

**Special Commission of Inquiry  
into Healthcare Funding**

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

**At Tamworth District Court  
Marius St & Fitzroy Street,  
Tamworth NSW 2340**

**Wednesday, 18 September 2024 at 9.32am**

**(Day 51)**

<b>Mr Ed Muston SC</b>	<b>(Senior Counsel Assisting)</b>
<b>Mr Ross Glover</b>	<b>(Counsel Assisting)</b>
<b>Dr Tamsin Waterhouse</b>	<b>(Counsel Assisting)</b>
<b>Mr Ian Fraser</b>	<b>(Counsel Assisting)</b>
<b>Mr Daniel Fuller</b>	<b>(Counsel Assisting)</b>

**Also present:**

**Mr Richard Cheney SC with Mr Hernan Pintos-Lopez for  
NSW Health**

1 THE COMMISSIONER: Good morning.  
2  
3 MR GLOVER: Commissioner, this morning we have Dr Ramsey  
4 Awad, whose presentation I mentioned briefly in opening  
5 yesterday.  
6  
7 THE COMMISSIONER: Yes.  
8  
9 MR GLOVER: He is joining us by AVL and he is on the  
10 screen now.  
11  
12 THE COMMISSIONER: Dr Awad, good morning.  
13  
14 THE WITNESS: Good morning, Commissioner.  
15  
16 THE COMMISSIONER: You can obviously hear me. Would you  
17 like to give your evidence by way of oath or affirmation?  
18  
19 THE WITNESS: Affirmation, please, Commissioner.  
20  
21 **<RAMSEY AWAD, AFFIRMED [9.32 am]**  
22  
23 **<EXAMINATION BY MR FULLER**  
24  
25 THE COMMISSIONER: Yes.  
26  
27 MR GLOVER: Q. Dr Awad, in a moment you may be able to  
28 see me, but can you at least for the present time hear me  
29 okay?  
30 A. I can. Thank you.  
31  
32 Q. Right. If at any stage the connection breaks up and  
33 you can't hear me or need something repeated, just let me  
34 know, all right?  
35 A. Thank you.  
36  
37 Q. Can you tell us your full name, please?  
38 A. So it's Ramsey Awad, A-W-A-D.  
39  
40 Q. And you are the executive director infrastructure,  
41 planning and sustainability in the Hunter New England Local  
42 Health District?  
43 A. That is correct.  
44  
45 Q. What does that mean, on a day-to-day basis?  
46 A. It means lots of things. There are several parts to  
47 my portfolio. One is clinical planning. So that unit

1 works on what are the clinical needs for our  
2 Hunter-New England communities now and into the future for  
3 the next 20 years, so working out what services we want and  
4 where. The other part of the portfolio is infrastructure  
5 delivery. So we have - over these last five years, we have  
6 about \$2.5 billion worth of infrastructure that is  
7 underway, a lot of it in regional New England. A lot of  
8 new hospitals going up. Engineering and maintenance, so  
9 maintaining all our existing facilities and hospitals, old  
10 and new, and sustainability is also a large part of my  
11 portfolio and there are some other bits and pieces which we  
12 don't need to get into, but it is a broad portfolio within  
13 the district.

14  
15 Q. Thank you. Before we get into the reason why we have  
16 brought you along today, can you just tell us a little bit  
17 about your professional background prior to landing in this  
18 role?

19 A. Absolutely. So my education is in - I have degrees in  
20 architecture and construction project management and PhDs  
21 in - a PhD in health and infrastructure and change  
22 management. I have worked for NSW Health at the ministry  
23 level, rolling out statewide change management performance  
24 improvement programs for NSW Health. I have worked in the  
25 construction industry delivering high risk New South Wales  
26 Government projects for the Olympics, the Circular Quay  
27 redevelopment, the Walsh Bay redevelopment, and I have  
28 spent the majority of my career working in health and  
29 either on the change operational side of things or  
30 delivering major infrastructure projects. And I've also  
31 worked for Ernst & Young as their executive director for  
32 government advisory in the particular focus of government  
33 and health.

34  
35 Q. Thank you.

36  
37 THE COMMISSIONER: Q. How did health and infrastructure  
38 find its way under the one PhD thesis, what was it on?

39 A. Well, it married - we looked at every emergency  
40 department that was built on the east coast of Australia  
41 for the last 25 years, and the question was: does new  
42 infrastructure actually make a difference in terms of the  
43 metrics we use to measure the performance of an emergency  
44 department in terms of triage times and throughput and  
45 morbidity? Because everyone thinks you get the new  
46 emergency department and everything gets better. The  
47 answer is in 70 per cent of every emergency department

1 we've built in this country, at least the majority of the  
2 country, there is no improvement in performance.

3  
4 Q. Was that surprising to find that out?

5 A. It's surprising for other people to hear that. It  
6 wasn't surprising for me, having worked in the industry for  
7 a while. 40 per cent actually get worse when they get a  
8 new emergency department. 30 per cent --

9  
10 Q. Just stop there. Stop there. Why do 40 per cent get  
11 worse?

12 A. Because what they do is they create more space and  
13 they redesign the physical space and theoretically the  
14 flows, but in parallel they don't redesign all the business  
15 processes, the clinical processes that are required. So  
16 one of the things that I've introduced in my current role  
17 is when we do a new infrastructure project, I have a whole  
18 team that focuses on the operational change management that  
19 needs to occur, working with those frontline clinical staff  
20 to say, "Hey, you got a new space but how are you going to  
21 be working in a new and a different way that improves your  
22 effectiveness and efficiency in that?" So you have to do  
23 things in parallel.

24  
25 Q. Sorry, I interrupted you. You had mentioned that  
26 40 per cent don't improve, but you were about to say  
27 30 per cent, and then I interrupted you.

28 A. Thank you. No, that's okay, Commissioner.  
29 30 per cent don't change at all; they continue to maintain  
30 their current performance. And there's 30 per cent that do  
31 improve. And the ones that do improve - and this links  
32 back to when I worked at the ministry, which was developing  
33 clinical redesign methodology, which occurred back - we  
34 started a process here at the John Hunter Hospital where we  
35 redesigned our systems and processes around patients - this  
36 is back in 2002 - and it has spawned, I guess, this  
37 methodology which exists all through Australia now, which  
38 is to, in tandem to delivering infrastructure or even if  
39 you're not delivering infrastructure, redesigning the  
40 systems and processes in a very structured way that brings  
41 people along with you, but also looks at the hard data, so  
42 you make the right decisions, because often in change  
43 management, you have two extremes.

44  
45 The consultants will come in and provide their advice  
46 and a report and the staff, you know, tell them to get  
47 lost, that we're not interested, or you allow the staff to

1 form committees and those committees often meet for a few  
2 years and it's often the person with the loudest voice gets  
3 what they want or nothing gets delivered at all. So this  
4 methodology that we delivered and developed 20 years ago  
5 combines those two elements to deliver real fundamental  
6 change, and one of the pieces of work I did for the  
7 Ministry of Health when I worked there was to set up a  
8 school. It is called the Centre for Healthcare Redesign,  
9 it is part of NSW Health, it has been running now for,  
10 I think, 15 years, and it gives our frontline managers,  
11 those change management skills and clinical redesign skills  
12 which are core, I think, to evolving the health service.  
13

14 Q. Because I have opened this up, I better make sure  
15 I understand it fully. Of the 40 per cent that you say -  
16 so 40/30/30 are the percentages?

17 A. Correct.

18  
19 Q. Of the 40 per cent that don't improve, having had a  
20 new ED, what are you measuring in terms of improvement?  
21 I imagine one would be wait times probably, but I don't  
22 know. You tell me what you were measuring for that?

23 A. You're spot-on, Commissioner. It is the triage time,  
24 so all the different categories 1 through 5. We measured  
25 morbidity as well. We measured return patients that were  
26 discharged, then returned to the ED. The only metric that  
27 went up was, I guess, staff and patients satisfaction in  
28 terms of the environment, that it felt nicer, it was  
29 cleaner, it was - and everything was new. That metric  
30 went --  
31

32 Q. Not as cramped?

33 A. Not as cramped. So that was an improvement. But in  
34 terms of how we measure how well an emergency department is  
35 performing, it didn't improve in a lot of the cases.  
36

37 THE COMMISSIONER: Okay. We might have to make a call for  
38 your PhD thesis and get it tendered.  
39

40 MR GLOVER: I was about to do the same thing.  
41

42 Q. Dr Awad, one of the projects that you are currently  
43 working on and implementing within the LHD is a  
44 sustainability project, correct?

45 A. Correct.  
46

47 Q. And we had the benefit of a presentation of yours on

1 Monday, and what I'm going to do is invite you to tell us a  
2 little bit about that project by reference to some slides  
3 that you have helpfully provided us. But before we get to  
4 the slides, can you just tell us what was the catalyst for  
5 this project?

6 A. It was our board chair, former board chair, Lyn  
7 Fragar. She was interested in sustainability and thought  
8 that we should be doing something as a district and as an  
9 organisation. She spoke to our then chief executive  
10 Michael Di Rienzo and asked him to put some energy into it  
11 and find someone to look at it. I had just started in this  
12 particular role, sustainability wasn't part of my job  
13 description, and, you know, there was a knock at my door  
14 and said, "Can you - there is a board meeting next week.  
15 Can you put something together for sustainability?"  
16

17 I presented next week, really the following week, one  
18 slide which was that we would be carbon and waste neutral  
19 by 2030 in this district, and the board were very excited,  
20 I think the chief executive was a bit worried about what  
21 I had committed us to, and then I outlined how we would do  
22 that. And with my background in change management in large  
23 organisations, I built a lot of our approach and strategy  
24 around that. I am not an expert in sustainability, or  
25 I wasn't when I started, but that was the catalyst of the  
26 project and we just got on with it.  
27

28 Q. I'll have the slides brought up on the screen,  
29 Dr Awad. Can you see those slides? You are no doubt  
30 familiar with them?

31 A. I am familiar but I can't see them, I'm sorry. Yes,  
32 I can now.  
33

34 Q. You can see them now?

35 A. Yes.  
36

37 Q. All right. If we pass over the title page.

38 A. Please.  
39

40 Q. And we acknowledge Country, as always. And then if we  
41 go to the third page, "why is a green vision?"

42 A. Yes.  
43

44 Q. You see that?

45 A. I can.  
46

47 Q. Now, can you just talk us through the concepts that

1 are described in this slide?

2 A. Absolutely. So World Health Organisation, in their  
3 research, have told us that 25 per cent of all human  
4 disease and death now can be linked to environmental  
5 factors, and with children that's higher, it's at  
6 36 per cent. So that's globally known as a fact. We, at  
7 the time - we're about to go into a drought season again -  
8 New England, in particular, has been at the forefront of a  
9 lot of those changes in terms of bushfires and drought.  
10 And when you look at the emissions that healthcare, the  
11 delivery of healthcare, generate in this country, they're  
12 at 7 per cent, so that gives you some context on that. The  
13 construction --

14  
15 THE COMMISSIONER: Q. Can I just pause you there.

16 A. Of course.

17

18 Q. The 25 per cent figure is sourced from WHO?

19 A. Correct.

20

21 Q. I think it can be taken as well-known that Australia  
22 and New South Wales is subject to climate change and  
23 extreme climate events, such as floods and also drought,  
24 and a lack of water security from time to time, and  
25 certainly projected for the future. Is there a figure,  
26 though, of that 25 per cent? Is there a figure for  
27 Australia that you're aware of?

28 A. No, I'm not aware of a figure particularly for  
29 Australia, Commissioner.

30

31 Q. And the 7 per cent of healthcare emissions, that is  
32 sourced from where?

33 A. I can provide that source for you.

34

35 Q. You can take it on notice and tell us later, yes.

36 A. Absolutely.

37

38 Q. Thanks.

39 A. So the provision of healthcare, as you said, is  
40 7 per cent. To give you some context, the construction  
41 industry in Australia - and that includes roads, mining,  
42 commercial, residential construction, per annum produces  
43 about 15 per cent of our emissions. So we're about half of  
44 that and when you put that into the context of how much  
45 construction goes on in this country, you get a sense that  
46 it is still a significant amount, and Health is, out of all  
47 government agencies, is by far the largest contributor to

1 emissions. Just the sheer nature of our scale and the  
2 amount of facilities that we own and the 24-hour nature of  
3 our facilities.  
4

5 So, we made a decision as an organisation that if we  
6 are in the game and the role of healthcare that we needed  
7 to play a very strong role in working towards reducing our  
8 contribution to those environmental factors which are  
9 causing human disease.  
10

11 MR GLOVER: Q. Thank you. If we go to the next slide.  
12 These are the three core principles of the vision; is that  
13 right?

14 A. Correct.  
15

16 THE COMMISSIONER: Q. I think you told us that "waste  
17 neutral" relates to landfill, correct?

18 A. That is correct, Commissioner. Would you like me to  
19 elaborate on any of these, or?  
20

21 MR GLOVER: Q. Yes, please.

22 A. Okay, sure. So the vision is to be carbon neutral,  
23 which a lot of government and non-government organisations  
24 are committing to by - in certain periods. We also want to  
25 be waste neutral by 2030. We set ourselves a 10-year  
26 window to achieve that. It is a very ambitious target and  
27 I can foresee some hurdles in us achieving that moving  
28 forward, unless there is some further support from policy  
29 from government that's going to be required to achieve  
30 that. But that's the target we've set.  
31

32 Q. What sort of hurdles, firstly, do you envisage in  
33 reaching that aim?

34 A. Just broadly, the biggest hurdle will be with regards  
35 to green energy. By far the biggest contributor to carbon  
36 emissions is the generation of electricity. That's  
37 probably 80 to 90 per cent of it. We at the moment are  
38 supplementing that through solar, but I will give you a  
39 good example. The John Hunter Hospital, which is the  
40 busiest trauma centre in New South Wales, the second  
41 busiest in the country, it is a large hospital, does have  
42 the largest solar panel installation in the world sitting  
43 on top of its roof. It is about a kilometre long. All of  
44 those solar panels only produce about 10 to 15 per cent of  
45 the energy that actually John Hunter uses each year.  
46

47 So although it is enormous and impressive, it is



1 nowhere near what is required to eliminate the coal-fired  
2 energy that we utilise. So what's going to have to - and  
3 we can buy green energy. That is, we have a statewide  
4 government contract, I believe with Shell, for all our  
5 energy supply. They do offer green energy. I can buy  
6 green energy for John Hunter, but it will cost me a couple  
7 of million dollars a year to do that and in a very tight  
8 financial environment, it's not really feasible to do that.  
9

10 THE COMMISSIONER: Q. That final shift is going to rely  
11 on government shifting the electricity market more towards  
12 renewables than relying on coal?

13 A. Absolutely.

14  
15 Q. Yes.

16 A. You are 100 per cent right. So we're looking at  
17 on-ground solar, we are looking at other ways we can reduce  
18 our energy consumption, but I know that I'm going to reach  
19 a stage in the next couple of years that for us to reach  
20 that zero target, I am going to need to buy green energy,  
21 and it is a question of how much that costs in a couple of  
22 years. And we have a real opportunity. See, John Hunter  
23 hospital with the solar we currently have, if we were to  
24 purchase green energy now, we could actually announce the  
25 first carbon neutral hospital in this country. It's within  
26 our grasp. It's really a financial hurdle which is  
27 stopping us doing that at the moment.  
28

29 Q. Do you know roughly how much more it would cost than  
30 current costs if you did that?

31 A. About \$2 million per annum.

32  
33 Q. Just for John Hunter?

34 A. Just for John Hunter, correct.  
35

36 MR GLOVER: Q. You mentioned requiring government  
37 support. In addition to support to shift to green energy  
38 more generally, is there anything else by way of support  
39 you see as being needed to achieve the carbon neutral by  
40 the 2030 goal?

41 A. Look, I think at a State level, greater coordination  
42 is required. And the reason I say that is at the moment,  
43 I think - well, I know that the secretary and the ministry  
44 are very much on board with sustainability as an important  
45 item of what we need to - important agenda item that we  
46 need to focus on. What we can improve on, though, is  
47 coordination. I - at the moment, I think within the

1 ministry there is probably six or seven groups that are  
2 working on sustainability, which is great. The ability to  
3 coordinate them, I think there are some real opportunities  
4 there.

5  
6 Then you have 15 LHDs, which are all focusing on  
7 sustainability. Then you have got these other government,  
8 New South Wales government, agencies and treasury and  
9 others which have a sustainability agenda. You have got  
10 the Federal Government that has a sustainability agenda,  
11 and then you've got private sector university research  
12 groups that are focusing on sustainability as well. It's  
13 fantastic that everyone is playing in this space, but,  
14 ultimately, I feel like you need - and the NHS has a  
15 sustainability officer, but it needs to bring all these  
16 people together. And the reason being that there is lots  
17 of energy being put into those individual groups, but from  
18 my perspective we need to do this work quickly, we need to  
19 identify what are the high value items that we need to  
20 pursue as a state government agency, as NSW Health, and  
21 what do I define as high value? I think one is reducing  
22 emissions and waste, but more important in the current  
23 fiscal environment is reducing cost.

24  
25 So if it was up to me, I would identify the top 10 or  
26 20 major initiatives that we're going to pursue as an  
27 organisation, align all those separate groups to those  
28 initiatives, and get on with it and really make some gains.  
29 And, importantly, if we ensure that those elements are  
30 cost-based, then re-invest the money we save into frontline  
31 clinical services, because that's where - that's our core  
32 business at the end of the day.

33  
34 THE COMMISSIONER: Q. But just sticking with carbon and  
35 being carbon neutral by 2030, that - I mean, that's  
36 ambitious. I'm not suggesting it's bad ambition, it's good  
37 ambition, but it is a fair way ahead of the New South Wales  
38 government legislated targets to get to net zero by,  
39 I think, 2050, with some interim targets on the way. So  
40 you are just setting yourself a massive challenge there  
41 beyond what is legislated.

42 A. I get bored easily, Commissioner.

43  
44 Q. Oh, okay.

45 A. It's something to do.

46  
47 Q. Well, better 2030 than 2080, I'm sure. So, yes.

1 A. Yes.

2

3 MR GLOVER: Q. And - sorry, Doctor?

4 A. No, that's okay. Just to finish that thought  
5 regarding what else we could be doing, I think also one of  
6 the things ministry has been helping with is allowing our  
7 staff - this is a change management exercise as much as,  
8 you know, reducing emissions; we want to win the hearts and  
9 minds of people. They have introduced, you know, funding  
10 for our clinical staff to develop sustainability  
11 initiatives and ideas, which is great. I think what else  
12 we could be doing to assist in that is knowledge  
13 management, and, you know, taking those good ideas and  
14 super-charging them and rolling them out across the whole  
15 state very quickly is something, I think, is a real  
16 opportunity for the ministry to be pursuing.

17

18 Q. What you are describing is greater coordination of  
19 effort and then with the ability to scale up those  
20 successful initiatives quickly across the board; is that  
21 the idea?

22 A. Correct, and to prioritise the initiatives which are  
23 going to help us achieve our goals, and the goal has to  
24 include saving dollars for Health.

25

26 Q. And we'll come to it in due course, but some of the  
27 initiatives that you have implemented in the district are  
28 already seeing some financial benefits, aren't they?

29 A. Correct.

30

31 Q. You tell us a little about the goal to be waste  
32 neutral by 2030? The Commissioner clarified with you  
33 earlier that's about landfill, but tell us a little bit  
34 more about that initiative and how it is going to be  
35 achieved.

36 A. Absolutely. So when we started in 2020, 92 per cent  
37 of our waste was going to landfill for Hunter New England  
38 Health. We want it to be zero by 2030. That is by far the  
39 hardest thing for us to achieve, for a number of reasons.  
40 One is we have to deal with clinical waste, which has to be  
41 dealt with in a particular sort of way in terms of its  
42 disposal and requires some legislative changes and some  
43 work with the EPA to maybe dispose of that clinical waste  
44 in a different and new way. But if we just focus on  
45 general waste, it is dependent on a number of factors. One  
46 is, particularly as you move further away from major  
47 centres like Sydney and Newcastle, you are reliant on the

1 councils having the ability to manage different types of  
2 waste, so organic waste, plastic waste, et cetera. They  
3 need the infrastructure and the systems to take that waste  
4 and do something which is more than just putting it into  
5 landfill.

6  
7 But this, I believe, is probably the area where  
8 I think there is the most excitement in terms of driving  
9 real change across Australia and NSW Health, that this is  
10 where we can - this is where innovation is required. We  
11 need partnerships. We need partnerships with other  
12 government agencies, we need partnerships with the private  
13 sector and the university research sector to help us solve  
14 some big challenges. And I think later in my presentation,  
15 I give an example of what we've been trying to do with  
16 gloves that we utilise, but this is an enormous challenge  
17 for us and we need, I think, less bureaucracy and a little  
18 bit of freedom in this particular space to trial and pilot  
19 things. I think that's one of the things that would help  
20 us progress that particular element of waste more rapidly.

21  
22 Q. If we go back to the slides, please. The second point  
23 on that page:

24  
25 *Reduce our environmental impact while*  
26 *continuing to focus on Excellence ...*

27  
28 The concept there is --

29 A. The concept there - yeah, sorry, the concept there  
30 is - sorry, did I cut you off? I apologise.

31  
32 Q. No, you go. You go?

33 A. Okay.

34  
35 THE COMMISSIONER: Q. Mr Glover can't give the answer as  
36 well as ask the question, so you give the answer and we'll  
37 go from there.

38 A. This is - I deliberately put this in when we first set  
39 up the program because, having worked in Health, there is  
40 always arguments about where you spend your money, and even  
41 more so now with the tight fiscal environment that we find  
42 ourselves in. This is there to ensure that everyone  
43 remembers that delivering clinical care is our core  
44 business, and --

45  
46 Q. So whatever you are doing about environmental impact  
47 and reducing emissions, it's not at the expense of

1 providing good clinical care, right?

2 A. Perfect.

3

4 Q. Yes.

5 A. And all of the initiatives that we put forward do not  
6 take any money away from frontline clinical services. In  
7 fact, the majority of them return money to those  
8 frontline clinical services. So that's a core fundamental.  
9 It's meant that we've had no opposition. From a change  
10 perspective, no-one has said, "This is a bad idea, because  
11 I can't afford A, B and C in my emergency department." So  
12 strategically, it is a very important position for us to  
13 have. And the third item there is Hunter New England is  
14 the largest employer in this region. We are the largest  
15 LHD in the State and one of the biggest in the country. We  
16 have the opportunity - and I think we've achieved this - to  
17 be real leaders in this particular space and, more  
18 importantly, start to drive a change in our market, the  
19 people we buy stuff from, that they know this is where  
20 we're heading and they start shifting the products they  
21 produce for us so that they become more and more  
22 sustainable.

23

24 MR GLOVER: Q. Can we go to the next slide, please.  
25 Could you just take us through?

26 A. Absolutely. These are the results of our third year  
27 of performance, and we established four high-level KPIs:  
28 CO2 emissions, rainwater captured and reused, water  
29 recycled re-used and waste going to landfill. They are the  
30 four elements we have been focusing on. Along the top  
31 line, you will see our 2020 baseline for each of those  
32 elements; and then, on the bottom line, you'll see our  
33 target for the third year, for 2023; and then in the  
34 circles above, you'll see what we have actually achieved in  
35 2023. So if I just run through each one of those quickly:

36

37 CO2, our baseline was 100,000 tonnes. Our target was  
38 30 per cent decrease. We've just met that target at  
39 31 per cent.

40

41 In terms of rainwater captured and reused, we were  
42 only doing that in 5 per cent of our facilities in 2020.  
43 We set ourselves a target for 30 per cent in year three and  
44 we are nearly at our fourth-year target. Essentially, we  
45 are looking for a 10 per cent improvement each year on each  
46 of those elements.

47

1 Water recycled and re-used. We will always need water  
2 in a health facility. We will always need to wash  
3 something, wash hands or clean something, but we were  
4 looking at a decrease in our water usage and we are just  
5 shy of the target at 28 per cent.  
6

7 And then the final element, which I mentioned earlier,  
8 is landfill. We wanted a 30 per cent decrease in waste  
9 going to landfill. We didn't achieve that. We are at the  
10 24 per cent metric for this particular year.  
11

12 Q. Thank you. Go to the next slide, please. These are  
13 recurrent savings achieved in the 2023 period?

14 A. That's correct, after year three. And just to put  
15 this in context, the most amount of money we've spent has  
16 been in the installation of solar panels across the  
17 district. So the John Hunter solar panel installation,  
18 which I mentioned earlier, cost us about \$3.5 million to  
19 \$4 million. The balance of all the solar installations we  
20 are putting on solar on every single one of our buildings  
21 across the district, that's about the same money again. So  
22 we've borrowed from Treasury, via a very low interest loan,  
23 about \$8 million. We are paying that loan off, and we are  
24 paying that off over the next four to six years, we'll have  
25 it all paid off. So this recurrent savings reflects us  
26 paying off money in parallel. So once we've paid back that  
27 principal, that loan that we've --  
28

29 THE COMMISSIONER: Q. Sorry, how do I understand that?  
30 The 3.38 million in recurrent savings takes into account  
31 your interest payments, or it doesn't?

32 A. It does.  
33

34 Q. Yep, great. Okay.

35 A. So I'll just - John Hunter is a really good example.  
36 So we borrowed the \$3.5 million-odd for that. We are  
37 paying back the loan. We are paying that off over six  
38 years and we're paying off - I'm just trying to do the  
39 maths in my head now. My mathematical skills are failing  
40 me.  
41

42 Q. You can get back to us in relation to any sums rather  
43 than doing them in your head on the run.

44 A. Thanks, Commissioner. We're paying back about  
45 \$500,000 to \$600,000 a year in that loan, but we are saving  
46 about \$1 million a year in our energy bill at John Hunter  
47 Hospital, so that \$400,000 that we --

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Q. You're in front.

A. Yes. We're in front, essentially. And that's one of - and if you were to - a simple decision for government would be to put solar panels on everything that they own and they would see a return immediately and set them up for the future. It is a no-brainer, as far as I'm concerned.

MR GLOVER: Q. Can I just ask you about the three largest components of this graph. The first being solar, 1.37 million. What is the saving that's under the category "Solar" in that chart?

A. That's from all the solar panels we've introduced across the district. And then you'll see electricity; if you split that out, electricity is really a movement to LED lighting --

Q. I see.

A. -- across the district and energy reduction initiatives that we've put in place, sensor lights and the like.

Q. We'll perhaps come to those in some later slides. And then the next largest is "Natural Gas"?

A. Yes.

Q. Where are those savings being driven?

A. Yes. So a lot of our - and this is occurring with our new facilities. A lot of our existing chillers that we use to air-condition our facilities run off natural gas. We're moving away from those and utilising electricity now. It is called "electrification", so John Hunter Hospital will be the first level 6 trauma hospital in New South Wales that will be electrified, ie, no gas, no natural gas. So when we do get green energy, it will all be green and we won't have to worry about natural gas.

Q. Thank you. Before we leave that slide, these are at 2023. Is it the case that once the initiative is rolled out across the district, you expect those overall recurrent savings to continue to rise?

A. Absolutely. I'm hoping that by the time we get to year 10 and we've paid back those loans, we would be closer to the \$15 million mark. That's just in the areas that we're focusing on. I'm hoping that if we make some big breakthroughs in the waste area that that figure could go up, but it's going to require a few innovative

1 breakthroughs and some legislative change, I think, to make  
2 this sort of - the waste piece be a bigger component in  
3 terms of savings.  
4

5 Q. Can we go to the next slide, please. There, six  
6 components of the initiative described. We have heard  
7 about energy, water and waste. Can you just tell us  
8 briefly about "Transport", "Procurement" and  
9 "Infrastructure", please?

10 A. Absolutely. So transport, our strategies there are  
11 fairly straightforward. One is to move our current  
12 combustible fleet vehicles to electric or electric hybrid.  
13 The reason we've gone - and we've started with hybrid  
14 vehicles. The big drawback to going fully electric has  
15 really been out in regional New South Wales, that to have  
16 the infrastructure to charge the vehicles hasn't existed to  
17 date, but Treasury have recently provided a substantial  
18 amount of money to our district to rollout charging  
19 stations, particularly in our regional areas, so we're in  
20 the process of doing that right now. So it allows more  
21 electric vehicles as we progress.  
22

23 The other thing we're doing, too, is working with our  
24 clinicians and our staff to think about whether they need  
25 to get in a fleet vehicle and whether they're - we've had  
26 lots of staff saying they'd like to get on an electric  
27 bike, so we've facilitated that. So swapping out fleet  
28 vehicles for electric bikes.  
29

30 The other few things we've done in transport is  
31 we've - for the first time in the country, we've set up  
32 with the salary packaging groups that all government  
33 agencies engage with to allow our staff to salary sacrifice  
34 to purchase an e-bike, encouraging staff to ride to work  
35 instead of bringing their car, which, of course,  
36 contributes to emissions, but also contributes to the  
37 congestion, particularly at our bigger hospitals. If more  
38 staff could ride, then there is more parking left for  
39 patients and carers.  
40

41 And the other basic thing we've done in transport is  
42 really just reduce the size of our fleet. There are -  
43 fleet vehicles are very important. We do a lot of hospital  
44 in the home care and that's important, but when you drill  
45 down and look at the fleet vehicles, we found about  
46 10 per cent of our vehicles were being driven less than  
47 2,000 kilometres a year, which points to if you can improve



1 booking systems and coordination and management of those  
2 fleet vehicles, you can really reduce your fleet  
3 significantly if you need to.  
4

5 Q. Thank you. And what are the "Procurement" initiatives  
6 as part of this plan?

7 A. Well, procurement initiatives, there is an  
8 international and Australian standard for green  
9 procurement. It has in place the things you expect for  
10 procurement in terms of cost and also the quality of what  
11 you're buying in terms of assessment criteria, but it  
12 introduces a third criteria, which is what is as green or,  
13 you know, how sustainable is the product? This is harder  
14 for us to play in, mainly because we are a local health  
15 district. The majority of the procurement is managed  
16 centrally at HealthShare level and NSW Health level. We  
17 are doing what we can in that particular space and we do  
18 buy some things. It is a harder space for us to influence  
19 and play in, and again, is a big - an area I know the  
20 ministry is starting to try to focus and talk about, but  
21 that's the goal there.  
22

23 Q. And what about "Infrastructure"?

24 A. Infrastructure is straightforward in terms of  
25 everything we build, we are insisting that Health  
26 Infrastructure, who are the NSW Health government delivery  
27 group for major infrastructure projects over \$10 million,  
28 is that we achieve a 5-star rating for our projects. This,  
29 you know, I think initially was difficult because with  
30 tightening budgets the simple thing to pull out of projects  
31 is sometimes the sustainability initiatives like solar and  
32 water tanks and so forth, but I believe Health  
33 Infrastructure in the last period of time are on board with  
34 this and are segmenting part of the budget now to ensure we  
35 achieve that particular target.  
36

37 Q. I take it you would be of the view that pulling out of  
38 solar and water-capturing and recycling programs is  
39 actually a false economy because of the savings delivered  
40 long term?

41 A. Absolutely. And if we talk about coordination at that  
42 state level, they're really - often what happens is parts  
43 of government agencies, their focus is on, you know, "Let's  
44 deliver this project on time and on budget, and that's our  
45 KPI," but the KPI of the operators is to reduce recurrent  
46 costs. Sometimes those KPIs are not aligned, and that's  
47 why I believe you require greater coordination and synergy

1 at the most senior levels to ensure that you don't  
2 sacrifice one thing for another.

3  
4 Q. And perhaps greater coordination at a project design  
5 level between operators and those designing the projects?

6 A. Yes, absolutely.

7  
8 Q. Do you see it as being the future of infrastructure  
9 projects as embedding some of these concepts in project  
10 design from the very early stages?

11 A. Yes, and I - look, it is a whole-of-life cycle - and  
12 I will put my construction hat back on. This is a  
13 whole-of-life cycle responsibility and work that needs to  
14 occur, but we can build buildings cheaply and effectively  
15 and efficiently, but the maintenance costs of looking after  
16 that building outweigh the money we're saving upfront. And  
17 that includes solar, but it also includes the type of  
18 air-conditioning systems you put in, the type of lighting  
19 systems you put in. There are some systems we put in which  
20 we know are going to not fail, but not operate as  
21 effectively and efficiently, and is going to cost us as  
22 operators a lot more to run and maintain in the future.  
23 But a whole-of-life cycle analysis needs to be upfront, and  
24 that can only happen when you bring in, like, a group like  
25 Health Infrastructure into those discussions together with  
26 the operators and ensure that we are aligned in terms of a  
27 whole cost analysis rather than in individual silos of  
28 delivery versus operations.

29  
30 Q. Can we go to the next slide, please, and I think we  
31 have probably covered most of this ground now. That's a  
32 picture of the roof of John Hunter Hospital, correct?

33 A. Correct, yes.

34  
35 Q. You have told us about the solar panel installations  
36 and the LED and light sensors. You mentioned briefly  
37 looking at ground-mounted solar. If you could just tell us  
38 a little bit about what the next move in that space is?

39 A. Yeah, look, we have a number of our regional hospitals  
40 which have lots of extra land which we're not utilising.  
41 Some of those smaller hospitals have small roof spaces. So  
42 my next thought is, well, what can we put on the ground?  
43 And then once we put solar on the ground, unlike John  
44 Hunter - John Hunter - we don't have any batteries at John  
45 Hunter, because all the power we produce gets used straight  
46 away. At our smaller facilities, as soon as we - we don't  
47 need that much power, so establishing ground-mounted solar

1 in combination with batteries means that we can start to  
2 sell some of our electricity back to the grid and make some  
3 of our smaller facilities take them off-grid altogether, if  
4 we're clever with where we invest the solar panels. We  
5 need some further funding support from Treasury and  
6 ministry to achieve that, but we are building those  
7 business cases now.

8  
9 THE COMMISSIONER: All right. So in some of the smaller  
10 sites it is appropriate to have storage by means of  
11 batteries, but John Hunter it doesn't make any sense at the  
12 moment because the solar is only a small percentage of the  
13 power it needs?

14 A. That's correct, exactly right.

15  
16 Q. How long has all the solar panels been there on - at  
17 John Hunter? When were they installed?

18 A. It's been two years now, Commissioner. I should have  
19 brought it up, but there's actually - we've got a - and  
20 maybe during the proceedings here I'll find it, but we  
21 there's a - we have a live report which shows us how many  
22 trees we've saved since we've had the solar panels, and it  
23 shows you how much you are saving on a daily basis. And,  
24 you know, it goes up and down whether it's cloudy or not.  
25 But we have some very detailed reporting.

26  
27 THE COMMISSIONER: "Two years" is good enough.

28  
29 MR GLOVER: Q. If we go to the next slide, please. Can  
30 you just tell us very briefly how we are to understand the  
31 data that is displayed here?

32 A. Absolutely. So this is a dashboard. We built a very  
33 simple reporting tool within the district here. It's  
34 nothing custom-made or didn't cost us very much. A young  
35 IT boffin in my team built this for us over a week. But  
36 essentially it shows two things: solar and LED. And to  
37 the right is a map of our LHD. It shows where we currently  
38 have solar and where we don't have solar. It shows where  
39 we currently have LEDs and we don't have LEDs. It also  
40 shows our progress. So from the top area there, 35 out of  
41 our 56 sites have solar in place now. And you can see --

42  
43 THE COMMISSIONER: Q. The 2.2 million-odd in estimated  
44 savings, is that a yearly figure?

45 A. Yes, it is. And equally with the LED, it just shows  
46 progress. Again, it is a tool for me to very simply see  
47 where we're up to and where we need to invest. But,

1 overall, we're going to have LEDs and solar, that program,  
2 completely rolled out by the end of this financial year.

3  
4 MR GLOVER: Q. The next slide, please. This is, as it  
5 says, a snapshot of the LED progress.

6 A. Yes.

7  
8 Q. The bottom line we take from it is - tell me if I've  
9 understood what you have said correctly - that by shifting  
10 to LED lighting, one is already seeing savings across the  
11 district of about \$1 million, and those savings will see  
12 the upfront cost being covered in a little over a year?

13 A. Exactly right, and a reduction in energy consumption  
14 by 80 per cent.

15  
16 Q. Next slide, please. We've touched on water savings,  
17 but can you just take us through in high-level terms each  
18 of these four principles?

19 A. Yes, of course. So rainwater tanks, we're all  
20 familiar with that on all our facilities, capturing any  
21 rain and re-using that water in a variety of different  
22 ways. The other is where we have renal dialysis services,  
23 there's RO water from the reverse osmosis. RO water is  
24 clean, filtered water that runs the dialysis machines.  
25 Traditionally, that goes down the drain.

26  
27 Tamworth Hospital is a good case study. 2.4 millions  
28 of RO water was going down the drain from their renal  
29 dialysis service. In a very simple way, like we do in our  
30 own homes, we take that water now and flush all the toilets  
31 at Tamworth Hospital. So that is a very simple saving and  
32 we are implementing that across all our renal dialysis  
33 facilities across Hunter New England.

34  
35 What we are working on now is low flow fixtures where  
36 appropriate, operating theatres having sensors on, you  
37 know, the scrub sinks which are often left on for extensive  
38 periods of time. And the other big thing we are focusing  
39 on, working with locals water suppliers like Hunter Water  
40 here, is leak detection. We discovered at one of our big  
41 campuses that there was a couple of million litres of water  
42 just through some cracks in some old piping that was  
43 disappearing each year, and we were able to make those  
44 repairs. So that's what we're focusing on from a water  
45 perspective at the moment.

46  
47 Q. Thank you. Can I pass over the next slide and come to

1 "Transport". I expect we have covered this already, but is  
2 there anything else you wish to add to your earlier answers  
3 on the transport initiatives?

4 A. No. I think I covered them thoroughly.

5  
6 Q. Can I then come - operator, I think it's page 18.  
7 Yes. The waste strategies. Again, we have covered a  
8 little bit of this but if we go to the very next slide, can  
9 you just take us through this summary and perhaps elaborate  
10 on some of the challenges that you described earlier and  
11 those that might require legislative intervention to  
12 overcome?

13 A. Of course.

14  
15 THE COMMISSIONER: Or innovation.

16  
17 MR GLOVER: Or innovation, yes.

18 A. So the biggest - thank you. The biggest challenge to  
19 date has been getting the reporting right. Again, there  
20 has been a statewide - I think just NSW Health statewide  
21 contract for waste, the collection of waste. Us really  
22 being able to get this sort of reporting has taken us - and  
23 we have only achieved this in the last year - working with  
24 the private providers who collect our waste to tell us what  
25 is the breakup of the waste that we're actually producing,  
26 so this is a great step forward, understanding what we've  
27 got, which you see there. What we need to do now is target  
28 that big box at the top, which is the general waste. We're  
29 doing well in that blue box, the recycling, and the  
30 organics, we need to see those going up and the red going  
31 down in terms of tonnage or kilograms that you see there.  
32 If we can just move to the next slide and I'll --

33  
34 THE COMMISSIONER: Q. You have done the low-hanging  
35 fruit, but the really difficult stuff is the general waste,  
36 and specifically one of the things you gave us an example  
37 of was gloves?

38 A. Yes. If we - I've got a slide on the gloves if that  
39 helps, Commissioner, further on.

40  
41 Q. Yes, thank you.

42 A. But one of the - yes, thank you. The other thing I'll  
43 just mention about reporting, and it is a slide that's a  
44 couple before this but I can talk to very easily, is our  
45 reporting now is such that every facility, including our  
46 very small facilities, can see how much of their waste is  
47 still going to landfill and how much is going to recycling.

1 This is fundamental, because you rely again on people to  
2 put stuff in the right bins and unless they do, it's very  
3 difficult.

4  
5 Having said that, we've just won an EPA grant; we're  
6 working with a private sector group that are using AI to  
7 design new bins. So, what happens - and we're in the first  
8 two months of this project - is when a clinician approaches  
9 a bin, there will be four bins there, one for organics, one  
10 for plastics, one for waste, one for general waste. The AI  
11 will, through their cameras, identify the waste in that  
12 person's hand and will open the lid of the appropriate bin.  
13 You will drop it into the right bin. So we're working on  
14 that right now.

15  
16 Q. That's a bit scary, that aspect.

17 A. So that's one of the things we're working on.

18  
19 Q. I don't know whether to be excited by that, Dr Awad,  
20 or scared?

21 A. Probably a bit scared? Yeah, probably a bit of both.

22  
23 Q. Anyway, gloves?

24 A. Gloves. So, look, this is - when I write our  
25 introduction about what I think we could be doing at a  
26 state level in terms of prioritising things, what do we  
27 prioritise, we went through a similar exercise of  
28 prioritising and having a look at what do we use the most  
29 of in Hunter New England. The thing at the top of the list  
30 was gloves. We use 30 million gloves that currently go to  
31 landfill. And we started a process of working through,  
32 well, what do we do in there? We start off with the  
33 simplest thing you can do, the low-hanging fruit, is let's  
34 use less of it.

35  
36 So one of the projects - some of our clinicians,  
37 clever clinicians - got up and running - and you can  
38 imagine in the clinical space everything needs to be  
39 published and scientifically backed. They went through a  
40 process of saying, well, do you actually need gloves in  
41 every clinical situation? Through their research and peer  
42 review, they identified that often it's best not to have  
43 gloves in some clinical situations. So they've developed  
44 an approach now which - it's being adopted by the rest of  
45 the State, but they pioneered it here at John Hunter, to  
46 reduce that 30 million, and we are pretty confident it is  
47 going to be close to \$15 million - 15 million gloves we'll

1 be utilising. So halving the utilisation. So that's the  
2 simple stuff you can do.

3  
4 The more interesting stuff is at either one of those  
5 ends of those scales. So in terms of disposal, can you  
6 dispose of something in a green way? We did this  
7 successfully with water bottles. Water bottles, plastic  
8 water bottles, we worked with a group here in Newcastle for  
9 our Maitland Hospital project. They take all our plastics  
10 that we produced across John Hunter and turned it into  
11 asphalt that we used to create the roads at the Maitland  
12 Hospital project. There is no such solution for gloves.  
13 It is made with a certain type of plastic that can't be  
14 used for that.

15  
16 So then we've looked at the front-end, can we buy a  
17 green glove? Can you imagine buying a glove that maybe  
18 just dissolves and doesn't contribute to landfill? We've  
19 struck out in that area. And I think this is where  
20 government can invest and, like the example I gave you with  
21 the bins and the AI, this is where we approached the  
22 private sector, the research university sector, to say, "We  
23 have a, in our district, a 30-million glove problem, but  
24 across Australia it is maybe a billion gloves that are  
25 going to landfill, what can we do with our clever people  
26 out there?" And that's where, from my perspective, is some  
27 excitement in terms of making some real breakthroughs in  
28 terms of dealing with that.

29  
30 Another couple of really good examples that we're on  
31 the cusp of breaking through is there is a German  
32 technology called Plastoil. It is essentially a machine  
33 that takes any plastic, any clinical plastic, and turns it  
34 into either two things: an oil product that can be used to  
35 create more plastic of exactly the same quality, or it can  
36 actually generate energy. And we - I've been looking at,  
37 and we have a \$1 million grant, I've been looking at trying  
38 to create a micro-factory here on the John Hunter campus to  
39 do such a thing, but we've run into some real hurdles with  
40 EPA of actually doing something like that. And we're sort  
41 of re-assessing how we might tackle something like that,  
42 but you can imagine that is a huge breakthrough for all  
43 government agencies and organisations.

44  
45 And the last really excellent example, which is  
46 e-water. E-water is like a zip boiler. It is the size of  
47 the zip boiler that you get boiling water from on your

1 wall, but instead of hot boiling water, it produces a  
2 chlorinated water. This water replaces the cleaning  
3 products that we currently use in all our facilities. We  
4 have TGA approval to utilise this in all of our kitchen  
5 spaces in our hospitals. So we are nearly - we have nearly  
6 rolled this out in every one of our facilities. We also  
7 have TGA approval to roll it - to utilise e-water in all  
8 our clinical spaces. We are just - we're still trying to  
9 get approval from our Clinical Excellence Commission to  
10 utilise it, despite us having TGA approval. It is one of  
11 the hurdles in terms of making - getting approvals through  
12 large organisations. But, once we have that, that will be,  
13 again, a very big game-changer for Health and for all  
14 government agencies.

15  
16 MR GLOVER: Q. Before we leave the sustainability  
17 strategy, is there anything that the wider health system  
18 could do by way of support to aid in the development and  
19 then rollout of initiatives like these, in your view?

20 A. It really comes back to some of those comments I made  
21 earlier on around knowledge management and clearing some of  
22 the - I think the ministry have done the right thing in the  
23 current fiscal environment. We have a lot of, you know,  
24 tightening in around procurement, how we purchase things,  
25 and so forth. They've had to do that; all government  
26 agencies have had to do that.

27  
28 It stifles innovation, though, at times, and I know  
29 they're working through solutions for that, but you need to  
30 give people the opportunity to sort of trial and pilot a  
31 few things. I know our neonatal and intensive care unit  
32 are trying to trial some green nappies and so forth. Our  
33 current systems and processes don't make that easy. There  
34 is a pathway to do that, and ministry have been working  
35 hard to clear those barriers, but just that ability to  
36 trial and error a few things, that needs to exist for the  
37 whole system, because that's - if you have to wait for a  
38 meeting and to get approval like the e-water - we've been  
39 trying to get that approved for a couple of years now for  
40 clinical areas - through the CEC, you know, people get  
41 despondent and give up and get on with other things, and  
42 I just feel you do need someone at the most senior level  
43 within NSW Health that can push these things through.

44  
45 And one of the great successes we've had with  
46 sustainability in this district is I still think I'm the  
47 only Health executive with "sustainability" in their title.



1 That may have changed, but there are lots of good people  
2 across LHDs who have been working in the sustainability  
3 space longer than us, but they haven't had someone at the  
4 executive level at an LHD that is focused on this, that can  
5 clear away the policy bureaucracy that has to exist within  
6 the Health service, but you need someone that can do that  
7 risk assessment and say, "Look, we're just getting on with  
8 this." Unless you have that, then lots of people find it  
9 easier to say "no" than "yes".

10  
11 THE COMMISSIONER: Q. Just pausing there. Your  
12 sustainability program, you've told us, results in net  
13 savings, correct?

14 A. Correct.

15  
16 Q. And will, moving forward, including the expenditure of  
17 interest payments for any loans or upfront costs, correct?

18 A. Correct.

19  
20 Q. And many of the things - please don't think I am  
21 downgrading it, it is the opposite of that, but many of the  
22 things that are part of your sustainability program, such  
23 as, for example, using solar panels, moving to LED  
24 lighting, using electric vehicles, the proper management of  
25 waste, saving water, are all things that can be readily  
26 done now, correct?

27 A. Correct.

28  
29 Q. Is there, to your knowledge, another - do other LHDs  
30 have similar-scaled sustainability programs to your LHD?

31 A. No.

32  
33 Q. Is there any reason that you know of as to why, at a  
34 practical level, or even a policy level as well, they  
35 couldn't?

36 A. No.

37  
38 Q. Well, I'm sure if that answer is wrong, Mr Cheney will  
39 vigorously cross-examine you. In other words, you would  
40 think it would be a good idea for other LHDs to adopt - no  
41 doubt it would be to some degree bespoke for each LHD, but  
42 for them to bring out or adopt their own bespoke  
43 sustainability-type program similar to yours on the basis  
44 that you would have a great deal of confidence that  
45 whatever it results in, there would be some level of  
46 saving?

47 A. Absolutely. And I'll just qualify, Commissioner, that

1 I know all the LHDs have said this is important for them  
2 and I do accept that we are probably a couple of years  
3 ahead of everyone else because we started early, but there  
4 is nothing holding anyone back to achieving what we've  
5 achieved. And we've hit - we're reaching a threshold now  
6 of what we can achieve with those elements that you  
7 described that we've put in place, the low-hanging fruit,  
8 the simple stuff, and our focus now is turning to how do  
9 you break through the next barrier, which we're very happy  
10 to do.

11  
12 THE COMMISSIONER: Sure.

13  
14 MR GLOVER: Q. Can we come now to the rural clinician  
15 accommodation strategy, and we will switch to the other set  
16 of slides. Are they on your screen, Dr Awad?

17 A. They're coming, I think. Yeah, here we go. I do have  
18 them, thank you.

19  
20 Q. All right. Just to lay some background, we've heard  
21 in each of our rural visits that one of the challenges in  
22 attracting workforce, whether it be permanent or even  
23 temporary, is the availability or lack of appropriate  
24 accommodation in some rural and regional areas. That's the  
25 experience in this LHD as well, I take it?

26 A. Absolutely.

27  
28 THE COMMISSIONER: More than a challenge, I think. It's  
29 an impediment. Yes.

30  
31 MR GLOVER: Q. Falling into the language trap. And this  
32 strategy was directed to meeting that impediment, correct?

33 A. Correct.

34  
35 Q. Can you just tell us in general terms what the  
36 strategy is?

37 A. Absolutely. So, rightly, you've said that - the  
38 impediment of attracting clinicians to some of our regional  
39 areas. But more acutely to some of our very small towns,  
40 and, you know, my wife is a surgeon, my brother is a  
41 surgeon, I've grown up in a health environment,  
42 I understand the mentality and the approach. And it is  
43 very challenging to get clinicians to move permanently.  
44 That does happen, absolutely, and people are committed to  
45 that, but, traditionally, clinicians gravitate towards the  
46 larger centres like Sydney or Newcastle or Port Macquarie,  
47 some of those bigger centres, because it affords them a

1 particular lifestyle. And that's - I'm just speaking very  
2 generally. But I - you know, we don't need to get into  
3 that today but there are, of course, things we can do to  
4 attract clinicians to those smaller towns in the future,  
5 but they are long- to medium-term strategies that need to  
6 be adopted by government in a coordinated fashion.

7  
8 So my view at the time when we started to look at  
9 this, and this was off the back of the rural and regional  
10 inquiry that occurred prior to the current government, that  
11 the best we could do in the short term was to attract  
12 clinicians that come on short-term contracts and provide a  
13 service there for a week or a few days to that particular  
14 community, which, in my understanding of clinicians that we  
15 have, there is a great appetite to do that. People love  
16 doing that work; it's very rewarding for them.

17  
18 The largest impediment to doing that, though, is a lot  
19 of our smaller regional communities, (a), don't have  
20 accommodation. If they do by chance have some form of  
21 hotel or motor inn, it is of a standard which would make  
22 them unhappy to stay in there and have, you know, come back  
23 from work and sit somewhere comfortable and happy where  
24 they could relax. That didn't really exist in most of the  
25 towns. And if we had on-site accommodation, that on-site  
26 accommodation primarily was of a very, very poor standard.  
27 We've got a lot of accommodation on our campuses which are  
28 old nursing homes that have been around for a hundred  
29 years. Again, not allowing people to cook or have any  
30 modern facilities.

31  
32 So our concept here - and the other big impediment  
33 with accommodation is where people have rolled it out in  
34 the past, is they often construct something which is very  
35 permanent, and I know we with all of our infrastructure  
36 projects, nearly all of them we've had to demolish an  
37 existing building, some of them are existing accommodation  
38 buildings, to allow for the expansion of the new  
39 facilities. So, again, a big cost impediment moving  
40 forward.

41  
42 And then, sorry, the last issue we were trying to  
43 tackle was when you build something on a campus, it is  
44 very - a Health campus, it is very disruptive to them, and  
45 we wanted to approach this so there would be minimal  
46 disruption to clinical operations. And in terms of timing,  
47 this was COVID, post-COVID, and we also saw an opportunity

1 to provide some stimulus to each of those rural towns, and  
2 we ensured that although we pre-fabricated this using  
3 pre-fabricated construction providers, we ensured all the  
4 site works, all the local connections to services, all the  
5 landscaping works, were done by local contractors, ensuring  
6 that we invest money into that small rural town as we roll  
7 this out.

8  
9 Q. Just pausing there, we might go ahead to  
10 slide number 6, please, operator. And this is a general  
11 overview of the strategy, but in order to overcome some of  
12 those impediments and issues that you were just describing,  
13 the district approached the modular housing market to  
14 design and install sustainable relocatable residential  
15 accommodation, correct?

16 A. Correct.

17  
18 Q. And that's what you were referring to by "prefab  
19 pods"?

20 A. Correct, yes. Something that could be craned into  
21 position within a day. They were architecturally designed,  
22 so actually lovely to be in, so when you came home from  
23 your shift, it was incredibly comfortable and had all the  
24 modern elements that you'd expect if you were staying  
25 somewhere, anywhere, as a senior clinician, and that you  
26 are able to pick it up and move it, if required, in the  
27 future to somewhere else that might need it or if it was in  
28 the way of a future development, we could move it very  
29 easily.

30  
31 THE COMMISSIONER: Q. When was this strategy developed?

32 A. It was developed in 2021. Yes, 2021. And we worked  
33 with regional New South Wales.

34  
35 Q. Who provided the funding?

36 A. Yes.

37  
38 Q. They provided the loan?

39 A. They provided the - well, it wasn't a loan, actually.  
40 They just --

41  
42 Q. It wasn't a loan; it was actual funding, was it?

43 A. It was actual funding through - they worked with  
44 Treasury to provide the money to our district to implement  
45 the project.

46  
47 Q. So the strategy was developed. I imagine there was

1 then a business case, was there?

2 A. There was, Commissioner. There was a business case  
3 which talked about - look, it was an opportunity because  
4 the rural and regional inquiry had identified all of these  
5 issues of attracting clinicians. There was a political  
6 element in terms of solving a political problem that  
7 I thought we could take advantage of, but we had to make  
8 the dollars stack up.

9

10 Q. Sure.

11 A. And we knew that we could deliver these units very  
12 efficiently. I think there is a slide there which talks  
13 about our costs. The units cost between 270 and 350 each,  
14 which, again, I thought was very competitive. The other  
15 thing we did to manage our cost is we worked with the  
16 Department of Public Works or Public Works Advisory. They  
17 are the State Government's delivery arm for all projects;  
18 all government agencies can utilise them. The advantage --

19

20 Q. You managed the construction of Health Infrastructure?

21 A. Correct.

22

23 MR GLOVER: Q. Was there any funding or other support  
24 from the ministry to develop and then implement the  
25 strategy?

26 A. For that particular project, no, not directly, but  
27 there is a - I know now that the concept has taken off  
28 across NSW Health and also New South Wales Government, and  
29 I know that the ministry did secure other funding to  
30 support other LHDs in their work, and --

31

32 Q. I'll come back to what's happened since, but was  
33 support, whether by funding or in kind support from the  
34 ministry, asked for during the development and then  
35 implementation of the strategy in this district?

36 A. Look, how you ask for money for infrastructure  
37 projects within the current systems and processes, to ask  
38 for money for something like this is - there's no mechanism  
39 to - there was no mechanism. Things may have changed, but  
40 at the time there was no mechanism to do that. At the  
41 moment - the process at the time was to submit a capital  
42 investment proposal. It is what all the districts have to  
43 do. Essentially, they write up their priorities of what we  
44 want money for, we put in and ask for money. That is a  
45 process that's done on an annual basis. And --

46

47 Q. That process wasn't amenable to this strategy; is that

1 the point?

2 A. Correct, because often those capital investment  
3 proposals are geared primarily towards clinical spaces. So  
4 we need new wards or new ED and so forth. They are --

5

6 THE COMMISSIONER: Q. And tell me the time, the time  
7 taken from giving the department of regional  
8 New South Wales the business case to the time of the  
9 approval of your funding, what was that?

10 A. Probably six months.

11

12 Q. Yes, okay.

13

14 MR GLOVER: Q. Can we go to page 8, please. Dr Awad,  
15 you mentioned some of these costs in an answer to the  
16 Commissioner earlier, but the average cost is between  
17 \$250,000 to \$340,000, correct?

18 A. That is correct.

19

20 Q. That is to build the pod and have it delivered to the  
21 site?

22 A. That is correct. And then \$200,000 to \$300,000  
23 depending where it was to do the site works, and that's the  
24 money we gave to the local rural trades.

25

26 Q. And that's for the whole site, isn't it? That's not  
27 per pod?

28 A. No, that's for the entire site, yes.

29

30 Q. And then you've mentioned earlier, and it is said  
31 again here, that the unit can be relocated. Why was that  
32 an important part of the strategy?

33 A. To ensure that it could be moved if we needed to do  
34 any other work on that particular campus. Simply, it is  
35 just picked up by a crane and moved. And theoretically, if  
36 they're not getting utilised - but they are getting heavily  
37 utilised - to move it somewhere else that might require it.  
38 And also just transport. You know, I think there is an  
39 image in one of the slides there, it just sits on the back  
40 of a truck and arrives and it's there.

41

42 Q. And there are some slides which report some feedback  
43 from those who have stayed in the accommodation, and it's  
44 generally positive, correct?

45 A. Correct.

46

47 Q. If we go to page 11, slide 11, this is some financial

1 evaluation of the model. Before you get into the detail of  
2 that, the high satisfaction with the standard of  
3 accommodation, has that led to or improved the ability of  
4 the district to attract clinicians to those sites?

5 A. Absolutely. So there are some earlier slides which  
6 talk about staff attraction, but I have them here, I can  
7 happily talk - we did an evaluation after the first six  
8 months and we accommodated 350 staff in that first six  
9 months. We've seen our agency staff there staying longer  
10 now. I gave an example of at Scone, one of the units is  
11 full-time for a junior medical officer. We were unable to  
12 get junior medical officers to Scone; now we have one all  
13 the time. We have seen a reduction in our utilisation of  
14 the virtual doctor because we have GPs/VMOs now staying in  
15 those units. Our response times have improved. We've seen  
16 an increase in obstetrics and midwife clinicians staying in  
17 those pods, again providing the service.

18  
19 THE COMMISSIONER: Can we just go back to the  
20 slide before? We skipped --

21  
22 MR GLOVER: Slide 11?

23  
24 THE COMMISSIONER: Q. Yeah, that one. The \$78,200 in  
25 savings, by my math that the 460 room nights by the 170  
26 approximation for a motel, correct?

27 A. Correct.

28  
29 Q. But you've got a - are there costs involved in  
30 maintaining the pods, like cleaning?

31 A. There are cleaning costs in there, but they're fairly  
32 minor, Commissioner. We already have HealthShare on site  
33 cleaning the hospital. So to clean them and the linen and  
34 so forth, it's part of their day-to-day.

35  
36 Q. I see. I see.

37 A. We haven't --

38  
39 Q. Gets you to other - yes, okay. Sorry, yes.

40 A. No, I apologise. We haven't included - see, there are  
41 other cost savings, so there are cost savings in terms of  
42 travel and taxi cabs and there's other things there that we  
43 haven't incorporated in that.

44  
45 Q. Oh, okay.

46 A. But we just wanted to give - and there is an  
47 opportunity to do a more comprehensive cost financial

1 evaluation.

2

3 Q. You're doing - I am not suggesting it is wildly  
4 inaccurate, but that is sort of a back-of-the-envelope type  
5 saving, rather - yes, okay.

6 A. And very conservative I would say, Commissioner.

7

8 THE COMMISSIONER: All right.

9

10 MR GLOVER: Q. In an earlier answer, you mentioned that  
11 this type of approach has been picked up in other areas of  
12 the State, correct?

13 A. Yes. I understand that all the other regional LHDs  
14 have a similar program. I know the ministry is managing a  
15 broader program with Health Infrastructure to deliver -  
16 I don't know if they're exactly these pods, but relocatable  
17 pods. I'm not sure how that is progressing. I don't have  
18 any intimate knowledge of that.

19

20 Q. Do you have any understanding of the costs to deliver  
21 the relocatable pods through that Health Infrastructure  
22 initiative?

23 A. Look, not first-hand, but I have heard from some of my  
24 peers who have similar roles to me across the district that  
25 the cost of them is significantly - I've had a few phone  
26 calls saying, "How did you get yours so cheaply? We're  
27 sort of getting quoted maybe \$600,000 for an equivalent  
28 pod."

29

30 THE COMMISSIONER: Q. Just pausing there, you said your  
31 people in similar positions across the district. You mean  
32 people in similar positions to you in other LHDs?

33 A. Correct.

34

35 Q. Yes. And I think you mentioned at the round table we  
36 had, and you mention it again the \$600,000, but when you  
37 say "getting quoted maybe 600,000", quoted by whom?

38 A. Whoever is - well, my understanding is Health  
39 Infrastructure is managing the rollout beyond our district  
40 of that program, and that's the prices that they've been  
41 quoted. But, again, this is secondhand to the (indistinct)  
42 office, Commissioner.

43

44 Q. Yes, okay. Don't worry, there's no objection to the  
45 hearsay at the moment. But just pausing there, is it your  
46 perhaps imperfect understanding or not full understanding  
47 but what you've just heard that the design and



1 construction - well, hang on, the design may have been -  
2 are these exactly the same kind of pods we're talking  
3 about?

4 A. I don't - I don't believe so.

5

6 Q. Oh, okay. So they might be a slightly different  
7 design, no doubt - and you're not sure whether the  
8 construction manager is the LHD or another arm of Health?

9 A. My understanding is Health Infrastructure is  
10 managing --

11

12 Q. I see.

13 A. -- the broader rollout of this program. So when  
14 I fielded questions about how we did it, I think the  
15 difference is that we - one - one of my project managers or  
16 facility planners that works for me was the lead of the  
17 project, so one person there from our end. But the other  
18 thing we did is worked with Public Works Advisory, and they  
19 have - their strength in regional New South Wales is they  
20 have offices in virtually every regional centre in  
21 New South Wales and were able - they've got the local  
22 contacts with builders, they've got the local staff there,  
23 so we were able to reduce our overheads significantly. I'm  
24 not aware of how Health Infrastructure is managing the  
25 rollout and whether they're using a reliable source.

26

27 Q. I will ask a different question to which I already  
28 know the answer, but the design and rollout of these pods  
29 within your LHD was well within, in your opinion, the  
30 competence of you and your colleagues to successfully do  
31 it?

32 A. Yes. And, look, Health Infrastructure play an  
33 important role in terms of assisting and delivering  
34 large-scale projects, but although this added up to  
35 20 million, it's not a large-scale project. It's very -  
36 you know, \$250,000 or \$300,000 for a unit times 44 is not  
37 complicated. They're very small, low-risk elements that a  
38 district - and, again, I am not aware of whether all  
39 districts have people like me and my team, but from our  
40 perspective, it is very bread and butter stuff for us.

41

42 MR GLOVER: Commissioner, I don't have any further  
43 questions for Dr Awad. Before I sit down, though, the  
44 slides will be tendered. But just for the purpose of the  
45 transcript, the sustainability slides are  
46 [MOH.0010.0668.0001] and the housing or the accommodation  
47 strategy slides are [MOH.0010.0667.0001].

1  
2 MR GLOVER: All right. Do you have any questions,  
3 Mr Cheney?  
4  
5 MR CHENEY: No, Commissioner. It may be that I have to  
6 get some instructions from Health Infrastructure and others  
7 about the wider rollout.  
8  
9 THE COMMISSIONER: Sure. Fair enough.  
10  
11 MR CHENEY: Thank you, Commissioner.  
12  
13 THE COMMISSIONER: Dr Awad, thank you very much for your  
14 time. We're very grateful, and you are excused.  
15  
16 THE WITNESS: A pleasure, Commissioner, and thank you also  
17 for allowing me to attend virtually. That has assisted me  
18 greatly from a personal perspective and I appreciate it.  
19 It is convenient.  
20  
21 THE COMMISSIONER: No drama.  
22  
23 THE WITNESS: Thank you so much.  
24  
25 THE COMMISSIONER: I think we will start Ms Wong, but we  
26 will have a morning break, I don't know, about 11.15 or  
27 something like that.  
28  
29 **<THE WITNESS WAS RELEASED**  
30  
31 THE COMMISSIONER: Ms Wong, come forward. The witness box  
32 is up here. Would you prefer to give an oath or an  
33 affirmation?  
34  
35 THE WITNESS: Affirmation.  
36  
37 **<JILL ASHLEY WONG, AFFIRMED [10.54 am]**  
38  
39 **<EXAMINATION BY MR FULLER**  
40  
41 MR FULLER: Q. Ms Wong, would you state your full name,  
42 please?  
43 A. Jill Ashley Wong.  
44  
45 Q. Your professional address is a PO box number in Port  
46 Macquarie New South Wales; that's right?  
47 A. Yes, thank you.

1  
2 Q. Do you mind just speaking up a little bit or perhaps  
3 sitting closer to the microphone. Thank you. You are the  
4 district director integrated care allied health and  
5 community services for the Mid North Coast Local Health  
6 District?  
7 A. Yes, I am.  
8  
9 Q. And you have made a statement to assist the inquiry?  
10 A. Yes.  
11  
12 Q. Do you have a copy of that there in front of you?  
13 A. Yes, I do.  
14  
15 Q. I understand there are a couple of corrections that  
16 you wanted to make at paragraph 35, is that right?  
17 A. That's correct.  
18  
19 Q. And just tell me if I got this right. In the second  
20 line of paragraph 35, there is a figure of 44 per cent, and  
21 that should instead say approximately 16 per cent?  
22 A. Yes, that's right.  
23  
24 Q. And then in the next line, the figure of  
25 11.62 per cent should be approximately 9 per cent.  
26 A. That's correct.  
27  
28 Q. With those changes, is the statement true and correct  
29 to the best of your knowledge and belief?  
30 A. Yes, it is to the best of my knowledge.  
31  
32 Q. Thank you. Can I start with the integrated care part  
33 of your role. Can I ask you just to explain as  
34 straightforwardly as you can what is meant by "integrated  
35 care" from your perspective.  
36 A. Sure. Integrated care from my perspective is the  
37 provision of seamless and efficient care that reflects the  
38 whole person's health needs across their whole journey. So  
39 the consideration of all aspects of the delivery of care  
40 from health promotion to health prevention to early  
41 intervention, all the way through their lifespan and health  
42 needs to end-of-life care. And this is across all planes  
43 of their being, whether that be physical, psychosocial,  
44 mental health, and across all streams that provide that  
45 care. So that's in partnership with not only the  
46 individual patient or person, but their carers, their  
47 families, and healthcare providers that might not sit

1 within the same funding stream as NSW Health, such as  
2 primary care providers, the Commonwealth Fund system,  
3 primary health network.  
4

5 Q. To try to put it simply, is it about the way in which  
6 care is, healthcare is provided in all aspects relating to  
7 an individual's health; is that right?

8 A. Yes. Considering a person holistically across all of  
9 those aspects.

10  
11 THE COMMISSIONER: Q. And that involves collaboration  
12 between or may involve collaboration between clinicians  
13 with different skill sets?

14 A. Yes.

15  
16 MR FULLER: Q. How does integrated care, as you have  
17 described it, relate to community services, that part of  
18 your role?

19 A. So integrated care, I guess, being the consideration  
20 of how we deliver care in that seamless or holistic way,  
21 facilitating collaboration across clinicians, is the  
22 premise of how community services are provided. So  
23 considering the whole person and the ability to pull in a  
24 range of clinical members into a multidisciplinary team to  
25 deliver care that the patient requires.  
26

27 Q. I take it you think it's important for your district  
28 to play a role in integrated care, is that right?

29 A. Yes, that's right.  
30

31 Q. Why is that?

32 A. I think it's important for us to consider care in an  
33 integrated manner, because the whole person's being is more  
34 than what they may present to our hospitals for. If I use  
35 an example that somebody might come into our hospital with  
36 a broken limb, there are other factors that might have  
37 contributed to the underlying cause or the reason for that  
38 patient coming through our front door, and taking a  
39 holistic approach to that patient's needs, their personal  
40 circumstances and the factors that contribute to their  
41 health and wellbeing is a vital aspect to look at effective  
42 and efficient care. But also to tailor the way we deliver  
43 care to those individual needs, whether that be through  
44 supporting, understanding health education, care navigation  
45 or their health literacy.  
46

47 Q. And is that because, in the first place, you think

1 that you understand the district has a role and a  
2 responsibility to provide care to individuals within its  
3 population that it's responsible for; is that right?

4 A. Yes.

5  
6 Q. And, secondly, there are practical consequences for  
7 the district if it doesn't pay attention to integrated  
8 care; is that right as well?

9 A. Yes.

10  
11 Q. And you told us about some of those practical issues  
12 in your statement. Can I start with at paragraph 8 of your  
13 statement, you talk about aged care and NDIS services, and  
14 the interaction of those with your district. In the second  
15 sentence there, you say:

16  
17 *Due to the variety of these services ...*

18  
19 That is, aged care and NDIS services:

20  
21 *... misalignment between supply and demand,*  
22 *and the nature of services provided by*  
23 *NSW Health, there is often either gap in*  
24 *available and funded service provision or*  
25 *duplication of service provision between*  
26 *these providers and NSW Health.*

27  
28 Firstly, can you give an example of a gap that you perceive  
29 to exist as a result of one of those causes that you have  
30 identified?

31 A. Yes, I can. So one example of a gap between the  
32 services that are under Commonwealth funding and State  
33 funding is a participant on the NDIS who may have a primary  
34 diagnosis of a mental health condition. They may also have  
35 a presenting chronic disease aspect to their  
36 whole-of-person health, but their primary focus is mental  
37 health and that is the eligibility that they've become a  
38 participant under the NDIS. That means that that  
39 particular participant is able to access mental health  
40 services under the scheme, but they are not eligible to  
41 access the range of chronic disease services that they may  
42 require, whether that be physiotherapy, early intervention  
43 for dietetics and nutrition, social work or other under the  
44 scheme. So they will then rely on our Mid North Coast  
45 Local Health District to provide that support from a  
46 chronic disease management perspective. And the reason  
47 that this is significant is that we are aware of statistics

1 that say that chronic disease is ten times more likely to  
2 result in premature death than, for example, suicide.  
3 However, we're not then considering a holistic approach to  
4 that individual's needs in the current structure and  
5 system.  
6

7 Q. Just starting with the chronic disease aspect of it,  
8 you said that they, in your example, that the participant  
9 may be eligible to access mental health services. That's  
10 through the NDIS scheme; is that right?

11 A. Yes.  
12

13 Q. But not eligible to access physiotherapy was one  
14 example that you gave. Why would that be, in your example?

15 A. Because the disability that they have been identified  
16 to have is relating to their mental health condition. So  
17 the other health factors that may or may not contribute to  
18 their mental wellbeing, or their mental health condition,  
19 are not necessarily included in their particular package  
20 and that would then require that individual to access those  
21 services either through their primary care provider or GP  
22 for a GP allied health plan or a chronic disease management  
23 plan, or through our public services, being Mid North Coast  
24 Local Health District.  
25

26 Q. Then in paragraph 8, you talk - there is the second  
27 thing you mention in that sentence in paragraph 8, is the  
28 duplication of service provision. Can you give an example  
29 of the way you see that happening?

30 A. Yes. So a duplication, I guess, might be around  
31 services that exist. So there are a range of, I guess,  
32 allied - private practice allied health services, and I am  
33 focusing on allied health as that is something that I am  
34 responsible for in Mid North Coast. Private practices that  
35 exist in the local market, and that is also an area of care  
36 or service provision that we have within Mid North Coast  
37 Local Health District. So you may be able to access  
38 physiotherapy in private and in public and, therefore,  
39 there is a gap, but there may not be availability in, for  
40 example, psychology services in the community or in our  
41 service in Mid North Coast Local Health District.  
42

43 Q. When you said just then, "Therefore, there is a gap,"  
44 did you mean a duplication?

45 A. Sorry, a duplication.  
46

47 Q. A duplication. And why is - to the extent there is a

1 duplication, why is that an issue from the district's  
2 perspective?

3 A. I don't think it is an issue, per se. I do think it  
4 is something for us to be aware of around if there is  
5 duplication, are we as a whole system providing the most  
6 effective or efficient care? And if there is a  
7 duplication, does that mean that there is a gap in another  
8 area that we could be better resourcing or stepping into?

9  
10 Q. Is that a planning issue, primarily, planning and  
11 coordination issue with those who do provide the duplicated  
12 services?

13 A. In part, yes, I do believe that there are  
14 opportunities to better plan or consider what is within the  
15 local market. I think for Mid North Coast Local Health  
16 District, one of the difficulties is that we don't  
17 necessarily have reach or governance of what is not funded  
18 within the Mid North Coast Local Health District via State  
19 Treasury. So in Mid North Coast, we have partnered with  
20 Northern NSW Local Health District and the primary health  
21 network in our geographically region, Healthy North Coast,  
22 and agreed on a memorandum of understanding which brings us  
23 together as three entities to look at opportunities to  
24 better streamline, but also to map the services that are  
25 available in our geographical landscape, which, I guess,  
26 goes to the point that you've just made.

27  
28 Q. When you said in that answer that you don't  
29 necessarily have reach or governance of what is not funded  
30 within the Mid North Coast Local Health District by State  
31 Treasury, can you just explain what you mean by that,  
32 please?

33 A. Yes. So within Mid North Coast Local Health District,  
34 we cannot control what private practices are established or  
35 what private practitioners choose to focus on. So if there  
36 are private clinicians or practitioners who would like to  
37 establish a private practice focusing on a disability  
38 navigation service or physiotherapy or a particular cohort  
39 of our patient community, that is outside of the remit or  
40 governance of Mid North Coast Local Health District.

41  
42 Q. And in paragraph 9 of your statement, you talk about  
43 the impact for NSW Health. Can I just ask you, firstly, to  
44 elaborate verbally for us here today on what you say the  
45 impact for NSW Health is of the issues that you have  
46 identified with the interaction with aged care and NDIS?

47 A. So if I focus on aged care first. At any one time in

1 the Mid North Coast Local Health District, there are  
2 between three and 5 per cent of our bed base with medically  
3 cleared patients who are awaiting or eligible for  
4 residential aged care homes. This equates to approximately  
5 8 to 10 per cent of ED-accessible beds. This is for a  
6 range of reasons. It could be the individual's choice and  
7 decision-making around their preference, so residential  
8 aged care home, but it also could be because of a lack of  
9 accessibility to a residential aged care home placement.

10  
11 This has an impact for NSW Health because these  
12 patients are not requiring any current acute medical care,  
13 per se, and this is a resource that would otherwise be  
14 utilised or provided to somebody who is medically unwell.  
15 These medically cleared or medically well patients are, of  
16 course, at risk of, you know, clinical deterioration the  
17 longer they stay in hospital unnecessarily, and are at  
18 greater risk of hospital-acquired infections the longer  
19 that they stay in our facilities unnecessarily, so that is  
20 a significant impact for us from a health and care  
21 perspective.

22  
23 It also has a financial impact for us because these  
24 patients who are on various aged care packages would  
25 potentially have some recoup to their aged care home that  
26 is not necessarily recouped into our Mid North Coast Local  
27 Health District system, and the intensity of resources that  
28 goes into keeping these patients safe and well and  
29 conditioned is intensive when they have not got an  
30 underlying medical condition keeping them in that bed.

31  
32 Q. I'll just pause there and explore a couple aspects of  
33 that answer. Firstly, you said that there were two reasons  
34 why an aged care patient in a hospital might not be able to  
35 move into an aged care bed. One is choice and preference,  
36 and the other being lack of access. Do you have a sense,  
37 from your position, of how much of the problem is  
38 associated with choice and preference versus lack of  
39 access?

40 A. I wouldn't have a number or a data point in my mind.  
41 I guess anecdotally, I do think that they are quite  
42 intertwined because choice and preference also is impacted  
43 by availability.

44  
45 Q. And then just so we understand --

46  
47 THE COMMISSIONER: Q. In the sense that the patient and



1 the patient's family might be accepting that a family  
2 member might be best placed in an aged care facility, but  
3 not the one that's available?

4 A. Yes.

5

6 Q. That's what you mean? Yeah.

7 A. Thank you.

8

9 MR FULLER: Q. And I think you tell us in your statement  
10 that choice and preference is one aspect of the aged care  
11 principles that have to be applied by aged care providers  
12 as well?

13 A. Yes.

14

15 Q. So it is integrated in that way, intertwined in that  
16 way as well; is that right?

17 A. Yes, that's right.

18

19 Q. Then in terms of the funding or financial issue that  
20 you mentioned, can I just make sure we understand that. In  
21 the example of - taking an example of an aged care resident  
22 who is living in residential aged care and has come in to  
23 the hospital for an acute care episode, starting with when  
24 they present to the ED, from that time the services that  
25 are provided to them are funded by the district/NSW Health;  
26 that's right?

27 A. That is my understanding.

28

29 Q. And to the extent they remain in a bed, in a public  
30 hospital, that is funded by NSW Health/the district; that's  
31 right?

32 A. Yes, that's right.

33

34 Q. There is no funding from the Commonwealth for the  
35 provision of those services in the public hospital, is that  
36 your understanding?

37 A. That is my understanding.

38

39 Q. And then you've said in paragraph 9 that the  
40 residential aged care home continues receiving funds for  
41 the residential bed, but those are funds from the  
42 Commonwealth; is that right?

43 A. That is my understanding. So funds from the  
44 Commonwealth, and any personal contribution that is  
45 required, depending on the fee structure of the individual  
46 aged care home.

47

1 Q. And is it your understanding that those funds from the  
2 Commonwealth and from the individual to the extent required  
3 continue to be paid to the residential aged care home, even  
4 though the patient is not occupying the bed in that home?

5 A. That is my understanding.

6

7 Q. And I take it from paragraph 9 that you understand  
8 there's no way of NSW Health, or the district, accessing  
9 that Commonwealth funding that continues to be paid for the  
10 bed while the patient is in fact in a public hospital?

11 A. That is my understanding.

12

13 MR FULLER: Right.

14

15 THE COMMISSIONER: Q. So we don't make a mistake, it  
16 might be helpful not today, Mr Cheney, but at some stage in  
17 the near future for perhaps NSW Health to give us some  
18 assistance with various scenarios relating to when an aged  
19 care patient is in a New South Wales public hospital, who  
20 is paying for what and whether there is any contribution to  
21 the Commonwealth from Commonwealth funding and, if so, when  
22 that applies, so that we have a really accurate picture  
23 about what the funding is for a variety of scenarios when  
24 an aged care patient might be in a public hospital,  
25 including when they could be discharged but there's no bed  
26 available or scenarios like where they have been in an aged  
27 care facility but for various reasons the aged care  
28 facility, as we have heard many times, won't take them  
29 back.

30

31 MR CHENEY: Yes.

32

33 THE COMMISSIONER: All those sort of scenarios. I think  
34 you know there are multiple permutations of this, but just  
35 so we have an absolutely accurate picture.

36

37 Q. This is not a criticism of you, by the way; this is  
38 something that has just occurred to me on the run. It  
39 would help if we had that. Do you know whether, within  
40 your LHD or more broadly in Health, there is data about  
41 what it is actually costing the LHD or NSW Health for aged  
42 care patients that are capable of being discharged to an  
43 aged care facility or are ready to be discharged to an aged  
44 care facility either for the first time or to be returned  
45 but they can't so they are in a public hospital bed, as to  
46 what that is costing?

47 A. I don't have those figures, but that would be

1 something that we could very accurately estimate based on a  
2 bed day cost and the time post medical clearance.

3  
4 THE COMMISSIONER: I don't know whether to burden you with  
5 that, but that's something else I think would be really  
6 useful for us to have as well, Mr Cheney, thanks.

7  
8 MR CHENEY: Right.

9  
10 MR FULLER: Q. And what about for NDIS patients? Could  
11 something similar be done for NDIS participants occupying  
12 beds in your district's facilities?

13 A. Yes, we do have the data on patients and where they're  
14 at in their medical clearance versus their length of stay,  
15 so that data could be reconciled as well.

16  
17 THE COMMISSIONER: Q. The reason I am asking for these  
18 data and that cost is because, certainly on one reading of  
19 the National Health Reform Agreement, the Commonwealth  
20 seems to have its hand up for responsibility for both  
21 primary care and aged care, but it may not extend to all  
22 aspects of the cost when New South Wales has aged care  
23 patients that don't need to be in a public hospital because  
24 either they didn't have a condition that required that or  
25 their acute episode has been resolved but there is no aged  
26 care bed. Anyway. That wasn't a question. That was a -  
27 talking to myself, I think.

28  
29 MR FULLER: I was listening.

30  
31 Q. Just sticking with aged care for a moment, can you  
32 have a look at paragraph 11 of your statement, please. In  
33 the fourth line, you refer to increased liquidity of the  
34 ageing population. Can I just ask you to explain what you  
35 mean by that?

36 A. Sure. For me, that's the, I guess, the anecdotal  
37 experience that we were having with our ageing population,  
38 where they have more funds available perhaps, or are in a  
39 more financially stable position, and I guess this goes to  
40 my earlier comment about choice. So there are a range of  
41 our aged population who are over the age of 65, who have  
42 higher expectations of care based on their ability to pay  
43 for care and perhaps have a preference to be in certain  
44 aged care homes as opposed to others.

45  
46 Q. Coming to NDIS, you talk about NDIS services in  
47 paragraphs 16 and 17. I'll come back to what you say about

1 community health earlier. In paragraph 16, you say:

2  
3 *For disability related services, the*  
4 *transfer of the funding has not necessarily*  
5 *resulted in the movement of associated*  
6 *clinical care ...*  
7

8 Can you just explain what you mean by "the transfer of  
9 funding"?

10 A. Yes. So what I mean by "the transfer of funding" is  
11 prior to the establishment of the NDIA, or NDIA, the  
12 service provision for those who were diagnosed with a  
13 disability or were needing care would seek that care and  
14 healthcare through NSW Health and/or the primary care  
15 landscape of their general practitioners and specialists,  
16 and since the establishment of NDIS, not all of that care  
17 has moved away. So we still have members of our community  
18 accessing NSW Health or Mid North Coast Local Health  
19 District services for support in regards to their  
20 presenting health needs relating to their disability.  
21

22 Q. When you say "transfer of funding", is it your  
23 understanding that there is, effectively, a bucket of  
24 funding that was provided by the Commonwealth to the states  
25 prior to the NDIA for disability care, but, instead, that  
26 money is now not coming to the states; it's instead going  
27 directly to NDIS providers, for example?

28 A. Yes. My understanding is that funding that may have  
29 been provided for disability service provision across the  
30 states and territories by the Commonwealth was then aligned  
31 to the NDIS and pulled back into a national scheme to  
32 support our whole community.  
33

34 Q. And the issue you are identifying in paragraph 16 is  
35 that despite there being, as you understand it, a reduction  
36 in funding to the states associated with disability care,  
37 the State is still providing care to disability patients  
38 for the reasons that you outline; is that right?

39 A. Yes.  
40

41 Q. At the end of paragraph 16, you refer to eligible  
42 participants not being able to access - tell me if I've got  
43 this right - not being able to access therapy in the  
44 community due to thin provider markets. Have I understood  
45 what you are saying there correctly?

46 A. Yes.  
47

1 Q. Can you just elaborate on what you mean by "thin  
2 provider markets", or what those look like?

3 A. So there are variations in what is available in the  
4 private provider market. So in the Mid North Coast Local  
5 Health District, there is great difficulty in accessing  
6 private occupational therapists who are quite vital in  
7 supporting participants, in particular, relating to their  
8 assessments for their NDIS plans and their re-assessments  
9 for the plans.

10  
11 Q. In paragraph 17, you talk about NSW Health becoming  
12 the default service provider. Is that because of the thin  
13 provider markets in the community?

14 A. Yes, I think that is part of the reason that  
15 New South Wales or particularly Mid North Coast Local  
16 Health District becomes the default. I think it is also  
17 because of the trust that the community have in the Mid  
18 North Coast Local Health District services. So there has  
19 been a knowledge or a comfort that the emergency  
20 departments are where they are, that the community health  
21 centres are where they are. So I think there's knowledge  
22 that there is the ability to access a health service that  
23 will provide an assessment and a, you know, support to the  
24 presenting health condition through the local health  
25 district-funded services.

26  
27 It is also a safe place for participants. So we have  
28 examples where there might be a social admission for a  
29 participant of the NDIA following a breakdown of their  
30 living arrangements or carer fatigue or inability to find  
31 respite care for that particular participant. NSW Health  
32 or Mid North Coast Local Health District is a safe and  
33 accessible place for that family to present.

34  
35 Q. You told us that NSW Health becoming a default or  
36 being a default service provider creates tensions between  
37 health staff providers and the NDIA. Can you just  
38 elaborate on what you mean by "tensions"?

39 A. I guess tension around the need to then have somebody  
40 who may not require a medical - you know, medical admission  
41 because of an acute medical presentation into an acute  
42 hospital bed. So the tension between the ability to have  
43 that bed available for somebody who is medically needing  
44 that placement within our hospital system, or that  
45 placement within our community health services, and the  
46 provision of that care to the person who is in front of us  
47 or needing that for another reason. With our NDIS

1 participants in particular, there is a high intensity  
2 needed for a multidisciplinary clinical team, and that  
3 requirement to best support that participant from a  
4 holistic perspective can at times take away the ability to  
5 provide that care to our other patients.  
6

7 Q. So it is a tension that is because someone is  
8 occupying a bed when perhaps they could or should be given  
9 the care that they're getting from the bed in the  
10 community; is that a fair summary?

11 A. A fair summary, yes.  
12

13 Q. And just finally on this topic, you've referred to  
14 that tension issues often having negative impacts for the  
15 NDIS participant. Can you just elaborate on what you see  
16 as being the negative impacts?

17 A. Yes. So for a participant who doesn't require a  
18 medical admission into a hospital to be in a hospital  
19 setting, that setting is not necessarily appropriate for  
20 somebody who should be able to freely move around, who  
21 should be able to have all choice in food or comforts of  
22 living in a supported independent living environment or in  
23 their own home, and the risks, of course, that come with an  
24 acute facility, whether that be the risk of, you know,  
25 hospital-acquired infection or deconditioning and, I guess,  
26 the discomfort of not being in your own surroundings.  
27

28 MR FULLER: Commissioner, I note the time. I'm about to  
29 move on.  
30

31 THE COMMISSIONER: Okay. We'll take a break now if that's  
32 convenient to you, and we'll come back at 11.40. We will  
33 adjourn until then.  
34

#### 35 **SHORT ADJOURNMENT**

36  
37 THE COMMISSIONER: Yes, Mr Fuller.  
38

39 MR FULLER: Q. Thank you, Commissioner.  
40

41 Q. Ms Wong, can I ask you now about paragraphs 12 to 14  
42 of your statement. In paragraph 12, and then you continue  
43 this in paragraph 14, you talk about opportunities to  
44 invest in a more whole-of-community and community-based  
45 approach to the delivery of healthcare. Can you just  
46 explain what the opportunities are that you identify?  
47

A. So what I was talking about in this section of my

1 statement was around the opportunity to invest or redirect  
2 funding to community-based or out-of-hospital based  
3 services that focus on prevention for the Mid North Coast  
4 Local Health District. We have a high representation of  
5 chronic disease compared to the rest of the state, and I do  
6 think there is an opportunity for us in the Mid North Coast  
7 to continue rediverting or investing in that prevention  
8 space. Chronic disease as a condition or a group of  
9 conditions often present to our system and require a lot of  
10 intensity, but there have been some really strong examples  
11 where early intervention models, up to two weeks of  
12 intensive multi-clinical teams, working with patients, has  
13 been shown to better support patients through the provision  
14 of that holistic care, creating that health awareness, and,  
15 I guess, empowering that patient to better manage their  
16 health condition, reducing the reliance on our acute  
17 system.

18  
19 THE COMMISSIONER: Q. Just pausing there, you said  
20 "redirect funding." Accepting you don't do the budget for  
21 the LHD, redirect from where?

22 A. I guess redirect, perhaps, from where we may see some  
23 opportunities to reduce lower value care. This may be from  
24 other areas of our health budget, be that the acute setting  
25 or other community health services that might be better  
26 reshaped into a preventative health model.

27  
28 Q. If you could redirect funding from funding that wasn't  
29 necessary or wasn't useful or was low value, you'd do that,  
30 otherwise rather than a redirection, there would be a need  
31 for additional funding for the kinds of early interventions  
32 you are talking about, correct?

33 A. Redirection versus investment, sorry, Commissioner?

34  
35 Q. If there wasn't an opportunity for redirection of  
36 funding, then to have more investment in the kinds of early  
37 intervention models you're talking about, you would require  
38 extra funding for that, correct?

39 A. Yes.

40  
41 Q. And what early intervention models of care are we  
42 talking about? What kind of patients, what kind of  
43 conditions are you talking about?

44 A. I guess there is a range of conditions. One example  
45 of a cohort of patients that might benefit from this would  
46 be, for example, our osteoarthritis cohort of patients who  
47 have been identified for a total knee replacement or knee

1 arthroscopy. There are alternatives to the surgical  
2 pathway. A conservative approach can be taken for some of  
3 these patients.  
4

5 Q. Are you talking about things like weight management  
6 lifestyle changes, that sort of thing?

7 A. Yes. So weight management lifestyle changes with the  
8 support of dietetics and nutrition, with the support of  
9 physiotherapy and occupational therapy. Social work,  
10 perhaps, depending on lifestyle underlying factors. We  
11 know that behavioural changes take time, so an intensive  
12 prehabilitation model or an out-of-hospital model to  
13 support individuals, one, to become aware of some of these  
14 factors - they may not know that that has an impact on  
15 their knee issues, or that it could resolve some of the  
16 pain or the impact that they have in regards to their  
17 presenting issue - but it also then allows for us to  
18 reserve costly and time-limited time in the operating  
19 theatre for those who do need the surgical intervention.  
20

21 Q. So any investment in those sorts of early intervention  
22 models is one aimed at better health outcomes, is one thing  
23 you are looking for, correct?

24 A. That's correct.  
25

26 Q. The other thing is, hopefully, an actual saving if  
27 more expensive health services are either not needed or are  
28 deferred?

29 A. Yes.  
30

31 Q. Correct? And whilst it would require some perhaps  
32 sophisticated economic modelling, the people you are  
33 talking about may maintain a level of productivity that  
34 might be useful if there's these sort of early intervention  
35 models rather than having them in acute care?

36 A. Absolutely.  
37

38 Q. And in better health?

39 A. Yes.  
40

41 MR FULLER: Q. You said in one of your earlier answers  
42 that these sorts of interventions have been shown to better  
43 support patients for the provision of holistic care. When  
44 you said "shown", are you aware of any evidence or research  
45 that has been done in relation to that?

46 A. Yes. So there has been a range of different pieces of  
47 research that have been undertaken, some by, for example,



1 the Agency for Clinical Innovation. So some of the work  
2 that has been done and measured within NSW Health more  
3 broadly, but there have been a range of peer-reviewed  
4 journals that have followed the outcome of patients who  
5 have gone down what is referred to as conservative pathways  
6 or alternative pathways to surgery. Similarly, there have  
7 been bodies of work undertaken for the early intervention  
8 for persons who have experienced violence, abuse and  
9 neglect, and the reduction of their chronic disease burden  
10 that is often seen reduced later in life.

11  
12 Q. In paragraph 14 of your statement, you mention in the  
13 second sentence a range of service models and you give a  
14 couple of examples. The examples that you have given here,  
15 are those actual programs that you are aware of being in  
16 place, or are they ideas?

17 A. Yes. So they are examples of programs that are in  
18 place in other LHDs. A lot of this innovation has come out  
19 of, you know, a COVID era where we are in a fiscally  
20 constrained environment, but they have been able to show  
21 and measure success for those patients in regards to  
22 avoiding presentations to ED or better supporting that  
23 person in the home.

24  
25 Q. So, taking the first example, programs providing rapid  
26 responses from community-based allied health and nursing  
27 services, what particular program did you have in mind when  
28 you were giving that example?

29 A. I had the - and I will get the name wrong, so if you  
30 bear with me a moment, I've spoken to it later in my  
31 statement, the quick access and response team, the QuART  
32 model, and there is also the RAID-ED model that is an  
33 example, which is the rapid access intervention and  
34 discharge model, which is a multi-disciplinary team at the  
35 front of house in the emergency department to avoid the  
36 admission.

37  
38 Q. This is paragraph 54 of your statement, is it?

39 A. I'll just check. Yes, that's correct.

40  
41 Q. So just with the RAID-ED model, can you just tell us  
42 your understanding of how that model works?

43 A. Yes. Noting that this is not a model that is in Mid  
44 North Coast, my understanding of the RAID-ED model is that  
45 there is a multidisciplinary allied health team placed and  
46 based in the emergency department to work alongside the  
47 nursing and medical staff in the emergency department, and

1 the focus is on patients that are coming through that can  
2 be managed and supported by the allied health team.

3  
4 So if I take a musculoskeletal presentation, the  
5 physiotherapist and the occupational therapist are very,  
6 very well-placed to provide an assessment, triage and  
7 diagnosis for that patient presenting. Their education and  
8 qualifications enable them to be skilled in that area, and  
9 that adds value to the emergency department where you are  
10 taking away the need for a nurse or a medical officer to  
11 then seek a referral to a physiotherapist or an  
12 occupational therapist, or to, at times, call for costly  
13 diagnostics that could otherwise be avoided with that early  
14 assessment by an allied health clinician.

15  
16 Q. Is there any reason why that model, to your knowledge,  
17 hasn't been implemented in your district or in other  
18 districts more broadly?

19 A. I guess my understanding of this is that we, in each  
20 LHD, need to make decisions about the limited resources  
21 that we have and where we're best able to utilise them. So  
22 within Mid North Coast Local Health District we have  
23 different types of services in place. We have a range of  
24 allied health-led services within our enhanced community  
25 care service, which is focusing on a similar but slightly  
26 different cohort preventing presentations to our emergency  
27 department by providing that intensive early intervention  
28 in the community. This is not a mandated service model.  
29 It's not funded as, you know, across the State. So there's  
30 no, I guess, expectation as a whole system that we have  
31 this. However, in Mid North Coast, it might just be around  
32 where we have chosen to place our staff and limited  
33 resources that we have.

34  
35 Q. The other model, just sticking with paragraph 54, that  
36 you talk about, is the allied health quick access response  
37 team, which you say was developed in Illawarra Shoalhaven  
38 LHD. Can you just tell us your understanding of that  
39 model?

40 A. Yes. And I am less familiar with this particular  
41 model's nuances, but my understanding is this is an  
42 intensive up to two-week multidisciplinary allied health  
43 team that can provide care in the patient's home to support  
44 that early discharge from hospital or the admission  
45 avoidance, so after we are aware of a patient then wrapping  
46 around a multidisciplinary team to support that person in  
47 the home.

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Q. Again, would I be right in thinking that in your district, that's something that, in theory, could be implemented but you have chosen to use your allied health resources in a different way that reflects the demands of the community that you are also in?

A. Yes. We have utilised the resources that we have in the ways that we are best able to.

Q. If you had the available resources, do you think it would be beneficial for your district to consider implementing models such as these? Do you have a view about that?

A. I do. I do have a view about that. I think for us we'd have to be very conscious of what the structure would be for our particular local health district, and we've got the variation of geography in our local health district and access. So all of that comes into play when we're thinking about how we best provide that care in an outreach perspective. I do think there is an opportunity to maximise technology in how we deliver clinical care where appropriate, and I guess the short answer is, yes, I do think that if we had additional resources or additional funding, we would be able to look at how we could invest in some of these models or models adjacent to this structure.

Q. Just wrapping it up, as a general proposition, you think it is a good idea to invest more in hospital admission prevention and presentation avoidance initiatives and it's a matter for each LHD district to work out what the best initiatives based on its own characteristics and those of the population it is serving? Is that a fair summary?

A. Yes, it is. I think the only thing that I would like to add to that is we as a local health district have chosen to utilise some of our funding or redirect some funding into other areas of prevention. I think what would benefit LHDs is the ability to be flexible in how we apply that, but some dedicated contribution or proportion of funding for preventative care would be - I think would be an ideal opportunity.

THE COMMISSIONER: Q. Sticking with paragraph 54 and the examples of initiatives you give, like RAID-ED and the quick access response team, when you've used an expression like "a range of initiatives" that "have had success", what do I understand by "have had success"? I mean, in one

1 sense it is an expression of your opinion, but your opinion  
2 would be based on certain data or certain information you  
3 have received. What is the success and what's the extent  
4 of it and has it been evaluated?

5 A. Yes.

6  
7 Q. Have they been evaluated, I'm sorry?

8 A. Yes, my understanding is that they have had their data  
9 mapped and evaluated. I can't speak to the specifics of  
10 that evaluation pathway. The information has been shared  
11 through a statewide forum --

12  
13 Q. Right?

14 A. -- for directors of allied health, facilitated by the  
15 chief allied health officer. And so, the value proposition  
16 that was shared was not only from a fiscal perspective  
17 around cost avoidance of bed days and ED admissions, but  
18 also patient-reported experience measures.

19  
20 THE COMMISSIONER: Thank you.

21  
22 MR FULLER: Q. The increased investment or redirection  
23 of funds to community-based care and preventative care that  
24 we've been talking about, do you view that as being able to  
25 address in any way the issues that we were talking about  
26 before the break with aged care and NDIS service  
27 availability in your district?

28 A. In part, yes. If I might talk a little bit about one  
29 of the preventative services that we have in place in the  
30 Mid North Coast, it is Mid North Coast Virtual Care. This  
31 has been a service that is aimed at preventing  
32 presentations to our emergency department and admissions  
33 into our hospital and supporting early discharge from our  
34 hospital. That is a virtual care service where clinical  
35 care is provided through telehealth or audiovisual means.

36  
37 I believe that there is an opportunity to continue to  
38 build on what we have found to be that success, again  
39 relying on the documented cost avoidance of our patients  
40 not then using a bed day or hospital admission and the  
41 patient-reported experience measures to support or keep  
42 residents in residential care homes where they do not need  
43 to be transferred into our emergency departments. We  
44 established the inaugural statewide procedure with NSW  
45 Ambulance for the Mid North Coast region to enable NSW  
46 Ambulance paramedics on-road to provide a point of care  
47 referral. At the moment that is restricted to point of

1 care referrals for individuals in their homes who meet  
2 particular criteria who have contacted triple-zero but do  
3 not require emergency presentation at the emergency  
4 department.

5  
6 So Mid North Coast Virtual Care enables a point of  
7 care referral from the paramedic on the ground through to  
8 our medical or nursing team and then connects that medical  
9 and nursing team to the patient in their home, to provide  
10 them with the clinical care that they require. So that  
11 model could be scalable, I believe, and could reach into  
12 settings such as aged care homes, and that would require a  
13 level of integration and collaboration with the 35  
14 different residential care homes in our geography.

15  
16 Q. You tell us about Mid North Coast Virtual Care in  
17 paragraphs 29 to 31 of your statement. Can I just ask you,  
18 taking a step back, to describe practically what is Mid  
19 North Coast Virtual Care; how does it work?

20 A. Certainly. So Mid North Coast Virtual Care is a  
21 virtual service made up of a multidisciplinary clinical  
22 team. We currently have about 20 full-time equivalent  
23 staff in that with administration, nursing and medical, and  
24 then a connection to hired health professions as needed.  
25 So that team focuses on receiving calls accessible through  
26 our landline number from our community who would otherwise  
27 be presenting to our emergency departments.

28  
29 Q. Just pausing there for a moment. When you say they  
30 would "otherwise be presenting to the emergency  
31 department", how do you know that? What makes you think  
32 that?

33 A. So over the last financial year, we had about 12,900  
34 referrals come through, and at the beginning of their phone  
35 call, they're asked a range of questions around, "Why have  
36 you contacted us?" and, "If we weren't able to provide you  
37 with a service, what would you do?" So a proportion, a  
38 small proportion would say, "Well, I would do nothing," but  
39 a large proportion would say that they would otherwise have  
40 presented to the emergency department.

41  
42 Q. So this is the data that you give us in paragraph 31,  
43 is that right?

44 A. Yes.

45  
46 Q. And, sorry, I interrupted you. You were at the point  
47 where the team is receiving calls through the landline

1 number from people who would otherwise be presenting. And  
2 then what happens at that point?

3 A. So our Mid North Coast Virtual Care team undertake a  
4 triage for that person contacting and will decide whether  
5 we can provide care to them within our clinical framework.  
6 If we deem that they are or should have contacted  
7 triple-zero or are an emergency presentation, we will  
8 direct them and/or do a warm transition for them, depending  
9 on the needs of that particular patient, through to the  
10 relevant place. Similarly, if they are seeking care  
11 navigation or could access a non-urgent clinical  
12 intervention or could be better serviced with a generalist  
13 community nursing or allied health community service, we  
14 will care, navigate and support that person down the right  
15 pathway. The care that we provide for the majority is a  
16 clinical intervention that keeps that patient at home  
17 within an urgent care services framework.

18  
19 So we've been very lucky to receive some funding from  
20 the ministry in line with their support for urgent care  
21 services. We are currently one of eight LHD-run urgent  
22 care services. We fulfil that urgent care services aspect  
23 to provide care between two hours and 12 hours of the  
24 person needing care that is not an emergency in the  
25 emergency department, but our Mid North Coast Virtual Care  
26 service also provides care for those patients who have been  
27 triaged and assessed in ED but could be discharged home  
28 with a clinical care team to support them, or a patient who  
29 has been admitted to hospital, undertaken a time stay in  
30 hospital and then can also be supported to be discharged  
31 early with the care of a clinical team, and that clinical  
32 team provides that care virtually or through telehealth.

33  
34 Q. That last aspect of the north coast virtual care is a  
35 way of freeing up beds where a person otherwise might have  
36 had to stay in hospital; is that right?

37 A. That's right.

38  
39 Q. Do you have a sense of how many of the patients  
40 treated or seen through Mid North Coast Virtual Care are  
41 ones who have contacted it because they can't access  
42 primary care in the community? For example, a general  
43 practitioner?

44 A. Yes, and anecdotally I would have to say the majority  
45 of those who are accessing our services are accessing the  
46 service because they cannot access a general practitioner  
47 in our community. I also am aware that we have repeat

1 patients and I think that after a first positive  
2 experience, they may choose to use Mid North Coast Virtual  
3 again instead of an access to their primary care provider.  
4 And the data that we have measured so far shows that  
5 96 per cent of our patients are rating their care as "very  
6 good" or "good" and 95 per cent of our patients are saying  
7 that they would use the service again, with 92 per cent  
8 saying that this was "as good as face-to-face care". So we  
9 have a very positive patient experience through our  
10 service, and I think that that also encourages the re-use  
11 of that service.

12  
13 THE COMMISSIONER: Q. When you say anecdotally patients  
14 can't access general practitioners, is that - first of all,  
15 is that because books are closed or is that because they  
16 can't afford to because there's not much access to bulk  
17 billing?

18 A. Both of those, is my understanding.

19  
20 Q. And when you say "anecdotally", the source of your  
21 information for that is - I mean, you live in the  
22 community, but is it colleagues, other sources? Tell me  
23 what?

24 A. It's the patients saying that, and so we can only take  
25 them for what the patients will say --

26  
27 Q. Of course.

28 A. -- that "I wasn't able to get into my GP" or,  
29 "I wasn't able to get an appointment." The reason for that  
30 is not always clear, whether there is a gap payment being  
31 charged or whether the books are closed or whether they had  
32 to wait a week or two weeks to see their normal  
33 practitioner.

34  
35 THE COMMISSIONER: Sure, sure.

36  
37 MR FULLER: Q. That information that comes from the  
38 patient, is that part of, like, a survey that you conduct  
39 after each virtual care session?

40 A. Yes. So yes, we ask a range of questions at the front  
41 end in amongst the triage and then we do send a follow-up  
42 survey to all of our patients who access the service,  
43 seeking their experience.

44  
45 THE COMMISSIONER: Q. And together, is that, the  
46 information from that, though, that questionnaire, is that  
47 then collated?

1 A. Yes.

2

3 MR FULLER: Q. Ms Wong, in paragraph 31, you tell us  
4 that the service equates to a conservative cost avoidance  
5 of about \$11.4 million. Are you able to give us any detail  
6 of how those savings have come about?

7 A. Yes, and I used the language "conservative cost  
8 avoidance" because, for us, we've taken that the patients  
9 we have seen in Mid North Coast Virtual Care have not then  
10 needed to utilise either an ED presentation or a bed day  
11 stay, but I can't say that it is, you know, a pure saving  
12 because those beds are still potentially being utilised and  
13 those ED time slots are still being utilised.

14

15 I used a very, I guess, crude measure of how many  
16 patients presented who have said they would otherwise have  
17 attended our emergency department and multiplied that by  
18 the average cost of an ED presentation, which is around  
19 \$800 or so dollars. Similarly, for those who were referred  
20 to us by the emergency department instead of being admitted  
21 for clinical care, I multiplied by a hospital bed day,  
22 around \$2,000. And, similarly, those patients who are  
23 discharged from hospital early, multiplying that by the  
24 singular bed day cost of approximately \$2,000. And the 283  
25 direct referrals from NSW Ambulance who would otherwise  
26 have presented at ED again fall into the ED presentation  
27 calculations. So that's how we have come up with the  
28 figure for the conservative cost avoidance.

29

30 We are currently undertaking some research to put a  
31 health economics lens across this to consider how we can  
32 better verify, but also map, the value-add of this service,  
33 hopefully not only in regard to the dollars that may have  
34 been cost-avoided, but the value based on the patients'  
35 experience and outcomes.

36

37 MR FULLER: Q. In that research that you have mentioned,  
38 is that being conducted with the university?

39 A. Yes, we're trying to negotiate at the moment to have a  
40 university work with us on that.

41

42 Q. So it is in the early stages?

43 A. Very early stages, yes.

44

45 Q. Can I ask you about a couple of the other  
46 community-based initiatives that your district invests in.  
47 One of them is Bowraville HealthOne that you tell us a bit



1 about in paragraph 27, an accredited general practice  
2 funded by the district. Can you just tell us a bit about  
3 Bowraville HealthOne, please?

4 A. Yes, so Bowraville HealthOne is a HealthOne community  
5 health centre that provides multiple services from that  
6 physical location. One of those services is our Bowraville  
7 GP clinic. The other services that function out of that  
8 area are a range of community services: integrated mental  
9 health; drug and alcohol services; drug and alcohol  
10 counselling; a range of violence, abuse and neglect  
11 services, including sexual assault counselling and child  
12 protection counselling; a range of wound-care clinics and  
13 other generalist community clinics.

14  
15 The Bowraville GP service has 1.5 full-time equivalent  
16 of general practitioner. We pay or employ those general  
17 practitioners and are under a 19(2) exemption with the  
18 Commonwealth to allow us to recoup through the MBS pathway.  
19 So we fall into the requirements of being accredited as a  
20 general practice, but the benefit for us in Mid North Coast  
21 is that we're able to provide a much needed service to a  
22 very vulnerable population and community in our LHD. There  
23 are a range of benefits that have come through this is  
24 around the connection to our internal LHD medical record,  
25 the general practice users of practice software like every  
26 other general practice does, but they do also have access  
27 to the Mid North Coast Local Health District medical record  
28 of that patient which, I believe, allows for that  
29 insightful but holistic care provision to the patient. It  
30 also is one of two practices that bulk bills. So the other  
31 practice in the geography that bulk bills is the Aboriginal  
32 medical service and the other nine practices have a range  
33 of either mixed billing or gap payments.

34  
35 THE COMMISSIONER: Q. It will be in our notes because  
36 we, as you know, because you were there, we did a site  
37 visit to Bowraville, but when, approximately, did this  
38 service commence, the practice?

39 A. (Indistinct - off-mic).

40  
41 Q. All right. We will both have to go to the notes. Can  
42 you remember why Bowraville was chosen? I mean, one reason  
43 was, and we were certainly told, that GPs had disappeared,  
44 but people had been without a GP in that town for quite a  
45 while before this was set up, is that your memory?

46 A. That's my understanding. We also had that anecdotal  
47 experience that a lot of patrons or community members were

1 relying on our Macksville emergency department for care.

2

3 Q. Yes.

4 A. An top of that, I guess the geography of Bowraville  
5 being an area that has limited public transportation, lower  
6 socioeconomic status and difficulty in accessing what might  
7 have been available in some of the larger areas.

8

9 Q. So there was - without a GP there or in the vicinity,  
10 there was a travel time --

11 A. Correct.

12

13 Q. -- but also - and distance, but also even if you had a  
14 car and you could drive, it didn't mean you were accepted  
15 as a patient to another GP practice, correct? Yes.

16

17 MR FULLER: Q. Why do you think it was important, and is  
18 important and appropriate for the district to be in the  
19 business of providing primary care through the Bowraville  
20 HealthOne?

21 A. I guess for us, and what I haven't spoken about is the  
22 cost for us. So, on average, the Bowraville GP clinic  
23 costs about \$1.1 million per annum and we recoup about  
24 \$650,000 through 19(2), which leaves a shortfall of  
25 approximately \$500,000 per annum. I believe that --

26

27 THE COMMISSIONER: Q. That's 450,000 that is coming out  
28 of the LHD budget?

29 A. The LHD budget.

30

31 Q. For primary care?

32 A. For primary care, yes. When we, I guess, think about  
33 this in one sense, if we can provide access to a sound  
34 primary care setting, we are maintaining the health and  
35 wellbeing of our community, we're reducing the reliance on  
36 our emergency services and therefore preserving those  
37 emergency services for emergencies, hopefully reducing the  
38 burden on NSW Ambulance for their emergency provision. But  
39 the other way, I guess --

40

41 Q. Sorry, just pausing there, the reason that you're  
42 telling us that is that whilst there is a cost to  
43 New South Wales on the arithmetic of \$450,000, there either  
44 is, or it's hoped, there's savings because you are making  
45 that investment in primary care?

46 A. Yes. And for me, thinking about it --

47

1 Q. They haven't precisely been evaluated, though?

2 A. No. So there is some research underway as well,  
3 partnering with the Charles Sturt University, around  
4 whether we have seen some of that direct benefit with our  
5 emergency department.  
6

7 Q. You mentioned a university. I didn't catch the --

8 A. Charles Sturt.  
9

10 Q. Charles Sturt. Thanks.

11 A. And I guess the other aspect is the investment to the  
12 community. Bowraville is a community of about 2,500  
13 people, and if we take the crude number of 500,000  
14 per annum, that's \$200 per person that we're investing in  
15 every year. And if we can use the access or the investment  
16 to support some of the tenants of things like the First  
17 2,000 Days or providing health literacy or health  
18 education, what is hoped is that we are creating increased  
19 knowledge and awareness in the community around health and  
20 wellbeing, and therefore making a contribution to the  
21 overall wellbeing of our community. And I spoke to this at  
22 the round table around the incidental clinical knowledge  
23 translation that might occur in a family setting, and  
24 I know that there has been some work in the UK around --  
25

26 Q. This is the subject where I actually asked you to  
27 provide us with some peer-reviewed research that you might  
28 have?

29 A. Yes. And I can do that after this, sure.  
30

31 Q. Sure, great. Thank you. Sorry, I interrupted you.

32 A. No, no. That's okay. In the UK, there is a notion  
33 that they refer to as "social prescribing", which is the  
34 investment in creating social networks to foster not only  
35 health and wellbeing of the community but incidental  
36 knowledge translation, and I hope and I believe that  
37 investing in some of these aspects of primary care is  
38 contributing to that overall productivity of the community,  
39 but the general health and wellbeing.  
40

41 Q. Can I just ask also, there's no aspect of Commonwealth  
42 funding in Bowraville, correct?

43 A. Only what we receive through bulk billing.  
44

45 Q. Sorry, bulk-billing. Right, okay.

46 A. Bulk billing that we're granting to.  
47

1 Q. No additional - I guess there is cooperation from the  
2 Commonwealth in terms of the 19(2) exemption, but not in  
3 relation to whatever is the shortfall to, or the cost,  
4 I should say, to NSW Health for providing a primary care  
5 service?

6 A. No.

7  
8 THE COMMISSIONER: Okay.

9  
10 MR FULLER: Q. My learned friend Mr Cheney has found a  
11 media release that suggests the Bowraville HealthOne might  
12 have opened in July 2022. Does that sound about right?

13 A. 2022 was when we moved our original premises.

14  
15 THE COMMISSIONER: I think that's the new premises.  
16 I think it was somewhere else before that. I want to say  
17 2018 or 2015.

18  
19 THE WITNESS: I want to say 2017 or 2018, but I can't be  
20 sure. I'm so sorry, I don't have that on hand.

21  
22 THE COMMISSIONER: We were told and someone has made a  
23 note, so we will get it from that source. It might have  
24 been that the HealthOne policy from the then government was  
25 2015. Bowraville put in an - or your LHD put in an  
26 application for Bowraville to be a site. It was selected,  
27 started somewhere else in 2018, and then got the new  
28 premises in 2022. The new premises also is New South Wales  
29 funding, correct, in terms of the fit-out and all of that?  
30 Yes.

31  
32 MR FULLER: Q. The other program you tell us about in  
33 paragraph 28 of your statement is a chronic care program in  
34 Kempsey, in partnership with the local Aboriginal medical  
35 service. Can you just tell us a bit more about that  
36 program?

37 A. Yes. So this program is, I guess, the collaboration  
38 of Mid North Coast Local Health District and Durri AMS to  
39 provide a connected clinical care service to those who need  
40 support in regards to their chronic disease management and  
41 their chronic presentation, and this is to ensure that  
42 there is partnership and, I guess, a seamless experience  
43 for the community member or the patient accessing that  
44 service, and it is also with the support of the primary  
45 health network. It just enables us to provide that  
46 coordination of clinical care across the shared patients,  
47 so patients who would be accessing primary care through

1 a GP, their chronic care plan, and those patients who may  
2 be accessing the Aboriginal medical service for either  
3 their primary care or another part of their care journey,  
4 and then those who need to access either the community  
5 health services based in Kempsey or our emergency  
6 department. And that way, we are considering that patient  
7 in an integrated manner as a person-centred approach rather  
8 than expecting the patient to navigate the three different  
9 pillars of their health service.

10  
11 Q. How is that program funded, do you know?

12 A. We each fund our own portion, and I guess it is a  
13 contribution in kind to bring our clinicians together to  
14 share information with patient consent and to provide that  
15 collaboration around who is best to take the lead in  
16 certain areas of that patient's care.

17  
18 Q. And do you have any observations about whether it has  
19 been a successful initiative?

20 A. I don't have the data on that, but I do have the  
21 anecdotal feedback, I guess, from the patient experience,  
22 which is that it is a positive or a more seamless  
23 experience that is taking away the need for a person or  
24 patient to navigate themselves across the three entities.

25  
26 Q. Are there any other --

27  
28 THE COMMISSIONER: Q. "We each fund a portion" means the  
29 PHN is giving a grant?

30 A. The PHN has supported with some grants.

31  
32 Q. Yeah, so that is Commonwealth funding?

33 A. Commonwealth funding.

34  
35 Q. And you're in equal measure? Or?

36 A. I can't - I don't have the factual --

37  
38 Q. You don't have that? Okay, I take all of that stuff  
39 about the amount of funding and whatnot on notice. Sorry,  
40 I forgot to ask you, when you were talking about the  
41 Charles Sturt evaluation in relation to the savings,  
42 potential savings in relation to Bowraville, is that  
43 looking only at Bowraville or at other sites as well, or  
44 just that?

45 A. That was to my understanding just looking at  
46 Bowraville and Macksville ED, that connection.

47

1 THE COMMISSIONER: Thanks.

2

3 MR FULLER: Q. Has that been completed or is it ongoing?

4 A. It's ongoing, is my understanding. I'm not across all  
5 the details. I actually have a session to hear more about  
6 the research later this week, so I'm sorry that I am not  
7 across all the details.

8

9 Q. Are there any other community health-based initiatives  
10 that your district is investing in that you'd like to draw  
11 to the inquiry's attention?

12 A. Yes, so there are a range of community health  
13 initiatives that we as an LHD have invested in. One of  
14 them is our collaboration with the lands council in  
15 Bellbrook to establish a virtual hub to connect the  
16 community at Bellbrook, which is probably about 30 minutes  
17 more inland from Kempsey, to services. That creates a  
18 space where people in that community can access a very  
19 central location and have connectivity through a virtual  
20 care setup to connect into a clinician on the other side of  
21 the screen. That reduces the burden on travel for that  
22 particular community, but also enables connection easily in  
23 a timely fashion to those who might otherwise not be able  
24 to travel out to Bellbrook or Bellbrook to travel in to a  
25 site.

26

27 Q. Just pausing on that one, that's a physical space that  
28 the district can set up where local residents can go and  
29 then access a virtual care service?

30 A. Yes.

31

32 Q. Is that right?

33 A. That is right.

34

35 Q. Is that Mid North Coast Virtual Care that they access  
36 through there, or a different kind of virtual care service?

37 A. So they can access anything that would require a  
38 virtual connection. So if the individual person has a  
39 specialist appointment that can be delivered by virtual  
40 connectivity, they can use that to setup for that  
41 specialist appointment. Similarly, they can use that setup  
42 to contact Mid North Coast Virtual Care or any other  
43 clinical service. So we have established the physical and  
44 equipment aspect so that individuals in the community  
45 aren't reliant on their own personal devices to be  
46 connected to virtual care.

47

1 Q. Thank you. I think I interrupted you. You were about  
2 to tell us about other initiatives?

3 A. Yes. I guess one of the other initiatives that has  
4 recently been established is our bush tucker partnership  
5 with the - where an AMS in Port Macquarie that has been  
6 funding internal to the local health district and income  
7 contribution from our Aboriginal medical service to  
8 establish a program of works that connection our community  
9 with traditional bush tucker food, and using that as a  
10 platform not only to create awareness for the community  
11 around healthy eating choices and lifestyle but also to  
12 connect people in that same fashion around social  
13 prescribing, creating a network, creating a bond over  
14 healthy food and bush tucker, but also then using that to  
15 educate and share information on chronic disease  
16 management, access to health, incidental screenings for,  
17 you know, whether that be information on breast screening  
18 or prostate.

19  
20 Some of the other initiatives that I would love to  
21 just share are around our cancer services. So Mid North  
22 Coast Local Health District is very lucky to have two  
23 campuses that provide cancer services. One is based in  
24 Port Macquarie, one is based in Coffs Harbour. We recently  
25 have established an outreach clinic in Kempsey to provide  
26 chemo-medical oncology services to the Kempsey region, and  
27 similarly, we have invested in a range of tumour stream  
28 options to support patients who are either managing their  
29 symptoms or who are recently into the survivorship of their  
30 cancer diagnosis and can be better supported in-home rather  
31 than needing to rely on emergency departments for care when  
32 there is an exacerbation.

33  
34 Q. Appreciating you are not the finance director, but to  
35 your knowledge does the district intend to continue  
36 investing in these sorts of programs that we've been  
37 discussing?

38 A. I hope so. I hope so.

39  
40 Q. Are there any particular challenges that you're aware  
41 of in the district continuing to invest in these sorts of  
42 programs?

43 A. I think sustainability is really challenging. When  
44 there are a range of different priorities that are expected  
45 of us as an LHD, whether they be the Premier's priorities  
46 or the priorities of the government of the day, and our  
47 need to ensure that we are fulfilling against all of those

1 aspects and then sustaining, perhaps, what could be deemed  
2 as innovative service provision that might be stepping into  
3 primary care or supporting gaps that we've identified in  
4 our community.

5  
6 The other aspect, I think for me, in working in this  
7 space is the difference in the metrics that are applied.  
8 So there is a very - we have a robust assessment or  
9 measurement system for our acute hospital setting, but it  
10 is very hard to measure what you have prevented coming in  
11 to the acute system.

12  
13 Q. Is it your opinion, though, that it is beneficial for  
14 the NSW Health system to invest in community health-based  
15 initiatives like those that you have been describing?

16 A. I do believe that it is worthwhile to invest in  
17 community or out-of-hospital services.

18  
19 Q. And that includes as a way of promoting high-quality  
20 health outcomes for the New South Wales community; is that  
21 right?

22 A. Yes, that's right.

23  
24 THE COMMISSIONER: Q. Just so we have it on the record,  
25 when you were saying that we have a robust assessment or  
26 measurement system for our acute hospital setting but it's  
27 hard to measure what you prevented coming into the acute  
28 system, what are the difficulties in measuring that sort of  
29 prevention?

30 A. In our current framework, I suppose measuring what  
31 doesn't come to the emergency department. So our service  
32 level agreements have metrics on number of ED  
33 presentations, how quickly we are able to triage those  
34 patients against their triage category, transfer of care.  
35 We don't necessarily have a current or consistent structure  
36 to measure those patients that we have provided care to  
37 that don't come to our emergency department, or a  
38 consistent way to, I guess, measure cost avoidance against  
39 certain metrics. So I think that is an opportunity for us  
40 to think about how we as a whole system can also consider  
41 that value-add and success and the time that it takes to  
42 invest in a preventive model around behaviour change,  
43 around societal change, to see the benefits of early  
44 intervention.

45  
46 Q. These are long-term projects?

47 A. These are long-term projects with a longitudinal,



1 I guess, profile that needs to go with that.

2

3 Q. You don't immediately get, for want of a better  
4 expression, either the pat on the back or the positive data  
5 from that investment in those sorts of programs; it is a -  
6 it might happen in 10 years or 20 years?

7 A. Yes. And I also believe that within Health, we are  
8 not always considering the interconnectedness of  
9 productivity in the community. So the investment in a  
10 preventative model where we are providing early  
11 intervention to a chronic disease management or in response  
12 to an adverse childhood experience, we are not necessarily  
13 measuring the value of that individual who then is  
14 attending school, who then goes on to, you know, be a  
15 productive provider in the community, working, who does not  
16 have as many chronic diseases or mental health burdens. So  
17 how we measure that value --

18

19 Q. This is the healthcare system as aiding productivity  
20 topic?

21 A. Yes.

22

23 MR FULLER: Q. Can I ask you now, Ms Wong, to put on one  
24 of your other hats, which is in relation to allied health.  
25 You have told us in your statement that you are  
26 strategically, operationally and professionally responsible  
27 for allied health professionals in your district. Can I  
28 just ask you what you mean by "professionally  
29 responsible"?

30 A. So as the director of allied health, I have a  
31 professional responsibility to all allied health  
32 professionals in the Mid North Coast Local Health District.  
33 I do not have operational management of all allied health  
34 staff in the district. So from a professional perspective,  
35 I am responsible for all 17 of the professions that are  
36 represented out of the 23 that are recognised, and I am  
37 responsible for providing that strategic and professional  
38 leadership and advocacy on behalf of allied health.

39

40 Q. Can I ask you, please, to have a look at paragraph 35  
41 of your statement. This is there paragraph where you made  
42 some changes to earlier. I am just going to ask you, about  
43 halfway down the paragraph, you talk about a 3.3 per cent  
44 growth rate in allied health for your district compared  
45 with an average of 12.6 per cent across rural or regional  
46 LHDs and 9.1 per cent across the State. Do you have any  
47 sense from your position as to why the growth rate in

1 allied health is so much lower in your district than in  
2 others?

3 A. There's a range of factors that I believe contribute  
4 to that. Some of that is around workforce pipeline and the  
5 ability to attract staff to our area. I do believe that  
6 some of that is also around the type of - the funding that  
7 is available for allied health and also the workforce that  
8 is available in regards to the positions. Some allied  
9 health positions are multidisciplinary classed, which means  
10 that they can be an allied health profession or a nursing  
11 profession, and so depending on the successful applicant,  
12 we might have seen a growth in nursing for that particular  
13 position as opposed to allied health, but in natural  
14 attrition the next person who might fill that position may  
15 be allied health. Ability to attract skilled workforce to  
16 the Mid North Coast Local Health District across allied  
17 health professions is very challenging.

18  
19 Q. You have told us in your statement that the retention  
20 rate for allied health professionals in your district is,  
21 I think it is fair to say, relatively high, greater than  
22 90 per cent. Is that a fair observation?

23 A. That is a fair observation.

24  
25 Q. And so, is the main issue attraction?

26 A. Yes. So I would say that the main issue was  
27 attraction to new funding or funding opportunities, as well  
28 as the nature of the staffing profile that we have. So the  
29 retention rates, to my knowledge and understanding, do not  
30 factor in for temporary vacancies, so parental leave,  
31 maternity leave, or other secondments, and that temporary  
32 aspect of vacancy again is very challenging to fill or to  
33 attract people from out of area to move into the Mid North  
34 Coast for a time-limited period.

35  
36 Q. So even though you might have a high retention rate on  
37 paper, you do still have vacancies as a result of things  
38 like parental leave that you find difficult to fill?

39 A. To fill, yes.

40  
41 Q. Just starting with "pipeline", which is one of the  
42 causes that you mentioned, you have told us in paragraph 40  
43 about junior practitioners who say there is an opportunity  
44 to better prepare in relation to specific requirements of  
45 NSW Health. Can I just ask you to elaborate on what you  
46 mean by that?

47 A. So my comment around - sorry, excuse me.

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Q. It's about halfway down paragraph 40.

A. The "better prepare practitioners in relation to the specific requirements for NSW Health"?

Q. Yes?

A. So what we have been seeing in the Mid North Coast is new graduates choosing to work as private practitioners in the area. If a new graduate graduates and applies for a role with NSW Health, they will often be remunerated at a level 1 year 4 rate, and within our award that equates to roughly \$38 to \$40 an hour. Those new graduates can work in the private market with an MBS rate of approximately \$75 for an intervention, and if we consider that from just a numerical perspective, it is very lucrative for new graduates to work in that space, or any allied health professional.

What we do hear and see is that working in private practice as a sole practitioner in a small practice does not have the same framework that you would have in a Mid North Coast Local Health District or NSW Health frame, where there is the embedding of clinical supervision, the support of clinical mentoring, professional growth and development, but also that framework and structure of exposure and support to clinical practice and development.

We use a notional post, years post-qualification, to assist us in benchmarking a qualified professional against the current allied health award, and after a couple of years, you know, I have written two to four years of post-graduate experience in a private practice, those staff may be eligible to apply for a more senior allied health role, however, have not had the benefit of understanding some of the supporting structures that exist within the allied health professional workforce such as the mentoring, the clinical supervision, the research aspects to clinical care and the, you know, policy and procedures and design that goes alongside clinical care.

Q. Just to understand the two to four years, is that - is the idea there that after they have spent two to - sorry. The amount that they are paid in private practice is equivalent to something like two to four years post-graduate under the relevant award, if they were to work in the NSW Health system?

A. Yes, it is much closer in an hourly rate estimate.

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Q. And that would be why more junior people would tend to be attracted to more senior positions in the NSW Health system compared with private practice; is that the idea?

A. That is my understanding and what we are experiencing anecdotally.

Q. And the other part of your answer is the general idea that in a world where a new graduate will be paid so much less in the NSW Health system compared with private practice, there need to be other reasons that make it attractive for them to come and work in the NSW Health system?

A. Yes.

Q. Is that - that's the idea?

A. That's the idea. I think that's also coupled with, perhaps, some missed opportunity to support student placements within the local health district. So there are two factors that we are experiencing around the challenge to attract students to undertake student placements to give experience or insight into what it's like to work within the LHD system, and then also the remuneration variation.

Q. Sorry, you mentioned two factors. Can you just clarify what are the two factors?

A. Student placements. So having students experience their time within the LHD system as an addition to why people might choose to work in private practice, being the remuneration aspect.

Q. You have told us - or just starting with student placements, can you just tell us firstly what you perceive the issue to be there?

A. Yes. For me, I perceive the issue is that there's no set way to facilitate student placements for our allied health professional groups. This is often undertaken on a local basis with the relevant tertiary institutes. It's not a consistent, I guess, pathway for all students. Some professional groups require one-day-a-week-type models for student placements, others replace block placements at different times of the year. We also have a competitive market with private practice. So we are aware in Mid North Coast that some private practices offer student placements as well as a part-time job or a temporary role which enables the continuity of a wage while undertaking a clinical placement. Those, I guess, flexibilities or

1 nuances are not necessarily available within the Mid North  
2 Coast Local Health District structure.

3  
4 Similarly, private practice is able to offer or  
5 confirm employment at the end of their clinical placement  
6 or student placement and, similarly, that is not always  
7 available or appropriate within the local health district  
8 structure.

9  
10 Q. Is there anything that you think can be done to  
11 address those issues?

12 A. There are a few things. I think one of the challenges  
13 is the diversity for allied health as a professional, you  
14 know, cohort of 23. I think that there are opportunities  
15 to strengthen our allied health clinical educators embedded  
16 within our local health district. There would be  
17 opportunities to look at how we partner with our tertiary  
18 facilities - sorry, tertiary institutes on how we utilise  
19 our maximise student placements, how many students are  
20 coming through our public health system, and at what times  
21 and rates. We could be looking or exploring opportunities  
22 to subsidise the cost of accommodation for those students  
23 who need to travel from out-of-area to be placed in a rural  
24 setting. We could enhance or prioritise, perhaps, rural  
25 LHDs or rural settings for clinical placements for allied  
26 health professionals and students going through their  
27 education.

28  
29 An example that I have been made aware of is in  
30 Queensland, there is a different award structure for their  
31 allied health professionals where there are some incentives  
32 for the employed allied health professionals within the  
33 Queensland system to support and mentor students, but  
34 there's also some more formalised agreements with the  
35 universities to support placements within the state system.  
36 I don't have all of the details, but that is something  
37 perhaps we could consider looking at and to see the  
38 feasibility within NSW Health.

39  
40 Q. I am sure we can find this out, but when you say in  
41 Queensland there are some incentives for employed allied  
42 health professionals to support and mentor students, do you  
43 have any sense of what is the nature of those incentives?

44 A. So my understanding is that, in Queensland, where we  
45 have an allied health award, they have an enterprise  
46 bargaining agreement and they provide, I guess, additional  
47 incentive payments or - I'm not sure what you would call

1 it. Like, a payment on top of their hourly rate to  
2 undertake higher study or education relating to their role,  
3 but also then to provide that clinical mentorship to a  
4 student or a junior allied health professional.

5  
6 Q. So it might be like a clinical educator allowance --

7 A. Yes.

8  
9 Q. -- if someone is prepared to perform that role?

10 A. Yes.

11  
12 Q. Just going through a few of the factors that you  
13 mentioned in your last answer, firstly, strengthening  
14 allied health clinical educators, can you just explain what  
15 you mean by that idea?

16 A. At the moment, and I'm so sorry that the report's  
17 title evades me but I will have it in my papers somewhere,  
18 there was a recent report provided on allied health  
19 workforce that related to allied health clinical educators  
20 that showed that across the State, on average, there is one  
21 allied health clinical educator for every 420 full-time  
22 equivalent. In contrast, if I can use nursing as an  
23 example, the data at the time showed one clinical nurse  
24 educator or clinical midwifery educator for every 42,  
25 I think, FTE. And I am aware that I've - 43, apologies.  
26 43 FTE.

27  
28 And so I do believe that there is an opportunity to  
29 look at how we better invest in clinical educator roles.  
30 At the moment, Mid North Coast has one allied health  
31 clinical educator with a radiography background, but given  
32 the diversity of the allied health professional workforce  
33 and what we are experiencing as the allied health pipeline  
34 shortages, investing in dedicated roles to support and grow  
35 that workforce pipeline through clinical education not only  
36 provides career opportunities for our current workforce,  
37 but it also helps to stabilise or to create that pipeline  
38 in the coming years. It then takes away the pressure on an  
39 individual LHD or somebody, I suppose, in my role, to make  
40 a decision around value for whether we pause or reduce some  
41 of the clinical services that we're providing to re-divert  
42 some of that into clinical education, which may not be  
43 patient-facing work, but is still extraordinarily important  
44 in regards to the whole system of workforce sustainability.

45  
46 Q. Can you just explain for us practically what the  
47 allied health clinical educator in your district does?

1 What is their job?

2 A. So for our allied clinical educator, their  
3 responsibility is specific to the radiography profession  
4 and cohort, and their role would be not only to facilitate  
5 the student placements coming through, but to provide an  
6 upskill on education best practice literature and ensuring  
7 that all of the staff within that cohort are up-to-date  
8 within their practice.

9

10 Q. Another thing that you mentioned was working with  
11 universities to maximise clinical placements. Do you have  
12 any views on how that might be done practically?

13 A. Yes. I guess, again, having the dedicated resources  
14 to navigate what that placement might look like. For  
15 allied health, we are very unique because there is such  
16 diversity but allied health professionals within a  
17 university structure are not within the same school of  
18 education either. So we're not negotiating with one school  
19 within a university; we have to navigate and negotiate, and  
20 partner, with a range of different clinical schools. So  
21 the, I guess, logistics of planning for placements is  
22 challenging.

23

24 If I take an example of where we are seeing some  
25 success, it's outside of allied health but there has been  
26 establishment of the rural medical clinical schools in both  
27 Port Macquarie and in Macksville/Coffs Harbour, and those  
28 schools have been really successful to date around taking a  
29 more tailored approach to supporting students who are  
30 undertaking their studies in this geographical area, but  
31 also supporting them with placements in our LHD.

32

33 So spreading out those placements to be, you know, for  
34 example, one day a week so there is some continuity, broken  
35 up with their tutorials and clinic days across the week, so  
36 there is a sustainability visibility for those students to  
37 also have part-time work and then they're living and  
38 working within the regional setting of the Mid North Coast,  
39 greater supports around social networks and stability  
40 around accommodation and housing because they're here for a  
41 longer period of time, and, hopefully, we will continue to  
42 see the retention of those students once they graduate in  
43 wanting to stay and work within Mid North Coast Local  
44 Health District.

45

46 Q. Am I right in understanding that for allied health,  
47 your district does not have a clinical placement

1 coordinator or facilitator?

2 A. That's correct.

3

4 Q. Do you think that would help in addressing some of the  
5 logistical issues that you have identified?

6 A. Absolutely.

7

8 Q. And that's in contrast to, for example, nursing and  
9 midwifery where there is dedicated clinical placement  
10 coordinator position; have I understood that correctly?

11 A. That is correct.

12

13 Q. The third thing you mentioned was the possibility of  
14 subsidised accommodation. Can you just explain why is  
15 accommodation cost an issue for students in your district?

16 A. I've drawn a conclusion that when we are having  
17 difficulties attracting staff or workforce to vacant  
18 positions because of an inability to access affordable  
19 accommodation that that would absolutely be a factor for  
20 students who are not necessarily earning money while they  
21 are undertaking their clinical placement. So without  
22 having access to a level of subsidised accommodation or  
23 without students actually residing in the area already,  
24 there is, I guess, a barrier in place for those students  
25 being able to travel to the Mid North Coast to undertake  
26 that placement.

27

28 Q. Can I ask you now about the last section of your  
29 statement, which deals with opportunities for innovation  
30 and reform. Firstly, in paragraph 53, you say that, in the  
31 first sentence, there is an appetite from the community and  
32 clinicians for the provision of clinical care virtually and  
33 to embed this as part of our normal practice. When you say  
34 there is an "appetite", what is your reason for thinking  
35 that?

36 A. My reason for thinking that, I guess, is based on the  
37 high uptake and the positive experiences based on the  
38 patients that we have provided care to through Mid North  
39 Coast Virtual Care and some of our other virtual care  
40 services such as Enhancing Community Care. I think  
41 stereotypically or anecdotally, we would have thought  
42 perhaps there would have been a lower uptake. There is  
43 commentary around concerns raised anecdotally around our  
44 aged population being comfortable using a device to access  
45 care when we historically have always undertaken to access  
46 care face-to-face and in person.

47



1 Mid North Coast has a significant - a proportion of  
2 our population over the age of 65, but the utilisation  
3 rates and the positive experience reports and the positive  
4 outcome measures that we have been collecting show that  
5 there is appetite from the community that they are willing  
6 to, and want to, use virtual care where it's appropriate,  
7 and I think that we can embed this more broadly as part of  
8 the way we deliver care.

9  
10 I think that there will always be a place for  
11 face-to-face care; of course we need to have that as  
12 modality, but there are aspects of care that can be  
13 provided through telehealth or audiovisual means.

14  
15 Q. Part of what you suggest should be done to try to  
16 embed virtual care as part of normal practice is to shift  
17 community expectations around the provision of remote care.  
18 Do you have anything in particular in mind as to how that  
19 might be done in practice?

20 A. I think we've been lucky in the Mid North Coast that  
21 we had some very good success with COVID. We used virtual  
22 care and telehealth to provide what we then called COVID  
23 care in the community, to keep our community safe and well  
24 at home. We had a very low admission rate in that COVID  
25 pandemic era. I guess the community expectations, because  
26 of that experience, was somewhat forced. People had to use  
27 technology to remain connected. That community expectation  
28 shifting and, I guess, marketing of how we can deliver very  
29 sound, safe, effective and efficient care through a virtual  
30 platform, is an opportunity to continue shifting or  
31 supporting that community expectation.

32  
33 I think also relying or utilising word-of-mouth based  
34 on positive experiences is assisting in shifting community  
35 expectations where we often have community members using  
36 our services, asking our permission to post on social media  
37 their experience with us, or on the various, you know,  
38 groups within social media for the townships that we have,  
39 to share their positive experience, and I think that  
40 creates awareness in the community around being able to  
41 access care in a way that's different to how we have  
42 historically.

43  
44 THE COMMISSIONER: Q. When you say there is an appetite  
45 from community clinicians for the provision of clinical  
46 care virtually and to embed this as a part of our "normal  
47 practice" and as a modality of clinical care rather than

1 additional or supplementary, how should I understand that  
2 suggestion or opinion with the Mid North Coast Virtual  
3 Care? Is what you are saying is that Mid North Coast  
4 Virtual Care could be significantly expanded?

5 A. That is my belief. I believe that the Mid North Coast  
6 Virtual Care service could be expanded to reach into a  
7 larger range of service provisions.

8  
9 Q. Does that mean that there is - if there were  
10 additional funding and resources for Mid North Coast  
11 Virtual Care, the demand for that service is there?

12 A. Yes.

13  
14 Q. And so the extra funding and extra resources would -  
15 if that supply was there, the demand would match it?

16 A. Yes, that is my understanding.

17  
18 THE COMMISSIONER: Okay.

19  
20 MR FULLER: Q. In paragraph 55, when you are talking  
21 about virtual care services and, in particular, the Mid  
22 North Coast Virtual Care, you say at the end of this  
23 paragraph that one issue is managing "the rapidly evolving  
24 technology outpacing the existing policies and guidelines."  
25 Can I ask you just to explain what you mean by that,  
26 please?

27 A. Yes. So, from an LHD perspective, with the delivery  
28 of a completely virtual service, the need to create and  
29 establish places within our electronic medical record to  
30 capture that accurately. Similarly, how we calculate and  
31 capture our activity associated with what is being  
32 delivered not in a face-to-face manner. So the definitions  
33 sometimes have been around how care has been delivered in a  
34 face-to-face setting, versus a care coordination which is  
35 not patient-facing, depending on how you're interpreting a  
36 virtual screen being patient-facing or not, so I think  
37 there are opportunities for us to include virtual  
38 modalities more broadly in some of our definitions for data  
39 capture.

40  
41 The other aspects for me to make this statement are  
42 around some of the manual requirements in how we deliver  
43 care. For example, the ability to have robust scanning  
44 technology into our medical records rather than handwritten  
45 or electronic scripting that is available for our virtual  
46 care services.

1 Q. In paragraph 57, you have told us that there are  
2 opportunities to shift the focus and understanding on the  
3 value of multidisciplinary clinical care models and  
4 structures within NSW Health systems. Can I ask you,  
5 please, just to explain what you mean by that?

6 A. This comment, and what I mean by this is around  
7 multidisciplinary care being care provided by allied health  
8 professionals as well as nurses and doctors. And, I guess,  
9 when I talk about marketing and celebrating the value  
10 proposition, I think at the moment we still see or we still  
11 have a general vision of health being provided primarily by  
12 doctors and nurses. It's in the media that we see. It's  
13 on television shows that are free-to-air. It is the  
14 general understanding of the community. More rarely do we  
15 see the value celebrated of an allied health professional  
16 workforce in care in contemporary media, and I think that  
17 there is an opportunity for us to share and celebrate, but  
18 also provide awareness on the value that that  
19 multidisciplinary or holistic clinical care team can  
20 provide.

21  
22 Q. You said that reliance or emphasis on high cost  
23 medical models in nursing has a direct impact on allied  
24 health resourcing, but also the ability to fulfil best  
25 patient care. Can you explain why you think that has an  
26 impact on patient care?

27 A. So my understanding of how we can best deliver patient  
28 care is to take a holistic approach in how we provide  
29 person-centred care using a multidisciplinary care team, so  
30 allied health, nursing and medical. Unfortunately, we have  
31 varying models and frames that sit around our different  
32 clinical groups. So nurses have a nursing hours per  
33 patient day ratio that is written into our systems and  
34 awards, and that is a requirement for us as a local health  
35 district to meet and fulfil, and that is to ensure that  
36 there is a safe ratio of nurses to patients in the acute  
37 setting.

38  
39 Unlike nursing, allied health does not have the  
40 equivalent version. There's not a set allied health hours  
41 per patient day and nor is there a set statewide metric  
42 around workload management for allied health, and as such,  
43 when we are needing to make decisions in a fiscally  
44 constrained environment, we need to ensure that we are  
45 fulfilling all of the requirements of our clinical team and  
46 then looking at how we can invest and reallocate within the  
47 envelope of funding that we have. And that goes to my

1 comment around at times this has a direct impact to allied  
2 health resourcing because there is not the equivalent of,  
3 you know, a metric such as nursing hours per patient day,  
4 which sometimes mean we have to make a very challenging  
5 decision around where to use a very limited pool of  
6 funding.

7  
8 Q. The other point concerning that sentence is, or the  
9 other impact you mention in that sentence, is on the whole  
10 cycle of workforce sustainability. Can you just elaborate  
11 on what you mean by that, please?

12 A. So where we have, for example, a high proportion of  
13 nurses in our staffing or workforce profile, if we see a  
14 natural attrition or a movement of those nurses, we then  
15 have a large vacancy across that nursing pool. Limited  
16 supply for the high demand means reliance on locum or  
17 agency nurses, which come at a premium cost, and that cost  
18 is far exceeding what we would expect to be paying for our  
19 clinical workforce, and that impacts the cycle of  
20 sustainability. So if we are relying on paying for premium  
21 labour across medical or nursing or allied health, because  
22 we haven't got an even spread or perhaps are unable to have  
23 the baseline of our workforce across all of the different  
24 professionals groups, we are then needing to expend more  
25 than expected to fill that baseline.

26  
27 Q. Is the idea that if we increase the resourcing and the  
28 role of allied health professionals in the delivery of  
29 patient care, then over time we would expect to reduce the  
30 burden on nurses and therefore the need to rely on, for  
31 example, agency nurses if there are shortages of nursing  
32 workforce?

33 A. Yes, I guess I am thinking more just the more that we  
34 grow our diversity in our clinical workforce, the less we  
35 are reliant on one particular supply and demand chain. So  
36 not necessarily taking away from the value of nurses or the  
37 need for nurses, but if we had more allied health as well  
38 as nurses as well as medical, we would be less impacted by  
39 the reliance on one singular supply and demand chain.

40  
41 MR FULLER: Thank you, Ms Wong. Those are my questions  
42 for this witness.

43  
44 THE COMMISSIONER: Q. So I understand what you are  
45 saying in paragraph 59, "opportunities to consider the  
46 reporting obligations, and return on investment  
47 considerations", I understand, at least I think, part of

1 what you are saying in that sentence in that there are -  
2 funding is sometimes made available for some initiative,  
3 I'll call it, but it might only be 12 months or a limited  
4 period and then when that funding, it either - it might be  
5 extended but it might not, and then if it's not extended,  
6 difficult decisions have to be made. That's part of what  
7 you are getting at there, is it?

8 A. Yes, Commissioner.  
9

10 Q. But in terms of reporting obligations, are you  
11 suggesting a better analysis of what the return on  
12 investment is of some of these programs that are only  
13 funded for short-term so that there is a better analysis  
14 done as to whether they should be extended?

15 A. Yes. So I think, exactly as you have said it,  
16 Commissioner, I think the other aspect is the reporting  
17 obligations that often sit alongside the time-limited  
18 funding streams are very difficult for LHDs, because if we  
19 cannot attract the workforce to a temporary position, we  
20 can then not accurately report or fulfil the obligations of  
21 reporting accurately on the value of that service --  
22

23 Q. Yes.

24 A. -- which then potentially has impacts on future  
25 opportunities or, you know, measuring accurately the return  
26 on investment that would otherwise have been present had we  
27 filled all of those clinical positions that were intended.  
28

29 Q. Is there any particular example you would like to draw  
30 my attention to to make good that, or is it a general  
31 observation?

32 A. I guess I can provide some examples. Following the  
33 Royal Commission into Institutional Responses to Child  
34 Sexual Abuse, we had a range of recommendations and  
35 NSW Health reviewed and re-invested into areas of violence,  
36 abuse and neglect. We have had a range of investments that  
37 have been partially time-limited and others that have been  
38 permanent across the range of violence, abuse and neglect  
39 services. For example, we have had time-limited funding  
40 for adult survivors of sexual assault.  
41

42 Q. Right.

43 A. That is usually provided by a social work or  
44 psychology-trained professional, and it is very challenging  
45 to fill a temporary role in our district with that  
46 particular professional cohort. That has meant for Mid  
47 North Coast that we have not been able to fully realise the

1 benefit that that service would potentially have for our  
2 community and the reporting obligations for us, which are  
3 quarterly or annually, depending on the agreement, may not  
4 encapsulate the details around the difficulties with the  
5 workforce impacting potentially the activity or the demand  
6 that exists.

7  
8 And another example, I guess, is for aged care  
9 services. NSW Health provide a multidisciplinary team to  
10 undertake aged care assessments, to assess patients before  
11 they go into aged care homes. That funding is through the  
12 Commonwealth to the State, to us. It requires, you know, a  
13 10- to 12-week education program to work within the  
14 Commonwealth portal, but that funding is time-limited and  
15 as we reach the end of a two-year contract, we often see  
16 natural attrition or movement of those skilled staff into  
17 permanent roles or into another setting for continuity and,  
18 you know, permanency of the individual, which means that we  
19 are needing to re-skill, re-educate and fill a vacancy with  
20 a very short period. So that leaves us with six months  
21 left of a contract to attract staff, and again --

22  
23 Q. That's very difficult.

24 A. -- it's very difficult.

25  
26 Q. Is there anything else you want me to understand about  
27 what you are saying in paragraph 59?

28 A. Commissioner, I think just coming back to that comment  
29 around the notion of whole-of-community and that some of  
30 the benefits or productivity metrics may not sit within the  
31 NSW Health system, and that I don't know the answer on how  
32 we would capture that value-add to the whole-of-community,  
33 but that is something that is in the back of my mind.

34  
35 Q. You mean they're not picked up by the KPIs?

36 A. They're not picked up, so the contribution to the  
37 community health and wellbeing is not necessarily picked up  
38 within KPIs specific to New South Wales.

39  
40 THE COMMISSIONER: Thank you. Did anything come out of  
41 that?

42  
43 MR FULLER: No, thank you.

44  
45 THE COMMISSIONER: Do you have any questions, Mr Cheney?

46  
47 MR CHENEY: No, Commissioner.

1  
2 THE COMMISSIONER: Thank you very much for your time,  
3 Ms Wong, we are very grateful. You are excused.  
4

5 **<THE WITNESS WAS RELEASED**

6  
7 THE COMMISSIONER: And is it okay to come back at ten past  
8 two, would that be enough time? All right. We will  
9 adjourn until ten past two.  
10

11 **LUNCHEON ADJOURNMENT**

12  
13 THE COMMISSIONER: Yes, Mr Glover.  
14

15 MR GLOVER: Thank you, Commissioner. The next witness is  
16 Ms Maisey and she is in the witness box.  
17

18 **<TRACEY MAISEY, AFFIRMED** [2.12 pm]

19  
20 **<EXAMINATION BY MR GLOVER**

21  
22 MR GLOVER: Q. Can you tell us your full name, please?

23 A. Tracey Maisey.  
24

25 Q. You are the chief executive of the Northern NSW Local  
26 Health District?

27 A. Yes, correct.  
28

29 Q. You have been in that role since about August 2023,  
30 correct?

31 A. Yes, yes.  
32

33 Q. And to assist the Commission, you have made a  
34 statement dated 9 September?

35 A. Yes.  
36

37 Q. And I understand there are a couple of corrections you  
38 wish to make; is that right?

39 A. Yes, that's right.  
40

41 Q. If we - I'll have it brought up on the screen, if you  
42 have a hard copy there with you, Ms Maisey, feel free to  
43 use whichever you prefer. If we go to paragraph 4,  
44 I understand you wish to correct "7,000" to read "6,500"?

45 A. Yes, that's right.  
46

47 Q. And then we head to paragraph 10(d), you wish to

1 correct "2019 to 2014" to "2019 to 2024"?

2 A. Yes, that's correct.

3

4 Q. We now head to paragraph 26. In the second-to-last  
5 line, I understand you wish to insert the word "medical"  
6 between "regarding" and "student placements"?

7 A. Yes.

8

9 Q. Paragraph 50, in the third line from the bottom,  
10 "catheterisation services" you now wish to change that to  
11 read, "commenced 10 September 2024"?

12 A. Yes.

13

14 Q. Paragraph 54, I understand you wish to correct that  
15 sentence to read:

16

17 *For the 2024/2025 financial year NNSWLHD*  
18 *has submitted eight proposals, seven of*  
19 *which were approved.*

20

21 A. Yes.

22

23 Q. And, finally, paragraph 139, in the second  
24 line "highest median age" should be corrected to read  
25 "highest median age in NSW Health in 2024"; is that right?

26 A. Yes. Yes, that's correct.

27

28 Q. Save for those matters, is the rest of your statement  
29 true and correct to the best of your knowledge and belief?

30 A. Yes, it is.

31

32 Q. Prior to commencing in your role as chief executive of  
33 the district, you have had a varied career in health  
34 systems across the globe, correct?

35 A. Yes.

36

37 Q. Including executive positions in New Zealand, with the  
38 NHS in the UK, and in Qatar; is that right?

39 A. Yes, that's right.

40

41 Q. Should we take it from that that some of the views and  
42 opportunities you identify in your statement is drawn from  
43 that breadth of experience in those other jurisdictions?

44 A. Yes, that's correct.

45

46 Q. Can we start with paragraph 9 of your statement,  
47 please, and there you refer to the district service



1 agreement with the secretary for the year 2023 to 2024?

2 A. Yes.

3

4 Q. You see that? Is there one for the year 2024-2025?

5 A. Yes, there is.

6

7 Q. I'll take you to the 2023-2024 one. I'll have that  
8 brought up on the screen. That is [MOH.9999.0064.0001].  
9 When was the 2024 to 2025 service agreement finalised,  
10 doing the best you can?

11 A. We signed it in August.

12

13 Q. I don't think it will matter for present purposes.  
14 I want to take you ahead to doc ID page 21, please.

15

16 THE COMMISSIONER: It's probably on the website, if you  
17 needed the --

18

19 MR GLOVER: That's right. I don't think it will matter  
20 too much for these purposes, but Ms Maisey will tell me if  
21 it does.

22

23 Q. On this page and what follows are the KPIs, and I take  
24 it you are fairly familiar with the KPIs that apply to the  
25 district?

26 A. Reasonably so, yes.

27

28 Q. One of the primary purposes of a local health district  
29 is to promote, protect and maintain the health of the  
30 community; that's correct, is it?

31 A. Yes, it is. Yes.

32

33 Q. Do you have a view about whether the KPIs that are  
34 applied to districts like yours accurately measure how well  
35 that function is performed?

36 A. There are a broad set of key performance indicators.  
37 I think there is in excess of 100 key performance  
38 indicators. And so it covers, as you said, the  
39 responsibilities we have to maintain the health of our  
40 community, and we obviously do that with our partner  
41 organisations. They cover functions of hospitals, so  
42 emergency departments, readmissions, which is obviously  
43 another indicator of good care. It covers waiting times.  
44 There is a whole range of indicators around specific  
45 initiatives that the Ministry of Health fund us directly  
46 outside of activity-based. I think it is a broad  
47 indication of responsibilities of a local health district.

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Q. One of the concepts you refer to in your statement, and we will return to it later, is the need to focus attention on health outcomes for the community, correct?

A. Yes.

Q. Do you have a view about whether the suite of KPIs, as broad as they are, give an indication of how well the district is promoting the health outcomes of its communities?

A. The key performance indicators tend to be what I call input-based indicators. So you would be familiar with the concept of input/output outcome, lead and lag indicators, and for an organisation you need to look at all five types. The indicators here, with the exceptions of some like immunisation rates, smoking, tend to focus on inputs, a number of presentations, or outputs in terms of people waiting on a waiting list, so they tend to be indicators that are easily metered. Outcomes indicators obviously tend to be longer term and don't generally fit well within an annual funding planning cycle, and so outcome indicators, in my experience, don't tend to be used a lot in service agreements because they're hard to measure and hard to quantify.

Q. Accepting the difficulty in applying them as you've indicated, in 12-month cycles, what are some metrics that might be used as outcome indicators, from your experience?

A. For example, if you are looking at diabetes rates, one of the indicators, it might be HBHA1C rates. An example I'm familiar with in New Zealand for primary care where there is capitation funding, they look at the incidence and impact of diabetes in particular. They look at a range of indicators ranging from the number of diabetic patients that are on the register, which is an input. They look at HBH1C rates to make sure that they are not only registering them, but they're also assessing and taking account of clinical indicators that would be an outcome indicator. Another outcome indicator could be around smoking, so an input indicator might be the number of people recorded in the Census for smoking. An output indicator might be reducing the incidence of smoking, and that could be measured through COPD rates or COAD rates, as a few examples.

Q. While perhaps difficult to measure, in your experience is the use of outcome indicators helpful to help the

1 administration generally?

2 A. I think if we're - the Health Services Act talks about  
3 promoting maintaining health, then you would want some  
4 indicators that talk about whether we have achieved that or  
5 not. And, as I said, I think you need all types of  
6 indicators within a service agreement input/output outcome,  
7 lead and lag indicators to make sure that you are not only  
8 looking at what has happened, but you are predicting what's  
9 coming.

10  
11 Q. Can I take you back to page 14, doc ID page 14. This  
12 is the budget snapshot. You have now been through two of  
13 lead service agreement processes, is that right, since you  
14 joined the district?

15 A. I started after last year's was negotiated, so I've  
16 been through one cycle, yes.

17  
18 Q. What was the process from your perspective in terms of  
19 arriving the budget? It is not the one on the screen,  
20 obviously, but the one for the current service agreement?

21 A. So there were several meetings with Ministry of Health  
22 officials regarding service agreement negotiations. We had  
23 an opportunity to put forward particular areas of  
24 investment and highlight any areas that we may have wanting  
25 to review as part of last year's service agreement. We  
26 then provided information to that effect, provided more  
27 detail on those, and then we received budget notification  
28 shortly after the New South Wales budget was released,  
29 which was, from memory, the second or third week in June.

30  
31 Q. As part of that process, was there account taken of  
32 the healthcare needs of the population within your  
33 district?

34 A. We had a conversation about the ageing profile of our  
35 district. You've seen through the statement that we have  
36 an elderly - a relatively elderly population. We talked to  
37 them about the growth that is being experienced in regard  
38 to both presentations, admissions, and community demand.  
39 As you'd appreciate, the older the population is, the more  
40 impact they have in terms of health services. We put that  
41 case forward. The result of that was with the exception of  
42 Tweed Valley Hospital, which was mostly funded, we received  
43 0.07 per cent growth.

44  
45 THE COMMISSIONER: Q. Just without wishing to be unduly  
46 critical, I'm not - certainly not being unduly critical,  
47 your question was: was there account taken of healthcare

1 needs of the population within your district? The thing is  
2 there is very many grades of "taking account". You might  
3 want to explore that.

4  
5 MR GLOVER: Q. Yes. We will explore this a little bit  
6 further later but you mention in your statement some  
7 approaches to planning of healthcare services.

8 A. Yes.

9  
10 Q. At a general level, will you agree that in planning  
11 healthcare services, one must start with an assessment of  
12 the healthcare needs of the population?

13 A. Yes. So if I talk about the commissioning cycle,  
14 which is what I am generally familiar with. So every three  
15 years, depending on Census cycles, you would start with a  
16 health needs assessment and that would obviously look at a  
17 broad range of both socioeconomic and health demand  
18 indicators, as well as trends in healthcare delivery,  
19 service utilisation, et cetera.

20  
21 You would then have conversations with key  
22 stakeholders, so you would have both a quantitative and a  
23 qualitative response. You would then look at areas of  
24 investment and also areas of disinvestment. Both are  
25 equally important. You would then consider appropriate  
26 commissioning models or contracting models to achieve the  
27 gains that you want out of the investment that you're  
28 making. You would then undertake the appropriate  
29 contracting approach and evaluation would occur, and you  
30 would start the cycle again. So that is the commissioning  
31 cycle that I would be familiar with.

32  
33 Q. Is that a cycle that occurred in arriving at the  
34 budget in the current services agreement?

35 A. No. No, it wasn't for this year, no.

36  
37 Q. Was there a healthcare needs assessment done across  
38 the population within the district that then fed into the  
39 budget negotiations as part of the current services  
40 agreement?

41 A. The Ministry of Health may have taken a technical  
42 health needs assessment approach through the modelling work  
43 that they've done. However, it wasn't in partnership with  
44 the local health district.

45  
46 Q. When you say a technical health needs assessment  
47 approach, what do you mean by that?

1 A. So they would have looked at Census data. They would  
2 have looked at some of the demographic changes. They  
3 would've, obviously, looked at service utilisation. They,  
4 obviously, also have information from the public health  
5 unit, the Ministry of Health public health unit. The  
6 factors that were taken into account in terms of  
7 determining our growth was undertaken by a team at the  
8 Ministry of Health, so I wouldn't be able to comment on the  
9 processes that they used to derive the 0.07 per cent growth  
10 that we had been given.

11

12 Q. On that page, activities funded at the state efficient  
13 price and for the period that was covered by this services  
14 agreement on the screen, that was \$5,207 per NWAU; do you  
15 see that?

16 A. Yes, I do.

17

18 Q. There may be a difference to this year's service  
19 agreement, but do you have a sense whether your district is  
20 able to deliver care at the state efficient price?

21 A. No, we're not at the moment. Our current cost per  
22 weighted activity unit, which is often referred to, the  
23 "DNR", and I think "DNR result" stands for "district  
24 network return effective in costing study", shows that our  
25 cost per weighted activity unit exceeds the state efficient  
26 price.

27

28 Q. By how much?

29 A. It's approximately \$2,000 per activity unit.

30

31 Q. Are there adjustments made in the budget to account  
32 for that fact?

33 A. There are some adjustments in regards to the funding  
34 model. So we have a rural - sorry, a small hospitals  
35 adjustment which takes account of economies of scale for  
36 our several small facilities. There are some block funding  
37 that it takes account of, fixed costs such as training and  
38 education, et cetera, but ostensibly it's an activity unit  
39 times state efficient price.

40

41 Q. Does that mean there is - despite those adjustments,  
42 there is still a shortfall between the amount funded at the  
43 state efficient price and the cost to deliver that activity  
44 within your district?

45 A. Yes, there is. That's correct.

46

47 Q. Go ahead to paragraph 10 of your statement, please.

1 There, you identify a number of key governance documents.  
2 I just want to take you briefly to the Healthcare Services  
3 Plan, which is [MOH.0010.0622.0001]. It should just be on  
4 the screen there to your left. This was a plan implemented  
5 in March of this year; that's right?

6 A. Yes.

7  
8 Q. What is the purpose of this plan?

9 A. To help us prioritise areas of focus for our local  
10 health district, based on assessment of a broad need.

11  
12 Q. I'll just ask you about a couple of consents which  
13 builds on, I think, some of the discussion we had earlier.  
14 If we go to doc ID page --

15  
16 THE COMMISSIONER: Sorry, I just need to interrupt.

17  
18 MR GLOVER: Yes.

19  
20 THE COMMISSIONER: Q. The difference of \$2,000 per  
21 activity unit that you've just given evidence about, and  
22 Mr Glover asked you about "are adjustments made?", and you  
23 said there are some adjustments and you explained a little  
24 bit of that, but do those adjustments - and then you were  
25 asked, "Does that mean despite those adjustments, there's  
26 still a shortfall?", and you said, "Yes, there is." What  
27 is the extent of the shortfall that's left?

28 A. So I guess that's the contribution towards our  
29 deficit. So we, obviously, are in deficit, and so we're  
30 unable currently to deliver services to the level of state  
31 efficient pricing.

32  
33 Q. But in dollar terms, what's the difference left after  
34 the adjustments?

35 A. I wouldn't be able to answer that because it's quite a  
36 broad --

37  
38 Q. You can take it on notice, though?

39 A. Yes. Yes.

40  
41 Q. And, I mean, we could make assumptions that you're not  
42 being efficient as you could be, but let's make the  
43 assumption that you are being as efficient as you can be in  
44 delivering the services. If you're funded on the state  
45 efficient price, then you can't possibly be funded enough  
46 to deliver the services that you have to for the cost of  
47 them?

1 A. For the state efficient price, as I understand it, is  
2 calculated from the average cost of delivering care.

3

4 Q. Yes.

5 A. And, as you will have seen, regional rural costs are  
6 ostensibly higher per unit.

7

8 Q. Yes.

9 A. And so, at the moment with the current service  
10 configuration that we have and the cost of premium labour,  
11 we'll be unable to deliver it at state efficient price.

12

13 Q. This isn't a criticism, but that's a long answer in  
14 terms of agreeing with my proposition?

15 A. I agree with the proposition, yes.

16

17 THE COMMISSIONER: Thanks.

18

19 MR GLOVER: Q. Does that mean from the commencement of  
20 the period covered by the services agreement, your district  
21 is underfunded in terms of the activity it is being  
22 required to perform?

23 A. So I don't think there is any government that can fund  
24 health to the level that we would like to have. At the  
25 moment, we are of course, are exceeding our budget. That's  
26 evident in the statement and the advice that I have  
27 included in there. I guess are we underfunded? We are  
28 certainly not being funded for the level of utility that we  
29 are providing. We have had growth year on year of circa  
30 4 per cent in the last two years, and that's projected to  
31 increase, so I think the answer is we're not being funded  
32 for the level of activity that we're currently providing.

33

34 THE COMMISSIONER: Q. Can I ask, someone else may  
35 provide this answer, but what do you understand to be the  
36 point of funding your LHD in circumstances where it must be  
37 known that there is going to be a deficit? What's the  
38 point of it?

39 A. The point of funding a local health district?

40

41 Q. Funding it to the extent that it must be almost  
42 guaranteed that you are going to be in deficit, rather than  
43 funding you so the deficit --

44 A. Oh, I see, I see. I understand the question now.  
45 I guess --

46

47 Q. From matters that seemingly might be beyond your

1 control?

2 A. Yes. I suppose the intent is to ensure that we  
3 continue to strive --

4  
5 Q. For it as hard as you can.

6 A. -- for it in terms of efficiency and economics.

7  
8 Q. Okay. And sorry if I have just not picked this up  
9 adequately by not listening carefully enough, but the  
10 0.07 per cent growth, what was that? How was that figure  
11 derived? How was that percentage arrived at?

12 A. I can't - I haven't been able to determine how --

13

14 Q. This is because you are so new that - or you just --

15 A. No, we haven't had it described to us as to how the  
16 0.07 per cent growth was determined.

17

18 Q. Sorry, you have asked and the answer is what?

19 A. "It's part of the growth calculation for your  
20 district."

21

22 Q. That's a statement of an assertion, but it doesn't  
23 give you much chance to understand.

24 A. We haven't been able to understand. I know there is a  
25 formula, Commissioner, but - yeah.

26

27 THE COMMISSIONER: Okay. I don't understand yet either,  
28 but that's fair enough given the chief executive doesn't.

29

30 MR GLOVER: Q. We'll come back to some of those concepts  
31 a little later, but can I, in this document, take you ahead  
32 to doc ID page 7, please. This is to build on some of the  
33 concepts you identify when talking about the service  
34 planning process earlier.

35 A. Yes.

36

37 Q. Under 1.1:

38

39 *About this Plan*

40

41 *LHDs have a responsibility to effectively*  
42 *plan services over the short- and long-term*  
43 *to enable service delivery that is*  
44 *responsive to the health needs of its*  
45 *defined population.*

46

47 Based on your answers earlier, I take it you would consider



1 that approach to be consistent with the obligations of the  
2 LHD to promote and protect the health of its community?

3 A. Yes, I would. Yes.

4  
5 Q. Then in the third paragraph under that heading:

6  
7 *When progressing the actions ... [the LHD]*  
8 *will have a focus on strong partnership*  
9 *approaches and working closely with key*  
10 *stakeholders ...*

11  
12 Do you see that?

13 A. Yes, I do.

14  
15 Q. Why is that an important part of the planning process?

16 A. Because we are a single organisation in a health  
17 ecosystem and our community interacts with a variety of  
18 organisations and obviously has a stake as well. So if we  
19 weren't talking to our community, engaging our partners,  
20 having conversations with organisations that are delivering  
21 services, then we wouldn't be able to determine health  
22 need, both qualitative and quantitative need of our  
23 community, and so I see that as a vital part of delivering  
24 excellent healthcare.

25  
26 Q. When you refer to either stakeholders or partners in  
27 that context, who do you have in mind?

28 A. Well, it is a long list, but I would start with,  
29 I guess, our community and our patients are first and  
30 foremost that is who we are here to deliver care for. And  
31 then we have our significant partner organisations such as  
32 our primary health network; Aboriginal medical services;  
33 NGOs that are providing a variety of healthcare; social  
34 agencies that advocate on behalf of the community in  
35 particular; patient groups; council, who obviously have an  
36 advocacy role and an interest in the profession of  
37 healthcare; chamber of commerce, the local health district  
38 is the biggest employer in the region; government  
39 stakeholders; Ministry of Health. I mean, the list is  
40 endless.

41  
42 Q. These concepts involve more than just consultation,  
43 though, do they? They require a joint planning approach?

44 A. Yeah, a joint planning approach is absolutely  
45 critical, and so the concept or contemporary concept of  
46 codesign of services, where you have multi-parties,  
47 including community and patient representatives sitting at

1 the table looking at opportunities for improvement  
2 together, having a holistic planning approach, is  
3 absolutely critical to ensuring that we're heading in the  
4 right direction.

5  
6 Q. You mentioned in an earlier answer the ecosystem, some  
7 may call it the fragmented nature of healthcare in this  
8 country. How do you see that joint planning approach being  
9 put into practice, given the varying partners or  
10 stakeholders?

11 A. I think the mistake that you can fall into is taking  
12 an approach of who's paying the money rather than approach  
13 from who is actually from the patient perspective, and so  
14 I guess in my experience, if you put the patient in the  
15 centre of that conversation and say actually, "What does  
16 this individual need?", in terms of supporting them on  
17 their healthcare journey and having a variety of those  
18 stakeholders that are described sitting there to have those  
19 conversations, and then you look at a care arrangement or a  
20 service delivery arrangement that meets the needs of those  
21 consumers and then you look at how that's going to be  
22 funded. That's a far more productive discussion than  
23 trying to work out the funding arrangements and then  
24 designing the services to suit the funding. You have to be  
25 a bit - that does require people to be flexible, have a  
26 will and intent to try something new. It does require a  
27 review of policy and regulation and all those things, so  
28 sometimes that can take time.

29  
30 Q. Can I take you ahead to doc ID page 23, please.  
31 I know there are a number of priority focus areas listed in  
32 this document, but just by way of example to demonstrate  
33 some of the - or explore some of the concepts that you have  
34 raised, but in "Overview", this box, "Overview":

35  
36 *Sustainable service delivery that meets*  
37 *population need is a key focus ...*

38  
39 So that's the ultimate goal, but if I go down four boxes:

40  
41 *Value based health care.*

42  
43 Do you see that box?

44 A. Yes.

45  
46 Q.  
47 *Efficiency, effectiveness and*

1                   *sustainability of care by considering*  
2                   *services from a population-based planning*  
3                   *lens.*

4  
5           Do you see that?

6           A.    Yes.

7  
8           Q.    What do you mean by "population-based planning lens"?

9           A.    So if I give you an example is probably the easiest  
10           way of describing it. So healthcare services planning  
11           based on health needs assessment needs to look at a  
12           critical mass of the population. So for Northern NSW Local  
13           Health District, we have 311,000 members in our community,  
14           and for those 311,000 you need certain minimum services to  
15           be available in the district. And then when you start  
16           looking at subspecialty services, they need a larger  
17           critical mass to be viable.

18  
19                    So, for example, heart transplants, you need a  
20           critical mass of population to make sure that you're  
21           maintaining those clinical standards and that there is a  
22           viable service, so you wouldn't have heart transplant  
23           services everywhere. So when you are looking at clinical  
24           service planning, an example of that in northern  
25           New South Wales, we need to be thinking about the critical  
26           mass of the population and making sure that we're using our  
27           workforce efficiently and effectively.

28  
29           Q.    Does part of that joint process involve, once the  
30           health needs assessment has been undertaken, identifying  
31           the range of services that are currently available in the  
32           district across the various providers?

33           A.    Yes. So part of this - the example here in terms of  
34           vulnerable services is where a service is vulnerable  
35           either, but generally because of workforce and workforce  
36           availability, and there are a number of subspecialty areas  
37           in our district where that would be the case.

38  
39           Q.    Has the district implemented measures towards these  
40           joint planning ideals?

41           A.    We are certainly in the progress to do that. So the  
42           development of the healthcare services plan was a really  
43           key milestone for our local health district. Within  
44           included in the plan, you will see all stakeholders that  
45           were engaged and the preparation for that. It also  
46           included our neighbour local health districts, the North  
47           Coast in particular, and there were conversations with Gold

1 Coast University Hospital in regards to services that are  
2 needing to receive tertiary care. So I guess doing that on  
3 a routine basis, so this is a 5- to 10-year plan, it is  
4 obviously quite a significant exercise. You wouldn't  
5 undertake a planning process like this every year; it would  
6 be every three to five years. And we need to make sure  
7 that your planning arrangements and the frameworks that you  
8 have in place, engaging with the community and partners as  
9 part of business as usual.

10  
11 Q. Is one of the steps taken towards pursuing those  
12 initiatives a memorandum of understanding between your  
13 district, Mid North Coast and the PHN?

14 A. Yes, that was a memorandum of understanding that was  
15 signed earlier this calendar year.

16  
17 Q. I will just have it brought up on the screen,  
18 [MOH.0010.0585.0001]. I'll just go to the next page.  
19 I think it might have been entered into just prior to the  
20 end of the last calendar year. What I want to draw your  
21 attention to actually on the next page, please, operator  
22 and the concept of thinking as one workforce, if we just  
23 scroll down a little. Thank you. Can you just have a read  
24 of that box, Ms Maisey, and let me know when you have done  
25 so. Maybe scroll down a little bit more. Thank you.

26 A. Yes.

27  
28 Q. When one thinks of the workforce being considered as  
29 one workforce across the myriad of stakeholders and service  
30 deliverers, how do you see that as ultimately coming to  
31 fruition?

32 A. So I think putting the organisational barriers aside  
33 and again focusing on the needs of the patient, you tend to  
34 end up with a complementary rather than competitive  
35 behaviour. And so, I'll give you an example. So, when we  
36 were designing - and I'll have to go back to New Zealand,  
37 if that's okay.

38  
39 So when I was designing a mental health service in  
40 Canterbury, we determined that we needed to look at  
41 workforce across a variety of organisations, because each  
42 of those organisations was having trouble recruiting for a  
43 variety of reasons. And so, when we did the service  
44 mapping, health needs assessment service mapping, we  
45 identified that some of the NGOs were stronger in terms of  
46 social work and counselling and had a variety of expertise  
47 in that area. The district health board, as it was at the

1 time, was expert in specialist care and supporting peer  
2 input.

3  
4 The primary health network, it is called "primary  
5 health organisations" in New Zealand, had a particular  
6 expertise in education and workforce development. So  
7 rather than all three organisations trying to do  
8 counselling and et cetera, we identified that if we could  
9 agree on the role of each organisation, we were able to  
10 provide a service that was more cohesive. And that process  
11 also allowed us to identify or more/better articulate roles  
12 and responsibilities, and so from an integrated continuity  
13 of care perspective, particularly around complex mental  
14 health patients, when they entered any of those  
15 organisations, sort of single door, the referral pathways  
16 and the clinical case management was more effective because  
17 each of those organisations and the clinicians within those  
18 organisations knew the roles they were to play to support  
19 that individual.

20  
21 Q. Were there benefits to patients in that approach?

22 A. Significant benefits to patients, because one of the  
23 things that we heard through that qualitative review  
24 co-design process was a term - I am not sure if you have  
25 this term in Australia - in New Zealand it is called  
26 "multiple cars in a driveway", and so you have a complex  
27 patient and in the morning might have a social worker, and  
28 then they have the clinical nurse and then they have the  
29 counsellor, and so there's multiple cars in the driveway.  
30 And so, this approach enabled a complex case management  
31 approach to be derived so that patient knew they could  
32 contact their complex caseworker and that complex  
33 caseworker would effectively help them navigate their care  
34 journey.

35  
36 Q. Are there also system benefits in that sort of  
37 approach?

38 A. Significant system benefits, and again I'll give you  
39 some examples. So workforce recruitment and retention, as  
40 I said, because each of those organisations was effectively  
41 focused on part of the care journey, we weren't all trying  
42 to compete for the same workforce, and so there was a  
43 collaboration rather than a competition. It was economic,  
44 because, again, we were able to hone in on the parts of the  
45 service delivery model that we were able to best specialise  
46 in. And there was a lot of non-cash benefits from  
47 collaboration around planning, around forward-thinking,

1 sharing information and intelligence. Facility design.  
2 I mean, yeah, it was significant.

3  
4 Q. I take it that the aims as set out in the memorandum  
5 of understanding, as you have expanded on in those few  
6 answers, are things that you see as being important to the  
7 future sustainability of the delivery of healthcare in your  
8 region?

9 A. It takes a whole system to design a whole system, and  
10 health is a complex adaptive system and you need to enable  
11 everyone to have a voice and to ensure that we're not  
12 competing for workforce, that we do have the needs and aims  
13 of our patients and our community at the forefront, and  
14 that we are partnering and designing care with them.

15  
16 Q. And that extends to Aboriginal medical services and  
17 Aboriginal community-controlled health organisations?

18 A. Absolutely. So the example I have just given to you  
19 around mental health, one of the key partners in that was  
20 an organisation, a Maori organisation, who had funding from  
21 the government to run what's called "Whanau hauora".  
22 "Whanau" is "family" in New Zealand, so - and "hauora" is  
23 "health", so it's "family health". A family health  
24 contract. And so they were able to take a holistic  
25 approach to care which was culturally appropriate for those  
26 members of our community that identified as Maori. And  
27 ensuring that we have culturally appropriate care for all  
28 members of our community, but in regard to the Aboriginal  
29 medical services, ensuring that they have a voice and that  
30 they are representing their clients is key to enabling  
31 equity of outcome.

32  
33 Q. Are there significant barriers in pursuing this joint  
34 approach that you have been describing?

35 A. I talk about in my statement a model care, rainbow  
36 model of care, and it talks about six dimensions. And  
37 I guess in my experience, organisations tend to be able to  
38 work through the clinical issues. By putting in health  
39 pathways and referral pathways, they tend to work through  
40 professional issues around scopes of practice and enabling  
41 effective multidisciplinary teams, and organisational  
42 issues around contracting and alliancing.

43  
44 And what's more tricky in terms of integration are the  
45 other three dimensions, so: system integration, which is  
46 around policy, regulation, procedures, funding models;  
47 functional integration, which is around technology

1 frameworks legislation; and then normative integration, and  
2 normative integration is around where you have culture and  
3 behaviour that is aligned, goals and visions that are  
4 aligned. So that's obviously - you know, that takes some  
5 time to do that.

6  
7 So whilst you might have organisations that can work  
8 clinically, unless the technology is enabling seamless  
9 transfer of records, unless the funding model is enabling  
10 those models of care to be put in place, unless a policy  
11 and regulation is adopted and changed to enable that to  
12 occur, sometimes it is those three types of integrated  
13 mechanisms that can get in the way of actually delivering  
14 integrated care at the clinical forefront.

15  
16 Q. What you are describing is a one system approach  
17 rather than --

18 A. Yes.

19  
20 Q. -- different systems plugging in and trying to  
21 integrate together?

22 A. It's a people-centric approach to healthcare, and  
23 it's - you can do it with multiple payers although again,  
24 in my experience, that does become a little more  
25 complicated because the functional element of integration,  
26 the funding incentives being aligned, can take some time to  
27 work out.

28  
29 Q. But it can be done with a different way of approaching  
30 the structures and delivering of healthcare?

31 A. Yes, I think it can. If you've got trust and  
32 confidence in each other and the will and intent to make a  
33 change, I believe you can do it.

34  
35 THE COMMISSIONER: Q. You're generally on the subject  
36 matter now of 188 of your statement, where you have  
37 referred us to the - I imagine it is a peer-reviewed paper,  
38 "Understanding Integrated Care".

39 A. Yes.

40  
41 Q. Is that the --

42 A. Yes.

43  
44 THE COMMISSIONER: Thanks.

45  
46 MR GLOVER: I might come back to a couple of those  
47 concepts later if convenient.

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THE COMMISSIONER: Yes.

MR GLOVER: Q. If we go back to your statement, please, and paragraph 31?

A. 31?

Q. Yes.

A. Yes.

Q. There you describe some of the features of the population of the district and, in particular, the higher prevalence than state average of several disease risk factors --

A. Yes.

Q. -- particularly in the consumption of alcohol and nicotine, and some more examples in the table below. Do you have a sense of any causative factors for those - that demographic within your district?

A. So I guess those factors tend to relate to socioeconomic deprivation and stress, and as you're aware, there's been a number of climate events in the district in recent years. I'm not suggesting that that's directly as a result of climate change, but I think it adds a level of stress to the community. Housing stress adds a level of - you know, housing availability and affordability, so there tend to be socioeconomic determinants as distinct from direct health determinants.

THE COMMISSIONER: Q. I think it's fair enough - I think the evidence is there to say that these extreme weather events are - there is a contribution from climate change.

A. Yes.

Q. I think the evidence is clear from that, and your district in terms of extreme weather events may be in the firing line, for want of a better expression.

A. Yes, Commissioner. That's correct.

MR GLOVER: Q. Can I move ahead to paragraph 36, please, and here you tell us about the change in the Modified Monash Model classification of that. Do you remember? Do you see that?

A. Yes.

Q. It was a 2 and it's now a 1 considered metro?



1 A. Yes.

2

3 Q. You tell us about one of the knock-on effects of that  
4 change about student placements. Are there others?

5 A. That's the one that has been raised with me on most  
6 occasions. This obviously happened before I arrived, but  
7 I'm not aware of any other significance in regards to the  
8 change. There may be some regulatory impact that  
9 I wouldn't necessarily be familiar with.

10

11 Q. Are there other parts of the district that are also  
12 affected by Modified Monash Models that at least you  
13 perceive don't necessarily reflect the reality of where  
14 those places are based?

15 A. I am still trying to understand the MMM rating. I'm  
16 not able to answer that question directly. Again, this  
17 would be the main example that's been provided to me since  
18 starting.

19

20 Q. Go ahead to paragraph 41, please. In this  
21 paragraph through to, really, paragraph 46, you describe  
22 some trends in activity.

23 A. Yes.

24

25 Q. Is it fair to say that over the last few years, there  
26 has been an upward trend in activity coming through  
27 facilities in the district?

28 A. Yes, that's correct.

29

30 Q. Has there been any analysis done to try to understand  
31 why there has been an uptick in activity?

32 A. Yes, there has.

33

34 Q. What has it discovered?

35 A. Some of it is obviously related to the ageing  
36 population. As you'd appreciate, the older members of our  
37 community experience more health need. There's also more  
38 people moving into the district, so there's a combination  
39 of ageing and volume of people. There's also some  
40 anecdotal evidence around challenges in accessing general  
41 practice services and so - and I would certainly, again  
42 from my experience, prior to coming to New South Wales,  
43 where there's challenges in primary care, first contact  
44 services, or delayed access to first contact services,  
45 there tends to be a flow-on effect through to secondary  
46 care services because people are delaying receiving  
47 treatment and, therefore, when they do come to an emergency

1 department, for example, the need is more acute. There's  
2 also the stresses that we have just talked about in terms  
3 of mental health and alcohol and other drugs.  
4

5 Q. Do all those factors combined to arrive at a position  
6 where the district has very little it can do to influence  
7 the levels of activity that are coming through its doors?

8 A. We can work with our partners to put in population  
9 prevention measures although, as you would appreciate, they  
10 tend to take some time to impact. If somebody comes to an  
11 emergency department, whatever the reason they've come to  
12 the emergency department, it's our obligation to ensure  
13 that they receive safe and appropriate care. We don't ask  
14 them, "Why did you come here and didn't go to the GP?", and  
15 so, yes, in regards to once they turn up at our hospital,  
16 there's limited action that we can do. Our role is to,  
17 I would suggest, to equally treat them well when they  
18 arrive, but intervene earlier to reduce the impact and  
19 incidence on the emergency department to begin with.  
20

21 Q. If we can go ahead to paragraph 87, please. From  
22 paragraph 87 down to 92, you tell us about the state of  
23 aged care facilities in the district. In paragraph 91, you  
24 tell us there is an under-supply of about 477 across the  
25 district and then the effect of that is the knock-on effect  
26 to the facilities of 61 patients as of 3 September being in  
27 facilities when they are ready for discharge.

28 A. Yes, that's correct.  
29

30 Q. Is that a trend that is relatively recent in terms of  
31 aged care patients being in hospital beds when they are  
32 ready for discharge if places were available?

33 A. I guess it's been made more acute since the floods and  
34 so - we've included in point 88, we know of at least two  
35 facilities with circa 100 beds, between them, that were  
36 lost to the floods, so it has been more acute since the  
37 floods. However, the number of people waiting, residential  
38 aged care places since I've been in the role in 12 months,  
39 has tended to be relatively steady, but I do understand  
40 that it's higher than previous years.  
41

42 THE COMMISSIONER: Q. That classification of waiting of  
43 35 days --

44 A. Yes.  
45

46 Q. -- who sets that? Is that your LHD or is that some  
47 national standard or State standard?

1 A. I think it's the standard set by the Ministry of  
2 Health, Commissioner, but I'd have to confirm that.

3  
4 Q. And is it 35 days in hospital including, for example,  
5 the period of time that the patient may have needed to be  
6 there to treat some acute condition, or is it 35 days from  
7 the point of time which the patient could have gone into an  
8 aged care facility but it wasn't available?

9 A. Length of stay of 35 days.

10  
11 Q. Right.

12 A. And they need to have had been cleared, medically  
13 cleared, for discharge, yes.

14  
15 MR GLOVER: Q. What's the effect on a facility in the  
16 district by having approximately two medical wards occupied  
17 by patients who are ready for discharge into aged care  
18 facilities, if there had been a place available?

19 A. That puts pressure on the remaining beds because if  
20 you have - and other reasons, other impacts. So I'll just  
21 talk about one first. So if you have, effectively, two  
22 wards of patients occupying the beds who have been  
23 medically cleared for discharge and we have people in the  
24 emergency department waiting to come in, we obviously need  
25 to churn over the remaining beds in order to let more  
26 people in, so that puts pressure on beds. But also more  
27 importantly, from my point of view, is those 61 patients  
28 aren't in the right place. So, you know, an acute hospital  
29 ward isn't a good environment for someone that needs a  
30 relatively calm environment.

31  
32 I'm not sure if you have been told of the term  
33 "hospital acquired dementia", which is a disorientation  
34 when patients are in hospital for lengths of time. So for  
35 me I actually don't want patients in hospital for any  
36 longer than they need to be in hospital because it's just  
37 not good for them. And so whilst there is some system  
38 benefit in obviously not having those patients in our  
39 wards, more importantly, it's just not the right  
40 environment for the patient.

41  
42 Residential aged care homes are designed to be  
43 home-like. They have expertise in caring for this group of  
44 patients and, therefore, it is far better for the  
45 community, the patient, the family and the local health  
46 district to have them in the right place, at the right  
47 time.

1  
2 Q. If we go ahead to paragraph 106, please, in this  
3 section of your statement, you refer to challenges and  
4 opportunities around the delivery of services.

5  
6 In paragraph 108, you tell us:

7  
8 *Addressing the noted health challenges and*  
9 *meeting the health needs of the NNSWLHD*  
10 *community requires innovation, shifts in*  
11 *investment towards community, ambulatory*  
12 *and in home service delivery, in active*  
13 *partnership arrangements with health and*  
14 *social organisations, and communities.*

15  
16 We've spoken a little bit about the need to partner with  
17 other stakeholders.

18 A. Yes.

19  
20 Q. But what do you see as being the main areas that  
21 require innovation and shifts in investment?

22 A. So I guess I'd talk about our local health district  
23 specifically. We have a relatively under-developed  
24 hospital in the Home and Community Care Program and so  
25 I think investment in keeping people well, firstly and  
26 foremostly, so that's around in population health and  
27 preventative care, but then, secondly, when they do need  
28 care and keeping them well in place, and so using virtual  
29 care models, service delivery models that take the care to  
30 the patient and reach into residential aged care providers;  
31 partnering with other NGO organisations, all of those  
32 things enable members of our community to stay well in  
33 place for longer, but I don't think we're using technology  
34 as well as what we could.

35  
36 Again, we have some virtual care models, but the  
37 advent of technology, wearable devices, is exponential in  
38 healthcare at the moment and, in my experience, healthcare  
39 organisations tend to be behind when it comes to  
40 innovations. I think there are lots of opportunities  
41 around using technology to remote-monitor patients. I'm  
42 not suggesting that it's not being done, but I just think  
43 there is more opportunities to do that.

44  
45 Q. What, an increased focus on out-of-hospital services  
46 delivered into communities?

47 A. Yes, both to keep people well in place if they don't

1 need care, but also to enable discharge so they're not  
2 spending more time in a hospital than they need to.

3

4 THE COMMISSIONER: Q. The shifts in investment, though,  
5 that you refer to in 108 --

6 A. Yes.

7

8 Q. -- what would you be shifting from?

9 A. So there's a propensity to keep opening more hospital  
10 beds. Hospital beds are expensive. It's not an either/or.  
11 You still need some hospital beds.

12

13 Q. Yes. Of course.

14 A. However --

15

16 Q. We accept that we have to provide the acute care  
17 services we have to provide.

18 A. Yes.

19

20 Q. But the shift might come from?

21 A. So, again - so rather than opening more beds, put that  
22 money into investing in more prevention, more allied health  
23 support in the community, more technology, remote  
24 monitoring; virtual care. Yeah. So just rather than build  
25 more hospitals.

26

27 Q. Those things might also, just for the sake of  
28 argument, require further investment as well without a  
29 diversion from something else?

30 A. That's correct, yes. I'd agree with that, yes.

31

32 MR GLOVER: Q. In part because some of the initiatives  
33 that you are describing, the benefits of those initiatives,  
34 might take some time to be ultimately realised, correct?

35 A. Yes, certainly.

36

37 Q. In the meantime, you still have an increase in trend  
38 of activity demand in your district?

39 A. Yes, we do.

40

41 Q. But you would see benefit, I take it, in starting the  
42 shift that you describe in paragraphs 108 and 109 of your  
43 statement now, while still maintaining a level of service  
44 you do in your facilities?

45 A. We need to be able to do both. It generally only  
46 starts with one step, so we need to take the step. And to  
47 be fair, there is already a lot of inactivity in place and

1 I was heartened to see the investment by the government  
2 this year in the emergency department alternatives around  
3 call centres and diversion, and we have benefited from that  
4 last year, around the establishment of the urgent care  
5 service for Tweed Valley which is partnering with advanced  
6 care paramedics in the region to our residential aged care  
7 homes. So there is lots of things happening. I just -  
8 I guess my view is we just need to make a stepped change in  
9 that direction because we're just not keeping up.

10  
11 Q. And the step change in that direction is critical in  
12 order to ensure the long-term sustainability of the public  
13 health system, do you agree with that?

14 A. Yes, I would. Yes.

15  
16 Q. Can I come to the topic of funding and this starts at  
17 paragraph 112 of your statement. In paragraph 116, you  
18 tell us there is clear evidence that the real healthcare  
19 disparities exist between rural and urban Australians and  
20 that rural and regional populations receive significantly  
21 less funding per capita. Do you see that?

22 A. Yes.

23  
24 Q. And then in the rest of the paragraph you give some  
25 examples. Where are you drawing those figures from?

26 A. So from that evidence base that's listed there, and  
27 they have cited a number of references within that  
28 document, yes.

29  
30 Q. In practical terms for your district, what does that  
31 mean, "disparity" that you describe in paragraph 116?

32 A. So, again, I'll give you an example. So where you  
33 have less GPs per capita, those members of our community  
34 aren't accessing obviously first contact services so  
35 they're not accessing MBS schedules and so that investment  
36 doesn't make its way to those individuals. Where there's  
37 large geographic areas to cover, the availability of health  
38 services isn't, obviously, as dense as in a metro; our  
39 workforce is more expensive. And so even though you make  
40 dollar-for-dollar, where you have a higher workforce cost  
41 then, obviously, that dollar doesn't go quite as far, so  
42 then there's less services provided.

43  
44 Residential aged care places. I just talk through  
45 that in terms of availability of places. Whilst the real  
46 estate may be cheaper, there isn't the demand in some of  
47 those isolated communities. So you'll see that, you know,

1 we have four multi-purpose services to take up some of that  
2 demand. That's an example.

3

4 Q. So the disparity is driven, to your understanding, at  
5 least in significant measure by there just being the lack  
6 of services available in regional and remote locations to  
7 draw on available sources of funding?

8 A. Yes, as well as providers not investing in areas  
9 because of disparate demand.

10

11 Q. That leads to the inequity in funding available to  
12 those living in metropolitan regions for their healthcare  
13 needs versus those living in parts of your region, correct?

14 A. Yes, that's correct.

15

16 Q. In paragraph 117, you refer to the NSW Health funding  
17 model as introductory to that paragraph?

18 A. Yes.

19

20 Q. Can you just tell us what are you referring to when  
21 you talk about the NSW Health funding model?

22 A. So that's the model on which our service agreement is  
23 based in terms of activity-based funding, small hospitals  
24 funding, block funding for training, education, et cetera,  
25 yes.

26

27 Q. You refer in that paragraph to some price weight  
28 adjustments but then in the second sentence, you tell us it  
29 didn't benefit your district as towns which might otherwise  
30 be eligible are serviced by MPS facilities; do you see  
31 that?

32 A. Yes.

33

34 Q. Can you just explain in practical terms the issue that  
35 you are identifying in that paragraph for us.

36 A. Yes. So for very remote areas, the state efficient  
37 price is adjusted to reflect the cost, whereas for  
38 multi-purpose services which are in Urbenville and Bonalbo,  
39 it's a pooled funding arrangement with the Commonwealth and  
40 so there isn't a flexed variable element to that. So we  
41 don't receive the benefit of having price weight  
42 adjustments as we would if we didn't have multi-purpose  
43 service.

44

45 Q. In paragraphs 119 and 120, you refer to some budget  
46 allocation in last year's budget for the opening of the  
47 Tweed Valley Hospital. Do you see that?

1 A. Yes.

2

3 Q. And then in paragraph 120, you tell us:

4

5 *From a financial perspective this means*  
6 *that the service will be in deficit until*  
7 *activity thresholds are achieved.*

8

9 A. Yes.

10

11 Q. Can you just walk us through, firstly, what was the  
12 initial allocation that you are describing in paragraph 119  
13 and then why, as a practical matter, the service is in  
14 deficit until activity thresholds are achieved?

15 A. Yes. I'll try to find my notes to give you the exact  
16 numbers but --

17

18 Q. Yes, take your time.

19 A. Give me a second. I've got it on the capital page.  
20 I can roughly tell you. So in 23/24, the Tweed Valley  
21 Hospital, we received six months. So November 2022 we put  
22 a funding submission in for the costs of opening additional  
23 capacity in the new Tweed Valley Hospital.

24

25 Q. Just pause there. That funding submission dealt with  
26 operational cost, staff --

27 A. Operating cost. Staff and operating cost, that's  
28 correct.

29

30 Q. Yes.

31 A. And so on the basis of that, we received six months  
32 funding in the 23/24 year, although the building didn't  
33 open until May 2024 because we had to have double staffing  
34 for a period of time. Not fully double staffing, but we  
35 had to take on additional staffing to commission the  
36 facility, do the training, education, et cetera, before the  
37 activities --

38

39 Q. Pausing there. Is that because it was a bigger  
40 facility?

41 A. Yes. Sorry, yes. So, Tweed Valley Hospital is three  
42 times the size of the Tweed Hospital.

43

44 Q. A bigger facility requires more staff, more cleaners,  
45 more operational staff, more nurses, more doctors; more  
46 everything?

47 A. All of the above, that's correct. And so we received



1 six month funding of our proposal. Through the service  
2 negotiations that we talked about earlier, we needed to get  
3 confirmation of our funding arrangement for Tweed Valley  
4 Hospital. Because we were starting to hire the staff, we  
5 were going to open in May. On the basis of the six-month  
6 funding, the board said go ahead and hire the staff, and so  
7 we did, and then we received funding confirmation for the  
8 24/25 year in June, the 24/25 service agreement. However,  
9 we didn't get another six months' worth of funding. So  
10 what happened was we'd taken on all the staff but then we  
11 only had - I think it was \$10 million less than our full  
12 year proposal.

13  
14 So when we talked to the Ministry of Health about  
15 that, the response was: we need you to build up the  
16 activity levels to confirm that that activity is going to  
17 go through that facility and then we will have a  
18 conversation with you about funding. However, we need the  
19 staff to build the activity levels up. So, for example,  
20 the cardiac cath lab, which we opened on 10 September, you  
21 have to do a certain number of patients before you can  
22 fully commission a 24/7 cath lab. Obviously you need to  
23 test procedures, need to test the equipment, et cetera. So  
24 whether you've got one cardiac cath patient coming through  
25 or you've got - I'm going to make a number up 10 - cardiac  
26 cath patients coming through, you've still got a certain  
27 number of minimum staffing and so hence my point about the  
28 deficit. Until we reach those activity levels, we've got  
29 sunk costs, we've got sunk staffing.

30  
31 As it stands, our Tweed Valley Hospital is already  
32 above target. That's because Tweed Hospital was above  
33 target and we've taken on that activity and we've grown  
34 since the new facility was opened.

35  
36 Q. Can I just step through certain parts.

37 A. Yes, sure.

38  
39 Q. So, the hospital was coming online in the last  
40 financial year and, in anticipation of that, a funding  
41 proposal was put up and six months of operational funding  
42 was provided, correct?

43 A. Yes.

44  
45 Q. The hospital opened in May?

46 A. Yes.

47

1 Q. And to operate the hospital, you need all of the staff  
2 that you have described and to operate the services, as  
3 each of the different services come online, you need the  
4 staff to staff them, correct?  
5 A. Yes.  
6  
7 Q. You can't do the activity without the staff, as is  
8 obvious.  
9 A. Yes.  
10  
11 Q. But in the next round of budget negotiations, that  
12 same level of funding for those staff wasn't provided to  
13 the district, have I understood you correctly?  
14 A. So we received the six months.  
15  
16 Q. Yes.  
17 A. But then we didn't receive an additional six months to  
18 take it to annual funding. We received a portion of the  
19 remaining funding that we'd asked for.  
20  
21 Q. Yes. From that answer, do we understand it that what  
22 you received was not enough to meet the cost of the staff  
23 that you required to operate the facility and build the  
24 services?  
25 A. Yes, that's correct.  
26  
27 Q. And where were you to find that money?  
28 A. Well, that's a good question. We had already hired  
29 the staff and we'd already made a commitment to the  
30 community, and we'd already made a commitment that we would  
31 be bringing those services on and so we, at the time, when  
32 that planning had been done, as I said, we expected to  
33 receive the funding effectively as deficit funding.  
34  
35 Q. And the indication from the ministry was that once  
36 activity targets were reached, there would be a discussion  
37 about further funding, is that right?  
38 A. Yes, that's correct.  
39  
40 Q. Okay. Has that discussion occurred, now that you have  
41 indicated that facility is at or above target?  
42 A. We're having a conversation in November about that.  
43  
44 Q. Can I then take you ahead to paragraph 121, please.  
45 Before I do that, was any reason given to you, or to the  
46 district by ministry, about why that funding for  
47 operational staff wasn't continued and there wouldn't be

1 further discussion about it until activity targets were  
2 met?

3 A. The conversation was they wanted to see the impact on  
4 repatriation of activity from Queensland to  
5 New South Wales. The Ministry of Health funds patients  
6 that go from New South Wales to Queensland and there was an  
7 expectation that with the opening of, particularly, the  
8 additional tertiary services that cardiac have, and  
9 radiation oncology, that there would be a repatriation of  
10 some of those patients back to New South Wales. So they  
11 wanted to see that occur, which I can understand that. And  
12 the other reason was at the time - we had this conversation  
13 in July and then August, we hadn't had the first month's  
14 results. We had June's results and June's were above  
15 target, but we hadn't had the July and August results, so  
16 they wanted to see the impact of opening the new facility  
17 before we had the conversation.

18  
19 Q. The impact of repatriation activity from Queensland  
20 wouldn't affect the minimum staff you required to operate  
21 that facility, though, would it?

22 A. No.

23  
24 Q. Nor would the activity targets, the activity flowing  
25 through that facility, is that right?

26 A. No, it was a funding source more than an increase in  
27 the activity numbers.

28  
29 Q. Thank you. In paragraph 121, you tell us that prior  
30 to 2022 - I appreciate some of this is before your time so  
31 if you can't answer, do let me know, but your understanding  
32 is the district was generally on budget?

33 A. Yes.

34  
35 Q. Since then, there have been some deficits?  
36 A. Yes.

37  
38 Q. Have you been able to identify particular causes of  
39 why that has occurred since that period in time?

40 A. Partly activity.

41  
42 Q. We'll come to activity.  
43 A. But also our premium labour costs. Before the floods,  
44 and COVID, northern New South Wales had a very low use of  
45 agency staff, locum medical and nursing. Post-COVID,  
46 I think most health systems had been impacted by workforce  
47 fatigue and we've had workforce leave and then the floods,

1 on top of that, exacerbated the situation in the district  
2 and I think, to be fair, we still have a high use of  
3 premium agency, both nursing and medical. That is coming  
4 down, you know, it's coming down each year, but certainly  
5 we're well above where we were before COVID.  
6

7 Q. You tell us that at the end of June 2023, the deficit  
8 was about \$109 million.

9 A. Yes.

10  
11 Q. And then the end-of-year position 2023 to 2024 was  
12 \$74 million.

13 A. Yes.

14  
15 Q. In 122, you tell us that that turnaround has been  
16 achieved firstly by the efficiency improvement program of  
17 \$48 million?

18 A. Yes.

19  
20 Q. Of which 40 was reduced cost and utilisation of  
21 premium labour. What did that's efficiency improvement  
22 program entail?

23 A. So apart from reducing premium labour, the \$8 million  
24 was around better procurement in terms of, you know, using  
25 contracts, making sure that we were applying good financial  
26 discipline; re-evaluating efficiencies like accommodation,  
27 transport travel, goods and services. Just good financial  
28 discipline would probably be the best way of explaining  
29 that.

30  
31 THE COMMISSIONER: Q. The program, who devised it? Was  
32 it the LHD or the ministry or --

33 A. Oh, the LHD, Commissioner, yes.

34  
35 Q. Okay. And was there - you call it a program. Was it  
36 in, like, some form of document with a series of  
37 recommendations to follow, or was it a bit more ad hoc than  
38 that?

39 A. So there were two documents. The Ministry of Health  
40 had a couple of people visit before I arrived and they did  
41 what was called the foundation review which went through  
42 and had a look at a whole range of matters. They  
43 provided --

44  
45 Q. They assisted in setting up the program?

46 A. It certainly was helpful having an independent review  
47 against benchmarking peers, et cetera; you know, areas of

1 opportunity.

2

3 Q. Yes.

4 A. And so that document was made available to us actually  
5 the second day I started.

6

7 Q. Right. Okay.

8 A. And so - but before that the team had already started  
9 working on particularly the premium labour with the  
10 overseas nurses recruitment that started before that formal  
11 review occurred.

12

13 Q. What does "recruitment slippage" mean in 122(b)?

14 A. So we're given funds for particular - it tends to be  
15 government priority initiatives and so "recruitment  
16 slippage" is where they may fund us for 12 months.  
17 However, we've been unable to recruit two positions and so,  
18 therefore, we haven't expended some of those funds for the  
19 - you know, that doesn't on start 1 July, we can't just  
20 suddenly recruit people.

21

22 Q. You have the funds, but you haven't been able to  
23 expend them because you haven't got the people to spend it  
24 on?

25 A. That's correct, Commissioner, yes. Yes.

26

27 Q. And reimbursement for activity over target, that's  
28 where more activity is being done and so you have been  
29 given some extra funding because of that?

30 A. Yes. So in 23/24, anything - so up to 4 per cent  
31 above target, we were funded 40 per cent of the national  
32 health rate. Because we were over target, we received some  
33 additional funding for that, yes.

34

35 Q. Thank you.

36

37 MR GLOVER: Q. But that's no longer the case?

38 A. That's correct.

39

40 Q. Do you know why?

41 A. No, I don't know why.

42

43 Q. Is it the case that any activity that is performed  
44 over target will not be funded?

45 A. That's what I've been told, that's correct. Well, no,  
46 sorry, I'll correct that statement.

47

- 1 Q. Yes.  
2 A. We're unable to accrue at this stage for that  
3 activity.  
4  
5 Q. Just help me, what's the distinction?  
6 A. In my mind the distinction would be at some point, you  
7 may be able to accrue for it but at the moment, you're not  
8 able to accrue for it.  
9  
10 Q. Is that a position that has commenced with the 24/25  
11 year?  
12 A. In July, we were informed that the 4 per cent would go  
13 to 2.5 per cent. So rather than being able to account for  
14 4 per cent over-provision, we would be able to account for  
15 2.5 per cent over provision.  
16  
17 Q. Just taking it step-by-step.  
18 A. Right.  
19  
20 Q. In previous years, activity up to 4 per cent above  
21 target was able to be funded at 40 per cent of the national  
22 efficient price?  
23 A. Yes.  
24  
25 Q. And this financial year, the position is activity up  
26 to 2.5 per cent above target attracts that same funding?  
27 A. That's what we were told in July.  
28  
29 Q. Yes.  
30 A. And then in August, when we started accruing on the  
31 basis of the 2.5 per cent, we were told that we couldn't  
32 accrue for that.  
33  
34 Q. So as it stands at the moment, you don't expect to  
35 receive any additional funding for activity performed over  
36 target?  
37 A. That's correct. We've taken it out of our forward  
38 program, improvement program, yes.  
39  
40 Q. That takes us to activity and the significance of  
41 activity on the LHD's finances. In paragraph 127, we have  
42 covered some of this ground already, but you tell us there  
43 are limited leaders to LHDs to control unplanned activity  
44 and we discussed earlier about people need services --  
45 A. Yes.  
46  
47 Q. -- when they come through your door and they need to

1 be treated. Then you tell us, at the end of the current  
2 financial year, it is estimated that 55 per cent of the  
3 projected deficit of approximately \$70 million will be  
4 attributable to activity provided but not funded. So  
5 that's activity over and above the purchase activity in the  
6 service agreement, is that right?

7 A. Yes, that's correct.

8

9 Q. Do I take it that that portion of the deficit is  
10 something that you would consider to be one that you have  
11 limited control over?

12 A. Yes, because once they come for care, we need to  
13 provide care to them. Yes.

14

15 Q. The remainder of the deficit, you tell us in 127(a),  
16 is projected to be 2.6 due to a small site funding gap?

17 A. Yes.

18

19 Q. What is the small site funding gap that you are  
20 referring to?

21 A. Sorry, small hospitals. It is a different funding  
22 model for small hospitals and the cost of delivering  
23 services there exceeds the funding that we were given under  
24 that funding model.

25

26 Q. And 3.9 million related to structural costs above the  
27 state efficient price for Tweed Valley Hospital.

28 A. Yes.

29

30 Q. We touched on earlier about the ability of the LHD to  
31 deliver one unit of NWAU at the state efficient price, so  
32 that portion of the deficit 3.9 is the extra cost of  
33 delivering care at Tweed Valley over and above the state  
34 efficient price, is that right?

35 A. Yes. The structural costs relate predominantly to the  
36 size of the facility, the additional cleaning orderlies,  
37 heating, et cetera, yes.

38

39 Q. In 127(b), you tell us of a projected \$25.4 million  
40 efficiency gap, do you see that?

41 A. Yes.

42

43 Q. What is the efficiency gap?

44 A. So that's the difference between what we're delivering  
45 the services for and state efficient price.

46

47 Q. Across the rest of the district?

1 A. Yes, across the rest of the district. Yes.

2

3 Q. Why is it called an efficiency gap?

4 A. It is the only way we could describe it. So it's the  
5 difference between cost and state efficient price and so we  
6 have deemed that to be an efficiency gap.

7

8 Q. Could it be described as "under-funding"?

9 A. It could potentially be described as under-funding.

10

11 Q. That sentence goes on to say:

12

13 *... including continued general --*

14

15 THE COMMISSIONER: Wildly different concepts, but, anyway.  
16 Maybe not.

17

18 MR GLOVER: Q. 127(b), after we identify the efficiency  
19 gap, it then says:

20

21 *... including continued general efficiency*  
22 *improvements.*

23

24 A. Yes.

25

26 Q. What's in that concept?

27 A. So that's, I guess, the fact that you can continue to  
28 be more efficient. So you can deliver care with  
29 technology. You can implement new models that improve  
30 flow. You can introduce new pharmacological drugs that  
31 reduce lengths of stay, et cetera, et cetera, and so every  
32 organisation needs to strive to continue to be more  
33 economic and more efficient, whether you're in the public  
34 or private systems. So what we're indicating is that we  
35 recognise this continued need to be - to look for  
36 efficiencies and, therefore, it's onus is on us to do that,  
37 you know, we're funded through public funds.

38

39 THE COMMISSIONER: Q. And, not to be flippant about it,  
40 as you said, say, funded through public funds for vital  
41 services, but because we're talking such large figures,  
42 small percentage changes in efficiency actually means quite  
43 a lot of money, which is why everyone is so vigilant about  
44 being as efficient as they can be?

45 A. That's correct, Commissioner.

46

47 MR GLOVER: Q. The 25.4 million efficiency gap, though,



1 is after the delivery of 40 million in efficiencies over  
2 the next financial year; is that right?

3 A. Yes, that's correct.

4

5 Q. So from that, do we understand it that the district  
6 has identified or targeting \$40 million in savings through  
7 efficiencies?

8 A. Yes.

9

10 Q. But at the moment there is still a projected shortfall  
11 of \$25.4 million after those initiatives have been  
12 exhausted; is that right?

13 A. That's correct, yes.

14

15 Q. Does that point to the fact that although one strives  
16 to be more efficient at all times, there are limits to how  
17 much saving can be generated through those initiatives?

18 A. Yes, that's correct. And I'd just qualify that by  
19 saying, you know, with the growth and activity that we  
20 have, I talk to the staff about "step change". And so the  
21 example of a cardiac cath that I gave. So, you need a  
22 certain level of staff to treat one patient, then you can  
23 treat up to - I'll make the number up for illustrative  
24 purposes - you can treat another, let's say, a number of  
25 staff can maybe treat another 15 patients, but when they  
26 get to the 16th patient, we've got to take another staff  
27 member on. And so, that is step change, and I would  
28 suggest that some of the facilities were at the top of the  
29 step change, yep.

30

31 Q. In paragraph 128, you tell us that "key quality and  
32 safety performance indicators have not been impacted by the  
33 efficiency improvement program, although the position may  
34 change over the next two years." Do you see that?

35 A. Yes.

36

37 Q. What are the key quality and safety performance  
38 indicators you are referring to there?

39 A. Those in our service agreement.

40

41 Q. So in terms of surgery waiting times; things like  
42 that?

43 A. Yes, and transfer of care in emergency department,  
44 et cetera.

45

46 Q. But what is the reason why that may change over the  
47 next two years?

1 A. Because of that step change, because we're going to  
2 need to open some more capacity, because of the  
3 presentations will get to the point that unless we take  
4 that step change, we will end up impacting on wait times in  
5 the emergency department, transfers of care. Yeah. So it  
6 is about how much you can do within the same amount of  
7 staffing.

8

9 Q. So there is limited - as we have discussed - limited  
10 levers that can be pulled to slow the activity coming  
11 through the facilities, correct?

12 A. In the short term, yes.

13

14 Q. There's limited or no funding available for activity  
15 performed over those targets, correct?

16 A. Yes.

17

18 Q. There's flow-on effects to the delivery of other  
19 services by increased activity coming through the district,  
20 such as elective surgery waiting times and the like?

21 A. Yes.

22

23 Q. And a number of these things are subject to key  
24 performance indicators in your service agreement; is that  
25 right?

26 A. That's correct, yes.

27

28 Q. Is there a tension between the number of those key  
29 performance indicators?

30 A. Yes, there is. That's right. And I guess every day  
31 we're balancing the need to ensure that we continue to  
32 provide quality care to our community, strive to meet our  
33 key performance indicators and do that with an efficient  
34 delivery model.

35

36 Q. One of the examples you give in this paragraph is that  
37 the measures the district is having to implement will  
38 likely have an impact on overdue planned surgery waiting  
39 times?

40 A. Yes.

41

42 Q. One of your KPIs?

43 A. Yes, that's correct.

44

45 Q. You then tell us that alternative strategies are being  
46 put in place to mitigate the impacts?

47 A. Yes.

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Q. What are they?

A. So, for example, when a surgeon goes on leave and we have a resource list, we're making sure that other surgeons are using that list so we don't have unutilised capacity. We're working with our clinicians around the wait lists that they have in their private rooms. There are initiatives like Direct Access Colonoscopy, which is a better value program to enable upstream intervention. There is a triage and prioritisation for access, working with general practice around falls prevention measures, re fractures for osteoporosis, et cetera. So not only are we trying - looking at start and finish times for theatres, all that good operational management to ensure that we're maximising resource capacity and that we are putting - enabling as many patients as we can to have treatment as well as at the same time, intervening upstream to reduce the number of patients that are coming onto the wait lists.

Q. And the effects of increased activity, constrained financial environments, for want of a better term, on your district, circling back to a topic we discussed before, point strongly, don't they, to the need for greater investment in preventative care measures, and care being delivered in the community to prevent as many of these patients from needing acute care as possible?

A. Absolutely, yes.

Q. In paragraph 129 and following, you tell us about some opportunities for approaches to funding. Do you see that?

A. Yes.

Q. In paragraph 130, you tell us that:

*A funding model which promotes greater collaboration between public health, primary care and residential aged care facilities is more likely to improve patient experience and outcomes ...*

Et cetera. Do you see that?

A. Yes.

Q. What does that funding model look like, to your mind?

A. So I'll give you an example, it's easier to illustrate. The urgent care service that I mentioned that's happening - opened this year at Tweed Valley, and so

1 the Ministry of Health is funding us - it's close to  
2 \$4 million - to put in an expert team to do inreach into  
3 residential aged care. So that includes a clinical nurse  
4 consultant, some other expert nurses in partnership with  
5 advanced care paramedics, and so referral from the  
6 residential aged care provider will channel through a  
7 different - whatever routes to that team. It is a virtual  
8 urgent care service. And then that urgent care is  
9 despatched into the residential aged care provider.

10  
11 So the funding - we're effectively the fund-holder for  
12 that service, and we contract, in this case, the aged -  
13 sorry, the advanced care paramedic as partners with our  
14 team to do that. So it's complimentary - I will come back  
15 to my earlier comments; complimentary scopes, aligned  
16 vision and values, established referral pathways, inreach  
17 into a home, keeping people well at home, and that has  
18 definitely - I can't remember the number, but I can tell  
19 you after this, the number of avoided ED presentations -  
20 there certainly has been a number of avoided ED  
21 presentations as a consequence of that.

22  
23 THE COMMISSIONER: Q. Sorry to interrupt you, but the  
24 term "urgent care service", should I understand that that  
25 is a state NSW Health service, not a Commonwealth service?  
26 A. Commissioner, so both the State and Commonwealth have  
27 funded urgent care services.

28  
29 Q. Yes.

30 A. The model that I've just described is unusual inasmuch  
31 as it is virtual.

32  
33 Q. Right. Is it funded only by NSW Health?

34 A. Yes, that's correct. Yes.

35  
36 MR GLOVER: Q. Do you see a scope for that type of  
37 approach to commissioning of services and funding to be  
38 rolled out more widely?

39 A. Yes, I can use an example from New Zealand, if that's  
40 helpful. So in Canterbury, where I was working, there was  
41 a model run by Pegasus which is the primary health  
42 organisation equivalent to PHN here. They ran a service  
43 where they contacted community nursing a general practice,  
44 home care supports, allied health with the support of the  
45 ambulance service, and then they would dispatch care teams  
46 to homes for a wide variety of conditions. The local  
47 health district funded that - district health board.

1 Sorry, the district health board funded that in partnership  
2 with some funding directly from the government, as well as  
3 from partnered-in-practice team.  
4

5 So it is a pooled funding model, but Pegasus did that  
6 on behalf of a range of providers. So they were a funding  
7 model. They had an integrated technology system, a shared  
8 care record. So whichever provider was providing that  
9 care, they could input into that shared care record. And  
10 just before I finished in that role, the residential aged  
11 care providers were also contributing into that shared care  
12 record, and so that continuity of care element made a  
13 material difference to the care that those patients were  
14 receiving.  
15

16 THE COMMISSIONER: Q. Sorry to interrupt you. I am  
17 told, because of an industrial issue, we have to be fully  
18 vacated the building by 4.00, and I am told that to allow  
19 everyone enough time, particularly those assisting us to  
20 get out, we have to finish in effectively five minutes.  
21 Just in relation to that, as I said in my note, in terms of  
22 Ms Maisey - sorry, can I just ask you, I don't think  
23 Mr Glover is going to finish in five minutes. Do you need  
24 to go home tonight? And before I say that, it will make no  
25 difference to us if you do, because we can adjourn your  
26 evidence part-heard and finish it remotely if that's more  
27 convenient to you?

28 A. I am booked to fly home in the morning, yes.  
29

30 Q. Right. What time in the morning? Early? Yeah.  
31 I think what we will do then is not inconvenience  
32 Ms Maisey. We will adjourn her evidence part-heard and we  
33 will find a day and time that is convenient to finish it  
34 off. It will probably be an hour at most, or whatever. It  
35 doesn't matter. But we will do that at a time that suits  
36 you as well as us, but doesn't mean you don't get home  
37 tomorrow morning.  
38

39 MR GLOVER: Can I use the five minutes?  
40

41 THE COMMISSIONER: You can, but I've got something else to  
42 say that we need to sort out within the time that we've  
43 got.  
44

45 Dr Grotowski - I hope I have said that right. Did I?  
46 Yes. Sorry. Dr Grotowski is scheduled to start at 9.30  
47 tomorrow morning but has to be finished at 10.30. Does

1 that mean we should start earlier than 9.30? 9.15?  
2 MR GLOVER: 9.15.

3  
4 THE COMMISSIONER: All right.

5  
6 THE WITNESS: Commissioner, I'm happy to change my flight.

7  
8 THE COMMISSIONER: No, no. I think that's crazy; you need  
9 to get back to work. I am not going to have you miss a  
10 flight for 20 minutes or an hour's evidence, so we'll -  
11 you're - no, you want the rest of the four minutes?

12  
13 MR GLOVER: Yes.

14  
15 Q. Just very quickly, and we might return to this next  
16 time we see you, but in paragraph 130 and again in 131, you  
17 describe funding models that are outcomes-based?

18 A. Yes.

19

20 Q. In the three and a half minutes we have left, what do  
21 you mean by an outcome-based funding model?

22 A. So, easiest if I use the example I've just given you?

23

24 Q. Yes. Yes.

25 A. And so that funding model which the district health  
26 board funded Pegasus to coordinate that care, the service  
27 level agreement that we had with them had a range of  
28 indicators within it, input/output outcome, and so the  
29 outcome was around avoidant transfers to the emergency  
30 department. It was around the clinical care that was  
31 provided and readmissions. It was also around our patient  
32 reported outcome measures, PROMs. It included a range of  
33 financial outcomes. Our expectation was that service  
34 delivery model was avoiding future cost, and so there was  
35 some economic analysis done around if those patients had  
36 come to hospital, the likelihood of them being admitted and  
37 the likely costs. So it was avoiding - it wasn't  
38 necessarily cash savings, but it was avoiding future cost.

39

40 Q. So the funding was delivered to those services based  
41 on the outcomes that were likely to be achieved; is that  
42 how it operated?

43 A. It was - to be fair, it was a mix of an input and an  
44 outcome based funding model, yes.

45

46 MR GLOVER: We will explore this further next time.

47

1 THE COMMISSIONER: All right. Thank you very much for  
2 your time today. We are very grateful. You are not  
3 released, but you are excused for now, and we will make  
4 arrangements for a convenient time to finish your evidence  
5 remotely, so thank you. We will otherwise adjourn until  
6 9.15 tomorrow morning. So we will adjourn until then.

7  
8 <WITNESS STOOD DOWN

9  
10 AT 3.45 PM THE HEARING WAS ADJOURNED TO 9.15 AM ON  
11 THURSDAY, 19 SEPTEMBER 2024  
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