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

THE COMMISSIONER: Good morning, everyone. Yes, Mr Glover.

MR GLOVER: Thank you, Commissioner. This morning the first two witnesses are Ms Hoskins and Mr Clout. They are being called together, and they are in the witness box.

<ELIZABETH HOSKINS, AFFIRMED [10.04 am]

<TERRY CLOUT, SWORN [10.04 am]

<EXAMINATION BY MR MUSTON

MR MUSTON: Ms Hoskins, can you state your full name please.

MS HOSKINS: Elizabeth Maria Hoskins

MR GLOVER: You are the current chair of the board of the Southern NSW Local Health District?

MS HOSKINS: Yes.

MR MUSTON: And you've held that role since 2023?

MS HOSKINS: Yes.

MR GLOVER: And been on the board since 2017; is that right?

MS HOSKINS: Yes.

MR GLOVER: To assist the commission in its work, you have prepared signed a statement dated 2 August 2024, correct?

MS HOSKINS: Yes.

MR GLOVER: Do you have a copy of it there with you?

MS HOSKINS: I do.

MR GLOVER: For the benefit of the transcript, it's MOH.0011.035.0001. Have you read it again before giving your evidence this morning?

MS HOSKINS: Yes.

MR GLOVER: And you are satisfied it is true and correct?

MS HOSKINS: Yes.

MR GLOVER: Mr Clout, can you tell us your full name, please?

MR CLOUT: Terence James Clout.

MR GLOVER: You are the deputy board chair of the Southern NSW Local Health District, correct?

MR CLOUT: Correct.

MR GLOVER: You have been on the board since 2020?

MR CLOUT: Correct.

MR GLOVER: And been deputy chair, either acting or substantive, since 2022?

MR CLOUT: Correct.

MR GLOVER: And you have also prepared a statement to assist the commission, correct?

MR CLOUT: I have.

MR GLOVER: Dated 6 August. That is MOH.0011.0040.0001. Have you read it again before giving your evidence today?

MR CLOUT: Yes, I have.

MR GLOVER: And you are satisfied that it is true and correct?

MR CLOUT: I am.

MR GLOVER: Just by way of introduction to how this morning will proceed, I will ask you a series of questions about topics referred to in your statement, perhaps others. I might direct the questions to one or other of you. Feel free to pipe up at the end of the answer and add to what one or other of you have said, even if I don't - I will try and direct that to you as well, but if I forget, feel free to interrupt me.

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

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

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

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

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

MR CLOUT: I have.

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

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

MR GLOVER: Mr Clout, do you have anything to add?

MR CLOUT: Yeah, I think there are a couple of others as well, which is clearly the culture of the organisation is critically important, and part of the role of the board is

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

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

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

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

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

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

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

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

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?

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

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

MR CLOUT: Absolutely.

THE COMMISSIONER: Thank you.

MR GLOVER: Why?

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

needs to be serious listening.

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

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

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

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

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

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

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

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

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

THE COMMISSIONER: Yeah, of course.

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

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

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

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

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

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

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

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

THE COMMISSIONER: Thank you.

MR CLOUT: Can I just add something?

THE COMMISSIONER: Yes, of course.

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

THE COMMISSIONER: Right. Yep.

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

THE COMMISSIONER: Yes.

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

THE COMMISSIONER: Yes.

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

is important.

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

MR CLOUT: Absolutely.

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

MR CLOUT: Correct.

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

MR CLOUT: Do you want to answer that first?

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

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

MS HOSKINS: They do come to board, yeah.

THE COMMISSIONER: In this LHD?

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

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

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

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

MR GLOVER: Set into the processes of the governance of the LHD?

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

MR CLOUT: Yeah.

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

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

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

MR CLOUT: They do.

MR GLOVER: Through that committee?

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?

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

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

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

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

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

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

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

MS HOSKINS: Sure.

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

MS HOSKINS: Critically important.

MR GLOVER: Why?

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

MR GLOVER: Mr Clout?

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

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

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

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

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

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

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

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

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

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

MR CLOUT: It is. Absolutely important.

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

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

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

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

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

MS HOSKINS: Completed in November.

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

THE COMMISSIONER: This is in the teal bundle?

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

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

MR CLOUT: It is.

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

MS HOSKINS: Yes.

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

> *Our processes for engagement are transparent.*

The first one:

> *Our engagement is open and honest and sets clear expectations. We explain what can and cannot be influenced and why.*

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

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

THE COMMISSIONER: Mr Clout, anything to add?

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

That's just the reality of it.

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

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

MR CLOUT: Absolutely.

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

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

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

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

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

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

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

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

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

MS HOSKINS: Yes, which is --

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

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

THE COMMISSIONER: They are, yes.

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

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

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

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

MR GLOVER: Having reviewed those reports about the

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

MS HOSKINS: Yes.

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

MS HOSKINS: No.

MR CLOUT: No.

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

MS HOSKINS: Sorry, could you repeat that question?

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

MR CLOUT: Yes.

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

> *We advise people how their input affected the decision and outcome*

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

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

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

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

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

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

MS HOSKINS: Yes.

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

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

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

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

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

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

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

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

treat that petition and how you perceive it as well?

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

THE COMMISSIONER: Yep.

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

THE COMMISSIONER: Yes.

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

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

THE COMMISSIONER: Yes, yes.

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

THE COMMISSIONER: Yes.

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

THE COMMISSIONER: As a board?

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

THE COMMISSIONER: Yes.

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

THE COMMISSIONER: Yes.

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

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

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

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

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

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

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

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

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

THE COMMISSIONER: Yes.

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

THE COMMISSIONER: Yes.

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

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

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

THE COMMISSIONER: Yes.

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

THE COMMISSIONER: Yes.

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

THE COMMISSIONER: So that's the workforce issue?

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

can be provided safely and appropriately.

THE COMMISSIONER: Yes.

MS HOSKINS: If I could add to that, I'm not from a medical background, but I can see that that decision to open day one level 4 was an inappropriate decision.

THE COMMISSIONER: Why do you say that?

MS HOSKINS: Because it will be - my understanding is that, and I've seen it --

THE COMMISSIONER: Was it a decision or a promise?

MS HOSKINS: Probably both.

THE COMMISSIONER: Was it a political promise or a decision?

MS HOSKINS: Is there much difference in that? I'm not sure.

THE COMMISSIONER: I think there probably is a difference. But, anyway, I interrupted you, you keep going.

MS HOSKINS: I don't see a difference, whether it's a promise.

MR CLOUT: From a board point of view, there is probably no difference.

MS HOSKINS: Yeah, no difference.

THE COMMISSIONER: Understood. Sorry, I interrupted.

MS HOSKINS: No. I was just going to say my understanding as far as Goulburn Hospital, which is a level 4, was that it was timed to move to level 4 when it was appropriately staffed. So to do that, you know, on day one, I think presents a challenge. As I said, I believe the LHD can do it, but it presents a challenge.

THE COMMISSIONER: Yes.

MR GLOVER: Mr Clout, in an earlier answer, you drew a distinction between community engagement and consumer

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

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

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

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

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

that?

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

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

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

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

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

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

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

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

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

MS HOSKINS: Absolutely. And --

MR GLOVER: I'm sorry, you go.

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

Indigenous space.

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

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

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

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

MR GLOVER: Please do.

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

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

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

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

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

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

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

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

MR GLOVER: Please do.

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

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

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

MS HOSKINS: Yes.

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

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

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

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

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

> *These facilities are low volume ...*

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

> *The LHD has provided information to NSW Health ...*

Et cetera. Do we have that information?

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

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

> *The LHD has requested that a change in funding ...*

Do we have that request?

MR GLOVER: Same answer again.

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

MR GLOVER: That's all right.

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

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

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

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

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

DR CLARKE: If I can just add to this?

MR GLOVER: Please do.

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

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

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

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

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

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

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

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

MR GLOVER: Mr Clout?

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

MS HOSKINS: Correct.

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

THE COMMISSIONER: Of course, yes.

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

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

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

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

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

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

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

MR CLOUT: Particularly for those two hospitals, yes.

MS HOSKINS: Could I try and explain that structural deficit a little better?

MR GLOVER: Please do.

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

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

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

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

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

MR GLOVER: In paragraph 20, Ms Hoskins --

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

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

MR CLOUT: Well --

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

THE COMMISSIONER: I was just saying it out loud.

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

THE COMMISSIONER: Yes.

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

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

MR CLOUT: Yes.

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

THE COMMISSIONER: Right.

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

MR CLOUT: Absolutely.

MR GLOVER: And the junior workforce?

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

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

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

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

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

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

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

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

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

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

probably about 10 minutes to go.

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

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

THE COMMISSIONER: Yes, yes.

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

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

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

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

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

MS HOSKINS: Correct.

THE COMMISSIONER: That's the next sentence.

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

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

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

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

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

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

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

MS HOSKINS: Yes.

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

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

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

MR CLOUT: Yes.

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

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

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

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

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

THE COMMISSIONER: So am I.

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

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

MR GLOVER: Buildings and equipment?

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

MR GLOVER: Just equipment?

MS HOSKINS: Yes.

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

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

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

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

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

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

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

MR CLOUT: Yes.

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

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

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

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

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

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

MS HOSKINS: Yes.

MR GLOVER: Mr Clout, do you agree?

MR CLOUT: Yes.

MR GLOVER: And not funded adequately to meet its capital maintenance needs and renewal needs at the moment?

MS HOSKINS: Correct.

MR GLOVER: Mr Clout?

MR CLOUT: Yes.

MR GLOVER: And not funded in a way that enables the district to look to pursue innovations, be it in service delivery or other programs?

MS HOSKINS: Correct.

MR GLOVER: Mr Clout?

MR CLOUT: Yes.

MR GLOVER: Thank you, Mr Commissioner. No further questions of these witnesses.

THE COMMISSIONER: Do you have any questions, Mr Chiu? Thank you both very much for your time. We are very grateful. You are both excused.

<WITNESSES RELEASED

THE COMMISSIONER: We will take a break until 12. Adjourn till then.

SHORT ADJOURNMENT

THE COMMISSIONER: Yes.

MR MUSTON: The next witness is Margaret Bennett.

<MARGARET BENNETT, AFFIRMED [12.03 pm]

<EXAMINATION BY MR MUSTON

MR MUSTON: Q. Could you say your full name for the record, please?

A. Margaret Louise Bennett.

Q. You are the chief executive of the Southern NSW Local Health District?
A. That's correct.

Q. And I think you have held that role since March 2020?
A. That's right.

Q. You've prepared two statements to assist the Inquiry with its work, the most recent of which is dated 6 August 2024?
A. That's correct.

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

Q. Have you had an opportunity to review it before giving your evidence today?
A. Thank you, I have.

Q. You are satisfied, to the best of your knowledge, its contents are true and correct?
A. I am.

MR MUSTON: Thank you. That will be tendered in due course, Commissioner.

THE COMMISSIONER: Thank you

MR MUSTON: Q. Can I ask, have you had, or did you have the opportunity to listen to the evidence that was being given by your board members shortly before you came to commence giving your evidence?
A. Yes. Yes, I did, thank you.

Q. I will try and do this in a relatively short-cut way. Did you hear the evidence given by them at the conclusion to the general effect that, in their view at least, budgetary allocation which is received by the LHD is insufficient to enable the LHD to deliver on the health needs of the community which accesses those services across your LHD?
A. Yes. I felt they expressed that very clearly.

Q. Is that a view that you share?
A. Yes, indeed.

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

that sense does create significant risks in terms of the delivery of safe and effective patient care?
A. Yes. So, obviously, we have a number of monitors in the intensive care unit and the emergency department. They're all the same age, and so when one or two are becoming not functioning then the risk rating goes off because you realise the others are not far behind that.

Q. Yes. There comes a point where you don't have enough left to cannibalise them for parts for those that are still working?
A. That's exactly the issue.

Q. And ideally, from the delivery of good patient care equipment, is it your view that equipment would be replaced long before it reached that state?
A. Yes, it's critical to have that reliability, I think, in any clinical setting, but particularly in isolated rural environments where you can't just grab something from a hospital down the road if you're in trouble.

Q. We heard some evidence yesterday about the costs associated with maintaining and repairing equipment which was effectively beyond its serviceable life, and the suggestion was that, at least in respect of some of the equipment, that cost might, in the long term, exceed the cost of replacing the equipment. Do you have a view about that?
A. Yeah, no. Absolutely. And in the case of that piece of equipment specifically at Cooma, it had been sent for fixing on three occasions and then it was replaced in April. We do now have across the system an asset management online system which will give very clear reporting across the LHD with regard to how many times any piece of equipment has had to be sent back for fixing, and then part of that would be if that was getting to a critical stage, two or three times, we would look to replace that. If it was under - if we were fortunate that it was under $10,000, we could do that quite quickly. If it was above that amount, we would need to look at that in terms of where that sits, because it won't be the only piece of equipment across the district that needs replacing. So it's a balancing game. But we would never not spend something if it was required to support patient safety.

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

capital budget and then a separate allocation within the budget for maintenance, which I think was described as about 5 or 6 six per cent of the total asset base. Is there anything about the way in which that funding is delivered to you, divvied up in that way, that actually prevents you from making what you think might be the better financial decision, if faced with that choice between replacing, on the one hand, or patching up and repairing on the other?
A. So we are working very closely with the ministry. Southern is not the only LHD that, in these financially challenged environments, are facing this challenge, and there's this new CAMP model that you heard the board chair refer to which, once it's implemented, should give us greater clarity over a five-year period of what our replacement opportunities would be, and we'd certainly - we would certainly welcome that, because if we had 10 million now against the 86, that would give us some help for a year or 18 months, and then if we knew that a similar allocation would follow that. So I think the biggest thing for us would be reliability of a funding line over a period of time that would enable us to trade out of trouble, as it were.

Q. The existing $86 million deficit in respect of capital, is it the case that the capital funding which is being received at the moment, at least, is doing anything to close that hole, or is the hole continuing to get bigger?
A. No, the hole is getting bigger.

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

Q. When you referred earlier to the challenging economic environment, I think we have heard it referred to as a challenging budgetary environment. There have been a range of different ways to describe it, but is that essentially, at least as lived experience within this LHD, just a polite way of saying, "We are not given enough money to meet the costs of running the LHD and addressing problems like the increasing capital deficit"?
A. Yes. I would respond to that by saying that I think that health is a very difficult environment for funding

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

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

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

Q. For all the reasons we have spoken about?
A. Yes.

Q. You know, locums, et cetera?
A. Yes.

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

the way in which, as a somewhat blunt instrument it has been structured, is an appropriate way for the State and the Commonwealth to divide as between themselves the cost of delivering acute care to the people of New South Wales, I gather from what you have told us it is your view that that same model ought not be applied when decisions are being made, as the determinant, when decisions are being made as to how much funding should be delivered to your LHD for the purpose of delivering a slice of that care that you do, because it is not a good measure of the cost of delivering that care?
A. I think so. Yes, I think that's correct. But what I'm trying to say is that there needs to be sustainable funding for an agreed service delivery model in our environment.

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

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

Q. In relation to that first component; that is, what the public health system actually needs to deliver from a safety perspective, some of these services which are being delivered at your smaller hospitals, for example, the maternity services, I gather from the evidence that we've heard fall very much into that category; would you agree with that?
A. Yes. I think something that we've talked about in the travels has been maternity services at Cooma, so a big investment for 150 babies a year, but then when you look at the geography and you consider snow and ice on the roads and you consider how far those women have already travelled in labour, it is my view, as an experienced midwife in

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

Q. You tell us in your statement at paragraph 103 that the costs to the district of the premium labour component of the workforce is 62.4 billion, there or thereabouts. In relation to that, we heard some evidence from the board to the effect that even if the - well, let me take it in two steps. That 62.4 million is the total spend on the premium labour?
A. So in the last year, around about 44 for medical and 20 for nursing, yeah.

Q. If you were to wake up tomorrow and all of your positions were fully recruited and you had no need to rely on premium labour, the LHD would still be required to spend a slice of that 62.4 million on the salaries and wages being paid to those members of the permanent work force who had slotted into those positions?
A. Yes. So the net, if you like, is about 30 million.

Q. And that's - in terms of budget deficits, it would be no answer to the budget deficit faced in this LHD; even if the premium labour could be reduced to a minimum or even reduced to nothing, there would still be a deficit?
A. That's correct, because the two major components of our deficit, of what you are just referring to, the premium cost of premium labour, and the other component as the board expressed so clearly, is the cost of doing business in southern, the actual raw cost of running these various units that we have described. And they're the two components that challenge us so significantly.

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

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

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

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

Q. And some craft groups?
A. That is my point.

Q. Just while we are on the craft groups and perhaps specialist and sub-specialist care, an important part of the care that is delivered by the public health system to the community includes outpatient clinics and specialist and sub-specialist care to those who need it. The demand for those services across all of the craft groups in this LHD, I gather from the answer you have just given, is probably not sufficient to sustain a complete workforce that covers the field in terms of those groups?
A. Look, that is the case, but it is also the case that we have the need and the planning focus on uplifting that considerably from where it is at the moment. So outpatient development is a big focus of that. We serve an isolated community, a low socioeconomic. It is really important, in Canberra, I have very long waiting lists.

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

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

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

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

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

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

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

Q. You point to Dr Piper's success with paediatrics at Bega as a good example of that, I assume?
A. Oh, that's outstanding on a national level.

Q. In terms of the forming of those connections, do you think there would be any utility in having the ministry involved at a more formal level, perhaps workforce branch, or some branch of the ministry, more involved at a formal level in trying to pair up some of the people that need to be paired up in order to meet need? For example, an ability for you to say, based on information received from your clinicians, "I need," say, 0.3 FTE of a gerontologist at Bega. I'm never going to be able to get 0.3 of a gerontologist to come down just for that, but the system won't be able to provide that for me. Please help facilitate that."
A. Yes, so there is nothing stopping me and others from doing that now, and you'd find with the other LHDs you're

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

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

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

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

firmer structures, including, potentially, employment arrangements as between the ministry and a specialist who might be employed in one location or the other, which actually locks in as a part of that person's job meeting those needs, not just immediately but going forward.
A. Yes. I would also add that I think it's critical for LHDs like ourselves to be incredibly flexible in what engagement looks like. So rather than perhaps what might have been the more traditional model of, "We've recruited you and you will move your family and you will buy a house on the coast," I mean, we welcome that, but also we need to be - and this will be particularly what we're focusing on with the development of Eurobodalla, is having a stable of people who belong to us but they belong elsewhere as well, and we know that Dr X who is at Illawarra will come down and do outpatients and a day of surgery and a day of follow-up every six weeks, and really be part of our medical staff council, be part of us, but with no expectation that she or he would ever live down here. So I think that flexible thing.

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

Q. I will come back to primary care in a moment, but in relation to the workforce challenges and Eurobodalla, or the reopening of the Eurobodalla hospital, you have no doubt heard the evidence that was given by the board chair to the effect that deciding/promising to open that hospital at a level 4 or as a level 4 facility is a real challenge. Is that a view you share?
A. Yes, it is a view I share. I'm very mindful of the direction from the Premier and the minister, and my answer to that has always been, "We're very clear, we will do everything we can." And certainly with particular focus around ICU, given that we don't provide this service at the moment, what we could promise is on the day it opens, if we had a patient that required ICU-level care, they would certainly get it. They would be ventilated and

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

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

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

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

A. The workforce?

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

disappear --
A. Not going to magically --

Q. Nor magically appear either?
A. No.

MR MUSTON: Q. Yes, the workforce is not going it magically appear?
A. Yes. So those problems aren't going to disappear. So whilst I am very conscious of the direction --

THE COMMISSIONER: Q. Yes.
A. -- that I'm given, I am an experienced CE who is saying, "I'm hearing you, we will do everything, but this is the headwind we need to contend with."

Q. Can you be given a direction to get to the moon safely and back, but there is a lot of work to be done?
A. That's right. A lot of risk as well. I would probably find the moon a bit easier at the moment.

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

MR MUSTON: Q. Correct me if I've misunderstood this, but I gather from one of the other answers that you have given around the need to get, for example, the intensive care unit staffed and at operating temperature before the hospital actually opens as a level 4 facility, that a range of those costs, including that workforce cost that you would incur in bringing the intensive care department to that position, would be incurred over a period, perhaps quite a way before the intensive care department at Moruya had the capacity to generate one single nWow?
A. Yeah, no. Absolutely. I mean, the recruitment of rare beings like intensive care doctors would need to start, you know, 18 months out. And even if they didn't start and they were working elsewhere or you had a partnership arrangement, or whatever, there's a whole lot, as you would understand, that you need to do with regard to protocol training, safety. You know, the success is all in the foundation, and the foundation would need to start at least, you know, at least 18 months out.

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

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

Q. Having said that, some evidence given by your board chair and a member of your board about the impact of trying to recruit within an environment which is underfunded - you recall hearing that evidence? That is to say that recruitment is hard enough in a district like southern, but it is exponentially harder when you are trying to recruit people into an environment where the existing workforce is stretched by funding constraints. Is that a view you share?
A. Yeah. Look, I think - and you probably heard some of that frustration. We've had tremendous success with recruitment, and you have heard that there has been an incredibly strong focus on positive culture, visible executive, visible board, good leadership, you know, good clinical leads and all of those things. So that's all great. But good clinicians are hungry for progress and service development and so forth, and you heard that yesterday. And so, that's where the difficulty can be, is that sort of thing about, "But I thought you said we'd have this or we'd be doing that," or, "What's the timeframe?" So to attract and maintain good clinicians, you need to be making sure the promised and required service delivery and the required equipment.

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

Q. Part of that, to pick up on some evidence given by the board, is driven by the fact that the clinicians have as their core focus the delivery of care to the community?
A. The doing, yes. Yes.

Q. But another part of it is also that by expanding the services in the way that you have just described creates an environment where the existing workforce and prospective workforce are able to feel like they are personally and professionally challenged and able to develop professionally in a way which makes it a fulfilling job and a desirable place to go and work?
A. Absolutely. Absolutely. You want to be able to grow an environment where there is an absolute recognition - and in fact celebration - of the specialty that is rural health, and that rather than, perhaps, a bit of a "poor cousin" sense. So rural health is amazing, but for it to meet the needs of a very diverse community, you need very skilled, multi-skilled generalists both in nursing, medicine and allied health, and a lot of investment needs to go into that, and a lot of investment in education, and we're behind where we should be in that regard.

THE COMMISSIONER: Q. This is the kind of multiple-hats clinicians that Dr Ayers was talking about yesterday in that?
A. Oh, absolutely. She was spot-on. Yeah, absolutely. So we've got all the right people who have got the right philosophy and vision, so that's a wonderful thing. We've got a very positive, engaged culture. It is the issue now of, you know, recognising that you can't sort of wave a magic wand, but it is an issue of getting greater equity in funding because we are expensive. We're necessary and we're good, but we're expensive.

MR MUSTON: Q. You mentioned a moment ago that education is an area where you are lagging behind a bit at the moment. What do you have in mind that could be done, or what are the plans for moving forward in relation to that area?
A. Well, there is a couple of things. So at a very basic level, we do not have a director of education in southern. So, you know, I still don't have a fully fleshed out, you know, executive team. I have got the most wonderful team you could imagine, but there are positions missing. And that's because we are in such a constrained environment - I'll try to stop saying that, but I can't just think of

what else to say.

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

MR MUSTON: Q. If you can't, "we can't afford it" is fine.
A. So that's the thing. And so therefore, you to need to have the right leadership. That doesn't stop my various executive - and they're great at furthering university and TAFE partnerships and so forth, but, you know, if you want a rich learning environment, you need to invest in the leadership and the governance of that so that there is that dedicated focus on what more could we be doing, what could we be doing with other LHDs.

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

Q. As part of that additional role within an executive of a director of education, the idea that there would be someone within your team who would be able to foster and develop these partnerships, work out as between the LHD and the education provider, what collaboratively could best be done to grow one's own workforce?
A. Yes, absolutely. And it seems possibly quite ridiculous, "Well, why don't you just appoint that person?", but in an environment where you are, you know, quite reasonably held to account for the savings that are required, putting on an additional senior staff member, it's a difficult balance when there is so much need.

Q. Just in relation to the education, it is probably a 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

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

Q. Do you - first of all, do you share the view that the relationship, the current structure whereby - well, let me take it in three steps. Are we right in our understanding that the current structure has your LHD tied only to the ACT medical service and, effectively, to use the words of others, invisible to New South Wales-based students who might be seeking internships through HETI, as the existing structure?
A. Okay, yeah, the existing structure is as you describe. We are absolutely committed to seeking our own, as well as not walking away from the Canberra arrangement that we appreciate. But we do need the next step, and conversations have started to actually have our own HETI arrangement. The critical issue for us, and this is crawl before you run, is to grow that sustainably, we needed to get success in the recruitment of senior doctors. That will be critical to providing both the supervision and the experience for the additional - for the HETI doctors.

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

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

A. Yes.

Q. -- for the delivery of interns. Are there discussions afoot for a similar arrangement in southern?
A. I'm very familiar, because I've come from that environment. So I'm familiar with that. "Discussions afoot" might be too strong a statement just at this stage, but certainly it is that mixed arrangement that I am seeing that we need to have here, and I know that HETI would be - I'm confident that HETI would be supportive of that.

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

Q. So the relationship with Canberra, at least at a geographical level, feels to a layperson like it might be mutually beneficial, particularly in facilities like Braidwood and Cooma?
A. Yeah, Queanbeyan and so forth. Yes. Yes, is the answer. We did establish the coastal network with the clear focus on having, I guess, greater emphasis on north-south, you know, into Illawarra, particularly with the development of the Illawarra hospital. So you can imagine that from, you know, now on there will need to be a very strong, and there should be a very - you've got, you know, the two hospitals being built there and Eurobodalla. So you would look to see how we could best network between those two districts. But always the focus for the west of our district is going to be strongly related to Canberra.

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

Q. Just briefly, what is your take?
A. There's no doubt it is easier if you've got one.

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

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

Q. And when you refer to "flow" there, I assume you refer to patient flow as one aspect of that, but also workforce flow?
A. Mm, workforce flow. And, I mean, and some arrangements that are tricky. We pay, for example, for ambulance going and coming, both ways. The award structure is different. And so the idea if you had a tertiary hospital in your own place, you'd be able to look at getting nurses and doctors to move between, and so forth, whereas that's much more difficult with Canberra. So those flexibilities don't follow that easily.

Q. It was somewhat lacking in specificity, but you may have given the evidence given yesterday by Dr Stapleton to the effect that he felt the LHD was not necessarily getting great value for money from its spend on the ACT Health service. Do you have a view in relation to that, at least as a blunt proposition?
A. Yes, I reflected on his comment. I suppose I see it a bit differently. I think that the - you know, there is a financial arrangement between the ministry and ACT for outpatients that they look after. So that's happening. I think the - sort of that broader partnership arrangement that, you know, that you would hope you would foster if you had your own tertiary facility, where senior staff, nursing, medical, allied health had a sense of ownership for their smaller facilities, that they sort of own the house more broadly. So I think that what Stuart perhaps might be thinking about is, "Oh, well, they're not doing much extra for us." Well, for me, that is not really what they're paid to do, in a way. So the funding, the money they get, is for the patients they look after, and so anything else with regard to sort of value-add clinical governance, education, support, would be a separate arrangement. And, yeah, so that's probably where I'd leave that.

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

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

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

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

MR MUSTON: I think so.

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

LUNCHEON ADJOURNMENT

THE COMMISSIONER: Yes, Mr Muston, thank you.

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

Q. You heard that passage of evidence whereby her view was financial constraints at Cooma hospital resulted in the need to use wound care products which were seen as less than optimal when compared with the alternatives. It is a pretty operational issue, I know, but do you have a view in relation to that as to whether it is a widespread problem and, if so, why?
A. No, I did - I did hear that, and I'll follow that up with Jo. I mean, certainly there is absolutely no direction for any compromise in clinical care. It is the fact that we talk to our leaders about financial constraints and talk to them about making wise decisions, so if there was a product that would be appropriate and adequate and safe, well, then, obviously use that rather

than something --

THE COMMISSIONER: She didn't say that there was any direction?
A. No.

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

MR MUSTON: For this service.

THE COMMISSIONER: For this service, and she has to make sure --
A. Mm.

Q. That the product she uses fits within that budget.
A. Mm.

Q. And the alternative product, as I understood her evidence, would not fit within that budget. That's how I heard it.
A. Yeah, and I think she's been very diligent and considered. I need to then reinforce with her, and with others, that you need to do the right thing for your patient, and if that meant that there was a need to be using expensive wound care that was going to take you outside your budget, well, then, that's something that we need to know about. And the direction from the board and from the executive is always very clear, that we will not compromise care.

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

MR MUSTON: Q. And, in a way, that necessary focus of the minutiae of the budget when combined with what has been characterised as a challenging budgetary environment results as the capacity to produce decisions like that?
A. Yeah. Yeah. Look, I think that it is a matter of - we tried to - well, we don't try. We actually focus on making sure that our leaders are absolutely across our overall situation. That's an important part of open and

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

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

Q. Another quick question about collaboration with partners. The LHD's collaboration with the Katungul Aboriginal Corporation Regional Health and Community Services that you tell us about in paragraph 81 of your statement, what is the nature of that collaboration? How do you look after that?
A. Yeah, quite detailed. And I'll list off some of the things that we're doing with them. The relationship is very solid, and I think the solidness of the relationship is demonstrated through the prolonged time of COVID where, you know, every day across seven days we were working in absolute, a very joined up partnership. But the sorts of things at the moment, the Katungul CE - you are aware that immediate past Katungul CE is now actually working for southern as a direct report to me.

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

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

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

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

Q. In relation to that, part of that is growing a workforce from members of the local community who could provide that care through that facility. What collaboration, if any, has there been, say, with TAFE and the universities locally, targeted at trying to develop that workforce more locally so they can train locally and work locally?
A. Thank you. That is such an important - and that is an area we need to do more, and there is almost sort of a symbolism in the fact that the new ERH - I don't know if you have seen the block where it is developed, but it co-locates. There is a fence between us and TAFE, and - not that you need the physical proximity, but I think that is a bit of a symbolism of a further engagement with TAFE in growing the workforce for the new hospital. But answering the question specifically, a really good example of a partnership at the moment, we really want to have more Aboriginal midwives, and the University of Canberra has been fabulous in their partnership to develop a pathway for young Aboriginal women who want to be a midwife. They may not have had the traditional pathway for university entrants, but they are looking at that flexibility. We have got three young women from here who are now on track to be midwives. So that's wonderful, but I think the area, as you identify, where there is a lot more room for formal development is with TAFE.

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

TAFE's narrow perspective may not be economically viable having regard to the number of students, are they the sort of discussions you anticipate?
A. Yes, absolutely. And I think also connecting in with what's - I mean, given that sort of broader rural partnership, but connecting in, there might be a TAFE course that's happening out in western LHD. So rather than having to duplicate that and if it is predominantly online, well, we would just hook in with that. But something we need, we do have an Aboriginal leader of workforce. We don't have the overarching director of workforce. And in the next sort of six months, it is the development of that dedicated leadership that we need to provide additional impetus and emphasis on training pathways.

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

Q. They have historically provided excellent primary care to their communities.
A. Mm.

Q. And, in addition to that, have provided care in an acute setting through the hospitals in their VMO roles. Do you have a view about whether that model is viable in a contemporary environment, having regard to work patterns, changing family and life patterns, and all of the various changes which have occurred over the past few decades?
A. So, you know, given that I've had now 50 years full-time in rural health across Australia, I'm in a good position to say that it is the development of that model, the supported - the growth and development of GP generalists and GP proceduralists, that is absolutely critical for rural health.

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

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

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

Q. And that - sorry, if you want to say something to me, you go ahead.
A. No, so it is the absolute focus on robust, reliable, sustainable primary health. That is the absolute foundation for a health system.

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

Q. And that you would be concerned to ensure that we, that is the LHD, does whatever it can to decrease the period of morbidity that your population has, because through those preventative early intervention measures that GPs in primary care is best placed to deliver, ultimately the hope is that that will decrease the number of people that are presenting for acute care in the public hospitals where things get really expensive?
A. Yes, that's exactly it. Exactly it.

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

through the hospital. Obviously, Bombala at the moment has a population of GPs who are delivering that in a market way, so it probably wasn't a good example, but to the extent that on a place-based analysis, it was perceived that that was a way to deliver that wouldn't interrupt an existing GP market, do you have a view about that?
A. I think that - I think what you describe is, you know, one of the options. I think what needs to happen with this place-based approach is that there needs to be careful consultation and discuss with all the relevant players and the question needs to be, you know, for what we know for the next five years, what would work here? And it could be a range of, you know, combinations, but it needs to be then, "Well, how do we make that work?", rather than getting stuck in the traditional boundaries. So I think the crisis that we knew has been coming for some time is upon us, and so the job of people like me, local government, and others, you know, Coordinaire, primary health network, rural doctors, is to say, "Right. Well, what can we do?" And all be equally committed to it, to a solution.

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

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

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

Q. Admittedly with the possibility of an arrangement being reached at some point with the Commonwealth about recovering some of that through, say, a 19(2) exemption?
A. Yes. All the goodwill in the world and partnership approach and innovation, you know, all of that has to be underpinned by making sure that the passion is backed up with sustainability.

Q. I gathered this from the answers you have given, but I assume a hard line in the sand to the effect that the Commonwealth funds and does primary care would be an approach that would lack the flexibility that you think is required?
A. I think some more flexibility would be helpful.

Q. Can I then turn to the issue of the closure of the Batemans Bay emergency department?
A. Sure. Yes.

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

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

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

THE COMMISSIONER: Yes.

MR MUSTON: Q. Let's just step through the process. Can I start with the public consultation aspect. What would you regard as being a good public consultation process to sit around a decision like the closure of an emergency department, accepting that this decision was made well before your tenure?
A. Yes. Yes. So the decision - I think that there are

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

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

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

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

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

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

I want to make sure I understand whether the evidence is relating to where the new hospital is going to be or closure of the ED here, or somehow both.
A. Yeah, I guess if I wasn't clear, whilst I'm aware and I've seen the documents that go, you know, back to, I think, 2005 I saw, then obviously I've got absolute familiarity with my four and a half years.

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

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

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

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

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

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

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

Q. Yes.
A. -- the conversation and the announcements have always been very clear.

Q. That two hospitals would become one and the fund would be at Moruya?
A. That the two hospitals would become one, and nothing about an island, you know, ED. But I do appreciate --

Q. Without necessarily anything expressly being said to begin with --
A. Well, just that the hospital --

Q. -- we want to make sure you understand the ED is closing here at Batemans Bay?
A. Yeah, the hospital is.

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

Q. "We didn't join the dots." Yeah.
A. And so I respect that there is a lot of passion around this. What I am saying is that both from HI, the ministry, and politicians of both sides, it was very clear that what was being promised was the closure of two hospitals --

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

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

A. It was a very deliberate process, yes.

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

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

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

So, going back to those points, the published material, have you read that? If you haven't, you can take the question on notice.
A. So are you referring to the media reports after that - yes.

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

say, you know, "This is what we heard from the community about the closure of the ED, and these questions were asked and these questions were asked," but there is nothing in them, that I could see, that had multiple people, that I am told, saying, "For God's sake don't do this. This is a terribly bad thing to do for the residents, for this big population, and it carries clinical risks," et cetera. Do you know anything about that?
A. No, I would have to take that on - all, I suppose, I can speak to is what I am accountable for, and --

Q. I am not suggesting this is you producing this material at all.
A. Yeah. Good. Good. So, I mean, I have been very clear in my reports and I have no doubt that HI would do the same.

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

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

Q. What have you heard about that, then? What is your understanding about that aspect.
A. So the community have been entirely consistent in their feedback. This has been tied up also with the issue of the bypass.

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

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

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

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

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

Q. I think, in fairness, that is probably a fair summary of what Dr Stapleton said yesterday.
A. Mm. Yeah. Yeah. Mm.

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

Q. 18,000 signatures from the community, accepting that some people that have signed it live outside the community, is a lot relative to the population.
A. No question, yes.

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

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

Q. It is just something that is floating around. What would you respond in relation to that?
A. So what I - what I would say - and, look, you know, since I've been CE I've gone back over this and, you know, I have chaired forums, and so forth. What I would say - because certainly it concerns me hugely.

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

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

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

Q. Yes.

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

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

Q. You're, I take it, very comfortable now that the framework for community consultation moving forward is what it should be?
A. So, well, I'm very comfortable that we've strengthened - you know, we've had lots of mechanisms in place, including small groups at the various hospitals around the district, and what we're putting in place now is these two, on top of that, these two bigger committees that go across the network, recognising that lots of service delivery and lots of need needs to be discussed across a broader geographic framework.

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

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

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

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

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

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

Q. Yes.
A. A more basic cancer services. We need cardiac diagnostics.

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

Q. Sure.
A. Mm.

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

THE COMMISSIONER: Which hospital?

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

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

Q. -- as to the extent to which they impact upon safe clinical care --
A. Mm.

Q. -- and the steps that might be taken to ameliorate any risks presented by the closure of the hospital from the perspective of safe clinical care?
A. Yes, a long deliberation, and taking of advice from, you know, experts, you know, ambulance, senior ED doctors, and so forth. And I - but whilst I absolutely recognise my responsibility for working to address the community concern and anxiety, I think that is just going to have to be progressive over time; very respectful. I think one of the difficult things is, whilst I hear the noise very much about "keep the ED open" here, in a small little - a littler ED, with no hospital and, you know, nothing further, really, than an ED - so you'd have a doctor and a nurse in the urgent care centre there, and a doctor and a nurse or two in the ED, I do not see that, as an experienced clinician myself back in the day, and an intensive care nurse, I do not see that as being - whilst it might provide some emotional support and comfort, I don't see that as being the thing that would bring the greatest safety and benefit to the community.

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

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

Q. Some of the concerns include concerns around ambulances being taken out of service to deal with patient transfers to Canberra --
A. Yes.

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

Q. -- about ensuring adequate cover is provided in Batemans Bay and its surrounds.
A. Yes, and the LHD has got a response - so transport, full stop, is a big issue. So we're looking at community-based transport. This is outside what you are saying, but the issue of getting people to appointments and so forth, so, we've got work to do there. There is very little public transport.

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

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

Q. -- and then having been discharged, having been in that hospital, returned to their homes.
A. Mm.

Q. Transport infrastructure around that, is that

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

Q. Moving away from the Batemans Bay and Moruya hospitals.
A. Mm.

Q. If finances were not a limiting factor for you in the LHD and you had the magic wand, what changes would you make to the system that you think might assist you, and those working in your LHD, to optimise the delivery of public healthcare across the large footprint that you occupy?
A. So one - just one wish?

Q. You can have as many as you want.

THE COMMISSIONER: Q. No, as many you want. This is fantasy land. Go for it.
A. Goodness, I'll send you a paper, Commissioner.

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

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

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

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

THE COMMISSIONER: Q. That doesn't sound like fantasy land, that just sounds like business as usual.
A. For me, Commissioner, it's - my wishes are - you know, that's fantasy for me.

Q. They're - reasonable wishes, aren't they? Yes.
A. And then the other thing is I think that - and I know there is a commitment in this area, but I guess, sort of, an acceleration of blended funding. You know, you need more agile and nuanced funding models so that we are looking at a whole range of funding possibilities to support and prop up primary health.

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

Q. In one sense it is irrelevant who funds it.
A. Yes. Well, it's --

Q. It just needs to be --
A. Yes. Yeah.

Q. -- funded and provided.
A. So I guess that sort of - you know, I can only say agility around blended funding models that look at how things are done.

Q. I can clarify that. It is probably not irrelevant to NSW Treasury as to who funds it --
A. No. No.

Q. -- but for the patients and for the healthcare clinicians, and for you, it's irrelevant.
A. Yes. Yes.

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

Q. You said there was a commitment, as you understood it in this area, or commitments have been made in this area. What do you understand those commitments to be? I think your phrase was some commitments have been made to accelerate the development of blended funding models, or words to that effect. "I know there is a commitment in this area but" --
A. Oh, okay, that there is a commitment in this area. Right. I guess all that I'm saying is - I mean, there are some examples around the State of sort of - so the traditional MPS model, but actually bringing that type of model more into a primary health/acute care.

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

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

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

Q. -- and perhaps even aged care --
A. Yes.

Q. -- to be delivered, in appropriate circumstances, by NSW Health.
A. Yes.

Q. Through a blended funding model that involves funding from the State?
A. Yes. Because at the end of the day, you know, whilst I'm sort of going on, you know, in my role about the funding for the LHD, the bigger risks to society are around the failure of aged care and the failure of primary health. So, there has got to be a lot more focus in that area.

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

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

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

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

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

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

Q. Yes.
A. Well, it is upon it.

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

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

Q. No.
A. -- but I am saying that so many of the things that are so central to safe and sustainable service delivery will be compromised if these areas of policy and funding are not resolved.

THE COMMISSIONER: Yes.

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

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

THE COMMISSIONER: Okay.

MR MUSTON: Q. Do feel free to --
A. Yes.

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

THE WITNESS: Can I say something?

THE COMMISSIONER: Q. Yes. Feel free to add anything that you want to. Yes.
A. This is the end of the southern, I just would like to have on record our appreciation to you, Commissioner, and your team for spending a week with us. It's been wonderful having you here and to have the opportunity for you to see all - you know, all and many of the great things that are happening in southern.

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

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

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

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

You got left out. Do you have any questions?

MR CHIU: No.

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

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

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

<WITNESS RELEASED

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

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

THE COMMISSIONER: Yes.

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

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

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

THE COMMISSIONER: So you want me to make this a non-publication order?

MR GLOVER: I do.

THE COMMISSIONER: I don't even know what it is about yet.

MR GLOVER: I will tell you immediately.

THE COMMISSIONER: Go on.

MR GLOVER: There are two very small parts of the document that contain some commercially sensitive pricing information.

THE COMMISSIONER: Sensitive what?

MR GLOVER: Pricing information.

THE COMMISSIONER: Right. I see.

MR GLOVER: They are only part of two pages of that bundle, but we have attached them to the order in the usual way.

THE COMMISSIONER: All right. On the basis of that, I will make the order that is set out here in this non-publication order pursuant to section 8 of the Special Commissions of Inquiry Act. So, that order is made.

MR GLOVER: And I otherwise tender the documents in the list.

THE COMMISSIONER: Does that include - I don't know whether this has an MFI?

MR GLOVER: It does.

THE COMMISSIONER: It does. All right. So those documents are tendered with the exhibit number given to them.

ADMITTED AND MARKED EXHIBITS #1.000 TO 1.045

MR GLOVER: Thank you. Thank you, Commissioner.

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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