self-evident that
15 if I really need - well, if I have got a 1 in 4 roster as a
16 senior doctor, I'm probably okay. If that's a 1 in 2
17 roster, that's onerous and doesn't give me a lifestyle or a
18 family life that is appropriate for me to think that this
19 is a place to stay.

20
21 MR GLOVER: Does the high use of premium labour, medical
22 locums and agency nurses, also have an impact on the
23 ability to recruit and retain a permanent work force?

24
25 MS HOSKINS: Absolutely. I was going to add to Terry's
26 comment. The LHD, in the current chief executive's time,
27 has recognised the critical importance of medical
28 leadership, and so the aim has been to have the appropriate
29 medical leadership in place before actively recruiting to
30 other positions.

31
32 We saw when we were on-site at a round table, we heard
33 from some of our clinicians in one of our areas, the area
34 of paediatrics, and you see how if you've got great medical
35 leadership, that can attract, you know, other clinicians.
36 And so, by attracting other clinicians, obviously that, you
37 know, helps us reduce our reliance on medical premium
38 labour. But it also, you know, is an obvious fact that our
39 locums, those that come for a short period of time - some
40 have been here for quite a long time, but those that come
41 for a short period of time are not invested in the LHD as
42 our employed clinicians are. So, absolutely, I think there
43 will be improvements in the medical culture and
44 improvements in our overall performance in all factors when
45 we have less reliance on medical locum labour.

46
47 MR GLOVER: Commissioner, I note the time. I have

1 probably about 10 minutes to go.

2

3 THE COMMISSIONER: I am entirely comfortable one way or
4 the other as to - it might be better for the witnesses to
5 finish rather than take the morning tea.

6

7 MR GLOVER: Finish the witnesses and then they can either
8 stay, if they wish, or go about their days.

9

10 THE COMMISSIONER: Yes, yes.

11

12 MR GLOVER: Ms Hoskins, in paragraph 20 of your statement,
13 you tell us:

14

15 *The funding model currently used in NSW*
16 *does not adequately or sustainably provide*
17 *for [the district] to deliver services in*
18 *line with community expectations.*

19

20 I'll just clarify, firstly, what the funding model that you
21 refer to is in that paragraph?

22

23 MS HOSKINS: That comment links to the comments we've had
24 around structural cost and low volume sites.

25

26 MR GLOVER: Just pausing there, that is the allocation of
27 resources to those sites using an ABF methodology?

28

29 MS HOSKINS: Correct.

30

31 THE COMMISSIONER: That's the next sentence.

32

33 MR GLOVER: Yes. Not the one highlighted on my page but,
34 anyway, that is my deficiency. Did you have anything to
35 add to the Commissioner pointing out my obvious oversight?

36

37 MS HOSKINS: I don't claim to have enough knowledge or
38 expertise to provide a response on what is the optimum
39 funding model, but my view is that there needs to be a
40 model that specifically recognises the differences of each
41 LHD, each rural LHD, because clearly we are all very
42 different. There may be - there is a good argument, I'm
43 sure, to retain the ABF funding model for large sites and
44 LHDs with high volumes, but in our rural setting it would
45 not seem appropriate any longer.

46

47 MR GLOVER: And when you say in that sentence, "does not

1 adequately or sustainably provide for the district to
2 deliver services in line with community expectation," what
3 about in relation to the needs of the community? Does it
4 enable the district to deliver services that meet the
5 health needs of those communities?
6

7 MS HOSKINS: I think it's part of the reason that we've
8 got such a significant deficit that we are aiming to meet
9 the needs of our community members.
10

11 An example of that would be I initially thought by
12 rolling out our virtual or generalist VRGS service we would
13 see a reduction in cost because there would be less locum
14 use, but I was incorrect in that space because the
15 community deserves to have complete coverage, medical
16 coverage, 24-hours a day in our facilities and that means
17 that they're higher-cost than they would be if we were not
18 aiming to meet the community expectations and the
19 healthcare needs of our community.
20

21 MR GLOVER: And in paragraph 18, you tell us that there
22 has been a request to change the methodology.
23

24 MS HOSKINS: Yes.
25

26 MR GLOVER: Just in general terms, what is the change that
27 has been requested by the LHD of ministry?
28

29 MS HOSKINS: We requested a change more in line with the
30 block funding method, given that's our only other option at
31 this point in time.
32

33 MR GLOVER: Mr Clout, in your statement, you tell us
34 similar things --
35

36 MR CLOUT: Yes.
37

38 MR GLOVER: -- that the adoption by ministry of the ABF
39 model in allocating resources to these sites is --
40

41 MR CLOUT: So my view is that the activity-based funding
42 model is a good model that should be retained generally as
43 a principle, but that it needs to be nuanced to recognise
44 those places, not just district, but those places. It
45 predominantly happens in rural, but not solely in rural.
46 Some of the outer services in outer Sydney might also be
47 affected by this in places. It needs to be nuanced so that

1 there is a recognition that where there are required
2 services to provide that have an accepted cost of providing
3 those services to a community, that that cost needs to be
4 recognised if the activity-based funding process does not
5 address that cost.

6
7 THE COMMISSIONER: Is that another way of saying maybe the
8 ABF model doesn't need to be nuanced by IHACPA, but the
9 people that fund you have to recognise that the ABF model
10 doesn't work perfectly for you, and have to fund you,
11 accordingly, with a greater eye to the actual costs to this
12 LHD of providing healthcare?

13
14 MR CLOUT: I am very comfortable with your construction of
15 that answer, Commissioner.

16
17 THE COMMISSIONER: So am I.

18
19 MR GLOVER: Finally, Ms Hoskins, can I ask you about
20 paragraph 26, where you tell us that the district has had,
21 historically, a low allocation of funds for asset renewal,
22 and there is currently an estimated \$86 million asset
23 backlog. In general terms, what comprises that \$86 million
24 backlog?

25
26 MS HOSKINS: All assets of priority that are required for
27 this district to operate appropriately.

28
29 MR GLOVER: Buildings and equipment?

30
31 MS HOSKINS: No. It doesn't include buildings.

32
33 MR GLOVER: Just equipment?

34
35 MS HOSKINS: Yes.

36
37 MR GLOVER: And how long has that backlog been growing?

38
39 MS HOSKINS: I couldn't speak to the number of years.
40 I can only say that we have, in my time, had a very low
41 allocation, and I know last year it was
42 two-point-something million dollars. So it doesn't go to
43 reducing our very significant backlog.

44
45 MR GLOVER: Mr Clout, in your long experience in the
46 health sector, is that a significant backlog in capital
47 expenditure?

1
2 MR CLOUT: I think it has been there for 40 years, but it
3 has been growing significantly. But what is most important
4 about that is that the risks associated with it growing are
5 becoming higher. So the Ministry of Health has a very good
6 model, the SAM/TAM model, for assessing the required cost
7 of the necessary replacement cost and cost of procurement
8 of this equipment, number one.
9

10 That is what is identifying as cost, not something
11 that the district is doing. It is doing it through that
12 model, which is a clear model established by NSW Health.
13 But what it requires us to do, and we do do, the ministry,
14 the executive, does it and the board monitors it, is say,
15 okay, of those, risk rate them. This is where the maturity
16 of the risk model in the district is helpful. Risk rate
17 them. Tell us what is an extreme risk. If it is an
18 extreme risk, it must be addressed. If we are over budget
19 by doing it, tough. It needs to be addressed. If it is
20 high, it should be addressed in an appropriate period of
21 time. So each of those are then monitored in terms of
22 doing them.
23

24 What that means is that anything below extreme or high
25 risk under that model is not going to get done. The
26 problem with that is until such time as it becomes a high
27 risk.
28

29 MR GLOVER: We heard some evidence yesterday about
30 maintaining equipment that ought to be replaced, and some
31 of that evidence extended to actually the costs involved in
32 maintaining the equipment over time may well exceed the
33 cost of replacement. Is that something of which the board
34 is aware?
35

36 MR CLOUT: Yes.
37

38 MS HOSKINS: Yes. Our repair costs are about 6 per cent
39 of our operational budget. We have targets that we need to
40 stick to there. We currently have not spent in excess of
41 that target. So - and I understand the formula that sits
42 behind that is based on our total asset value, so a
43 percentage of our total asset value should be our repair
44 spend. So I think the point with that is that that is
45 not - if we were spending double what our target was in
46 that space, that might be an alert to NSW Health.
47 Currently we're underspending in that space, despite the

1 stories that you hear about, you know, the money spent to
2 keep our equipment up and running.

3
4 Just to add to the point Terry touched on, the most
5 recent budget announcement included what I think was
6 250 million towards critical assets, a critical asset
7 program. That is the CAMP program. So there were three
8 asset frameworks or program, SAM/TAM and now CAMP, and
9 under the CAMP program I have just recently seen where our
10 10 most critical assets have been reported up to
11 NSW Health, and negotiations are ongoing as far as the
12 funding under that CAMP program. That represented about
13 \$10 million to us, and included some of the assets actually
14 that people spoke to out on site.

15
16 MR GLOVER: Just leaving that program to one side for the
17 moment, based on the annual allocations for capital
18 renewal, though, do I understand the answer you gave
19 earlier that that is just enough to deal with emerging
20 issues but not clear the backlog?

21
22 MS HOSKINS: Not enough to even do that. And if I can
23 add, one of the great disappointments for me, and I would
24 think for the entire board, is that the concern we have
25 around the backlog of critical asset funding means that we
26 can't get capital funding for projects of innovation or
27 projects around sustainability and the environment. An
28 example of that might be that we're encouraged - or one of
29 our targets is to move our fleet, our motor vehicle fleet,
30 to more of an electric model. We can't do that because we
31 can't get capital funding for the electrical charging
32 stations. We are going to - some programs we will do
33 because we have to, and I understand the LHD will expand
34 our virtual services in this year, but there is no capital
35 funding available for the expansion of those services. We
36 will be funded for the operational cost, but we are not
37 currently able to access funding for expansion and
38 including the capital component.

39
40 MR GLOVER: Do I take it that it is your view that at the
41 moment the LHD is not funded adequately to deliver the
42 services it needs to do over the district, firstly?

43
44 MS HOSKINS: Yes.

45
46 MR GLOVER: Mr Clout, do you agree?
47

1 MR CLOUT: Yes.
2
3 MR GLOVER: And not funded adequately to meet its capital
4 maintenance needs and renewal needs at the moment?
5
6 MS HOSKINS: Correct.
7
8 MR GLOVER: Mr Clout?
9
10 MR CLOUT: Yes.
11
12 MR GLOVER: And not funded in a way that enables the
13 district to look to pursue innovations, be it in service
14 delivery or other programs?
15
16 MS HOSKINS: Correct.
17
18 MR GLOVER: Mr Clout?
19
20 MR CLOUT: Yes.
21
22 MR GLOVER: Thank you, Mr Commissioner. No further
23 questions of these witnesses.
24
25 THE COMMISSIONER: Do you have any questions, Mr Chiu?
26 Thank you both very much for your time. We are very
27 grateful. You are both excused.
28
29 **<WITNESSES RELEASED**
30
31 THE COMMISSIONER: We will take a break until 12. Adjourn
32 till then.
33
34
35 **SHORT ADJOURNMENT**
36
37
38 THE COMMISSIONER: Yes.
39
40 MR MUSTON: The next witness is Margaret Bennett.
41
42 **<MARGARET BENNETT, AFFIRMED** [12.03 pm]
43
44 **<EXAMINATION BY MR MUSTON**
45
46 MR MUSTON: Q. Could you say your full name for the
47 record, please?

- 1 A. Margaret Louise Bennett.
2
3 Q. You are the chief executive of the Southern NSW Local
4 Health District?
5 A. That's correct.
6
7 Q. And I think you have held that role since March 2020?
8 A. That's right.
9
10 Q. You've prepared two statements to assist the Inquiry
11 with its work, the most recent of which is dated 6 August
12 2024?
13 A. That's correct.
14
15 Q. Do you have a copy of that with you?
16 A. Thank you, I do.
17
18 Q. Have you had an opportunity to review it before giving
19 your evidence today?
20 A. Thank you, I have.
21
22 Q. You are satisfied, to the best of your knowledge, its
23 contents are true and correct?
24 A. I am.
25
26 MR MUSTON: Thank you. That will be tendered in due
27 course, Commissioner.
28
29 THE COMMISSIONER: Thank you
30
31 MR MUSTON: Q. Can I ask, have you had, or did you have
32 the opportunity to listen to the evidence that was being
33 given by your board members shortly before you came to
34 commence giving your evidence?
35 A. Yes. Yes, I did, thank you.
36
37 Q. I will try and do this in a relatively short-cut way.
38 Did you hear the evidence given by them at the conclusion
39 to the general effect that, in their view at least,
40 budgetary allocation which is received by the LHD is
41 insufficient to enable the LHD to deliver on the health
42 needs of the community which accesses those services across
43 your LHD?
44 A. Yes. I felt they expressed that very clearly.
45
46 Q. Is that a view that you share?
47 A. Yes, indeed.

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Q. Essentially, for the same reasons as they gave?

A. That's correct.

Q. Can I just dive very quickly into the \$86 million capital deficit as it's perhaps euphemistically, perhaps technically, described. That, we were told by the board chair, related to equipment. That \$86 million, does that extend also to ICT? That is, computer equipment and the like?

A. No, ICT is separate. That is an additional \$6 million at the moment.

Q. So we can understand it, 86 million is things like the endoscopy equipment that we were told about by Ms Cawthorne yesterday, and a whole lot of other pieces of clinical equipment like it?

A. Yes. Things like - in the top 10 we include the cardiac monitoring equipment at south east regional, which is reaching end of life.

Q. When you say "end of life" in relation to that, we have heard some evidence in our travels about a distinction between end of life from Medicare's perspective, that is the point in time at which Medicare ceases paying a rebate in respect of, say, scanning equipment which is used, and then a different sort of end of life, which is actually when it's - when the equipment stops working?

A. Yes, when the ability to provide parts to fix up older models is becoming increasingly --

THE COMMISSIONER: Q. When it's continually breaking down, that sort of thing?

A. Yes, yes, with the firm saying, you know, because it is an outdated model, that they can't help us much further to keep that machine on the go.

MR MUSTON: Q. When you use the term " end of life" you are referring to that, I take it, rather than a Medicare construct?

A. Yes, indeed.

Q. We have heard about the risk ratings of some of these capital projects, but once something reaches end of life, like some cardiac monitoring equipment, for example, it sounds, at least to a layperson, as though using that cardiac monitoring equipment which is at end of life in

1 that sense does create significant risks in terms of the
2 delivery of safe and effective patient care?

3 A. Yes. So, obviously, we have a number of monitors in
4 the intensive care unit and the emergency department.
5 They're all the same age, and so when one or two are
6 becoming not functioning then the risk rating goes off
7 because you realise the others are not far behind that.

8

9 Q. Yes. There comes a point where you don't have enough
10 left to cannibalise them for parts for those that are still
11 working?

12 A. That's exactly the issue.

13

14 Q. And ideally, from the delivery of good patient care
15 equipment, is it your view that equipment would be replaced
16 long before it reached that state?

17 A. Yes, it's critical to have that reliability, I think,
18 in any clinical setting, but particularly in isolated rural
19 environments where you can't just grab something from a
20 hospital down the road if you're in trouble.

21

22 Q. We heard some evidence yesterday about the costs
23 associated with maintaining and repairing equipment which
24 was effectively beyond its serviceable life, and the
25 suggestion was that, at least in respect of some of the
26 equipment, that cost might, in the long term, exceed the
27 cost of replacing the equipment. Do you have a view about
28 that?

29 A. Yeah, no. Absolutely. And in the case of that piece
30 of equipment specifically at Cooma, it had been sent for
31 fixing on three occasions and then it was replaced
32 in April. We do now have across the system an asset
33 management online system which will give very clear
34 reporting across the LHD with regard to how many times any
35 piece of equipment has had to be sent back for fixing, and
36 then part of that would be if that was getting to a
37 critical stage, two or three times, we would look to
38 replace that. If it was under - if we were fortunate that
39 it was under \$10,000, we could do that quite quickly. If
40 it was above that amount, we would need to look at that in
41 terms of where that sits, because it won't be the only
42 piece of equipment across the district that needs
43 replacing. So it's a balancing game. But we would never
44 not spend something if it was required to support patient
45 safety.

46

47 Q. We heard some evidence from the board chair about the

1 capital budget and then a separate allocation within the
2 budget for maintenance, which I think was described as
3 about 5 or 6 six per cent of the total asset base. Is
4 there anything about the way in which that funding is
5 delivered to you, divvied up in that way, that actually
6 prevents you from making what you think might be the better
7 financial decision, if faced with that choice between
8 replacing, on the one hand, or patching up and repairing on
9 the other?

10 A. So we are working very closely with the ministry.
11 Southern is not the only LHD that, in these financially
12 challenged environments, are facing this challenge, and
13 there's this new CAMP model that you heard the board chair
14 refer to which, once it's implemented, should give us
15 greater clarity over a five-year period of what our
16 replacement opportunities would be, and we'd certainly - we
17 would certainly welcome that, because if we had 10 million
18 now against the 86, that would give us some help for a year
19 or 18 months, and then if we knew that a similar allocation
20 would follow that. So I think the biggest thing for us
21 would be reliability of a funding line over a period of
22 time that would enable us to trade out of trouble, as it
23 were.

24
25 Q. The existing \$86 million deficit in respect of
26 capital, is it the case that the capital funding which is
27 being received at the moment, at least, is doing anything
28 to close that hole, or is the hole continuing to get
29 bigger?

30 A. No, the hole is getting bigger.

31
32 Q. So in order to close the hole, accepting that that's
33 something that might need to take a number of years,
34 significantly more capital funding would need to be
35 received by the LHD?

36 A. That's correct.

37
38 Q. When you referred earlier to the challenging economic
39 environment, I think we have heard it referred to as a
40 challenging budgetary environment. There have been a range
41 of different ways to describe it, but is that essentially,
42 at least as lived experience within this LHD, just a polite
43 way of saying, "We are not given enough money to meet the
44 costs of running the LHD and addressing problems like the
45 increasing capital deficit"?

46 A. Yes. I would respond to that by saying that I think
47 that health is a very difficult environment for funding

1 across the board because of growing demand, growing costs,
2 everything that you know. I think the situation then in
3 southern has got a particular nuance because of our
4 geography - and I know you've heard this. But if we could
5 gather our 220,000 people up into one decent-sized town, we
6 would be doing fine. It is the fact that we are providing
7 two intensive care units; five birthing suites; we are
8 about to, in a couple of years, open yet another level 4
9 hospital. So in fact into the forwards, our financial
10 challenges will increase with a very beautiful and very
11 necessary and very welcomed level 4 Eurobodalla hospital,
12 but obviously the costs of establishing that level 4, and
13 maintaining that, will be significantly higher than what
14 we've got now.

15
16 THE COMMISSIONER: Q. You don't have to convince me that
17 funding health must occupy a lot of thinking by Treasury,
18 because it is such a huge part of the New South Wales
19 budget. And as an aside, I was listening to a podcast
20 recently where they were discussing the NHS and how the
21 UK Government is at risk of becoming a health service with
22 a few things tacked on like education and roads, but
23 I imagine if we put it in a nutshell, your concerns as the
24 CE of this LHD in terms of funding would be, one, you want
25 to be funded so that you can provide a good level and an
26 adequate level of healthcare services for the population of
27 the Southern NSW LHD, but, two, also, that you get
28 equitable funding with other LHDs, including metropolitan
29 LHDs? Would that be fair as a really general proposition?
30 A. That is exactly correct. Thank you. And I guess the
31 thing that, you know, I'm speaking about is not so much
32 activity-based, whilst I recognise that as a good
33 foundation, but really that needs to be nuanced with the
34 focus on rural-based.

35
36 Q. To equitably fund you, maybe different considerations
37 are required for a regional LHD like this than they are in
38 some of the city-based LHDs?

39 A. Yes, exactly.

40
41 Q. For all the reasons we have spoken about?

42 A. Yes.

43
44 Q. You know, locums, et cetera?

45 A. Yes.

46
47 MR MUSTON: Q. Whether or not activity-based funding in

1 the way in which, as a somewhat blunt instrument it has
2 been structured, is an appropriate way for the State and
3 the Commonwealth to divide as between themselves the cost
4 of delivering acute care to the people of New South Wales,
5 I gather from what you have told us it is your view that
6 that same model ought not be applied when decisions are
7 being made, as the determinant, when decisions are being
8 made as to how much funding should be delivered to your LHD
9 for the purpose of delivering a slice of that care that you
10 do, because it is not a good measure of the cost of
11 delivering that care?

12 A. I think so. Yes, I think that's correct. But what
13 I'm trying to say is that there needs to be sustainable
14 funding for an agreed service delivery model in our
15 environment.

16
17 Q. Coming to that issue of the agreed service delivery
18 model, part of that involves a discussion with the
19 community about what the public health system should look
20 like and should deliver.

21 A. Mm.

22
23 Q. And I guess that can be divided into two components.
24 There is, in the first part, those things that the public
25 health service needs to deliver in order to meet with sort
26 of their needs of the community, from a safety and
27 wellbeing perspective. And then in addition to that, there
28 are other services which, as part of the social contract
29 between the community and the public health system, a
30 discussion needs to be had about exactly what it is you
31 should be getting locally as opposed to perhaps having to
32 travel to a larger centre for. Would you agree with that?

33 A. Yes.

34
35 Q. In relation to that first component; that is, what the
36 public health system actually needs to deliver from a
37 safety perspective, some of these services which are being
38 delivered at your smaller hospitals, for example, the
39 maternity services, I gather from the evidence that we've
40 heard fall very much into that category; would you agree
41 with that?

42 A. Yes. I think something that we've talked about in the
43 travels has been maternity services at Cooma, so a big
44 investment for 150 babies a year, but then when you look at
45 the geography and you consider snow and ice on the roads
46 and you consider how far those women have already travelled
47 in labour, it is my view, as an experienced midwife in

1 rural environments, that it's very appropriate and we're
2 doing the right thing by the community to maintain a safe
3 and appropriately resourced maternity service at Cooma.
4 But it has to be said that is getting increasingly
5 difficult. You need 12 midwives to do that. We've got
6 2.5. So we are relying on bringing in locum midwives,
7 Queensland and elsewhere, to keep that service going.
8 That's an extraordinary challenge.
9

10 Q. You tell us in your statement at paragraph 103 that
11 the costs to the district of the premium labour component
12 of the workforce is 62.4 billion, there or thereabouts. In
13 relation to that, we heard some evidence from the board to
14 the effect that even if the - well, let me take it in two
15 steps. That 62.4 million is the total spend on the premium
16 labour?

17 A. So in the last year, around about 44 for medical and
18 20 for nursing, yeah.
19

20 Q. If you were to wake up tomorrow and all of your
21 positions were fully recruited and you had no need to rely
22 on premium labour, the LHD would still be required to spend
23 a slice of that 62.4 million on the salaries and wages
24 being paid to those members of the permanent work force who
25 had slotted into those positions?

26 A. Yes. So the net, if you like, is about 30 million.
27

28 Q. And that's - in terms of budget deficits, it would be
29 no answer to the budget deficit faced in this LHD; even if
30 the premium labour could be reduced to a minimum or even
31 reduced to nothing, there would still be a deficit?

32 A. That's correct, because the two major components of
33 our deficit, of what you are just referring to, the premium
34 cost of premium labour, and the other component as the
35 board expressed so clearly, is the cost of doing business
36 in southern, the actual raw cost of running these various
37 units that we have described. And they're the two
38 components that challenge us so significantly.
39

40 The other thing is it is not reasonable for us to
41 consider that you would ever replace all your locum doctors
42 because you will always have some reliance - it would be
43 wonderful if it could be decreased by 50 per cent over next
44 five years, but you have heard Terry talk about the fact
45 that we don't have a private hospital. So you've got to -
46 to attract a doctor to sort of really be part of the
47 permanent arrangement, there has to be enough work in

1 private or at the hospital to generate that. So to
2 maintain the on-call, you won't always be able, and then
3 the number of craft groups, you won't have enough work to
4 generate the income that you need to cover the on-call
5 roster. So my point is you are always going to need to
6 utilise locum staff.

7
8 Q. We have heard evidence in our travels to the effect
9 that locums will always form an important part of any
10 medical workforce because they enable people to take a day
11 off --

12 A. Yes.

13
14 Q. -- and go on holiday, and equally give a health
15 district an ability to flex up and down as demand might
16 change throughout a year. Is it your point that, having
17 regard to the particular issues, including the absence of a
18 private hospital and the ability to engage in private
19 billing within the LHD, the locum component of the
20 workforce is always going to be a little bit more than that
21 in southern? That is, it will always form part of,
22 effectively, the permanent workforce?

23 A. Yes.

24
25 Q. And some craft groups?

26 A. That is my point.

27
28 Q. Just while we are on the craft groups and perhaps
29 specialist and sub-specialist care, an important part of
30 the care that is delivered by the public health system to
31 the community includes outpatient clinics and specialist
32 and sub-specialist care to those who need it. The demand
33 for those services across all of the craft groups in this
34 LHD, I gather from the answer you have just given, is
35 probably not sufficient to sustain a complete workforce
36 that covers the field in terms of those groups?

37 A. Look, that is the case, but it is also the case that
38 we have the need and the planning focus on uplifting that
39 considerably from where it is at the moment. So outpatient
40 development is a big focus of that. We serve an isolated
41 community, a low socioeconomic. It is really important, in
42 Canberra, I have very long waiting lists.

43
44 So it is very critical to us meeting the needs of the
45 community that we are growing our outpatient capacity to
46 give that access, but we won't be able to do it in every
47 field, but we need to have a lot more availability than

1 we've got now. It is also the case, and our clinical
2 service plan is very clear about this, some of the things
3 that frustrate our fabulous clinical leaders - and you
4 heard from several of them yesterday - is the fact that we
5 know we quickly need to have more diagnostic capacity
6 around cardiology, and we need pain clinics and we need
7 all - everything that these passionate, capable, clinicians
8 are saying is correct, and the frustration is that we share
9 their impatience to see these services developed. But,
10 unfortunately, we do need to go incrementally and make sure
11 that we can fund and sustain what we do so we're setting up
12 a reliable future, but it's never as fast as we would like
13 it to be.

14
15 Q. Putting to one side the way it might be dealt with as
16 book entries between LHDs and the ministry, do you think
17 that challenge or some of those challenges would be
18 alleviated if there were more formal arrangements with
19 metropolitan tertiary hospitals whereby, say, a
20 rheumatologist who might be employed at, say, the Royal
21 Prince Alfred Hospital, for example, that as part of their
22 employment, an expectation that they would be delivering a
23 particular number of clinics or a particular number of days
24 in a month worth of clinics and care in facilities in your
25 LHD?

26 A. No, that's exactly the direction we're going in. We
27 are - every success we have in southern is due to our
28 partnership focus, either collegiality and the support not
29 only from Canberra but from the metropolitan LHDs is
30 fabulous, and there is already a lot of examples. For
31 example, we wouldn't be having a level 4 ICU at Goulburn if
32 it was not for the south west Sydney intensivist support
33 from Liverpool. We have got cardiac outreach clinics from
34 Sydney Kids. So there is already a number of things that
35 we're doing. In the next 12 months, we want to expand
36 that. And gerontology is something we hope to develop
37 soon.

38
39 Q. In terms of those connections or partnerships that
40 already exist, have they come about by the implementation
41 of any formal - the implementation of any formal policy or
42 structure? Or is a little bit more ad hoc in the sense
43 that either you and one of your chief executive colleagues
44 have put your heads together to solve an emergent problem
45 or, alternatively, one of your clinicians has put their
46 head together with a university colleague or professional
47 colleague of theirs in a metro area to bring about a

1 solution to an emergent problem?

2 A. Look, to be honest a bit of both and I think that's
3 the way to go. I mean, it's not - it's within our planned
4 structure. These are all the things we need to establish
5 in southern, and you're encouraging your senior staff to
6 have very connected relationships with their colleagues in
7 metropolitan LHDs, and sometimes opportunities present
8 themselves and you jump into that, you know, straight away.
9 But certainly I would say one of the hallmarks of the
10 New South Wales system is the extraordinary collaboration,
11 cooperation and partnerships with all of the CEs. There is
12 not one of them - I see them all monthly. There is not one
13 of them that I couldn't ring and say, "This is my problem
14 at the moment, what opportunities for telehealth or for a
15 visiting service?" So that's the direction we are going
16 in.

17
18 The other thing I would say, a lot of the development
19 in southern is about getting the foundations in place to go
20 forward, and part of that has been the appointment of 14
21 fabulous district medical leads in all the various craft
22 groups. All of these people are well-known across the
23 State and have relationships in other LHDs and, to be
24 frank, good gets good and so it is often - a lot of our
25 incredible success with recruitment in the last 12 months
26 has been because you've got, I guess, the reliability and
27 the leadership of district medical leads who support
28 opportunities for partnership and also recruitment.

29
30 Q. You point to Dr Piper's success with paediatrics at
31 Bega as a good example of that, I assume?

32 A. Oh, that's outstanding on a national level.

33
34 Q. In terms of the forming of those connections, do you
35 think there would be any utility in having the ministry
36 involved at a more formal level, perhaps workforce branch,
37 or some branch of the ministry, more involved at a formal
38 level in trying to pair up some of the people that need to
39 be paired up in order to meet need? For example, an
40 ability for you to say, based on information received from
41 your clinicians, "I need," say, 0.3 FTE of a gerontologist
42 at Bega. I'm never going to be able to get 0.3 of a
43 gerontologist to come down just for that, but the system
44 won't be able to provide that for me. Please help
45 facilitate that."

46 A. Yes, so there is nothing stopping me and others from
47 doing that now, and you'd find with the other LHDs you're

1 visiting there are so many examples. The natural pairing
2 for us is with Illawarra Shoalhaven to our immediate north
3 and south west Sydney, and in the case of Illawarra, that's
4 even further strengthened by that's the same footprint as
5 Coordinaire, the primary health network. So we have a
6 collaborative arrangement around planning that includes
7 looking at primary health. And so, we've got that natural
8 pairing, but it might just be that additional palliative
9 care or other things would come from yet another LHD. So
10 I think it's important that we can graze wherever the
11 opportunity might present, because of the dynamic nature of
12 health.

13
14 Q. Does the potential advantage of a slightly greater
15 role for the ministry in that process include that you,
16 whilst you have no doubt strong relationships with
17 Illawarra, Shoalhaven, south west Sydney, you don't really
18 know necessarily whether this, say - Hunter New England
19 also, one of their facilities needs 0.7 of a gerontologist
20 and some sort of central body that has all of the data
21 available to it and a capacity to pair things up and try
22 and assist in creating workforce solutions might be useful,
23 do you think?

24 A. Yes. I mean, I think we already do that. There are
25 very effective monthly state executive formal meetings with
26 the secretary and dep secs and all the CEs, and frequently
27 on the agenda of that committee is a presentation on
28 partnership arrangements. I've done one of those myself
29 around what have we got and recognising a number of
30 partners in the room, but also what do we need. So, you
31 know, I guess a bit like anything we talk about in such an
32 inquiry, you can always do more, but I would say that the
33 leadership from the ministry and the facilitation and
34 certainly the mindset of the CEs is incredibly
35 partnership-focused, and I think the greatest success will
36 come from CEs taking the initiative to regularly send an
37 email. I mean, I would never have a problem emailing and
38 saying, "These are my immediate needs, is anyone able to
39 support?", and I would know that if anyone could help, they
40 would. So I think that's the way to keep - you've got to
41 have that passion, I think, and leadership at a local
42 level.

43
44 Q. Yes. Perhaps the next level is whilst that assists
45 with immediate needs, in order to ensure that those needs
46 are filled over the foreseeable horizon, so in five,
47 10 years, that probably involves putting in place some

1 firmer structures, including, potentially, employment
2 arrangements as between the ministry and a specialist who
3 might be employed in one location or the other, which
4 actually locks in as a part of that person's job meeting
5 those needs, not just immediately but going forward.

6 A. Yes. I would also add that I think it's critical for
7 LHDs like ourselves to be incredibly flexible in what
8 engagement looks like. So rather than perhaps what might
9 have been the more traditional model of, "We've recruited
10 you and you will move your family and you will buy a house
11 on the coast," I mean, we welcome that, but also we need to
12 be - and this will be particularly what we're focusing on
13 with the development of Eurobodalla, is having a stable of
14 people who belong to us but they belong elsewhere as well,
15 and we know that Dr X who is at Illawarra will come down
16 and do outpatients and a day of surgery and a day of
17 follow-up every six weeks, and really be part of our
18 medical staff council, be part of us, but with no
19 expectation that she or he would ever live down here. So
20 I think that flexible thing.

21
22 The other thing, our EDMS, our executive director of
23 medical services often speaks about, particularly with the
24 desperate need for GPs, is to look at creative ways where
25 you could, quite possibly, find good GPs in Sydney that
26 certainly don't want to relocate, but they have always come
27 down here for holidays, they like this part of the world.
28 Could we get six of them on a roster that could come a
29 week-about to a Bombala or to a Pambula or whatever and
30 actually at least keep the show on the road where you can't
31 find a permanent local doctor.

32
33 Q. I will come back to primary care in a moment, but in
34 relation to the workforce challenges and Eurobodalla, or
35 the reopening of the Eurobodalla hospital, you have no
36 doubt heard the evidence that was given by the board chair
37 to the effect that deciding/promising to open that hospital
38 at a level 4 or as a level 4 facility is a real challenge.
39 Is that a view you share?

40 A. Yes, it is a view I share. I'm very mindful of the
41 direction from the Premier and the minister, and my answer
42 to that has always been, "We're very clear, we will do
43 everything we can." And certainly with particular focus
44 around ICU, given that we don't provide this service at the
45 moment, what we could promise is on the day it opens, if we
46 had a patient that required ICU-level care, they would
47 certainly get it. They would be ventilated and

1 resuscitated and everything that you would expect of a
2 level 4 ICU. But whether that meant that the whole unit
3 was fully functioning, so then risk to the care that
4 individual would get, for sure, but I can't promise what
5 I don't know in terms of our capacity to fully staff an
6 ICU. Recognising that the level of ICU at Bega took some
7 years to establish. So my focus will be on doing
8 everything, and we have already started. The reason we
9 established the critical care unit at Moruya was to provide
10 upskilling of staff, and so that's just below an ICU, but
11 it is increasing capacity and capability. But it is going
12 to mean, in a constrained funding environment, that we will
13 need to employ intensivists before the new hospital opens,
14 so they are doing the training and developing the
15 protocols, and so forth, that would enable a level 4 ICU to
16 open. So, exciting but very challenging and very expensive
17 times ahead of us.

18
19 Q. So just breaking that down, there is a few elements to
20 an ability to open as a level 4 facility. The first is you
21 need to have sufficient funding to create the FTE in the
22 particular craft groups and qualification levels amongst
23 medical staff that you need in order to do that. The
24 second is you need to actually find the warm-blooded beings
25 who are willing to step into those roles. And then a third
26 is both of those things need to happen at a time before the
27 facility opens, so on the day the ribbon is cut, they're
28 ready to roll.

29 A. And not wanting to confound that with even more
30 challenges. But one of the big things that we - I don't
31 think we've spoken about yesterday or today, but is the
32 very significant issue around staff accommodation. So even
33 to get the warm-blooded individuals, there needs to be
34 somewhere that they can live and afford to live. So
35 accommodation across southern, but particularly on the
36 coast, is, number one, hard to get and, number two, very
37 expensive. So, you know, if I had funding right now for
38 staff accommodation - and certainly that's something the
39 ministry is working very hard on, and I do expect that we
40 will be supported in that way, but that will be a
41 rate-limiting step in recruitment.

42
43 Q. Just going through each of those steps, at the moment,
44 in terms of funding of sufficient FTE to at least create
45 positions for the workforce that you would need, do you -
46 I assume you don't currently have it?

47 A. The workforce?

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Q. That you would need for --

A. No.

Q. Do you have any - is there any projection or planning which has gone into identifying what that additional funding envelope would look like in order for you to be in a position, assuming you could get the warm-blooded individuals, to --

A. Yes. So as part of, you know, the sort of standard governance and requirements of developing a new regional hospital, and obviously HI have got the lead on this, but there is a detailed workforce plan. And as I have mentioned, some of those - and a clinical services plan as well. And that would be - that's a challenging - exciting but challenging thing in any environment. But in our case, we're coming from further back in the pack. So it's not as if you are moving an already established small ICU into a bigger environment. You actually haven't got the service at all. And so, there are some particular nuances in the service planning to successfully establish Eurobodalla, and once it's up and going successfully, the issue then, as I have mentioned, will continue to be - hopefully by then and from this Inquiry - there will be a reliable funding model that will enable yet again a low volume level 4 facility to be sustained.

THE COMMISSIONER: Q. Just so I understand it, is it the plan or the certainty the new hospital will open as a level 4 facility or because of workforce issues is there some doubt surrounding whether it will open as a level 4 facility?

A. So, look, the direction - the direction from the Premier and the minister is very clear that it will open as level 4. So I'm very clear about that direction, and doing everything in our power with we know what we've got to do, we know the workforce, we know the whatever. We are advocating for the accommodation. You have seen many of our pretty fabulous medical leads, and we have got an equal lot of wonderful nursing, so we have all the right leadership people. You know, the "but" of course is it's hard. We're currently a bit under, what, about 170 nursing FTE down today. Today, we're using 94 locum doctors. So that's not going to magically disappear. So given we're that far behind and we're working towards that --

Q. The lack of workforce is not going to magically

1 disappear --

2 A. Not going to magically --

3

4 Q. Nor magically appear either?

5 A. No.

6

7 MR MUSTON: Q. Yes, the workforce is not going it
8 magically appear?

9 A. Yes. So those problems aren't going to disappear. So
10 whilst I am very conscious of the direction --

11

12 THE COMMISSIONER: Q. Yes.

13 A. -- that I'm given, I am an experienced CE who is
14 saying, "I'm hearing you, we will do everything, but this
15 is the headwind we need to contend with."

16

17 Q. Can you be given a direction to get to the moon safely
18 and back, but there is a lot of work to be done?

19 A. That's right. A lot of risk as well. I would
20 probably find the moon a bit easier at the moment.

21

22 THE COMMISSIONER: Yeah, I was going to say. Yeah. Well,
23 the Apollo program was satisfactorily done in seven years
24 and this hospital has been in planning since 2004.

25

26 MR MUSTON: Q. Correct me if I've misunderstood this,
27 but I gather from one of the other answers that you have
28 given around the need to get, for example, the intensive
29 care unit staffed and at operating temperature before the
30 hospital actually opens as a level 4 facility, that a range
31 of those costs, including that workforce cost that you
32 would incur in bringing the intensive care department to
33 that position, would be incurred over a period, perhaps
34 quite a way before the intensive care department at Moruya
35 had the capacity to generate one single nWow?

36 A. Yeah, no. Absolutely. I mean, the recruitment of
37 rare beings like intensive care doctors would need to
38 start, you know, 18 months out. And even if they didn't
39 start and they were working elsewhere or you had a
40 partnership arrangement, or whatever, there's a whole lot,
41 as you would understand, that you need to do with regard to
42 protocol training, safety. You know, the success is all in
43 the foundation, and the foundation would need to start at
44 least, you know, at least 18 months out.

45

46 Q. So in the ABF model or environment that you exist in,
47 that is 18 months' worth of expense which is not matched by

1 any ABF return in the form of activity?

2 A. That's correct. And this is already something -
3 I mean, the ministry are no strangers to new hospital
4 developments and so forth, and we're already having those
5 conversations, and there'd be no disagreement at all on
6 what I'm saying. Of course, we come back to the vexed
7 issue of, you know, that the State is predicting a deficit
8 budget for the next four years, so it's not a fabulous time
9 to be seeking, you know, significant uplift in funds.

10

11 Q. Having said that, some evidence given by your board
12 chair and a member of your board about the impact of trying
13 to recruit within an environment which is underfunded - you
14 recall hearing that evidence? That is to say that
15 recruitment is hard enough in a district like southern, but
16 it is exponentially harder when you are trying to recruit
17 people into an environment where the existing workforce is
18 stretched by funding constraints. Is that a view you
19 share?

20

21 A. Yeah. Look, I think - and you probably heard some of
22 that frustration. We've had tremendous success with
23 recruitment, and you have heard that there has been an
24 incredibly strong focus on positive culture, visible
25 executive, visible board, good leadership, you know, good
26 clinical leads and all of those things. So that's all
27 great. But good clinicians are hungry for progress and
28 service development and so forth, and you heard that
29 yesterday. And so, that's where the difficulty can be, is
30 that sort of thing about, "But I thought you said we'd have
31 this or we'd be doing that," or, "What's the timeframe?"
32 So to attract and maintain good clinicians, you need to be
33 making sure the promised and required service delivery and
34 the required equipment.

34

35 So the sorts of things that any of our many good
36 clinicians on the coast would be saying at the moment, "We
37 need more structured cardiac diagnostics," "We need a
38 stroke unit," you know, et cetera, et cetera. "We need
39 pain," "We need outpatients." We need all that. We agree;
40 everything they say is right. And so the frustration then,
41 and that tension, arrives between they are right, they're
42 engaged with me and other members of the executive, the
43 board is informed, we've got the plan, we've got the whole
44 thing, but it is then sort of managing that tension in
45 terms of bringing things online as they can be funded and
46 sustained.

47

1 Q. Part of that, to pick up on some evidence given by the
2 board, is driven by the fact that the clinicians have as
3 their core focus the delivery of care to the community?

4 A. The doing, yes. Yes.

5

6 Q. But another part of it is also that by expanding the
7 services in the way that you have just described creates an
8 environment where the existing workforce and prospective
9 workforce are able to feel like they are personally and
10 professionally challenged and able to develop
11 professionally in a way which makes it a fulfilling job and
12 a desirable place to go and work?

13 A. Absolutely. Absolutely. You want to be able to grow
14 an environment where there is an absolute recognition - and
15 in fact celebration - of the specialty that is rural
16 health, and that rather than, perhaps, a bit of a "poor
17 cousin" sense. So rural health is amazing, but for it to
18 meet the needs of a very diverse community, you need very
19 skilled, multi-skilled generalists both in nursing,
20 medicine and allied health, and a lot of investment needs
21 to go into that, and a lot of investment in education, and
22 we're behind where we should be in that regard.

23

24 THE COMMISSIONER: Q. This is the kind of multiple-hats
25 clinicians that Dr Ayers was talking about yesterday in
26 that?

27 A. Oh, absolutely. She was spot-on. Yeah, absolutely.
28 So we've got all the right people who have got the right
29 philosophy and vision, so that's a wonderful thing. We've
30 got a very positive, engaged culture. It is the issue now
31 of, you know, recognising that you can't sort of wave a
32 magic wand, but it is an issue of getting greater equity in
33 funding because we are expensive. We're necessary and
34 we're good, but we're expensive.

35

36 MR MUSTON: Q. You mentioned a moment ago that education
37 is an area where you are lagging behind a bit at the
38 moment. What do you have in mind that could be done, or
39 what are the plans for moving forward in relation to that
40 area?

41 A. Well, there is a couple of things. So at a very basic
42 level, we do not have a director of education in southern.
43 So, you know, I still don't have a fully fleshed out, you
44 know, executive team. I have got the most wonderful team
45 you could imagine, but there are positions missing. And
46 that's because we are in such a constrained environment -
47 I'll try to stop saying that, but I can't just think of

1 what else to say.

2

3 THE COMMISSIONER: Don't, don't stop. Don't edit
4 yourself.

5

6 MR MUSTON: Q. If you can't, "we can't afford it" is
7 fine.

8

9 A. So that's the thing. And so therefore, you to need to
10 have the right leadership. That doesn't stop my various
11 executive - and they're great at furthering university and
12 TAFE partnerships and so forth, but, you know, if you want
13 a rich learning environment, you need to invest in the
14 leadership and the governance of that so that there is that
15 dedicated focus on what more could we be doing, what could
16 we be doing with other LHDs.

17

18 The other thing that I have currently said is the need
19 for us to be successful in establishing a university
20 department of rural health. There are 18 or 19 of those
21 already in rural Australia. I have worked in an
22 environment in my CE role in Victoria where I have seen the
23 benefit this brings. We've got three university partners
24 that are fabulous and they have all got footprints, you
25 know, in southern. But establishing a university
26 department of rural health takes that to the next level in
27 terms of funding and capacity, and importantly, it will
28 enable us - we've got to have the pipeline from students.
29 We need to be growing more medical students and more
30 nursing students.

31

32 Q. As part of that additional role within an executive of
33 a director of education, the idea that there would be
34 someone within your team who would be able to foster and
35 develop these partnerships, work out as between the LHD and
36 the education provider, what collaboratively could best be
37 done to grow one's own workforce?

38

39 A. Yes, absolutely. And it seems possibly quite
40 ridiculous, "Well, why don't you just appoint that
41 person?", but in an environment where you are, you know,
42 quite reasonably held to account for the savings that are
43 required, putting on an additional senior staff member,
44 it's a difficult balance when there is so much need.

45

46 Q. Just in relation to the education, it is probably a
47 useful segue into the pre-vocational education component of
the medical workforce. We have heard some evidence about
the relationship between your LHD and the ACT medical

1 service insofar as the delivery of interns and
2 prevocational trainees is concerned, and we have also heard
3 some evidence about the absence of an equivalent
4 relationship with HETI and the challenges that some of the
5 witnesses who have given evidence over the past couple
6 of days have found that that produces.

7 A. Yes.

8
9 Q. Do you - first of all, do you share the view that the
10 relationship, the current structure whereby - well, let me
11 take it in three steps. Are we right in our understanding
12 that the current structure has your LHD tied only to the
13 ACT medical service and, effectively, to use the words of
14 others, invisible to New South Wales-based students who
15 might be seeking internships through HETI, as the existing
16 structure?

17 A. Okay, yeah, the existing structure is as you describe.
18 We are absolutely committed to seeking our own, as well as
19 not walking away from the Canberra arrangement that we
20 appreciate. But we do need the next step, and
21 conversations have started to actually have our own HETI
22 arrangement. The critical issue for us, and this is crawl
23 before you run, is to grow that sustainably, we needed to
24 get success in the recruitment of senior doctors. That
25 will be critical to providing both the supervision and the
26 experience for the additional - for the HETI doctors.

27
28 I guess a very good demonstration of success at the
29 moment - and you heard Dr Nathan Oates talk about this, and
30 I recognise his fabulous leadership in the area, but we're
31 very hopeful that we will get John Flynn doctors, so that
32 is a sort of HETI-brokered Commonwealth-funded PGY3-type
33 doctors. So, you know, HETI are prepared to fund us for
34 that and we're well established now at southeast regional
35 to take on, well, at least six of those. So that would be,
36 really, the beginning and would be addressing the things
37 that Jenny Gordon, you know, is so passionate about, and we
38 appreciate her leadership in that area. The thing - if we
39 could do that this year, the thing then would be to
40 duplicate that at Goulburn next year and really push the
41 development of the two level 4s before we're challenged
42 with the development of a third level 4.

43
44 Q. We have heard some evidence about the other people's
45 understanding, at least, of the arrangements at Albury
46 whereby there is almost a tripartite agreement between the
47 Victorian industry, HETI, and the relevant LHD --

1 A. Yes.

2

3 Q. -- for the delivery of interns. Are there discussions
4 afoot for a similar arrangement in southern?

5 A. I'm very familiar, because I've come from that
6 environment. So I'm familiar with that. "Discussions
7 afoot" might be too strong a statement just at this stage,
8 but certainly it is that mixed arrangement that I am seeing
9 that we need to have here, and I know that HETI would be -
10 I'm confident that HETI would be supportive of that.

11

12 I also am confident that Canberra would be supportive,
13 because they are going to also be challenged to meet their
14 own internal needs with the expansion of their health
15 services. So we won't walk away, ever, from the importance
16 of that tertiary partnership, but I think in terms of
17 sustainable workforce partnerships, we need to have a
18 couple of other angles as well.

19

20 Q. So the relationship with Canberra, at least at a
21 geographical level, feels to a layperson like it might be
22 mutually beneficial, particularly in facilities like
23 Braidwood and Cooma?

24 A. Yeah, Queanbeyan and so forth. Yes. Yes, is the
25 answer. We did establish the coastal network with the
26 clear focus on having, I guess, greater emphasis on
27 north-south, you know, into Illawarra, particularly with
28 the development of the Illawarra hospital. So you can
29 imagine that from, you know, now on there will need to be a
30 very strong, and there should be a very - you've got, you
31 know, the two hospitals being built there and Eurobodalla.
32 So you would look to see how we could best network between
33 those two districts. But always the focus for the west of
34 our district is going to be strongly related to Canberra.

35

36 Q. We have heard about some of the challenges created by
37 the absence of a tertiary facility in the LHD.

38 A. Yes.

39

40 Q. Just briefly, what is your take?

41 A. There's no doubt it is easier if you've got one.

42

43 Q. In what sense? What are the benefits?

44 A. So you could say, well, what's different to what we've
45 got? I think you've got to get the cross-border
46 complication out of your head and work on relationships and
47 patient flow. And we do that all the time. We have joint

1 executive meetings. You know, I'm talking very, very
2 regularly to the chief executive, and so forth. So it's
3 not a great impediment, but I think when you've got your
4 own tertiary hospital within your immediate family, that
5 flow and that collaboration and cooperation without, you
6 know, cross-border arrangements and funding arrangements
7 and different award structures and so forth, I think you
8 have to make - you have to work harder to make it work
9 effectively when your tertiary hospital is in another
10 jurisdiction.

11
12 Q. And when you refer to "flow" there, I assume you refer
13 to patient flow as one aspect of that, but also workforce
14 flow?

15 A. Mm, workforce flow. And, I mean, and some
16 arrangements that are tricky. We pay, for example, for
17 ambulance going and coming, both ways. The award structure
18 is different. And so the idea if you had a tertiary
19 hospital in your own place, you'd be able to look at
20 getting nurses and doctors to move between, and so forth,
21 whereas that's much more difficult with Canberra. So those
22 flexibilities don't follow that easily.

23
24 Q. It was somewhat lacking in specificity, but you may
25 have given the evidence given yesterday by Dr Stapleton to
26 the effect that he felt the LHD was not necessarily getting
27 great value for money from its spend on the ACT Health
28 service. Do you have a view in relation to that, at least
29 as a blunt proposition?

30 A. Yes, I reflected on his comment. I suppose I see it a
31 bit differently. I think that the - you know, there is a
32 financial arrangement between the ministry and ACT for
33 outpatients that they look after. So that's happening.
34 I think the - sort of that broader partnership arrangement
35 that, you know, that you would hope you would foster if you
36 had your own tertiary facility, where senior staff,
37 nursing, medical, allied health had a sense of ownership
38 for their smaller facilities, that they sort of own the
39 house more broadly. So I think that what Stuart perhaps
40 might be thinking about is, "Oh, well, they're not doing
41 much extra for us." Well, for me, that is not really what
42 they're paid to do, in a way. So the funding, the money
43 they get, is for the patients they look after, and so
44 anything else with regard to sort of value-add clinical
45 governance, education, support, would be a separate
46 arrangement. And, yeah, so that's probably where I'd leave
47 that.

1
2 MR MUSTON: Is that a convenient time? I am about to move
3 on to another topic.
4

5 THE COMMISSIONER: What's the best? Is it better to keep
6 going and finish, or given - I have forgotten when we have
7 to leave.
8

9 MR MUSTON: 3. We have to leave by 3. Maybe if we have a
10 45-minute lunch adjournment, if that would be convenient to
11 everyone. I am comfortable that we will leave at that
12 time.
13

14 THE COMMISSIONER: I will be guided by you, given you are
15 asking most of the questions. So you think a 45-minute
16 lunch?
17

18 MR MUSTON: I think so.
19

20 THE COMMISSIONER: All right. We will adjourn till 1.45.
21 Adjourn till then.
22

23
24 **LUNCHEON ADJOURNMENT**
25

26
27 THE COMMISSIONER: Yes, Mr Muston, thank you.
28

29 MR MUSTON: Q. Just I want to pick up on something that
30 was raised by Ms Cawthorne in her evidence yesterday around
31 wound care products. Did you --
32 A. Yes.
33

34 Q. You heard that passage of evidence whereby her view
35 was financial constraints at Cooma hospital resulted in the
36 need to use wound care products which were seen as less
37 than optimal when compared with the alternatives. It is a
38 pretty operational issue, I know, but do you have a view in
39 relation to that as to whether it is a widespread problem
40 and, if so, why?

41 A. No, I did - I did hear that, and I'll follow that up
42 with Jo. I mean, certainly there is absolutely no
43 direction for any compromise in clinical care. It is the
44 fact that we talk to our leaders about financial
45 constraints and talk to them about making wise decisions,
46 so if there was a product that would be appropriate and
47 adequate and safe, well, then, obviously use that rather

1 than something --

2

3 THE COMMISSIONER: She didn't say that there was any
4 direction?

5 A. No.

6

7 THE COMMISSIONER: I think what I heard her say was, apart
8 from what Mr Muston said about "less than optimal", what
9 I heard her say is that she has got a certain budget for
10 these products.

11

12 MR MUSTON: For this service.

13

14 THE COMMISSIONER: For this service, and she has to make
15 sure --

16 A. Mm.

17

18 Q. That the product she uses fits within that budget.

19 A. Mm.

20

21 Q. And the alternative product, as I understood her
22 evidence, would not fit within that budget. That's how
23 I heard it.

24 A. Yeah, and I think she's been very diligent and
25 considered. I need to then reinforce with her, and with
26 others, that you need to do the right thing for your
27 patient, and if that meant that there was a need to be
28 using expensive wound care that was going to take you
29 outside your budget, well, then, that's something that we
30 need to know about. And the direction from the board and
31 from the executive is always very clear, that we will not
32 compromise care.

33

34 It is the fact, though, that you've got these
35 wonderful diligent staff who are very connected with and
36 very focused on the minutiae of their budget, as indeed we
37 need them to be, but that needs to be balanced with what is
38 the right thing for their patient.

39

40 MR MUSTON: Q. And, in a way, that necessary focus of
41 the minutiae of the budget when combined with what has been
42 characterised as a challenging budgetary environment
43 results as the capacity to produce decisions like that?

44 A. Yeah. Yeah. Look, I think that it is a matter of -
45 we tried to - well, we don't try. We actually focus on
46 making sure that our leaders are absolutely across our
47 overall situation. That's an important part of open and

1 transparent communication. We also stress that the
2 greatest areas that they can assist us in is the area of
3 labour and making sure that we're managing rosters and
4 we're managing access to locum and agency staff as
5 diligently as we can. So that's the biggest area of focus
6 that we're asking our leaders, like Jo, to concentrate on.

7
8 Their focus on why their wound dressings or any of the
9 other drugs, radiology, anything else, is what we would
10 expect is if you, for this month, are outside your budget,
11 why is that so? Why? So that you can explain, "This is
12 why. We had a high needs patient. This is what was
13 required." And as long as that's understood and it's not
14 sort of, like, a trend that's happening that's not being
15 clearly understood and managed, there would never be an
16 issue. And that's frequently the case.

17
18 Q. Another quick question about collaboration with
19 partners. The LHD's collaboration with the Katungul
20 Aboriginal Corporation Regional Health and Community
21 Services that you tell us about in paragraph 81 of your
22 statement, what is the nature of that collaboration? How
23 do you look after that?

24 A. Yeah, quite detailed. And I'll list off some of the
25 things that we're doing with them. The relationship is
26 very solid, and I think the solidness of the relationship
27 is demonstrated through the prolonged time of COVID where,
28 you know, every day across seven days we were working in
29 absolute, a very joined up partnership. But the sorts of
30 things at the moment, the Katungul CE - you are aware that
31 immediate past Katungul CE is now actually working for
32 southern as a direct report to me.

33
34 That, in itself, a bit of serendipity really, because
35 she understands both worlds so well, but the Katungul, the
36 incoming Katungul CE, is a member of our Aboriginal board
37 sub-committee, so that is an important thing from a
38 governance point of view, to make sure that they're engaged
39 and contributing to planning and service delivery. But
40 other areas at the moment, particularly over here, the
41 Katungul partnership includes their very close engagement
42 with the development of the Eurobodalla hospital and the
43 model of care around birthing on Country, so their team are
44 part of that, and that's a big deal. We've got a number of
45 partnerships in immunisation, otitis media, looking after
46 kids with problem ears. We've got partnerships with breast
47 screening for women. It is well-detailed; happy to provide

1 that. But it's a very, very active partnership.

2
3 I think that there is room for more development. We
4 both have got real challenges in recruiting and furthering
5 workforce and that's something that Kayeleen, our director
6 now, has talked to me about in her first three weeks with
7 us in southern, that she could see a joined up partnership
8 with workforce that could enrich both organisations.
9 I think that would be great.

10
11 We are absolutely focused that the new Eurobodalla
12 Regional Hospital, it is all very well to have birthing on
13 Country and all of these, you know, sort of co-design, but
14 we really must have more Aboriginal staff, you know, for
15 the community to feel that comfortable access, and so the
16 workforce plan together will be the next thing we do.

17
18 Q. In relation to that, part of that is growing a
19 workforce from members of the local community who could
20 provide that care through that facility. What
21 collaboration, if any, has there been, say, with TAFE and
22 the universities locally, targeted at trying to develop
23 that workforce more locally so they can train locally and
24 work locally?

25 A. Thank you. That is such an important - and that is an
26 area we need to do more, and there is almost sort of a
27 symbolism in the fact that the new ERH - I don't know if
28 you have seen the block where it is developed, but it
29 co-locates. There is a fence between us and TAFE, and -
30 not that you need the physical proximity, but I think that
31 is a bit of a symbolism of a further engagement with TAFE
32 in growing the workforce for the new hospital. But
33 answering the question specifically, a really good example
34 of a partnership at the moment, we really want to have more
35 Aboriginal midwives, and the University of Canberra has
36 been fabulous in their partnership to develop a pathway for
37 young Aboriginal women who want to be a midwife. They may
38 not have had the traditional pathway for university
39 entrants, but they are looking at that flexibility. We
40 have got three young women from here who are now on track
41 to be midwives. So that's wonderful, but I think the area,
42 as you identify, where there is a lot more room for formal
43 development is with TAFE.

44
45 Q. For example, with discussions with TAFE around the
46 potential economic benefits within the health system of
47 running a course for a small number of people, which from

1 TAFE's narrow perspective may not be economically viable
2 having regard to the number of students, are they the sort
3 of discussions you anticipate?

4 A. Yes, absolutely. And I think also connecting in with
5 what's - I mean, given that sort of broader rural
6 partnership, but connecting in, there might be a TAFE
7 course that's happening out in western LHD. So rather than
8 having to duplicate that and if it is predominantly online,
9 well, we would just hook in with that. But something we
10 need, we do have an Aboriginal leader of workforce. We
11 don't have the overarching director of workforce. And in
12 the next sort of six months, it is the development of that
13 dedicated leadership that we need to provide additional
14 impetus and emphasis on training pathways.

15
16 Q. Shifting to another topic, historically across the
17 LHD, as we understand it, and continuing to a large extent
18 to this day, has been the use of GP VMOs in the facilities.
19 A. Yes.

20
21 Q. They have historically provided excellent primary care
22 to their communities.

23 A. Mm.

24
25 Q. And, in addition to that, have provided care in an
26 acute setting through the hospitals in their VMO roles. Do
27 you have a view about whether that model is viable in a
28 contemporary environment, having regard to work patterns,
29 changing family and life patterns, and all of the various
30 changes which have occurred over the past few decades?

31 A. So, you know, given that I've had now 50 years
32 full-time in rural health across Australia, I'm in a good
33 position to say that it is the development of that model,
34 the supported - the growth and development of GP
35 generalists and GP proceduralists, that is absolutely
36 critical for rural health.

37
38 What needs to happen, and you can see some of these
39 things happening, but joint employment models, flexibility
40 in funding models so that, you know, they are supported to
41 work in GP world and supported to work in the hospital.
42 That increasingly if you look at, you know, we are at least
43 20 per cent down with GPs needed in this district, we feel
44 that every day. And so - and many of the GPs that we do
45 deal with are very open in speaking about their exhaustion
46 and the fact that they feel a bit forgotten. They want to
47 sell, they want to get out, but they can't. So what you're

1 describing is a model that must flourish, but there needs
2 to be a whole lot of flexibility to ensure that that
3 occurs.

4
5 THE COMMISSIONER: Q. When you say it "must flourish",
6 I assume there is a multitude of reasons that you say that.
7 One is - it's probably a given, but I'll get it on the
8 transcript, anyway - that it would be a concern to you and
9 your colleagues in the executive of the LHD that some towns
10 here, it seems, beyond argument have GPs with their books
11 closed and six-week waiting times to get into GPs. That is
12 obviously a matter that would concern you?

13 A. Yes, absolutely.

14
15 Q. And that - sorry, if you want to say something to me,
16 you go ahead.

17 A. No, so it is the absolute focus on robust, reliable,
18 sustainable primary health. That is the absolute
19 foundation for a health system.

20
21 Q. And that is because - and tell me if I'm wrong - apart
22 from it being a statutory obligation, no doubt your desire
23 is to ensure that the health of the population you serve
24 improves, for a start?

25 A. Yes.

26
27 Q. And that you would be concerned to ensure that we,
28 that is the LHD, does whatever it can to decrease the
29 period of morbidity that your population has, because
30 through those preventative early intervention measures that
31 GPs in primary care is best placed to deliver, ultimately
32 the hope is that that will decrease the number of people
33 that are presenting for acute care in the public hospitals
34 where things get really expensive?

35 A. Yes, that's exactly it. Exactly it.

36
37 MR MUSTON: Q. You may have heard some questions that
38 have been put to other witnesses through the course over
39 the last two days about the possibility of one of the
40 place-based solutions that might be implemented in
41 locations where there is either no or no viable GP
42 market-based product, as it were, for the LHD to recruit a
43 rural generalist/general practitioner with advanced skills,
44 have them deliver - on a salaried model, have them deliver
45 primary care through, say, co-located clinics within an
46 MBS, much like co-located clinics at Bombala, and at the
47 same time provide care in a more acute setting as required

1 through the hospital. Obviously, Bombala at the moment has
2 a population of GPs who are delivering that in a market
3 way, so it probably wasn't a good example, but to the
4 extent that on a place-based analysis, it was perceived
5 that that was a way to deliver that wouldn't interrupt an
6 existing GP market, do you have a view about that?

7 A. I think that - I think what you describe is, you know,
8 one of the options. I think what needs to happen with this
9 place-based approach is that there needs to be careful
10 consultation and discuss with all the relevant players and
11 the question needs to be, you know, for what we know for
12 the next five years, what would work here? And it could be
13 a range of, you know, combinations, but it needs to be
14 then, "Well, how do we make that work?", rather than
15 getting stuck in the traditional boundaries. So I think
16 the crisis that we knew has been coming for some time is
17 upon us, and so the job of people like me, local
18 government, and others, you know, Coordinaire, primary
19 health network, rural doctors, is to say, "Right. Well,
20 what can we do?" And all be equally committed to it, to a
21 solution.

22
23 Now, you know, one of the things could be - there is
24 about a dozen different models that you could look at. You
25 could even look at creating some interesting partnerships
26 with metropolitan GPs who might be prepared on a sort of a
27 rotational basis, they have always been, you know, they
28 love the South Coast and whatever, but they might come for
29 a week every six or eight weeks. So you could do all sorts
30 of different things. You could - some doctors are
31 committed to rural practice but they are not too mad about
32 the idea of being small business owners. So, you know, we
33 could talk all afternoon about the different options, but
34 I think that that place-based approach needs to be: well,
35 what would work in this setting?

36
37 The PRGS that you have heard a lot about, that serves
38 a pretty fabulous purpose of providing some support to solo
39 or busy GPs where they can have a weekend off, or a night
40 off, or a break, without having that traditional sense of
41 guilt that they're leaving the town without a doctor. So,
42 you know, I mean, technology can provide part of a solution
43 here, not the whole solution. I think the most critical
44 thing to support the crisis that we have at the moment is a
45 willingness for all parties to be very committed to agility
46 and flexibility in finding solutions.

47

1 Q. And that commitment, I assume, involves a willingness
2 where a place-based solution requires it on the part of the
3 State, or the LHD, to step in and contribute to the funding
4 of the delivery of that primary care?

5 A. Mm.

6
7 Q. Admittedly with the possibility of an arrangement
8 being reached at some point with the Commonwealth about
9 recovering some of that through, say, a 19(2) exemption?

10 A. Yes. All the goodwill in the world and partnership
11 approach and innovation, you know, all of that has to be
12 underpinned by making sure that the passion is backed up
13 with sustainability.

14
15 Q. I gathered this from the answers you have given, but
16 I assume a hard line in the sand to the effect that the
17 Commonwealth funds and does primary care would be an
18 approach that would lack the flexibility that you think is
19 required?

20 A. I think some more flexibility would be helpful.

21
22 Q. Can I then turn to the issue of the closure of the
23 Batemans Bay emergency department?

24 A. Sure. Yes.

25
26 Q. We have heard some evidence about the planning process
27 and consultation process that has occurred, but we have
28 also, as you will have heard, heard evidence of the 18,000
29 signatures on the petition expressing their concern about
30 the closure of Batemans Bay Hospital.

31
32 THE COMMISSIONER: It's probably "opposition" that it's
33 referring to, rather than "concern".

34
35 MR MUSTON: Well, probably of this 18,000 there is no
36 doubt an array of views within a spectrum, none of which
37 would include supporting it.

38
39 THE COMMISSIONER: Yes.

40
41 MR MUSTON: Q. Let's just step through the process.
42 Can I start with the public consultation aspect. What
43 would you regard as being a good public consultation
44 process to sit around a decision like the closure of an
45 emergency department, accepting that this decision was made
46 well before your tenure?

47 A. Yes. Yes. So the decision - I think that there are

1 many steps in arriving at that point. So, you know - and
2 sort of right back from - and in the case of Batemans Bay,
3 it goes right back, I think, to 2004 or 2005, whereas I've
4 seen documents in that time and local government survey and
5 what the community wants, and so on and so forth.
6

7 Sort of answering your questions, what do you think
8 the right steps are? Well, from there being a starting
9 point which could come from local government, it could come
10 from the community, just in anywhere, there is the - there
11 is then, you know, that whole planning thing about, you
12 know, that sounds like a great idea, but what does the data
13 tell us? What's this? What's the view of the ministry?
14 So, you know, what is that starting point where it is seen
15 in our case by the ministry that there is community
16 interest and, so there is - let's develop a business case
17 to see what the facts of the matter are. Let's then make
18 sure that that goes out to a very structured consultation
19 process.
20

21 And in the case of how we do things in
22 New South Wales, that is led predominantly by HI. That's
23 the domain of Health Infrastructure to drive that
24 engagement and consultation process, and it doesn't
25 diminish the health services responsibility. You do that
26 in partnership, and the health service will have further
27 meetings and will be consulting also with the various
28 subgroups that we work with all the time.
29

30 I think in - so I think that there is a process of
31 planning, data, community engagement, seeking external
32 advice, and then you get to a point where, "Well, what are
33 we trying to do here?" Is this then going to be - is this
34 about now we are actually feeling there is the support and
35 the data for there to be a new hospital? And then --
36

37 MR MUSTON: Implicit in your answer, but the starting
38 point happens long before the final decision has been made?
39

40 THE COMMISSIONER: Q. I am just worried we are confusing
41 two things. One is the decision to build a new hospital
42 and where it is placed, and the separate decision - I get
43 that it is linked - but the separate decision to close the
44 ED in Batemans Bay. Because Ms Bennett was just talking
45 about the new hospital then in the course of what I thought
46 you were going down an inquiry about the closure of the new
47 ED. Maybe they're both important to discuss together, but

1 I want to make sure I understand whether the evidence is
2 relating to where the new hospital is going to be or
3 closure of the ED here, or somehow both.

4 A. Yeah, I guess if I wasn't clear, whilst I'm aware and
5 I've seen the documents that go, you know, back to,
6 I think, 2005 I saw, then obviously I've got absolute
7 familiarity with my four and a half years.

8

9 Q. Yes.

10 A. But then I have also looked back over the beginning of
11 the clinical services planning in 2018. So everything that
12 I've sort of seen spoke to the two little hospitals closing
13 and the development of a one hospital. So the ED bit
14 wasn't a separate component, because the Batemans Bay
15 Hospital was closing.

16

17 Q. All right. Help me with this. There is public
18 information about we're going to have a new - let's call it
19 a level 4 hospital - and it's going to be based in the
20 area, then there is some consultation, it seems, about
21 where, you know, consideration to sites here, around here,
22 obviously in Moruya, with ultimately a decision about -
23 sorry for the distraction - the opposition to the ED has
24 fired right up. The decision's made for the new hospital
25 will be at Moruya. Was that simultaneously with the
26 announcement that the ED at Batemans Bay would close or
27 were the public told about that later?

28

A. So --

29

30 Q. Do you know?

31 A. No, well, I suppose the thing is that in my time, the
32 Batemans Bay ED was never a separate - like, I understand
33 that, and note Mr Ryan is in the room, and so forth, and
34 I understand that some members of the community, whilst
35 they knew the hospital was closing, they didn't think the
36 ED was closing. I've heard that.

37

38 What I am trying to say is in all of my knowledge and
39 communication, it was always very clear that the
40 development of - and the political announcements and all of
41 those things - that the two hospitals, the two district
42 hospitals, were closing in toto --

43

44 Q. Yes.

45 A. -- when the new hospital opened. So the ED wasn't
46 sort of a separate bit in that. It was - no, that -
47 I understand that some members of the community never

1 thought that the hospital closing was the ED closing, and
2 people come to information in different times, and so
3 forth.

4

5 Q. Yes. Yes.

6 A. What I can say is that from what I have seen, and
7 certainly standing beside ministers of both Liberal and
8 Labor during my time --

9

10 Q. Yes.

11 A. -- the conversation and the announcements have always
12 been very clear.

13

14 Q. That two hospitals would become one and the fund would
15 be at Moruya?

16 A. That the two hospitals would become one, and nothing
17 about an island, you know, ED. But I do appreciate --

18

19 Q. Without necessarily anything expressly being said to
20 begin with --

21 A. Well, just that the hospital --

22

23 Q. -- we want to make sure you understand the ED is
24 closing here at Batemans Bay?

25 A. Yeah, the hospital is.

26

27 Q. The hospital is.

28 A. The hospital is closing and Batemans Bay is closing.
29 But I respect, and I have heard from Peter and others,
30 "Yes, we heard that, but we didn't know that meant the ED
31 was closing."

32

33 Q. "We didn't join the dots." Yeah.

34 A. And so I respect that there is a lot of passion around
35 this. What I am saying is that both from HI, the ministry,
36 and politicians of both sides, it was very clear that what
37 was being promised was the closure of two hospitals --

38

39 Q. Yes.

40 A. -- and the opening of one level 4, and the reasons
41 around that were consistently explained.

42

43 Q. Forgetting - putting aside for a moment the choice of
44 Moruya as the site, because whilst I haven't made a final
45 decision, we're so far down the track with that that it
46 might be actually unhelpful for this inquiry to involve
47 itself as to whether that was the best site or not.

1 A. It was a very deliberate process, yes.

2

3 Q. Well, leaving that aside, and just even if it falls
4 within our terms of reference, because basically everything
5 does, still I don't want to do anything that is not
6 helpful, and unless it is really helpful that we look at
7 it, that's probably a ship that has sailed, but I think
8 from the point of view of those that are part of the "don't
9 close Batemans Bay emergency department" both petition and
10 community group, I think we have already discussed one of
11 their concerns, as I understand them, which was lack of
12 consultation of even the decision being made. Put that
13 aside because, I think, you have covered that.

14 A. Mm.

15

16 Q. I think the other things I would like your view on
17 that they have a concern about - in no particular order,
18 just the order I can remember them - one is, I think, there
19 is a level of dissatisfaction in the published material
20 about capturing their opposition. In other words, the
21 government has published material concerning what's being
22 said at community consultations, and that material talks
23 about questions that are raised but doesn't, at least as
24 far as I've read it, capture what I'm told was some of the
25 vigorous opposition to the closure of the ED. So that's
26 one thing. I'll come back to it, to get your views on it.

27

28 I think the other concern is why would you close an ED
29 in a town with 20,000 population, with 50 or 60,000 people
30 that come additionally in summer, which is, too, I think,
31 the concern about travel times, that we heard some
32 discussion about yesterday, particularly with Dr Stapleton,
33 who told me that lights on, sirens flashing, it's
34 12 minutes from here to Moruya and that the ambulance
35 service is comfortable that that's the time, but it is a
36 concern that the residents have. And I think the other
37 concern is, the main one, is whatever an urgent care clinic
38 is, and I think there is some mixed messaging on actually
39 what they are, but that that is not a substitute for an ED.

40

41 So, going back to those points, the published
42 material, have you read that? If you haven't, you can take
43 the question on notice.

44 A. So are you referring to the media reports after that -
45 yes.

46

47 Q. Yes, I am referring to the government documents that

1 say, you know, "This is what we heard from the community
2 about the closure of the ED, and these questions were asked
3 and these questions were asked," but there is nothing in
4 them, that I could see, that had multiple people, that I am
5 told, saying, "For God's sake don't do this. This is a
6 terribly bad thing to do for the residents, for this big
7 population, and it carries clinical risks," et cetera. Do
8 you know anything about that?

9 A. No, I would have to take that on - all, I suppose,
10 I can speak to is what I am accountable for, and --

11
12 Q. I am not suggesting this is you producing this
13 material at all.

14 A. Yeah. Good. Good. So, I mean, I have been very
15 clear in my reports and I have no doubt that HI would do
16 the same.

17
18 Q. Yes.

19 A. In, you know, it is our habit to be very clear --

20
21 Q. Yes.

22 A. -- about, you know, the communities' expressed views.
23 So what you are describing, the issues of the travel time
24 and --

25
26 Q. What have you heard about that, then? What is your
27 understanding about that aspect.

28 A. So the community have been entirely consistent in
29 their feedback. This has been tied up also with the issue
30 of the bypass.

31
32 Q. Yes.

33 A. And there was - you know, I sort of gained a sense
34 that if the bypass was agreed and funded and there was a
35 timeframe, that that might give some - the Moruya Bridge
36 comes up all the time as an issue. We've had forums with
37 the community where we've had the superintendent of
38 ambulance, you know, just so we were getting people to
39 speak to the community, and he was saying that, you know,
40 that they are very good at getting through difficult
41 situations and that they would work with the police if
42 necessary, and so forth.

43
44 Dr Stapleton - so there was another issue was that,
45 you know, people will die in the back of an ambulance, and
46 Dr Stapleton spoke very clearly to the fact that, you know,
47 with highly trained paramedics and ambulances the way they

1 are these days, they are in fact a mobilised ICU, that you
2 are much better off, you know, with your chest pain in
3 Batemans Bay, to be straight into an ambulance with your
4 little mobile intensive care and going to definitive care,
5 and not going to - sorry, at the level 4 --
6

7 Q. Yes.

8 A. -- where if you need more than that, there is a
9 helicopter base right there and you would be going to
10 wherever you need to go, so that trying to explain and
11 whilst respectfully understanding the connection and, you
12 know, the great work that the Batemans Bay ED has done over
13 the years, and still does do, but trying to also explain
14 that an ED on its own, without a hospital that's equipped,
15 it isn't - it might sound reassuring to you, but, actually,
16 to be honest, if you're crook, being in an intensive care
17 ambulance - and surely, making sure that we have enough
18 ambulances for the coast --
19

20 Q. Yes.

21 A. -- but that getting to a level 4 - so all I can say
22 and I speak very frankly, as you might imagine, at these
23 forums, I'm saying if it is me or someone belonging to me,
24 I want them in an ambulance with defibrillator and
25 everything, able to intubate, everything, racing to a
26 level 4 hospital. That's the best outcome, rather than
27 coming to a little isolated ED that exists in isolation to
28 an appropriately equipped hospital.
29

30 Q. I think, in fairness, that is probably a fair summary
31 of what Dr Stapleton said yesterday.

32 A. Mm. Yeah. Yeah. Mm.
33

34 Q. But can I ask you perhaps a slightly more general
35 question and see if you can help with this.

36 A. Mm.
37

38 Q. 18,000 signatures from the community, accepting that
39 some people that have signed it live outside the community,
40 is a lot relative to the population.

41 A. No question, yes.
42

43 Q. I know what limits to what inferences I can draw from
44 that. I'm not a clinician, but I am a lawyer. But to some
45 extent, that level of signatures does at least hint at, to
46 me, that the consultation process, forgetting who is
47 responsible, somehow failed in some way, that it didn't

1 reach the community and provide all of the information that
2 perhaps the community needed if there is that level of
3 signatures. Now, that's not a finding I am making.

4 A. Yeah.

5
6 Q. It is just something that is floating around. What
7 would you respond in relation to that?

8 A. So what I - what I would say - and, look, you know,
9 since I've been CE I've gone back over this and, you know,
10 I have chaired forums, and so forth. What I would say -
11 because certainly it concerns me hugely.

12
13 Q. Yes.

14 A. Because I would say we're out there all the time,
15 we're talking to small groups and big groups. We're
16 putting - you know, everything is on the website. We're
17 putting - you know, so by any measure there is a great -
18 and I know you've got all of this, but there's a huge
19 amount, and you would say an appropriate level of
20 communication, consultation, forums, big and small, and so
21 forth. But I would absolutely agree, and it has somewhat
22 astounded me, that despite all of that, that there is some
23 sections of the community who never felt that that meant
24 that the ED was going to close.

25
26 So I find that somewhat bewildering, but I accept that
27 that's how they feel. And I don't know whether sometimes
28 there is so much information happening that it's not until
29 it really - you know, and we'd sort of feel lots of people
30 were well engaged and asking questions, and even during
31 COVID we had online forums. So I would have said to you
32 along the way, you know, there is good engagement and we're
33 talking to the council and we're doing all of those things,
34 but the fact remains that there are people sort of still
35 coming forward now who weren't aware of any of that.

36
37 Q. Yes.

38 A. So, you know, no lack of - and I'd have to say all the
39 big change that I've been engaged in rural communities
40 across Australia, for the amount of commitment and effort
41 and openness that went into the LHD and, I would say, HI as
42 well, talking, speaking, you know, at everywhere, and with
43 the doctors, there hasn't been a medical staff council
44 meeting or a clinical council meeting, or anything, that
45 hasn't been bringing this up in four years.

46
47 Q. Yes.

1 A. So it still - it is really disappointing and
2 concerning that there was something in it - it is a weird
3 thing that hearing the hospital is closing didn't resonate
4 with you that the hospital is closing in total.

5
6 Q. All right. Moving forward, though, we have heard from
7 the board members today about the November 2023
8 consultation framework that has been brought in, and
9 obviously a significant amount of work that is being done
10 in relation to that, which, no doubt, includes you.

11 A. Mm.

12
13 Q. You're, I take it, very comfortable now that the
14 framework for community consultation moving forward is what
15 it should be?

16 A. So, well, I'm very comfortable that we've
17 strengthened - you know, we've had lots of mechanisms in
18 place, including small groups at the various hospitals
19 around the district, and what we're putting in place now is
20 these two, on top of that, these two bigger committees that
21 go across the network, recognising that lots of service
22 delivery and lots of need needs to be discussed across a
23 broader geographic framework.

24
25 Q. Yes.

26 A. But this is the tricky thing. Even doing that - and
27 that got off to a great start - that still doesn't mean
28 that you get to everybody.

29
30 Q. Yes.

31 A. So, you know, I think that with community engagement
32 and consultation, you're never done. You can never rest on
33 your laurels. What you've got to do is to have as many
34 irons in the fire, and that includes the importance of, you
35 know, well-informed community nurses and well-informed GPs
36 who are talking to people more one-on-one.

37
38 So what I'm confident about is that this additional
39 development takes across - takes account of looking at
40 things like community transport, service planning, how
41 South East Regional Hospital and the new Eurobodalla
42 Regional Hospital will work together, because the next
43 thing is they won't be able to completely replicate. You
44 can't have - you don't have a major orthopaedic program at
45 south east regional? Well, that will mean there will be a
46 smaller orthopaedic --
47

1 Q. Yes.

2 A. You know, so there will still be challenges ahead of
3 us in that regard.

4

5 Q. Sure.

6 A. I don't think you can have any framework that is going
7 to mean that everyone you would want to have an input and
8 hear - but I think what we have to keep doing is
9 strengthening the framework.

10

11 Q. Yes, understood.

12 A. And I think now what we've got to keep doing is using
13 the next two and a half or three years - and we're doing
14 this to say, "Right. Very specifically, this is what we're
15 doing, these are the services." The way I am speaking now,
16 you might gather, I am a fairly frank communicator. But
17 talking to the community about what I am worried about and
18 what is possible. In this room here, not that long ago, we
19 had a big - another community forum, and another big area
20 of focus for a section of the community is the issue of
21 will radiation therapy be developed at the same time? And,
22 quite understandably, there is an enormous amount of
23 passion around that as well. And, look, you know, I just
24 spoke there and I said, "Wouldn't that be wonderful?" And
25 we do know that there is a - that the numbers are there to
26 support a business case, but I said it would cost about
27 100 million to develop. It would then cost significant
28 money to run sustainably, and whilst if money was no
29 object, you know, let's see if the government could do that
30 for us, but at the moment, I need staff accommodation.
31 I need equipment. We need basic things like pain
32 management.

33

34 Q. Yes.

35 A. A more basic cancer services. We need cardiac
36 diagnostics.

37

38 Q. Yes.

39 A. All of those things. So I think being very frank with
40 the community about, "Yes, I agree with you, but this is
41 where it is," and this is, you know, in the cascade of
42 service development, and I think the community appreciate
43 that frankness.

44

45 Q. Sure.

46 A. Mm.

47

1 MR MUSTON: To round out on the discussion around the
2 hospital, you are --

3

4 THE COMMISSIONER: Which hospital?

5

6 MR MUSTON: Q. The closure of the Batemans Bay Hospital,
7 I should say, you are comfortable, you are familiar with
8 each of the concerns that have been expressed by those
9 members of the community who are troubled by the closure of
10 the Batemans Bay Hospital?

11 A. Yes.

12

13 Q. And those concerns have each been given, at least from
14 an LHD level, insofar as you are aware, careful
15 consideration --

16 A. Yes.

17

18 Q. -- as to the extent to which they impact upon safe
19 clinical care --

20 A. Mm.

21

22 Q. -- and the steps that might be taken to ameliorate any
23 risks presented by the closure of the hospital from the
24 perspective of safe clinical care?

25 A. Yes, a long deliberation, and taking of advice from,
26 you know, experts, you know, ambulance, senior ED doctors,
27 and so forth. And I - but whilst I absolutely recognise my
28 responsibility for working to address the community concern
29 and anxiety, I think that is just going to have to be
30 progressive over time; very respectful. I think one of the
31 difficult things is, whilst I hear the noise very much
32 about "keep the ED open" here, in a small little - a
33 littler ED, with no hospital and, you know, nothing
34 further, really, than an ED - so you'd have a doctor and a
35 nurse in the urgent care centre there, and a doctor and a
36 nurse or two in the ED, I do not see that, as an
37 experienced clinician myself back in the day, and an
38 intensive care nurse, I do not see that as being - whilst
39 it might provide some emotional support and comfort,
40 I don't see that as being the thing that would bring the
41 greatest safety and benefit to the community.

42

43 I think that the focus now needs to be on working with
44 the ambulance. So in two and a half years' time, what
45 other ambulance infrastructure do we need here and, you
46 know, are we sure of that and making it really clear -
47 educating the community about what you do. If you're a

1 holiday-maker, or you are here, and you've got any of these
2 things: chest pain, collapse, you dial the ambulance, you
3 don't pop up to the urgent care centre, you know, and so
4 making sure we put a huge amount of learning from, you
5 know, the fact that we think we're communicating and not
6 everyone is hearing. So really putting additional
7 emphasis, signs up around town, everything, into what do
8 you do. What do you do. And making sure that ambulance
9 transport through to the new ERH is what everyone knows
10 they do when they have an emergency.

11
12 Q. Some of the concerns include concerns around
13 ambulances being taken out of service to deal with patient
14 transfers to Canberra --

15 A. Yes.

16
17 Q. -- and the like. It would be right to assume that
18 that's part of the discussion with ambulance --

19 A. Yes.

20
21 Q. -- about ensuring adequate cover is provided in
22 Batemans Bay and its surrounds.

23 A. Yes, and the LHD has got a response - so transport,
24 full stop, is a big issue. So we're looking at
25 community-based transport. This is outside what you are
26 saying, but the issue of getting people to appointments and
27 so forth, so, we've got work to do there. There is very
28 little public transport.

29
30 The LHD has a responsibility also to look at our
31 patient transport internally that we run, to make sure that
32 we're not calling ambulances for patient transport that
33 could quite appropriately go in an LHD patient transport
34 vehicle, so we've got work to do there as well.

35
36 Q. Coming back to your comment about the lack of public
37 transport infrastructure that exists up and down the coast,
38 some particular concerns were expressed on behalf of the
39 First Nations community around that ability to access the
40 hospital down in Moruya --

41 A. Yes.

42
43 Q. -- and then having been discharged, having been in
44 that hospital, returned to their homes.

45 A. Mm.

46
47 Q. Transport infrastructure around that, is that

1 something that's currently under active consideration?
2 A. Yes, that's part of what - we don't have as - this is
3 a challenging matter, but we know that needs to be
4 addressed. So I think there's going to end up being -
5 I mean, in some other areas, for example, we've got some
6 similar challenges over in Jindabyne, and so forth, rapid
7 growing, that issue of transport, getting people to
8 appointments, and what's working over there might not work
9 here. But I think having some community-based transport
10 options, you know, volunteer drivers, even with an LHD
11 vehicle. So some of that will be part of the solution.
12 You know, who knows, we might have to look at things that
13 are quite possible, like an LHD, you know, sort of taxi bus
14 going backwards and forwards between Batemans Bay and
15 Moruya for appointments at certain times of the day. But,
16 yeah, we're - we know that has got to be addressed, and
17 that needs to be a big focus over the next couple of years
18 now. We've got time to get it right.

19
20 Q. Moving away from the Batemans Bay and Moruya
21 hospitals.

22 A. Mm.

23

24 Q. If finances were not a limiting factor for you in the
25 LHD and you had the magic wand, what changes would you make
26 to the system that you think might assist you, and those
27 working in your LHD, to optimise the delivery of public
28 healthcare across the large footprint that you occupy?

29 A. So one - just one wish?

30

31 Q. You can have as many as you want.

32

33 THE COMMISSIONER: Q. No, as many you want. This is
34 fantasy land. Go for it.

35 A. Goodness, I'll send you a paper, Commissioner.

36

37 Q. You are very welcomed to do that as well.

38

39 MR MUSTON: You are very welcome to.

40 A. Okay. So the first one that I think you have gathered
41 that I've already - we've already talked about, but it is
42 having - I mean, taking away the day-to-day housekeeping of
43 not having enough money to run an LHD. So, having a
44 sustainable funding allocation to deliver agreed services
45 in southern. So if we did that, that would be a start.

46

47 The other bit, before I go on to other things, is

1 actually taking all the noise away from the housekeeping
2 things, like, you know, solving accommodation, because that
3 then starts to free up some of these accommodation
4 pipelines. At the same time, taking the noise away and the
5 anxiety around sustainability. So, adequate funding to
6 replace equipment as it needs to be. I mean, it will never
7 be enough, but at least not building an \$80 million
8 liability.

9
10 THE COMMISSIONER: Q. That doesn't sound like fantasy
11 land, that just sounds like business as usual.

12 A. For me, Commissioner, it's - my wishes are - you know,
13 that's fantasy for me.

14
15 Q. They're - reasonable wishes, aren't they? Yes.

16 A. And then the other thing is I think that - and I know
17 there is a commitment in this area, but I guess, sort of,
18 an acceleration of blended funding. You know, you need
19 more agile and nuanced funding models so that we are
20 looking at a whole range of funding possibilities to
21 support and prop up primary health.

22
23 Q. Yes.

24 A. And work in partnership. So sort of - rather than
25 saying, "Well, that's the Commonwealth and that's us",
26 I think that that's a much bigger thing. We've got a
27 crisis --

28
29 Q. In one sense it is irrelevant who funds it.

30 A. Yes. Well, it's --

31
32 Q. It just needs to be --

33 A. Yes. Yeah.

34
35 Q. -- funded and provided.

36 A. So I guess that sort of - you know, I can only say
37 agility around blended funding models that look at how
38 things are done.

39
40 Q. I can clarify that. It is probably not irrelevant to
41 NSW Treasury as to who funds it --

42 A. No. No.

43
44 Q. -- but for the patients and for the healthcare
45 clinicians, and for you, it's irrelevant.

46 A. Yes. Yes.

47

1 MR MUSTON: Just so I can understand that one, the blended
2 funding models is a blending of funding models to deliver
3 both primary and acute care.

4 A. Yes. Yes.

5

6 Q. You said there was a commitment, as you understood it
7 in this area, or commitments have been made in this area.
8 What do you understand those commitments to be? I think
9 your phrase was some commitments have been made to
10 accelerate the development of blended funding models, or
11 words to that effect. "I know there is a commitment in
12 this area but" --

13 A. Oh, okay, that there is a commitment in this area.
14 Right. I guess all that I'm saying is - I mean, there are
15 some examples around the State of sort of - so the
16 traditional MPS model, but actually bringing that type of
17 model more into a primary health/acute care.

18

19 Q. Yes.

20 A. There are little bits of that here and there, but
21 I think that needs to become the norm. The norm.

22

23 Q. Yes.

24 A. So that is - you know, my wishes are going pretty well
25 at this point if I got all of those.

26

27 Q. When you say "to become the norm", blended funding to
28 enable primary and acute care --

29 A. Yeah.

30

31 Q. -- and perhaps even aged care --

32 A. Yes.

33

34 Q. -- to be delivered, in appropriate circumstances, by
35 NSW Health.

36 A. Yes.

37

38 Q. Through a blended funding model that involves funding
39 from the State?

40 A. Yes. Because at the end of the day, you know, whilst
41 I'm sort of going on, you know, in my role about the
42 funding for the LHD, the bigger risks to society are around
43 the failure of aged care and the failure of primary health.
44 So, there has got to be a lot more focus in that area.

45

46 If you look at the number of nursing homes that have
47 closed down across Australia in the last 18 months, that's

1 a pretty terrifying number when you consider, you know, the
2 growing gap. So we can't say, you know, "Well, that's the
3 Commonwealth problem". I think we become the provider of
4 last resort and so at the moment - I don't know today's
5 figures, but we do have them every couple of days - the
6 number of nursing home and NDIS patients that are occupying
7 ED accessible beds, in New South Wales public hospitals, it
8 sits between 650 and 820. I mean, that's - you know,
9 people get used to those numbers but that --

10
11 THE COMMISSIONER: Q. Should I understand what you said
12 when you said - you were talking about the number of aged
13 care places that have closed across Australia in the last
14 18 months being terrifying --

15 A. Mm.

16
17 Q. -- and you said, "We can't say that's the Commonwealth
18 problem", should I understand that to mean whilst maybe the
19 Commonwealth should be funding this, and maybe it should be
20 funding primary care better, you, as an LHD, just can't
21 ignore the problem. Is that what you mean?

22 A. That's the point.

23
24 Q. Yes.

25 A. And I understand - I'm not trying to be trite.
26 I understand it is a complex field.

27
28 Q. Yes. Yes.

29 A. But there has been - and I certainly don't know
30 everything about all the nuances and the politics, but the
31 reality is we've been talking for ages now about, you know,
32 the crisis with regard to rural GPs.

33
34 Q. Yes.

35 A. Well, it is upon it.

36
37 Q. Yes.

38 A. There has been talking for ages about the failures in
39 residential aged care. Well, it's upon us. And more
40 recently the increasing complexity around NDIS.

41
42 Q. Yes.

43 A. And so I guess, you know, there is so much to be proud
44 of with the New South Wales system and the opportune - you
45 know, the - and you don't want to be sick anywhere else.
46 So I'm not sort of, you know, saying everything is bad --
47

1 Q. No.

2 A. -- but I am saying that so many of the things that are
3 so central to safe and sustainable service delivery will be
4 compromised if these areas of policy and funding are not
5 resolved.

6
7 THE COMMISSIONER: Yes.

8
9 MR MUSTON: Unless you have more things on your wish list,
10 I have no more questions for this witness, Commissioner.

11
12 THE COMMISSIONER: Q. You can take that question on
13 notice and if there is a lot more that you wish to flag --
14 A. Yes, I'd love to do that because there are more things
15 on my wish list.

16
17 THE COMMISSIONER: Okay.

18
19 MR MUSTON: Q. Do feel free to --

20 A. Yes.

21
22 THE COMMISSIONER: Open for business for a while yet, so
23 feel free. Thank you.

24
25 THE WITNESS: Can I say something?

26
27 THE COMMISSIONER: Q. Yes. Feel free to add anything
28 that you want to. Yes.

29 A. This is the end of the southern, I just would like to
30 have on record our appreciation to you, Commissioner, and
31 your team for spending a week with us. It's been wonderful
32 having you here and to have the opportunity for you to see
33 all - you know, all and many of the great things that are
34 happening in southern.

35
36 I suppose I am - I'm wanting to emphasise, the
37 fantastic staff in southern are doing amazing work every
38 day, and I think you've had a bit of a flavour of that.

39
40 We know that we've still got plenty to do in our own -
41 what's in our own capacity to improve, but certainly some
42 of the things we have talked about are getting in the way
43 of the progress that we need to make, and you can see the
44 fabulous staff and clinicians that we've got, but you could
45 also feel their frustration, because they have been picked
46 because of that passion and that knowledge. They're
47 exactly the people we need to take southern forward, but,

1 of course, that tension then exists between funding and
2 moving forward at a rate that the community needs, but also
3 that drives clinician engagement and satisfaction, and so
4 I recognise that is always going to be a healthy tension.
5 I guess we just need the tension to be a little bit
6 healthier than it is at the moment, but I just want to say
7 thank you. I think this has been a great opportunity to
8 give you a little insight to our world.

9
10 THE COMMISSIONER: Thank you. I have to be careful what
11 I say, which I don't always do, but I think I will just
12 have to say that we are very grateful for the time your
13 clinicians and staff gave it, and we found it very
14 valuable. So, thank you.

15
16 You got left out. Do you have any questions?

17
18 MR CHIU: No.

19
20 THE COMMISSIONER: Well, that doesn't surprise me either.

21
22 Thank you again, and thank you for your time, and you
23 are excused, save for telling us more things about your
24 wish list.

25
26 THE WITNESS: Thank you. No, I will certainly do that.
27 Thank you.

28
29 **<WITNESS RELEASED**

30
31 THE COMMISSIONER: We adjourn to 9 September, is that
32 right?

33
34 MR GLOVER: Yes. Before we do that, can I just deal with
35 the documents.

36
37 THE COMMISSIONER: Yes.

38
39 MR GLOVER: I hand up a list, in the usual way, together
40 with a non-publication order over two very small parts.

41
42 THE COMMISSIONER: This is the material from the two
43 tender bundles, is it?

44
45 MR GLOVER: It is, yes, Commissioner. So I tender - hang
46 on, there is about to be something that is maybe going to
47 cause some alarm.

1
2 THE COMMISSIONER: So you want me to make this a
3 non-publication order?
4
5 MR GLOVER: I do.
6
7 THE COMMISSIONER: I don't even know what it is about yet.
8
9 MR GLOVER: I will tell you immediately.
10
11 THE COMMISSIONER: Go on.
12
13 MR GLOVER: There are two very small parts of the document
14 that contain some commercially sensitive pricing
15 information.
16
17 THE COMMISSIONER: Sensitive what?
18
19 MR GLOVER: Pricing information.
20
21 THE COMMISSIONER: Right. I see.
22
23 MR GLOVER: They are only part of two pages of that bundle,
24 but we have attached them to the order in the usual way.
25
26 THE COMMISSIONER: All right. On the basis of that,
27 I will make the order that is set out here in this
28 non-publication order pursuant to section 8 of the Special
29 Commissions of Inquiry Act. So, that order is made.
30
31 MR GLOVER: And I otherwise tender the documents in the
32 list.
33
34 THE COMMISSIONER: Does that include - I don't know
35 whether this has an MFI?
36
37 MR GLOVER: It does.
38
39 THE COMMISSIONER: It does. All right. So those
40 documents are tendered with the exhibit number given to
41 them.
42
43
44 **ADMITTED AND MARKED EXHIBITS #1.000 TO 1.045**
45
46
47 MR GLOVER: Thank you. Thank you, Commissioner.

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THE COMMISSIONER: Thank you. So we adjourn until
17 September in Tamworth at, probably, 10am. All right.
We will adjourn until then. Thank you.

**AT 2.47PM THE SPECIAL COMMISSION OF INQUIRY WAS ADJOURNED
TO TUESDAY, 17 SEPTEMBER 2024 IN TAMWORTH**

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