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)

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

Also present:

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

THE COMMISSIONER: Good morning.

MR GLOVER: Commissioner, this morning we have Dr Ramsey Awad, whose presentation I mentioned briefly in opening yesterday.

THE COMMISSIONER: Yes.

MR GLOVER: He is joining us by AVL and he is on the screen now.

THE COMMISSIONER: Dr Awad, good morning.

THE WITNESS: Good morning, Commissioner.

THE COMMISSIONER: You can obviously hear me. Would you like to give your evidence by way of oath or affirmation?

THE WITNESS: Affirmation, please, Commissioner.

<RAMSEY AWAD, AFFIRMED [9.32 am]

<EXAMINATION BY MR FULLER

THE COMMISSIONER: Yes.

MR GLOVER: Q. Dr Awad, in a moment you may be able to see me, but can you at least for the present time hear me okay?
A. I can. Thank you.

Q. Right. If at any stage the connection breaks up and you can't hear me or need something repeated, just let me know, all right?
A. Thank you.

Q. Can you tell us your full name, please?
A. So it's Ramsey Awad, A-W-A-D.

Q. And you are the executive director infrastructure, planning and sustainability in the Hunter New England Local Health District?
A. That is correct.

Q. What does that mean, on a day-to-day basis?
A. It means lots of things. There are several parts to my portfolio. One is clinical planning. So that unit

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

Q. Thank you. Before we get into the reason why we have brought you along today, can you just tell us a little bit about your professional background prior to landing in this role?
A. Absolutely. So my education is in - I have degrees in architecture and construction project management and PhDs in - a PhD in health and infrastructure and change management. I have worked for NSW Health at the ministry level, rolling out statewide change management performance improvement programs for NSW Health. I have worked in the construction industry delivering high risk New South Wales Government projects for the Olympics, the Circular Quay redevelopment, the Walsh Bay redevelopment, and I have spent the majority of my career working in health and either on the change operational side of things or delivering major infrastructure projects. And I've also worked for Ernst & Young as their executive director for government advisory in the particular focus of government and health.

Q. Thank you.

THE COMMISSIONER: Q. How did health and infrastructure find its way under the one PhD thesis, what was it on?
A. Well, it married - we looked at every emergency department that was built on the east coast of Australia for the last 25 years, and the question was: does new infrastructure actually make a difference in terms of the metrics we use to measure the performance of an emergency department in terms of triage times and throughput and morbidity? Because everyone thinks you get the new emergency department and everything gets better. The answer is in 70 per cent of every emergency department

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

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

Q. Just stop there. Stop there. Why do 40 per cent get worse?
A. Because what they do is they create more space and they redesign the physical space and theoretically the flows, but in parallel they don't redesign all the business processes, the clinical processes that are required. So one of the things that I've introduced in my current role is when we do a new infrastructure project, I have a whole team that focuses on the operational change management that needs to occur, working with those frontline clinical staff to say, "Hey, you got a new space but how are you going to be working in a new and a different way that improves your effectiveness and efficiency in that?" So you have to do things in parallel.

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

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

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

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

Q. Of the 40 per cent that don't improve, having had a new ED, what are you measuring in terms of improvement? I imagine one would be wait times probably, but I don't know. You tell me what you were measuring for that?
A. You're spot-on, Commissioner. It is the triage time, so all the different categories 1 through 5. We measured morbidity as well. We measured return patients that were discharged, then returned to the ED. The only metric that went up was, I guess, staff and patients satisfaction in terms of the environment, that it felt nicer, it was cleaner, it was - and everything was new. That metric went --

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

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

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

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

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

Monday, and what I'm going to do is invite you to tell us a little bit about that project by reference to some slides that you have helpfully provided us. But before we get to the slides, can you just tell us what was the catalyst for this project?
A. It was our board chair, former board chair, Lyn Fragar. She was interested in sustainability and thought that we should be doing something as a district and as an organisation. She spoke to our then chief executive Michael Di Rienzo and asked him to put some energy into it and find someone to look at it. I had just started in this particular role, sustainability wasn't part of my job description, and, you know, there was a knock at my door and said, "Can you - there is a board meeting next week. Can you put something together for sustainability?"

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

Q. I'll have the slides brought up on the screen, Dr Awad. Can you see those slides? You are no doubt familiar with them?
A. I am familiar but I can't see them, I'm sorry. Yes, I can now.

Q. You can see them now?
A. Yes.

Q. All right. If we pass over the title page.
A. Please.

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

Q. You see that?
A. I can.

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

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

THE COMMISSIONER: Q. Can I just pause you there.
A. Of course.

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

Q. I think it can be taken as well-known that Australia and New South Wales is subject to climate change and extreme climate events, such as floods and also drought, and a lack of water security from time to time, and certainly projected for the future. Is there a figure, though, of that 25 per cent? Is there a figure for Australia that you're aware of?
A. No, I'm not aware of a figure particularly for Australia, Commissioner.

Q. And the 7 per cent of healthcare emissions, that is sourced from where?
A. I can provide that source for you.

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

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

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

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

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

THE COMMISSIONER: Q. I think you told us that "waste neutral" relates to landfill, correct?
A. That is correct, Commissioner. Would you like me to elaborate on any of these, or?

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

Q. What sort of hurdles, firstly, do you envisage in reaching that aim?
A. Just broadly, the biggest hurdle will be with regards to green energy. By far the biggest contributor to carbon emissions is the generation of electricity. That's probably 80 to 90 per cent of it. We at the moment are supplementing that through solar, but I will give you a good example. The John Hunter Hospital, which is the busiest trauma centre in New South Wales, the second busiest in the country, it is a large hospital, does have the largest solar panel installation in the world sitting on top of its roof. It is about a kilometre long. All of those solar panels only produce about 10 to 15 per cent of the energy that actually John Hunter uses each year.

So although it is enormous and impressive, it is

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

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

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

Q. Do you know roughly how much more it would cost than current costs if you did that?
A. About $2 million per annum.

Q. Just for John Hunter?
A. Just for John Hunter, correct.

MR GLOVER: Q. You mentioned requiring government support. In addition to support to shift to green energy more generally, is there anything else by way of support you see as being needed to achieve the carbon neutral by the 2030 goal?
A. Look, I think at a State level, greater coordination is required. And the reason I say that is at the moment, I think - well, I know that the secretary and the ministry are very much on board with sustainability as an important item of what we need to - important agenda item that we need to focus on. What we can improve on, though, is coordination. I - at the moment, I think within the

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

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

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

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

Q. Oh, okay.
A. It's something to do.

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

A. Yes.

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

Q. What you are describing is greater coordination of effort and then with the ability to scale up those successful initiatives quickly across the board; is that the idea?
A. Correct, and to prioritise the initiatives which are going to help us achieve our goals, and the goal has to include saving dollars for Health.

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

Q. You tell us a little about the goal to be waste neutral by 2030? The Commissioner clarified with you earlier that's about landfill, but tell us a little bit more about that initiative and how it is going to be achieved.
A. Absolutely. So when we started in 2020, 92 per cent of our waste was going to landfill for Hunter New England Health. We want it to be zero by 2030. That is by far the hardest thing for us to achieve, for a number of reasons. One is we have to deal with clinical waste, which has to be dealt with in a particular sort of way in terms of its disposal and requires some legislative changes and some work with the EPA to maybe dispose of that clinical waste in a different and new way. But if we just focus on general waste, it is dependent on a number of factors. One is, particularly as you move further away from major centres like Sydney and Newcastle, you are reliant on the

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

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

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

Reduce our environmental impact while continuing to focus on Excellence ...

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

Q. No, you go. You go?
A. Okay.

THE COMMISSIONER: Q. Mr Glover can't give the answer as well as ask the question, so you give the answer and we'll go from there.
A. This is - I deliberately put this in when we first set up the program because, having worked in Health, there is always arguments about where you spend your money, and even more so now with the tight fiscal environment that we find ourselves in. This is there to ensure that everyone remembers that delivering clinical care is our core business, and --

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

providing good clinical care, right?
A. Perfect.

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

MR GLOVER: Q. Can we go to the next slide, please. Could you just take us through?
A. Absolutely. These are the results of our third year of performance, and we established four high-level KPIs: CO2 emissions, rainwater captured and reused, water recycled re-used and waste going to landfill. They are the four elements we have been focusing on. Along the top line, you will see our 2020 baseline for each of those elements; and then, on the bottom line, you'll see our target for the third year, for 2023; and then in the circles above, you'll see what we have actually achieved in 2023. So if I just run through each one of those quickly:

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

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

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

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

Q. Thank you. Go to the next slide, please. These are recurrent savings achieved in the 2023 period?
A. That's correct, after year three. And just to put this in context, the most amount of money we've spent has been in the installation of solar panels across the district. So the John Hunter solar panel installation, which I mentioned earlier, cost us about $3.5 million to $4 million. The balance of all the solar installations we are putting on solar on every single one of our buildings across the district, that's about the same money again. So we've borrowed from Treasury, via a very low interest loan, about $8 million. We are paying that loan off, and we are paying that off over the next four to six years, we'll have it all paid off. So this recurrent savings reflects us paying off money in parallel. So once we've paid back that principal, that loan that we've --

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

Q. Yep, great. Okay.
A. So I'll just - John Hunter is a really good example. So we borrowed the $3.5 million-odd for that. We are paying back the loan. We are paying that off over six years and we're paying off - I'm just trying to do the maths in my head now. My mathematical skills are failing me.

Q. You can get back to us in relation to any sums rather than doing them in your head on the run.
A. Thanks, Commissioner. We're paying back about $500,000 to $600,000 a year in that loan, but we are saving about $1 million a year in our energy bill at John Hunter Hospital, so that $400,000 that we --

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

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

Q. Can we go to the next slide, please. There, six components of the initiative described. We have heard about energy, water and waste. Can you just tell us briefly about "Transport", "Procurement" and "Infrastructure", please?
A. Absolutely. So transport, our strategies there are fairly straightforward. One is to move our current combustible fleet vehicles to electric or electric hybrid. The reason we've gone - and we've started with hybrid vehicles. The big drawback to going fully electric has really been out in regional New South Wales, that to have the infrastructure to charge the vehicles hasn't existed to date, but Treasury have recently provided a substantial amount of money to our district to rollout charging stations, particularly in our regional areas, so we're in the process of doing that right now. So it allows more electric vehicles as we progress.

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

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

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

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

Q. Thank you. And what are the "Procurement" initiatives as part of this plan?
A. Well, procurement initiatives, there is an international and Australian standard for green procurement. It has in place the things you expect for procurement in terms of cost and also the quality of what you're buying in terms of assessment criteria, but it introduces a third criteria, which is what is as green or, you know, how sustainable is the product? This is harder for us to play in, mainly because we are a local health district. The majority of the procurement is managed centrally at HealthShare level and NSW Health level. We are doing what we can in that particular space and we do buy some things. It is a harder space for us to influence and play in, and again, is a big - an area I know the ministry is starting to try to focus and talk about, but that's the goal there.

Q. And what about "Infrastructure"?
A. Infrastructure is straightforward in terms of everything we build, we are insisting that Health Infrastructure, who are the NSW Health government delivery group for major infrastructure projects over $10 million, is that we achieve a 5-star rating for our projects. This, you know, I think initially was difficult because with tightening budgets the simple thing to pull out of projects is sometimes the sustainability initiatives like solar and water tanks and so forth, but I believe Health Infrastructure in the last period of time are on board with this and are segmenting part of the budget now to ensure we achieve that particular target.

Q. I take it you would be of the view that pulling out of solar and water-capturing and recycling programs is actually a false economy because of the savings delivered long term?
A. Absolutely. And if we talk about coordination at that state level, they're really - often what happens is parts of government agencies, their focus is on, you know, "Let's deliver this project on time and on budget, and that's our KPI," but the KPI of the operators is to reduce recurrent costs. Sometimes those KPIs are not aligned, and that's why I believe you require greater coordination and synergy

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

Q. And perhaps greater coordination at a project design level between operators and those designing the projects?
A. Yes, absolutely.

Q. Do you see it as being the future of infrastructure projects as embedding some of these concepts in project design from the very early stages?
A. Yes, and I - look, it is a whole-of-life cycle - and I will put my construction hat back on. This is a whole-of-life cycle responsibility and work that needs to occur, but we can build buildings cheaply and effectively and efficiently, but the maintenance costs of looking after that building outweigh the money we're saving upfront. And that includes solar, but it also includes the type of air-conditioning systems you put in, the type of lighting systems you put in. There are some systems we put in which we know are going to not fail, but not operate as effectively and efficiently, and is going to cost us as operators a lot more to run and maintain in the future. But a whole-of-life cycle analysis needs to be upfront, and that can only happen when you bring in, like, a group like Health Infrastructure into those discussions together with the operators and ensure that we are aligned in terms of a whole cost analysis rather than in individual silos of delivery versus operations.

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

Q. You have told us about the solar panel installations and the LED and light sensors. You mentioned briefly looking at ground-mounted solar. If you could just tell us a little bit about what the next move in that space is?
A. Yeah, look, we have a number of our regional hospitals which have lots of extra land which we're not utilising. Some of those smaller hospitals have small roof spaces. So my next thought is, well, what can we put on the ground? And then once we put solar on the ground, unlike John Hunter - John Hunter - we don't have any batteries at John Hunter, because all the power we produce gets used straight away. At our smaller facilities, as soon as we - we don't need that much power, so establishing ground-mounted solar

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

THE COMMISSIONER: All right. So in some of the smaller sites it is appropriate to have storage by means of batteries, but John Hunter it doesn't make any sense at the moment because the solar is only a small percentage of the power it needs?
A. That's correct, exactly right.

Q. How long has all the solar panels been there on - at John Hunter? When were they installed?
A. It's been two years now, Commissioner. I should have brought it up, but there's actually - we've got a - and maybe during the proceedings here I'll find it, but we there's a - we have a live report which shows us how many trees we've saved since we've had the solar panels, and it shows you how much you are saving on a daily basis. And, you know, it goes up and down whether it's cloudy or not. But we have some very detailed reporting.

THE COMMISSIONER: "Two years" is good enough.

MR GLOVER: Q. If we go to the next slide, please. Can you just tell us very briefly how we are to understand the data that is displayed here?
A. Absolutely. So this is a dashboard. We built a very simple reporting tool within the district here. It's nothing custom-made or didn't cost us very much. A young IT boffin in my team built this for us over a week. But essentially it shows two things: solar and LED. And to the right is a map of our LHD. It shows where we currently have solar and where we don't have solar. It shows where we currently have LEDs and we don't have LEDs. It also shows our progress. So from the top area there, 35 out of our 56 sites have solar in place now. And you can see --

THE COMMISSIONER: Q. The 2.2 million-odd in estimated savings, is that a yearly figure?
A. Yes, it is. And equally with the LED, it just shows progress. Again, it is a tool for me to very simply see where we're up to and where we need to invest. But,

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

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

Q. The bottom line we take from it is - tell me if I've understood what you have said correctly - that by shifting to LED lighting, one is already seeing savings across the district of about $1 million, and those savings will see the upfront cost being covered in a little over a year?
A. Exactly right, and a reduction in energy consumption by 80 per cent.

Q. Next slide, please. We've touched on water savings, but can you just take us through in high-level terms each of these four principles?
A. Yes, of course. So rainwater tanks, we're all familiar with that on all our facilities, capturing any rain and re-using that water in a variety of different ways. The other is where we have renal dialysis services, there's RO water from the reverse osmosis. RO water is clean, filtered water that runs the dialysis machines. Traditionally, that goes down the drain.

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

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

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

"Transport". I expect we have covered this already, but is there anything else you wish to add to your earlier answers on the transport initiatives?
A. No. I think I covered them thoroughly.

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

THE COMMISSIONER: Or innovation.

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

THE COMMISSIONER: Q. You have done the low-hanging fruit, but the really difficult stuff is the general waste, and specifically one of the things you gave us an example of was gloves?
A. Yes. If we - I've got a slide on the gloves if that helps, Commissioner, further on.

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

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

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

Q. That's a bit scary, that aspect.
A. So that's one of the things we're working on.

Q. I don't know whether to be excited by that, Dr Awad, or scared?
A. Probably a bit scared? Yeah, probably a bit of both.

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

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

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

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

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

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

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

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

MR GLOVER: Q. Before we leave the sustainability strategy, is there anything that the wider health system could do by way of support to aid in the development and then rollout of initiatives like these, in your view?
A. It really comes back to some of those comments I made earlier on around knowledge management and clearing some of the - I think the ministry have done the right thing in the current fiscal environment. We have a lot of, you know, tightening in around procurement, how we purchase things, and so forth. They've had to do that; all government agencies have had to do that.

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

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

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

THE COMMISSIONER: Q. Just pausing there. Your sustainability program, you've told us, results in net savings, correct?
A. Correct.

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

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

Q. Is there, to your knowledge, another - do other LHDs have similar-scaled sustainability programs to your LHD?
A. No.

Q. Is there any reason that you know of as to why, at a practical level, or even a policy level as well, they couldn't?
A. No.

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

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

THE COMMISSIONER: Sure.

MR GLOVER: Q. Can we come now to the rural clinician accommodation strategy, and we will switch to the other set of slides. Are they on your screen, Dr Awad?
A. They're coming, I think. Yeah, here we go. I do have them, thank you.

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

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

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

Q. Can you just tell us in general terms what the strategy is?
A. Absolutely. So, rightly, you've said that - the impediment of attracting clinicians to some of our regional areas. But more acutely to some of our very small towns, and, you know, my wife is a surgeon, my brother is a surgeon, I've grown up in a health environment, I understand the mentality and the approach. And it is very challenging to get clinicians to move permanently. That does happen, absolutely, and people are committed to that, but, traditionally, clinicians gravitate towards the larger centres like Sydney or Newcastle or Port Macquarie, some of those bigger centres, because it affords them a

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

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

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

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

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

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

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

Q. And that's what you were referring to by "prefab pods"?
A. Correct, yes. Something that could be craned into position within a day. They were architecturally designed, so actually lovely to be in, so when you came home from your shift, it was incredibly comfortable and had all the modern elements that you'd expect if you were staying somewhere, anywhere, as a senior clinician, and that you are able to pick it up and move it, if required, in the future to somewhere else that might need it or if it was in the way of a future development, we could move it very easily.

THE COMMISSIONER: Q. When was this strategy developed?
A. It was developed in 2021. Yes, 2021. And we worked with regional New South Wales.

Q. Who provided the funding?
A. Yes.

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

Q. It wasn't a loan; it was actual funding, was it?
A. It was actual funding through - they worked with Treasury to provide the money to our district to implement the project.

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

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

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

Q. You managed the construction of Health Infrastructure?
A. Correct.

MR GLOVER: Q. Was there any funding or other support from the ministry to develop and then implement the strategy?
A. For that particular project, no, not directly, but there is a - I know now that the concept has taken off across NSW Health and also New South Wales Government, and I know that the ministry did secure other funding to support other LHDs in their work, and --

Q. I'll come back to what's happened since, but was support, whether by funding or in kind support from the ministry, asked for during the development and then implementation of the strategy in this district?
A. Look, how you ask for money for infrastructure projects within the current systems and processes, to ask for money for something like this is - there's no mechanism to - there was no mechanism. Things may have changed, but at the time there was no mechanism to do that. At the moment - the process at the time was to submit a capital investment proposal. It is what all the districts have to do. Essentially, they write up their priorities of what we want money for, we put in and ask for money. That is a process that's done on an annual basis. And --

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

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

THE COMMISSIONER: Q. And tell me the time, the time taken from giving the department of regional New South Wales the business case to the time of the approval of your funding, what was that?
A. Probably six months.

Q. Yes, okay.

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

Q. That is to build the pod and have it delivered to the site?
A. That is correct. And then $200,000 to $300,000 depending where it was to do the site works, and that's the money we gave to the local rural trades.

Q. And that's for the whole site, isn't it? That's not per pod?
A. No, that's for the entire site, yes.

Q. And then you've mentioned earlier, and it is said again here, that the unit can be relocated. Why was that an important part of the strategy?
A. To ensure that it could be moved if we needed to do any other work on that particular campus. Simply, it is just picked up by a crane and moved. And theoretically, if they're not getting utilised - but they are getting heavily utilised - to move it somewhere else that might require it. And also just transport. You know, I think there is an image in one of the slides there, it just sits on the back of a truck and arrives and it's there.

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

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

evaluation of the model. Before you get into the detail of that, the high satisfaction with the standard of accommodation, has that led to or improved the ability of the district to attract clinicians to those sites?
A. Absolutely. So there are some earlier slides which talk about staff attraction, but I have them here, I can happily talk - we did an evaluation after the first six months and we accommodated 350 staff in that first six months. We've seen our agency staff there staying longer now. I gave an example of at Scone, one of the units is full-time for a junior medical officer. We were unable to get junior medical officers to Scone; now we have one all the time. We have seen a reduction in our utilisation of the virtual doctor because we have GPs/VMOs now staying in those units. Our response times have improved. We've seen an increase in obstetrics and midwife clinicians staying in those pods, again providing the service.

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

MR GLOVER: Slide 11?

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

Q. But you've got a - are there costs involved in maintaining the pods, like cleaning?
A. There are cleaning costs in there, but they're fairly minor, Commissioner. We already have HealthShare on site cleaning the hospital. So to clean them and the linen and so forth, it's part of their day-to-day.

Q. I see. I see.
A. We haven't --

Q. Gets you to other - yes, okay. Sorry, yes.
A. No, I apologise. We haven't included - see, there are other cost savings, so there are cost savings in terms of travel and taxi cabs and there's other things there that we haven't incorporated in that.

Q. Oh, okay.
A. But we just wanted to give - and there is an opportunity to do a more comprehensive cost financial

evaluation.

Q. You're doing - I am not suggesting it is wildly inaccurate, but that is sort of a back-of-the-envelope type saving, rather - yes, okay.
A. And very conservative I would say, Commissioner.

THE COMMISSIONER: All right.

MR GLOVER: Q. In an earlier answer, you mentioned that this type of approach has been picked up in other areas of the State, correct?
A. Yes. I understand that all the other regional LHDs have a similar program. I know the ministry is managing a broader program with Health Infrastructure to deliver - I don't know if they're exactly these pods, but relocatable pods. I'm not sure how that is progressing. I don't have any intimate knowledge of that.

Q. Do you have any understanding of the costs to deliver the relocatable pods through that Health Infrastructure initiative?
A. Look, not first-hand, but I have heard from some of my peers who have similar roles to me across the district that the cost of them is significantly - I've had a few phone calls saying, "How did you get yours so cheaply? We're sort of getting quoted maybe $600,000 for an equivalent pod."

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

Q. Yes. And I think you mentioned at the round table we had, and you mention it again the $600,000, but when you say "getting quoted maybe 600,000", quoted by whom?
A. Whoever is - well, my understanding is Health Infrastructure is managing the rollout beyond our district of that program, and that's the prices that they've been quoted. But, again, this is secondhand to the (indistinct) office, Commissioner.

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

construction - well, hang on, the design may have been - are these exactly the same kind of pods we're talking about?
A. I don't - I don't believe so.

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

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

Q. I will ask a different question to which I already know the answer, but the design and rollout of these pods within your LHD was well within, in your opinion, the competence of you and your colleagues to successfully do it?
A. Yes. And, look, Health Infrastructure play an important role in terms of assisting and delivering large-scale projects, but although this added up to 20 million, it's not a large-scale project. It's very - you know, $250,000 or $300,000 for a unit times 44 is not complicated. They're very small, low-risk elements that a district - and, again, I am not aware of whether all districts have people like me and my team, but from our perspective, it is very bread and butter stuff for us.

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

MR GLOVER: All right. Do you have any questions, Mr Cheney?

MR CHENEY: No, Commissioner. It may be that I have to get some instructions from Health Infrastructure and others about the wider rollout.

THE COMMISSIONER: Sure. Fair enough.

MR CHENEY: Thank you, Commissioner.

THE COMMISSIONER: Dr Awad, thank you very much for your time. We're very grateful, and you are excused.

THE WITNESS: A pleasure, Commissioner, and thank you also for allowing me to attend virtually. That has assisted me greatly from a personal perspective and I appreciate it. It is convenient.

THE COMMISSIONER: No drama.

THE WITNESS: Thank you so much.

THE COMMISSIONER: I think we will start Ms Wong, but we will have a morning break, I don't know, about 11.15 or something like that.

<THE WITNESS WAS RELEASED

THE COMMISSIONER: Ms Wong, come forward. The witness box is up here. Would you prefer to give an oath or an affirmation?

THE WITNESS: Affirmation.

<JILL ASHLEY WONG, AFFIRMED [10.54 am]

<EXAMINATION BY MR FULLER

MR FULLER: Q. Ms Wong, would you state your full name, please?
A. Jill Ashley Wong.

Q. Your professional address is a PO box number in Port Macquarie New South Wales; that's right?
A. Yes, thank you.

Q. Do you mind just speaking up a little bit or perhaps sitting closer to the microphone. Thank you. You are the district director integrated care allied health and community services for the Mid North Coast Local Health District?
A. Yes, I am.

Q. And you have made a statement to assist the inquiry?
A. Yes.

Q. Do you have a copy of that there in front of you?
A. Yes, I do.

Q. I understand there are a couple of corrections that you wanted to make at paragraph 35, is that right?
A. That's correct.

Q. And just tell me if I got this right. In the second line of paragraph 35, there is a figure of 44 per cent, and that should instead say approximately 16 per cent?
A. Yes, that's right.

Q. And then in the next line, the figure of 11.62 per cent should be approximately 9 per cent.
A. That's correct.

Q. With those changes, is the statement true and correct to the best of your knowledge and belief?
A. Yes, it is to the best of my knowledge.

Q. Thank you. Can I start with the integrated care part of your role. Can I ask you just to explain as straightforwardly as you can what is meant by "integrated care" from your perspective.
A. Sure. Integrated care from my perspective is the provision of seamless and efficient care that reflects the whole person's health needs across their whole journey. So the consideration of all aspects of the delivery of care from health promotion to health prevention to early intervention, all the way through their lifespan and health needs to end-of-life care. And this is across all planes of their being, whether that be physical, psychosocial, mental health, and across all streams that provide that care. So that's in partnership with not only the individual patient or person, but their carers, their families, and healthcare providers that might not sit

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

Q. To try to put it simply, is it about the way in which care is, healthcare is provided in all aspects relating to an individual's health; is that right?
A. Yes. Considering a person holistically across all of those aspects.

THE COMMISSIONER: Q. And that involves collaboration between or may involve collaboration between clinicians with different skill sets?
A. Yes.

MR FULLER: Q. How does integrated care, as you have described it, relate to community services, that part of your role?
A. So integrated care, I guess, being the consideration of how we deliver care in that seamless or holistic way, facilitating collaboration across clinicians, is the premise of how community services are provided. So considering the whole person and the ability to pull in a range of clinical members into a multidisciplinary team to deliver care that the patient requires.

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

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

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

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

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

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

> *Due to the variety of these services ...*

That is, aged care and NDIS services:

> *... misalignment between supply and demand, and the nature of services provided by NSW Health, there is often either gap in available and funded service provision or duplication of service provision between these providers and NSW Health.*

Firstly, can you give an example of a gap that you perceive to exist as a result of one of those causes that you have identified?
A. Yes, I can. So one example of a gap between the services that are under Commonwealth funding and State funding is a participant on the NDIS who may have a primary diagnosis of a mental health condition. They may also have a presenting chronic disease aspect to their whole-of-person health, but their primary focus is mental health and that is the eligibility that they've become a participant under the NDIS. That means that that particular participant is able to access mental health services under the scheme, but they are not eligible to access the range of chronic disease services that they may require, whether that be physiotherapy, early intervention for dietetics and nutrition, social work or other under the scheme. So they will then rely on our Mid North Coast Local Health District to provide that support from a chronic disease management perspective. And the reason that this is significant is that we are aware of statistics

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

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

Q. But not eligible to access physiotherapy was one example that you gave. Why would that be, in your example?
A. Because the disability that they have been identified to have is relating to their mental health condition. So the other health factors that may or may not contribute to their mental wellbeing, or their mental health condition, are not necessarily included in their particular package and that would then require that individual to access those services either through their primary care provider or GP for a GP allied health plan or a chronic disease management plan, or through our public services, being Mid North Coast Local Health District.

Q. Then in paragraph 8, you talk - there is the second thing you mention in that sentence in paragraph 8, is the duplication of service provision. Can you give an example of the way you see that happening?
A. Yes. So a duplication, I guess, might be around services that exist. So there are a range of, I guess, allied - private practice allied health services, and I am focusing on allied health as that is something that I am responsible for in Mid North Coast. Private practices that exist in the local market, and that is also an area of care or service provision that we have within Mid North Coast Local Health District. So you may be able to access physiotherapy in private and in public and, therefore, there is a gap, but there may not be availability in, for example, psychology services in the community or in our service in Mid North Coast Local Health District.

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

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

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

Q. Is that a planning issue, primarily, planning and coordination issue with those who do provide the duplicated services?
A. In part, yes, I do believe that there are opportunities to better plan or consider what is within the local market. I think for Mid North Coast Local Health District, one of the difficulties is that we don't necessarily have reach or governance of what is not funded within the Mid North Coast Local Health District via State Treasury. So in Mid North Coast, we have partnered with Northern NSW Local Health District and the primary health network in our geographically region, Healthy North Coast, and agreed on a memorandum of understanding which brings us together as three entities to look at opportunities to better streamline, but also to map the services that are available in our geographical landscape, which, I guess, goes to the point that you've just made.

Q. When you said in that answer that you don't necessarily have reach or governance of what is not funded within the Mid North Coast Local Health District by State Treasury, can you just explain what you mean by that, please?
A. Yes. So within Mid North Coast Local Health District, we cannot control what private practices are established or what private practitioners choose to focus on. So if there are private clinicians or practitioners who would like to establish a private practice focusing on a disability navigation service or physiotherapy or a particular cohort of our patient community, that is outside of the remit or governance of Mid North Coast Local Health District.

Q. And in paragraph 9 of your statement, you talk about the impact for NSW Health. Can I just ask you, firstly, to elaborate verbally for us here today on what you say the impact for NSW Health is of the issues that you have identified with the interaction with aged care and NDIS?
A. So if I focus on aged care first. At any one time in

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

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

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

Q. I'll just pause there and explore a couple aspects of that answer. Firstly, you said that there were two reasons why an aged care patient in a hospital might not be able to move into an aged care bed. One is choice and preference, and the other being lack of access. Do you have a sense, from your position, of how much of the problem is associated with choice and preference versus lack of access?
A. I wouldn't have a number or a data point in my mind. I guess anecdotally, I do think that they are quite intertwined because choice and preference also is impacted by availability.

Q. And then just so we understand --

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

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

Q. That's what you mean? Yeah.
A. Thank you.

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

Q. So it is integrated in that way, intertwined in that way as well; is that right?
A. Yes, that's right.

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

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

Q. There is no funding from the Commonwealth for the provision of those services in the public hospital, is that your understanding?
A. That is my understanding.

Q. And then you've said in paragraph 9 that the residential aged care home continues receiving funds for the residential bed, but those are funds from the Commonwealth; is that right?
A. That is my understanding. So funds from the Commonwealth, and any personal contribution that is required, depending on the fee structure of the individual aged care home.

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

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

MR FULLER: Right.

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

MR CHENEY: Yes.

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

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

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

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

MR CHENEY: Right.

MR FULLER: Q. And what about for NDIS patients? Could something similar be done for NDIS participants occupying beds in your district's facilities?
A. Yes, we do have the data on patients and where they're at in their medical clearance versus their length of stay, so that data could be reconciled as well.

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

MR FULLER: I was listening.

Q. Just sticking with aged care for a moment, can you have a look at paragraph 11 of your statement, please. In the fourth line, you refer to increased liquidity of the ageing population. Can I just ask you to explain what you mean by that?
A. Sure. For me, that's the, I guess, the anecdotal experience that we were having with our ageing population, where they have more funds available perhaps, or are in a more financially stable position, and I guess this goes to my earlier comment about choice. So there are a range of our aged population who are over the age of 65, who have higher expectations of care based on their ability to pay for care and perhaps have a preference to be in certain aged care homes as opposed to others.

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

community health earlier. In paragraph 16, you say:

> *For disability related services, the transfer of the funding has not necessarily resulted in the movement of associated clinical care ...*

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

Q. When you say "transfer of funding", is it your understanding that there is, effectively, a bucket of funding that was provided by the Commonwealth to the states prior to the NDIA for disability care, but, instead, that money is now not coming to the states; it's instead going directly to NDIS providers, for example?
A. Yes. My understanding is that funding that may have been provided for disability service provision across the states and territories by the Commonwealth was then aligned to the NDIS and pulled back into a national scheme to support our whole community.

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

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

Q. Can you just elaborate on what you mean by "thin provider markets", or what those look like?
A. So there are variations in what is available in the private provider market. So in the Mid North Coast Local Health District, there is great difficulty in accessing private occupational therapists who are quite vital in supporting participants, in particular, relating to their assessments for their NDIS plans and their re-assessments for the plans.

Q. In paragraph 17, you talk about NSW Health becoming the default service provider. Is that because of the thin provider markets in the community?
A. Yes, I think that is part of the reason that New South Wales or particularly Mid North Coast Local Health District becomes the default. I think it is also because of the trust that the community have in the Mid North Coast Local Health District services. So there has been a knowledge or a comfort that the emergency departments are where they are, that the community health centres are where they are. So I think there's knowledge that there is the ability to access a health service that will provide an assessment and a, you know, support to the presenting health condition through the local health district-funded services.

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

Q. You told us that NSW Health becoming a default or being a default service provider creates tensions between health staff providers and the NDIA. Can you just elaborate on what you mean by "tensions"?
A. I guess tension around the need to then have somebody who may not require a medical - you know, medical admission because of an acute medical presentation into an acute hospital bed. So the tension between the ability to have that bed available for somebody who is medically needing that placement within our hospital system, or that placement within our community health services, and the provision of that care to the person who is in front of us or needing that for another reason. With our NDIS

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

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

Q. And just finally on this topic, you've referred to that tension issues often having negative impacts for the NDIS participant. Can you just elaborate on what you see as being the negative impacts?
A. Yes. So for a participant who doesn't require a medical admission into a hospital to be in a hospital setting, that setting is not necessarily appropriate for somebody who should be able to freely move around, who should be able to have all choice in food or comforts of living in a supported independent living environment or in their own home, and the risks, of course, that come with an acute facility, whether that be the risk of, you know, hospital-acquired infection or deconditioning and, I guess, the discomfort of not being in your own surroundings.

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

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

SHORT ADJOURNMENT

THE COMMISSIONER: Yes, Mr Fuller.

MR FULLER: Q. Thank you, Commissioner.

Q. Ms Wong, can I ask you now about paragraphs 12 to 14 of your statement. In paragraph 12, and then you continue this in paragraph 14, you talk about opportunities to invest in a more whole-of-community and community-based approach to the delivery of healthcare. Can you just explain what the opportunities are that you identify?
A. So what I was talking about in this section of my

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

THE COMMISSIONER: Q. Just pausing there, you said "redirect funding." Accepting you don't do the budget for the LHD, redirect from where?
A. I guess redirect, perhaps, from where we may see some opportunities to reduce lower value care. This may be from other areas of our health budget, be that the acute setting or other community health services that might be better reshaped into a preventative health model.

Q. If you could redirect funding from funding that wasn't necessary or wasn't useful or was low value, you'd do that, otherwise rather than a redirection, there would be a need for additional funding for the kinds of early interventions you are talking about, correct?
A. Redirection versus investment, sorry, Commissioner?

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

Q. And what early intervention models of care are we talking about? What kind of patients, what kind of conditions are you talking about?
A. I guess there is a range of conditions. One example of a cohort of patients that might benefit from this would be, for example, our osteoarthritis cohort of patients who have been identified for a total knee replacement or knee

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

Q. Are you talking about things like weight management lifestyle changes, that sort of thing?
A. Yes. So weight management lifestyle changes with the support of dietetics and nutrition, with the support of physiotherapy and occupational therapy. Social work, perhaps, depending on lifestyle underlying factors. We know that behavioural changes take time, so an intensive prehabilitation model or an out-of-hospital model to support individuals, one, to become aware of some of these factors - they may not know that that has an impact on their knee issues, or that it could resolve some of the pain or the impact that they have in regards to their presenting issue - but it also then allows for us to reserve costly and time-limited time in the operating theatre for those who do need the surgical intervention.

Q. So any investment in those sorts of early intervention models is one aimed at better health outcomes, is one thing you are looking for, correct?
A. That's correct.

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

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

Q. And in better health?
A. Yes.

MR FULLER: Q. You said in one of your earlier answers that these sorts of interventions have been shown to better support patients for the provision of holistic care. When you said "shown", are you aware of any evidence or research that has been done in relation to that?
A. Yes. So there has been a range of different pieces of research that have been undertaken, some by, for example,

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

Q. In paragraph 14 of your statement, you mention in the second sentence a range of service models and you give a couple of examples. The examples that you have given here, are those actual programs that you are aware of being in place, or are they ideas?
A. Yes. So they are examples of programs that are in place in other LHDs. A lot of this innovation has come out of, you know, a COVID era where we are in a fiscally constrained environment, but they have been able to show and measure success for those patients in regards to avoiding presentations to ED or better supporting that person in the home.

Q. So, taking the first example, programs providing rapid responses from community-based allied health and nursing services, what particular program did you have in mind when you were giving that example?
A. I had the - and I will get the name wrong, so if you bear with me a moment, I've spoken to it later in my statement, the quick access and response team, the QuART model, and there is also the RAID-ED model that is an example, which is the rapid access intervention and discharge model, which is a multi-disciplinary team at the front of house in the emergency department to avoid the admission.

Q. This is paragraph 54 of your statement, is it?
A. I'll just check. Yes, that's correct.

Q. So just with the RAID-ED model, can you just tell us your understanding of how that model works?
A. Yes. Noting that this is not a model that is in Mid North Coast, my understanding of the RAID-ED model is that there is a multidisciplinary allied health team placed and based in the emergency department to work alongside the nursing and medical staff in the emergency department, and

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

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

Q. Is there any reason why that model, to your knowledge, hasn't been implemented in your district or in other districts more broadly?
A. I guess my understanding of this is that we, in each LHD, need to make decisions about the limited resources that we have and where we're best able to utilise them. So within Mid North Coast Local Health District we have different types of services in place. We have a range of allied health-led services within our enhanced community care service, which is focusing on a similar but slightly different cohort preventing presentations to our emergency department by providing that intensive early intervention in the community. This is not a mandated service model. It's not funded as, you know, across the State. So there's no, I guess, expectation as a whole system that we have this. However, in Mid North Coast, it might just be around where we have chosen to place our staff and limited resources that we have.

Q. The other model, just sticking with paragraph 54, that you talk about, is the allied health quick access response team, which you say was developed in Illawarra Shoalhaven LHD. Can you just tell us your understanding of that model?
A. Yes. And I am less familiar with this particular model's nuances, but my understanding is this is an intensive up to two-week multidisciplinary allied health team that can provide care in the patient's home to support that early discharge from hospital or the admission avoidance, so after we are aware of a patient then wrapping around a multidisciplinary team to support that person in the home.

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

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

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

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

THE COMMISSIONER: Thank you.

MR FULLER: Q. The increased investment or redirection of funds to community-based care and preventative care that we've been talking about, do you view that as being able to address in any way the issues that we were talking about before the break with aged care and NDIS service availability in your district?
A. In part, yes. If I might talk a little bit about one of the preventative services that we have in place in the Mid North Coast, it is Mid North Coast Virtual Care. This has been a service that is aimed at preventing presentations to our emergency department and admissions into our hospital and supporting early discharge from our hospital. That is a virtual care service where clinical care is provided through telehealth or audiovisual means.

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

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

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

Q. You tell us about Mid North Coast Virtual Care in paragraphs 29 to 31 of your statement. Can I just ask you, taking a step back, to describe practically what is Mid North Coast Virtual Care; how does it work?
A. Certainly. So Mid North Coast Virtual Care is a virtual service made up of a multidisciplinary clinical team. We currently have about 20 full-time equivalent staff in that with administration, nursing and medical, and then a connection to hired health professions as needed. So that team focuses on receiving calls accessible through our landline number from our community who would otherwise be presenting to our emergency departments.

Q. Just pausing there for a moment. When you say they would "otherwise be presenting to the emergency department", how do you know that? What makes you think that?
A. So over the last financial year, we had about 12,900 referrals come through, and at the beginning of their phone call, they're asked a range of questions around, "Why have you contacted us?" and, "If we weren't able to provide you with a service, what would you do?" So a proportion, a small proportion would say, "Well, I would do nothing," but a large proportion would say that they would otherwise have presented to the emergency department.

Q. So this is the data that you give us in paragraph 31, is that right?
A. Yes.

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

number from people who would otherwise be presenting. And then what happens at that point?
A. So our Mid North Coast Virtual Care team undertake a triage for that person contacting and will decide whether we can provide care to them within our clinical framework. If we deem that they are or should have contacted triple-zero or are an emergency presentation, we will direct them and/or do a warm transition for them, depending on the needs of that particular patient, through to the relevant place. Similarly, if they are seeking care navigation or could access a non-urgent clinical intervention or could be better serviced with a generalist community nursing or allied health community service, we will care, navigate and support that person down the right pathway. The care that we provide for the majority is a clinical intervention that keeps that patient at home within an urgent care services framework.

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

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

Q. Do you have a sense of how many of the patients treated or seen through Mid North Coast Virtual Care are ones who have contacted it because they can't access primary care in the community? For example, a general practitioner?
A. Yes, and anecdotally I would have to say the majority of those who are accessing our services are accessing the service because they cannot access a general practitioner in our community. I also am aware that we have repeat

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

THE COMMISSIONER: Q. When you say anecdotally patients can't access general practitioners, is that - first of all, is that because books are closed or is that because they can't afford to because there's not much access to bulk billing?
A. Both of those, is my understanding.

Q. And when you say "anecdotally", the source of your information for that is - I mean, you live in the community, but is it colleagues, other sources? Tell me what?
A. It's the patients saying that, and so we can only take them for what the patients will say --

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

THE COMMISSIONER: Sure, sure.

MR FULLER: Q. That information that comes from the patient, is that part of, like, a survey that you conduct after each virtual care session?
A. Yes. So yes, we ask a range of questions at the front end in amongst the triage and then we do send a follow-up survey to all of our patients who access the service, seeking their experience.

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

A. Yes.

MR FULLER: Q. Ms Wong, in paragraph 31, you tell us that the service equates to a conservative cost avoidance of about $11.4 million. Are you able to give us any detail of how those savings have come about?
A. Yes, and I used the language "conservative cost avoidance" because, for us, we've taken that the patients we have seen in Mid North Coast Virtual Care have not then needed to utilise either an ED presentation or a bed day stay, but I can't say that it is, you know, a pure saving because those beds are still potentially being utilised and those ED time slots are still being utilised.

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

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

MR FULLER: Q. In that research that you have mentioned, is that being conducted with the university?
A. Yes, we're trying to negotiate at the moment to have a university work with us on that.

Q. So it is in the early stages?
A. Very early stages, yes.

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

about in paragraph 27, an accredited general practice funded by the district. Can you just tell us a bit about Bowraville HealthOne, please?
A. Yes, so Bowraville HealthOne is a HealthOne community health centre that provides multiple services from that physical location. One of those services is our Bowraville GP clinic. The other services that function out of that area are a range of community services: integrated mental health; drug and alcohol services; drug and alcohol counselling; a range of violence, abuse and neglect services, including sexual assault counselling and child protection counselling; a range of wound-care clinics and other generalist community clinics.

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

THE COMMISSIONER: Q. It will be in our notes because we, as you know, because you were there, we did a site visit to Bowraville, but when, approximately, did this service commence, the practice?
A. (Indistinct - off-mic).

Q. All right. We will both have to go to the notes. Can you remember why Bowraville was chosen? I mean, one reason was, and we were certainly told, that GPs had disappeared, but people had been without a GP in that town for quite a while before this was set up, is that your memory?
A. That's my understanding. We also had that anecdotal experience that a lot of patrons or community members were

relying on our Macksville emergency department for care.

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

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

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

MR FULLER: Q. Why do you think it was important, and is important and appropriate for the district to be in the business of providing primary care through the Bowraville HealthOne?
A. I guess for us, and what I haven't spoken about is the cost for us. So, on average, the Bowraville GP clinic costs about $1.1 million per annum and we recoup about $650,000 through 19(2), which leaves a shortfall of approximately $500,000 per annum. I believe that --

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

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

Q. Sorry, just pausing there, the reason that you're telling us that is that whilst there is a cost to New South Wales on the arithmetic of $450,000, there either is, or it's hoped, there's savings because you are making that investment in primary care?
A. Yes. And for me, thinking about it --

Q. They haven't precisely been evaluated, though?
A. No. So there is some research underway as well, partnering with the Charles Sturt University, around whether we have seen some of that direct benefit with our emergency department.

Q. You mentioned a university. I didn't catch the --
A. Charles Sturt.

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

Q. This is the subject where I actually asked you to provide us with some peer-reviewed research that you might have?
A. Yes. And I can do that after this, sure.

Q. Sure, great. Thank you. Sorry, I interrupted you.
A. No, no. That's okay. In the UK, there is a notion that they refer to as "social prescribing", which is the investment in creating social networks to foster not only health and wellbeing of the community but incidental knowledge translation, and I hope and I believe that investing in some of these aspects of primary care is contributing to that overall productivity of the community, but the general health and wellbeing.

Q. Can I just ask also, there's no aspect of Commonwealth funding in Bowraville, correct?
A. Only what we receive through bulk billing.

Q. Sorry, bulk-billing. Right, okay.
A. Bulk billing that we're granting to.

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

THE COMMISSIONER: Okay.

MR FULLER: Q. My learned friend Mr Cheney has found a media release that suggests the Bowraville HealthOne might have opened in July 2022. Does that sound about right?
A. 2022 was when we moved our original premises.

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

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

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

MR FULLER: Q. The other program you tell us about in paragraph 28 of your statement is a chronic care program in Kempsey, in partnership with the local Aboriginal medical service. Can you just tell us a bit more about that program?
A. Yes. So this program is, I guess, the collaboration of Mid North Coast Local Health District and Durri AMS to provide a connected clinical care service to those who need support in regards to their chronic disease management and their chronic presentation, and this is to ensure that there is partnership and, I guess, a seamless experience for the community member or the patient accessing that service, and it is also with the support of the primary health network. It just enables us to provide that coordination of clinical care across the shared patients, so patients who would be accessing primary care through

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

Q. How is that program funded, do you know?
A. We each fund our own portion, and I guess it is a contribution in kind to bring our clinicians together to share information with patient consent and to provide that collaboration around who is best to take the lead in certain areas of that patient's care.

Q. And do you have any observations about whether it has been a successful initiative?
A. I don't have the data on that, but I do have the anecdotal feedback, I guess, from the patient experience, which is that it is a positive or a more seamless experience that is taking away the need for a person or patient to navigate themselves across the three entities.

Q. Are there any other --

THE COMMISSIONER: Q. "We each fund a portion" means the PHN is giving a grant?
A. The PHN has supported with some grants.

Q. Yeah, so that is Commonwealth funding?
A. Commonwealth funding.

Q. And you're in equal measure? Or?
A. I can't - I don't have the factual --

Q. You don't have that? Okay, I take all of that stuff about the amount of funding and whatnot on notice. Sorry, I forgot to ask you, when you were talking about the Charles Sturt evaluation in relation to the savings, potential savings in relation to Bowraville, is that looking only at Bowraville or at other sites as well, or just that?
A. That was to my understanding just looking at Bowraville and Macksville ED, that connection.

THE COMMISSIONER: Thanks.

MR FULLER: Q. Has that been completed or is it ongoing?
A. It's ongoing, is my understanding. I'm not across all the details. I actually have a session to hear more about the research later this week, so I'm sorry that I am not across all the details.

Q. Are there any other community health-based initiatives that your district is investing in that you'd like to draw to the inquiry's attention?
A. Yes, so there are a range of community health initiatives that we as an LHD have invested in. One of them is our collaboration with the lands council in Bellbrook to establish a virtual hub to connect the community at Bellbrook, which is probably about 30 minutes more inland from Kempsey, to services. That creates a space where people in that community can access a very central location and have connectivity through a virtual care setup to connect into a clinician on the other side of the screen. That reduces the burden on travel for that particular community, but also enables connection easily in a timely fashion to those who might otherwise not be able to travel out to Bellbrook or Bellbrook to travel in to a site.

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

Q. Is that right?
A. That is right.

Q. Is that Mid North Coast Virtual Care that they access through there, or a different kind of virtual care service?
A. So they can access anything that would require a virtual connection. So if the individual person has a specialist appointment that can be delivered by virtual connectivity, they can use that to setup for that specialist appointment. Similarly, they can use that setup to contact Mid North Coast Virtual Care or any other clinical service. So we have established the physical and equipment aspect so that individuals in the community aren't reliant on their own personal devices to be connected to virtual care.

Q. Thank you. I think I interrupted you. You were about to tell us about other initiatives?
A. Yes. I guess one of the other initiatives that has recently been established is our bush tucker partnership with the - where an AMS in Port Macquarie that has been funding internal to the local health district and income contribution from our Aboriginal medical service to establish a program of works that connection our community with traditional bush tucker food, and using that as a platform not only to create awareness for the community around healthy eating choices and lifestyle but also to connect people in that same fashion around social prescribing, creating a network, creating a bond over healthy food and bush tucker, but also then using that to educate and share information on chronic disease management, access to health, incidental screenings for, you know, whether that be information on breast screening or prostate.

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

Q. Appreciating you are not the finance director, but to your knowledge does the district intend to continue investing in these sorts of programs that we've been discussing?
A. I hope so. I hope so.

Q. Are there any particular challenges that you're aware of in the district continuing to invest in these sorts of programs?
A. I think sustainability is really challenging. When there are a range of different priorities that are expected of us as an LHD, whether they be the Premier's priorities or the priorities of the government of the day, and our need to ensure that we are fulfilling against all of those

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

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

Q. Is it your opinion, though, that it is beneficial for the NSW Health system to invest in community health-based initiatives like those that you have been describing?
A. I do believe that it is worthwhile to invest in community or out-of-hospital services.

Q. And that includes as a way of promoting high-quality health outcomes for the New South Wales community; is that right?
A. Yes, that's right.

THE COMMISSIONER: Q. Just so we have it on the record, when you were saying that we have a robust assessment or measurement system for our acute hospital setting but it's hard to measure what you prevented coming into the acute system, what are the difficulties in measuring that sort of prevention?
A. In our current framework, I suppose measuring what doesn't come to the emergency department. So our service level agreements have metrics on number of ED presentations, how quickly we are able to triage those patients against their triage category, transfer of care. We don't necessarily have a current or consistent structure to measure those patients that we have provided care to that don't come to our emergency department, or a consistent way to, I guess, measure cost avoidance against certain metrics. So I think that is an opportunity for us to think about how we as a whole system can also consider that value-add and success and the time that it takes to invest in a preventive model around behaviour change, around societal change, to see the benefits of early intervention.

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

I guess, profile that needs to go with that.

Q. You don't immediately get, for want of a better expression, either the pat on the back or the positive data from that investment in those sorts of programs; it is a - it might happen in 10 years or 20 years?
A. Yes. And I also believe that within Health, we are not always considering the interconnectedness of productivity in the community. So the investment in a preventative model where we are providing early intervention to a chronic disease management or in response to an adverse childhood experience, we are not necessarily measuring the value of that individual who then is attending school, who then goes on to, you know, be a productive provider in the community, working, who does not have as many chronic diseases or mental health burdens. So how we measure that value --

Q. This is the healthcare system as aiding productivity topic?
A. Yes.

MR FULLER: Q. Can I ask you now, Ms Wong, to put on one of your other hats, which is in relation to allied health. You have told us in your statement that you are strategically, operationally and professionally responsible for allied health professionals in your district. Can I just ask you what you mean by "professionally responsible"?
A. So as the director of allied health, I have a professional responsibility to all allied health professionals in the Mid North Coast Local Health District. I do not have operational management of all allied health staff in the district. So from a professional perspective, I am responsible for all 17 of the professions that are represented out of the 23 that are recognised, and I am responsible for providing that strategic and professional leadership and advocacy on behalf of allied health.

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

allied health is so much lower in your district than in others?
A. There's a range of factors that I believe contribute to that. Some of that is around workforce pipeline and the ability to attract staff to our area. I do believe that some of that is also around the type of - the funding that is available for allied health and also the workforce that is available in regards to the positions. Some allied health positions are multidisciplinary classed, which means that they can be an allied health profession or a nursing profession, and so depending on the successful applicant, we might have seen a growth in nursing for that particular position as opposed to allied health, but in natural attrition the next person who might fill that position may be allied health. Ability to attract skilled workforce to the Mid North Coast Local Health District across allied health professions is very challenging.

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

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

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

Q. Just starting with "pipeline", which is one of the causes that you mentioned, you have told us in paragraph 40 about junior practitioners who say there is an opportunity to better prepare in relation to specific requirements of NSW Health. Can I just ask you to elaborate on what you mean by that?
A. So my comment around - sorry, excuse me.

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.

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

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

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

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

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

Q. I am sure we can find this out, but when you say in Queensland there are some incentives for employed allied health professionals to support and mentor students, do you have any sense of what is the nature of those incentives?
A. So my understanding is that, in Queensland, where we have an allied health award, they have an enterprise bargaining agreement and they provide, I guess, additional incentive payments or - I'm not sure what you would call

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

Q. So it might be like a clinical educator allowance --
A. Yes.

Q. -- if someone is prepared to perform that role?
A. Yes.

Q. Just going through a few of the factors that you mentioned in your last answer, firstly, strengthening allied health clinical educators, can you just explain what you mean by that idea?
A. At the moment, and I'm so sorry that the report's title evades me but I will have it in my papers somewhere, there was a recent report provided on allied health workforce that related to allied health clinical educators that showed that across the State, on average, there is one allied health clinical educator for every 420 full-time equivalent. In contrast, if I can use nursing as an example, the data at the time showed one clinical nurse educator or clinical midwifery educator for every 42, I think, FTE. And I am aware that I've - 43, apologies. 43 FTE.

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

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

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

Q. Another thing that you mentioned was working with universities to maximise clinical placements. Do you have any views on how that might be done practically?
A. Yes. I guess, again, having the dedicated resources to navigate what that placement might look like. For allied health, we are very unique because there is such diversity but allied health professionals within a university structure are not within the same school of education either. So we're not negotiating with one school within a university; we have to navigate and negotiate, and partner, with a range of different clinical schools. So the, I guess, logistics of planning for placements is challenging.

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

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

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

coordinator or facilitator?
A. That's correct.

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

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

Q. The third thing you mentioned was the possibility of subsidised accommodation. Can you just explain why is accommodation cost an issue for students in your district?
A. I've drawn a conclusion that when we are having difficulties attracting staff or workforce to vacant positions because of an inability to access affordable accommodation that that would absolutely be a factor for students who are not necessarily earning money while they are undertaking their clinical placement. So without having access to a level of subsidised accommodation or without students actually residing in the area already, there is, I guess, a barrier in place for those students being able to travel to the Mid North Coast to undertake that placement.

Q. Can I ask you now about the last section of your statement, which deals with opportunities for innovation and reform. Firstly, in paragraph 53, you say that, in the first sentence, there is an appetite from the community and clinicians for the provision of clinical care virtually and to embed this as part of our normal practice. When you say there is an "appetite", what is your reason for thinking that?
A. My reason for thinking that, I guess, is based on the high uptake and the positive experiences based on the patients that we have provided care to through Mid North Coast Virtual Care and some of our other virtual care services such as Enhancing Community Care. I think stereotypically or anecdotally, we would have thought perhaps there would have been a lower uptake. There is commentary around concerns raised anecdotally around our aged population being comfortable using a device to access care when we historically have always undertaken to access care face-to-face and in person.

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

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

Q. Part of what you suggest should be done to try to embed virtual care as part of normal practice is to shift community expectations around the provision of remote care. Do you have anything in particular in mind as to how that might be done in practice?
A. I think we've been lucky in the Mid North Coast that we had some very good success with COVID. We used virtual care and telehealth to provide what we then called COVID care in the community, to keep our community safe and well at home. We had a very low admission rate in that COVID pandemic era. I guess the community expectations, because of that experience, was somewhat forced. People had to use technology to remain connected. That community expectation shifting and, I guess, marketing of how we can deliver very sound, safe, effective and efficient care through a virtual platform, is an opportunity to continue shifting or supporting that community expectation.

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

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

additional or supplementary, how should I understand that suggestion or opinion with the Mid North Coast Virtual Care? Is what you are saying is that Mid North Coast Virtual Care could be significantly expanded?
A. That is my belief. I believe that the Mid North Coast Virtual Care service could be expanded to reach into a larger range of service provisions.

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

Q. And so the extra funding and extra resources would - if that supply was there, the demand would match it?
A. Yes, that is my understanding.

THE COMMISSIONER: Okay.

MR FULLER: Q. In paragraph 55, when you are talking about virtual care services and, in particular, the Mid North Coast Virtual Care, you say at the end of this paragraph that one issue is managing "the rapidly evolving technology outpacing the existing policies and guidelines." Can I ask you just to explain what you mean by that, please?
A. Yes. So, from an LHD perspective, with the delivery of a completely virtual service, the need to create and establish places within our electronic medical record to capture that accurately. Similarly, how we calculate and capture our activity associated with what is being delivered not in a face-to-face manner. So the definitions sometimes have been around how care has been delivered in a face-to-face setting, versus a care coordination which is not patient-facing, depending on how you're interpreting a virtual screen being patient-facing or not, so I think there are opportunities for us to include virtual modalities more broadly in some of our definitions for data capture.

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

Q. In paragraph 57, you have told us that there are opportunities to shift the focus and understanding on the value of multidisciplinary clinical care models and structures within NSW Health systems. Can I ask you, please, just to explain what you mean by that?
A. This comment, and what I mean by this is around multidisciplinary care being care provided by allied health professionals as well as nurses and doctors. And, I guess, when I talk about marketing and celebrating the value proposition, I think at the moment we still see or we still have a general vision of health being provided primarily by doctors and nurses. It's in the media that we see. It's on television shows that are free-to-air. It is the general understanding of the community. More rarely do we see the value celebrated of an allied health professional workforce in care in contemporary media, and I think that there is an opportunity for us to share and celebrate, but also provide awareness on the value that that multidisciplinary or holistic clinical care team can provide.

Q. You said that reliance or emphasis on high cost medical models in nursing has a direct impact on allied health resourcing, but also the ability to fulfil best patient care. Can you explain why you think that has an impact on patient care?
A. So my understanding of how we can best deliver patient care is to take a holistic approach in how we provide person-centred care using a multidisciplinary care team, so allied health, nursing and medical. Unfortunately, we have varying models and frames that sit around our different clinical groups. So nurses have a nursing hours per patient day ratio that is written into our systems and awards, and that is a requirement for us as a local health district to meet and fulfil, and that is to ensure that there is a safe ratio of nurses to patients in the acute setting.

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

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

Q. The other point concerning that sentence is, or the other impact you mention in that sentence, is on the whole cycle of workforce sustainability. Can you just elaborate on what you mean by that, please?
A. So where we have, for example, a high proportion of nurses in our staffing or workforce profile, if we see a natural attrition or a movement of those nurses, we then have a large vacancy across that nursing pool. Limited supply for the high demand means reliance on locum or agency nurses, which come at a premium cost, and that cost is far exceeding what we would expect to be paying for our clinical workforce, and that impacts the cycle of sustainability. So if we are relying on paying for premium labour across medical or nursing or allied health, because we haven't got an even spread or perhaps are unable to have the baseline of our workforce across all of the different professionals groups, we are then needing to expend more than expected to fill that baseline.

Q. Is the idea that if we increase the resourcing and the role of allied health professionals in the delivery of patient care, then over time we would expect to reduce the burden on nurses and therefore the need to rely on, for example, agency nurses if there are shortages of nursing workforce?
A. Yes, I guess I am thinking more just the more that we grow our diversity in our clinical workforce, the less we are reliant on one particular supply and demand chain. So not necessarily taking away from the value of nurses or the need for nurses, but if we had more allied health as well as nurses as well as medical, we would be less impacted by the reliance on one singular supply and demand chain.

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

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

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

Q. But in terms of reporting obligations, are you suggesting a better analysis of what the return on investment is of some of these programs that are only funded for short-term so that there is a better analysis done as to whether they should be extended?
A. Yes. So I think, exactly as you have said it, Commissioner, I think the other aspect is the reporting obligations that often sit alongside the time-limited funding streams are very difficult for LHDs, because if we cannot attract the workforce to a temporary position, we can then not accurately report or fulfil the obligations of reporting accurately on the value of that service --

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

Q. Is there any particular example you would like to draw my attention to to make good that, or is it a general observation?
A. I guess I can provide some examples. Following the Royal Commission into Institutional Responses to Child Sexual Abuse, we had a range of recommendations and NSW Health reviewed and re-invested into areas of violence, abuse and neglect. We have had a range of investments that have been partially time-limited and others that have been permanent across the range of violence, abuse and neglect services. For example, we have had time-limited funding for adult survivors of sexual assault.

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

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

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

Q. That's very difficult.
A. -- it's very difficult.

Q. Is there anything else you want me to understand about what you are saying in paragraph 59?
A. Commissioner, I think just coming back to that comment around the notion of whole-of-community and that some of the benefits or productivity metrics may not sit within the NSW Health system, and that I don't know the answer on how we would capture that value-add to the whole-of-community, but that is something that is in the back of my mind.

Q. You mean they're not picked up by the KPIs?
A. They're not picked up, so the contribution to the community health and wellbeing is not necessarily picked up within KPIs specific to New South Wales.

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

MR FULLER: No, thank you.

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

MR CHENEY: No, Commissioner.

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

<THE WITNESS WAS RELEASED

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

LUNCHEON ADJOURNMENT

THE COMMISSIONER: Yes, Mr Glover.

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

<TRACEY MAISEY, AFFIRMED [2.12 pm]

<EXAMINATION BY MR GLOVER

MR GLOVER: Q. Can you tell us your full name, please?
A. Tracey Maisey.

Q. You are the chief executive of the Northern NSW Local Health District?
A. Yes, correct.

Q. You have been in that role since about August 2023, correct?
A. Yes, yes.

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

Q. And I understand there are a couple of corrections you wish to make; is that right?
A. Yes, that's right.

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

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

correct "2019 to 2014" to "2019 to 2024"?
A. Yes, that's correct.

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

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

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

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

A. Yes.

Q. And, finally, paragraph 139, in the second line "highest median age" should be corrected to read "highest median age in NSW Health in 2024"; is that right?
A. Yes. Yes, that's correct.

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

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

Q. Including executive positions in New Zealand, with the NHS in the UK, and in Qatar; is that right?
A. Yes, that's right.

Q. Should we take it from that that some of the views and opportunities you identify in your statement is drawn from that breadth of experience in those other jurisdictions?
A. Yes, that's correct.

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

agreement with the secretary for the year 2023 to 2024?
A. Yes.

Q. You see that? Is there one for the year 2024-2025?
A. Yes, there is.

Q. I'll take you to the 2023-2024 one. I'll have that brought up on the screen. That is [MOH.9999.0064.0001]. When was the 2024 to 2025 service agreement finalised, doing the best you can?
A. We signed it in August.

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

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

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

Q. On this page and what follows are the KPIs, and I take it you are fairly familiar with the KPIs that apply to the district?
A. Reasonably so, yes.

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

Q. Do you have a view about whether the KPIs that are applied to districts like yours accurately measure how well that function is performed?
A. There are a broad set of key performance indicators. I think there is in excess of 100 key performance indicators. And so it covers, as you said, the responsibilities we have to maintain the health of our community, and we obviously do that with our partner organisations. They cover functions of hospitals, so emergency departments, readmissions, which is obviously another indicator of good care. It covers waiting times. There is a whole range of indicators around specific initiatives that the Ministry of Health fund us directly outside of activity-based. I think it is a broad indication of responsibilities of a local health district.

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

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

Q. Can I take you back to page 14, doc ID page 14. This is the budget snapshot. You have now been through two of lead service agreement processes, is that right, since you joined the district?
A. I started after last year's was negotiated, so I've been through one cycle, yes.

Q. What was the process from your perspective in terms of arriving the budget? It is not the one on the screen, obviously, but the one for the current service agreement?
A. So there were several meetings with Ministry of Health officials regarding service agreement negotiations. We had an opportunity to put forward particular areas of investment and highlight any areas that we may have wanting to review as part of last year's service agreement. We then provided information to that effect, provided more detail on those, and then we received budget notification shortly after the New South Wales budget was released, which was, from memory, the second or third week in June.

Q. As part of that process, was there account taken of the healthcare needs of the population within your district?
A. We had a conversation about the ageing profile of our district. You've seen through the statement that we have an elderly - a relatively elderly population. We talked to them about the growth that is being experienced in regard to both presentations, admissions, and community demand. As you'd appreciate, the older the population is, the more impact they have in terms of health services. We put that case forward. The result of that was with the exception of Tweed Valley Hospital, which was mostly funded, we received 0.07 per cent growth.

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

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

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

Q. At a general level, will you agree that in planning healthcare services, one must start with an assessment of the healthcare needs of the population?
A. Yes. So if I talk about the commissioning cycle, which is what I am generally familiar with. So every three years, depending on Census cycles, you would start with a health needs assessment and that would obviously look at a broad range of both socioeconomic and health demand indicators, as well as trends in healthcare delivery, service utilisation, et cetera.

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

Q. Is that a cycle that occurred in arriving at the budget in the current services agreement?
A. No. No, it wasn't for this year, no.

Q. Was there a healthcare needs assessment done across the population within the district that then fed into the budget negotiations as part of the current services agreement?
A. The Ministry of Health may have taken a technical health needs assessment approach through the modelling work that they've done. However, it wasn't in partnership with the local health district.

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

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

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

Q. There may be a difference to this year's service agreement, but do you have a sense whether your district is able to deliver care at the state efficient price?
A. No, we're not at the moment. Our current cost per weighted activity unit, which is often referred to, the "DNR", and I think "DNR result" stands for "district network return effective in costing study", shows that our cost per weighted activity unit exceeds the state efficient price.

Q. By how much?
A. It's approximately $2,000 per activity unit.

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

Q. Does that mean there is - despite those adjustments, there is still a shortfall between the amount funded at the state efficient price and the cost to deliver that activity within your district?
A. Yes, there is. That's correct.

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

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

Q. What is the purpose of this plan?
A. To help us prioritise areas of focus for our local health district, based on assessment of a broad need.

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

THE COMMISSIONER: Sorry, I just need to interrupt.

MR GLOVER: Yes.

THE COMMISSIONER: Q. The difference of $2,000 per activity unit that you've just given evidence about, and Mr Glover asked you about "are adjustments made?", and you said there are some adjustments and you explained a little bit of that, but do those adjustments - and then you were asked, "Does that mean despite those adjustments, there's still a shortfall?", and you said, "Yes, there is." What is the extent of the shortfall that's left?
A. So I guess that's the contribution towards our deficit. So we, obviously, are in deficit, and so we're unable currently to deliver services to the level of state efficient pricing.

Q. But in dollar terms, what's the difference left after the adjustments?
A. I wouldn't be able to answer that because it's quite a broad --

Q. You can take it on notice, though?
A. Yes. Yes.

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

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

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

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

Q. This isn't a criticism, but that's a long answer in terms of agreeing with my proposition?
A. I agree with the proposition, yes.

THE COMMISSIONER: Thanks.

MR GLOVER: Q. Does that mean from the commencement of the period covered by the services agreement, your district is underfunded in terms of the activity it is being required to perform?
A. So I don't think there is any government that can fund health to the level that we would like to have. At the moment, we are of course, are exceeding our budget. That's evident in the statement and the advice that I have included in there. I guess are we underfunded? We are certainly not being funded for the level of utility that we are providing. We have had growth year on year of circa 4 per cent in the last two years, and that's projected to increase, so I think the answer is we're not being funded for the level of activity that we're currently providing.

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

Q. Funding it to the extent that it must be almost guaranteed that you are going to be in deficit, rather than funding you so the deficit --
A. Oh, I see, I see. I understand the question now. I guess --

Q. From matters that seemingly might be beyond your

control?
A. Yes. I suppose the intent is to ensure that we continue to strive --

Q. For it as hard as you can.
A. -- for it in terms of efficiency and economics.

Q. Okay. And sorry if I have just not picked this up adequately by not listening carefully enough, but the 0.07 per cent growth, what was that? How was that figure derived? How was that percentage arrived at?
A. I can't - I haven't been able to determine how --

Q. This is because you are so new that - or you just --
A. No, we haven't had it described to us as to how the 0.07 per cent growth was determined.

Q. Sorry, you have asked and the answer is what?
A. "It's part of the growth calculation for your district."

Q. That's a statement of an assertion, but it doesn't give you much chance to understand.
A. We haven't been able to understand. I know there is a formula, Commissioner, but - yeah.

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

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

Q. Under 1.1:

> *About this Plan*
>
> *LHDs have a responsibility to effectively plan services over the short- and long-term to enable service delivery that is responsive to the health needs of its defined population.*

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

that approach to be consistent with the obligations of the LHD to promote and protect the health of its community?
A. Yes, I would. Yes.

Q. Then in the third paragraph under that heading:

When progressing the actions ... [the LHD] will have a focus on strong partnership approaches and working closely with key stakeholders ...

Do you see that?
A. Yes, I do.

Q. Why is that an important part of the planning process?
A. Because we are a single organisation in a health ecosystem and our community interacts with a variety of organisations and obviously has a stake as well. So if we weren't talking to our community, engaging our partners, having conversations with organisations that are delivering services, then we wouldn't be able to determine health need, both qualitative and quantitative need of our community, and so I see that as a vital part of delivering excellent healthcare.

Q. When you refer to either stakeholders or partners in that context, who do you have in mind?
A. Well, it is a long list, but I would start with, I guess, our community and our patients are first and foremost that is who we are here to deliver care for. And then we have our significant partner organisations such as our primary health network; Aboriginal medical services; NGOs that are providing a variety of healthcare; social agencies that advocate on behalf of the community in particular; patient groups; council, who obviously have an advocacy role and an interest in the profession of healthcare; chamber of commerce, the local health district is the biggest employer in the region; government stakeholders; Ministry of Health. I mean, the list is endless.

Q. These concepts involve more than just consultation, though, do they? They require a joint planning approach?
A. Yeah, a joint planning approach is absolutely critical, and so the concept or contemporary concept of codesign of services, where you have multi-parties, including community and patient representatives sitting at

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

Q. You mentioned in an earlier answer the ecosystem, some may call it the fragmented nature of healthcare in this country. How do you see that joint planning approach being put into practice, given the varying partners or stakeholders?
A. I think the mistake that you can fall into is taking an approach of who's paying the money rather than approach from who is actually from the patient perspective, and so I guess in my experience, if you put the patient in the centre of that conversation and say actually, "What does this individual need?", in terms of supporting them on their healthcare journey and having a variety of those stakeholders that are described sitting there to have those conversations, and then you look at a care arrangement or a service delivery arrangement that meets the needs of those consumers and then you look at how that's going to be funded. That's a far more productive discussion than trying to work out the funding arrangements and then designing the services to suit the funding. You have to be a bit - that does require people to be flexible, have a will and intent to try something new. It does require a review of policy and regulation and all those things, so sometimes that can take time.

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

> *Sustainable service delivery that meets population need is a key focus ...*

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

> *Value based health care.*

Do you see that box?
A. Yes.

Q.

> *Efficiency, effectiveness and*

sustainability of care by considering services from a population-based planning lens.

Do you see that?
A. Yes.

Q. What do you mean by "population-based planning lens"?
A. So if I give you an example is probably the easiest way of describing it. So healthcare services planning based on health needs assessment needs to look at a critical mass of the population. So for Northern NSW Local Health District, we have 311,000 members in our community, and for those 311,000 you need certain minimum services to be available in the district. And then when you start looking at subspecialty services, they need a larger critical mass to be viable.

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

Q. Does part of that joint process involve, once the health needs assessment has been undertaken, identifying the range of services that are currently available in the district across the various providers?
A. Yes. So part of this - the example here in terms of vulnerable services is where a service is vulnerable either, but generally because of workforce and workforce availability, and there are a number of subspecialty areas in our district where that would be the case.

Q. Has the district implemented measures towards these joint planning ideals?
A. We are certainly in the progress to do that. So the development of the healthcare services plan was a really key milestone for our local health district. Within included in the plan, you will see all stakeholders that were engaged and the preparation for that. It also included our neighbour local health districts, the North Coast in particular, and there were conversations with Gold

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

Q. Is one of the steps taken towards pursuing those initiatives a memorandum of understanding between your district, Mid North Coast and the PHN?
A. Yes, that was a memorandum of understanding that was signed earlier this calendar year.

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

Q. When one thinks of the workforce being considered as one workforce across the myriad of stakeholders and service deliverers, how do you see that as ultimately coming to fruition?
A. So I think putting the organisational barriers aside and again focusing on the needs of the patient, you tend to end up with a complementary rather than competitive behaviour. And so, I'll give you an example. So, when we were designing - and I'll have to go back to New Zealand, if that's okay.

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

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

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

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

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

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

Q. I take it that the aims as set out in the memorandum of understanding, as you have expanded on in those few answers, are things that you see as being important to the future sustainability of the delivery of healthcare in your region?
A. It takes a whole system to design a whole system, and health is a complex adaptive system and you need to enable everyone to have a voice and to ensure that we're not competing for workforce, that we do have the needs and aims of our patients and our community at the forefront, and that we are partnering and designing care with them.

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

Q. Are there significant barriers in pursuing this joint approach that you have been describing?
A. I talk about in my statement a model care, rainbow model of care, and it talks about six dimensions. And I guess in my experience, organisations tend to be able to work through the clinical issues. By putting in health pathways and referral pathways, they tend to work through professional issues around scopes of practice and enabling effective multidisciplinary teams, and organisational issues around contracting and alliancing.

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

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

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

Q. What you are describing is a one system approach rather than --
A. Yes.

Q. -- different systems plugging in and trying to integrate together?
A. It's a people-centric approach to healthcare, and it's - you can do it with multiple payers although again, in my experience, that does become a little more complicated because the functional element of integration, the funding incentives being aligned, can take some time to work out.

Q. But it can be done with a different way of approaching the structures and delivering of healthcare?
A. Yes, I think it can. If you've got trust and confidence in each other and the will and intent to make a change, I believe you can do it.

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

Q. Is that the --
A. Yes.

THE COMMISSIONER: Thanks.

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

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?

A. Yes.

Q. You tell us about one of the knock-on effects of that change about student placements. Are there others?
A. That's the one that has been raised with me on most occasions. This obviously happened before I arrived, but I'm not aware of any other significance in regards to the change. There may be some regulatory impact that I wouldn't necessarily be familiar with.

Q. Are there other parts of the district that are also affected by Modified Monash Models that at least you perceive don't necessarily reflect the reality of where those places are based?
A. I am still trying to understand the MMM rating. I'm not able to answer that question directly. Again, this would be the main example that's been provided to me since starting.

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

Q. Is it fair to say that over the last few years, there has been an upward trend in activity coming through facilities in the district?
A. Yes, that's correct.

Q. Has there been any analysis done to try to understand why there has been an uptick in activity?
A. Yes, there has.

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

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

Q. Do all those factors combined to arrive at a position where the district has very little it can do to influence the levels of activity that are coming through its doors?
A. We can work with our partners to put in population prevention measures although, as you would appreciate, they tend to take some time to impact. If somebody comes to an emergency department, whatever the reason they've come to the emergency department, it's our obligation to ensure that they receive safe and appropriate care. We don't ask them, "Why did you come here and didn't go to the GP?", and so, yes, in regards to once they turn up at our hospital, there's limited action that we can do. Our role is to, I would suggest, to equally treat them well when they arrive, but intervene earlier to reduce the impact and incidence on the emergency department to begin with.

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

Q. Is that a trend that is relatively recent in terms of aged care patients being in hospital beds when they are ready for discharge if places were available?
A. I guess it's been made more acute since the floods and so - we've included in point 88, we know of at least two facilities with circa 100 beds, between them, that were lost to the floods, so it has been more acute since the floods. However, the number of people waiting, residential aged care places since I've been in the role in 12 months, has tended to be relatively steady, but I do understand that it's higher than previous years.

THE COMMISSIONER: Q. That classification of waiting of 35 days --
A. Yes.

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

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

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

Q. Right.
A. And they need to have had been cleared, medically cleared, for discharge, yes.

MR GLOVER: Q. What's the effect on a facility in the district by having approximately two medical wards occupied by patients who are ready for discharge into aged care facilities, if there had been a place available?
A. That puts pressure on the remaining beds because if you have - and other reasons, other impacts. So I'll just talk about one first. So if you have, effectively, two wards of patients occupying the beds who have been medically cleared for discharge and we have people in the emergency department waiting to come in, we obviously need to churn over the remaining beds in order to let more people in, so that puts pressure on beds. But also more importantly, from my point of view, is those 61 patients aren't in the right place. So, you know, an acute hospital ward isn't a good environment for someone that needs a relatively calm environment.

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

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

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

In paragraph 108, you tell us:

Addressing the noted health challenges and meeting the health needs of the NNSWLHD community requires innovation, shifts in investment towards community, ambulatory and in home service delivery, in active partnership arrangements with health and social organisations, and communities.

We've spoken a little bit about the need to partner with other stakeholders.
A. Yes.

Q. But what do you see as being the main areas that require innovation and shifts in investment?
A. So I guess I'd talk about our local health district specifically. We have a relatively under-developed hospital in the Home and Community Care Program and so I think investment in keeping people well, firstly and foremostly, so that's around in population health and preventative care, but then, secondly, when they do need care and keeping them well in place, and so using virtual care models, service delivery models that take the care to the patient and reach into residential aged care providers; partnering with other NGO organisations, all of those things enable members of our community to stay well in place for longer, but I don't think we're using technology as well as what we could.

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

Q. What, an increased focus on out-of-hospital services delivered into communities?
A. Yes, both to keep people well in place if they don't

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

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

Q. -- what would you be shifting from?
A. So there's a propensity to keep opening more hospital beds. Hospital beds are expensive. It's not an either/or. You still need some hospital beds.

Q. Yes. Of course.
A. However --

Q. We accept that we have to provide the acute care services we have to provide.
A. Yes.

Q. But the shift might come from?
A. So, again - so rather than opening more beds, put that money into investing in more prevention, more allied health support in the community, more technology, remote monitoring; virtual care. Yeah. So just rather than build more hospitals.

Q. Those things might also, just for the sake of argument, require further investment as well without a diversion from something else?
A. That's correct, yes. I'd agree with that, yes.

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

Q. In the meantime, you still have an increase in trend of activity demand in your district?
A. Yes, we do.

Q. But you would see benefit, I take it, in starting the shift that you describe in paragraphs 108 and 109 of your statement now, while still maintaining a level of service you do in your facilities?
A. We need to be able to do both. It generally only starts with one step, so we need to take the step. And to be fair, there is already a lot of inactivity in place and

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

Q. And the step change in that direction is critical in order to ensure the long-term sustainability of the public health system, do you agree with that?
A. Yes, I would. Yes.

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

Q. And then in the rest of the paragraph you give some examples. Where are you drawing those figures from?
A. So from that evidence base that's listed there, and they have cited a number of references within that document, yes.

Q. In practical terms for your district, what does that mean, "disparity" that you describe in paragraph 116?
A. So, again, I'll give you an example. So where you have less GPs per capita, those members of our community aren't accessing obviously first contact services so they're not accessing MBS schedules and so that investment doesn't make its way to those individuals. Where there's large geographic areas to cover, the availability of health services isn't, obviously, as dense as in a metro; our workforce is more expensive. And so even though you make dollar-for-dollar, where you have a higher workforce cost then, obviously, that dollar doesn't go quite as far, so then there's less services provided.

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

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

Q. So the disparity is driven, to your understanding, at least in significant measure by there just being the lack of services available in regional and remote locations to draw on available sources of funding?
A. Yes, as well as providers not investing in areas because of disparate demand.

Q. That leads to the inequity in funding available to those living in metropolitan regions for their healthcare needs versus those living in parts of your region, correct?
A. Yes, that's correct.

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

Q. Can you just tell us what are you referring to when you talk about the NSW Health funding model?
A. So that's the model on which our service agreement is based in terms of activity-based funding, small hospitals funding, block funding for training, education, et cetera, yes.

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

Q. Can you just explain in practical terms the issue that you are identifying in that paragraph for us.
A. Yes. So for very remote areas, the state efficient price is adjusted to reflect the cost, whereas for multi-purpose services which are in Urbenville and Bonalbo, it's a pooled funding arrangement with the Commonwealth and so there isn't a flexed variable element to that. So we don't receive the benefit of having price weight adjustments as we would if we didn't have multi-purpose service.

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

A. Yes.

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

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

A. Yes.

Q. Can you just walk us through, firstly, what was the initial allocation that you are describing in paragraph 119 and then why, as a practical matter, the service is in deficit until activity thresholds are achieved?
A. Yes. I'll try to find my notes to give you the exact numbers but --

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

Q. Just pause there. That funding submission dealt with operational cost, staff --
A. Operating cost. Staff and operating cost, that's correct.

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

Q. Pausing there. Is that because it was a bigger facility?
A. Yes. Sorry, yes. So, Tweed Valley Hospital is three times the size of the Tweed Hospital.

Q. A bigger facility requires more staff, more cleaners, more operational staff, more nurses, more doctors; more everything?
A. All of the above, that's correct. And so we received

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

So when we talked to the Ministry of Health about that, the response was: we need you to build up the activity levels to confirm that that activity is going to go through that facility and then we will have a conversation with you about funding. However, we need the staff to build the activity levels up. So, for example, the cardiac cath lab, which we opened on 10 September, you have to do a certain number of patients before you can fully commission a 24/7 cath lab. Obviously you need to test procedures, need to test the equipment, et cetera. So whether you've got one cardiac cath patient coming through or you've got - I'm going to make a number up 10 - cardiac cath patients coming through, you've still got a certain number of minimum staffing and so hence my point about the deficit. Until we reach those activity levels, we've got sunk costs, we've got sunk staffing.

As it stands, our Tweed Valley Hospital is already above target. That's because Tweed Hospital was above target and we've taken on that activity and we've grown since the new facility was opened.

Q. Can I just step through certain parts.
A. Yes, sure.

Q. So, the hospital was coming online in the last financial year and, in anticipation of that, a funding proposal was put up and six months of operational funding was provided, correct?
A. Yes.

Q. The hospital opened in May?
A. Yes.

Q. And to operate the hospital, you need all of the staff that you have described and to operate the services, as each of the different services come online, you need the staff to staff them, correct?
A. Yes.

Q. You can't do the activity without the staff, as is obvious.
A. Yes.

Q. But in the next round of budget negotiations, that same level of funding for those staff wasn't provided to the district, have I understood you correctly?
A. So we received the six months.

Q. Yes.
A. But then we didn't receive an additional six months to take it to annual funding. We received a portion of the remaining funding that we'd asked for.

Q. Yes. From that answer, do we understand it that what you received was not enough to meet the cost of the staff that you required to operate the facility and build the services?
A. Yes, that's correct.

Q. And where were you to find that money?
A. Well, that's a good question. We had already hired the staff and we'd already made a commitment to the community, and we'd already made a commitment that we would be bringing those services on and so we, at the time, when that planning had been done, as I said, we expected to receive the funding effectively as deficit funding.

Q. And the indication from the ministry was that once activity targets were reached, there would be a discussion about further funding, is that right?
A. Yes, that's correct.

Q. Okay. Has that discussion occurred, now that you have indicated that facility is at or above target?
A. We're having a conversation in November about that.

Q. Can I then take you ahead to paragraph 121, please. Before I do that, was any reason given to you, or to the district by ministry, about why that funding for operational staff wasn't continued and there wouldn't be

further discussion about it until activity targets were met?
A. The conversation was they wanted to see the impact on repatriation of activity from Queensland to New South Wales. The Ministry of Health funds patients that go from New South Wales to Queensland and there was an expectation that with the opening of, particularly, the additional tertiary services that cardiac have, and radiation oncology, that there would be a repatriation of some of those patients back to New South Wales. So they wanted to see that occur, which I can understand that. And the other reason was at the time - we had this conversation in July and then August, we hadn't had the first month's results. We had June's results and June's were above target, but we hadn't had the July and August results, so they wanted to see the impact of opening the new facility before we had the conversation.

Q. The impact of repatriation activity from Queensland wouldn't affect the minimum staff you required to operate that facility, though, would it?
A. No.

Q. Nor would the activity targets, the activity flowing through that facility, is that right?
A. No, it was a funding source more than an increase in the activity numbers.

Q. Thank you. In paragraph 121, you tell us that prior to 2022 - I appreciate some of this is before your time so if you can't answer, do let me know, but your understanding is the district was generally on budget?
A. Yes.

Q. Since then, there have been some deficits?
A. Yes.

Q. Have you been able to identify particular causes of why that has occurred since that period in time?
A. Partly activity.

Q. We'll come to activity.
A. But also our premium labour costs. Before the floods, and COVID, northern New South Wales had a very low use of agency staff, locum medical and nursing. Post-COVID, I think most health systems had been impacted by workforce fatigue and we've had workforce leave and then the floods,

on top of that, exacerbated the situation in the district and I think, to be fair, we still have a high use of premium agency, both nursing and medical. That is coming down, you know, it's coming down each year, but certainly we're well above where we were before COVID.

Q. You tell us that at the end of June 2023, the deficit was about $109 million.
A. Yes.

Q. And then the end-of-year position 2023 to 2024 was $74 million.
A. Yes.

Q. In 122, you tell us that that turnaround has been achieved firstly by the efficiency improvement program of $48 million?
A. Yes.

Q. Of which 40 was reduced cost and utilisation of premium labour. What did that's efficiency improvement program entail?
A. So apart from reducing premium labour, the $8 million was around better procurement in terms of, you know, using contracts, making sure that we were applying good financial discipline; re-evaluating efficiencies like accommodation, transport travel, goods and services. Just good financial discipline would probably be the best way of explaining that.

THE COMMISSIONER: Q. The program, who devised it? Was it the LHD or the ministry or --
A. Oh, the LHD, Commissioner, yes.

Q. Okay. And was there - you call it a program. Was it in, like, some form of document with a series of recommendations to follow, or was it a bit more ad hoc than that?
A. So there were two documents. The Ministry of Health had a couple of people visit before I arrived and they did what was called the foundation review which went through and had a look at a whole range of matters. They provided --

Q. They assisted in setting up the program?
A. It certainly was helpful having an independent review against benchmarking peers, et cetera; you know, areas of

opportunity.

Q. Yes.
A. And so that document was made available to us actually the second day I started.

Q. Right. Okay.
A. And so - but before that the team had already started working on particularly the premium labour with the overseas nurses recruitment that started before that formal review occurred.

Q. What does "recruitment slippage" mean in 122(b)?
A. So we're given funds for particular - it tends to be government priority initiatives and so "recruitment slippage" is where they may fund us for 12 months. However, we've been unable to recruit two positions and so, therefore, we haven't expended some of those funds for the - you know, that doesn't on start 1 July, we can't just suddenly recruit people.

Q. You have the funds, but you haven't been able to expend them because you haven't got the people to spend it on?
A. That's correct, Commissioner, yes. Yes.

Q. And reimbursement for activity over target, that's where more activity is being done and so you have been given some extra funding because of that?
A. Yes. So in 23/24, anything - so up to 4 per cent above target, we were funded 40 per cent of the national health rate. Because we were over target, we received some additional funding for that, yes.

Q. Thank you.

MR GLOVER: Q. But that's no longer the case?
A. That's correct.

Q. Do you know why?
A. No, I don't know why.

Q. Is it the case that any activity that is performed over target will not be funded?
A. That's what I've been told, that's correct. Well, no, sorry, I'll correct that statement.

Q. Yes.
A. We're unable to accrue at this stage for that activity.

Q. Just help me, what's the distinction?
A. In my mind the distinction would be at some point, you may be able to accrue for it but at the moment, you're not able to accrue for it.

Q. Is that a position that has commenced with the 24/25 year?
A. In July, we were informed that the 4 per cent would go to 2.5 per cent. So rather than being able to account for 4 per cent over-provision, we would be able to account for 2.5 per cent over provision.

Q. Just taking it step-by-step.
A. Right.

Q. In previous years, activity up to 4 per cent above target was able to be funded at 40 per cent of the national efficient price?
A. Yes.

Q. And this financial year, the position is activity up to 2.5 per cent above target attracts that same funding?
A. That's what we were told in July.

Q. Yes.
A. And then in August, when we started accruing on the basis of the 2.5 per cent, we were told that we couldn't accrue for that.

Q. So as it stands at the moment, you don't expect to receive any additional funding for activity performed over target?
A. That's correct. We've taken it out of our forward program, improvement program, yes.

Q. That takes us to activity and the significance of activity on the LHD's finances. In paragraph 127, we have covered some of this ground already, but you tell us there are limited leaders to LHDs to control unplanned activity and we discussed earlier about people need services --
A. Yes.

Q. -- when they come through your door and they need to

be treated. Then you tell us, at the end of the current financial year, it is estimated that 55 per cent of the projected deficit of approximately $70 million will be attributable to activity provided but not funded. So that's activity over and above the purchase activity in the service agreement, is that right?
A. Yes, that's correct.

Q. Do I take it that that portion of the deficit is something that you would consider to be one that you have limited control over?
A. Yes, because once they come for care, we need to provide care to them. Yes.

Q. The remainder of the deficit, you tell us in 127(a), is projected to be 2.6 due to a small site funding gap?
A. Yes.

Q. What is the small site funding gap that you are referring to?
A. Sorry, small hospitals. It is a different funding model for small hospitals and the cost of delivering services there exceeds the funding that we were given under that funding model.

Q. And 3.9 million related to structural costs above the state efficient price for Tweed Valley Hospital.
A. Yes.

Q. We touched on earlier about the ability of the LHD to deliver one unit of NWAU at the state efficient price, so that portion of the deficit 3.9 is the extra cost of delivering care at Tweed Valley over and above the state efficient price, is that right?
A. Yes. The structural costs relate predominantly to the size of the facility, the additional cleaning orderlies, heating, et cetera, yes.

Q. In 127(b), you tell us of a projected $25.4 million efficiency gap, do you see that?
A. Yes.

Q. What is the efficiency gap?
A. So that's the difference between what we're delivering the services for and state efficient price.

Q. Across the rest of the district?

A. Yes, across the rest of the district. Yes.

Q. Why is it called an efficiency gap?
A. It is the only way we could describe it. So it's the difference between cost and state efficient price and so we have deemed that to be an efficiency gap.

Q. Could it be described as "under-funding"?
A. It could potentially be described as under-funding.

Q. That sentence goes on to say:

... including continued general --

THE COMMISSIONER: Wildly different concepts, but, anyway. Maybe not.

MR GLOVER: Q. 127(b), after we identify the efficiency gap, it then says:

... including continued general efficiency improvements.

A. Yes.

Q. What's in that concept?
A. So that's, I guess, the fact that you can continue to be more efficient. So you can deliver care with technology. You can implement new models that improve flow. You can introduce new pharmacological drugs that reduce lengths of stay, et cetera, et cetera, and so every organisation needs to strive to continue to be more economic and more efficient, whether you're in the public or private systems. So what we're indicating is that we recognise this continued need to be - to look for efficiencies and, therefore, it's onus is on us to do that, you know, we're funded through public funds.

THE COMMISSIONER: Q. And, not to be flippant about it, as you said, say, funded through public funds for vital services, but because we're talking such large figures, small percentage changes in efficiency actually means quite a lot of money, which is why everyone is so vigilant about being as efficient as they can be?
A. That's correct, Commissioner.

MR GLOVER: Q. The 25.4 million efficiency gap, though,

is after the delivery of 40 million in efficiencies over the next financial year; is that right?
A. Yes, that's correct.

Q. So from that, do we understand it that the district has identified or targeting $40 million in savings through efficiencies?
A. Yes.

Q. But at the moment there is still a projected shortfall of $25.4 million after those initiatives have been exhausted; is that right?
A. That's correct, yes.

Q. Does that point to the fact that although one strives to be more efficient at all times, there are limits to how much saving can be generated through those initiatives?
A. Yes, that's correct. And I'd just qualify that by saying, you know, with the growth and activity that we have, I talk to the staff about "step change". And so the example of a cardiac cath that I gave. So, you need a certain level of staff to treat one patient, then you can treat up to - I'll make the number up for illustrative purposes - you can treat another, let's say, a number of staff can maybe treat another 15 patients, but when they get to the 16th patient, we've got to take another staff member on. And so, that is step change, and I would suggest that some of the facilities were at the top of the step change, yep.

Q. In paragraph 128, you tell us that "key quality and safety performance indicators have not been impacted by the efficiency improvement program, although the position may change over the next two years." Do you see that?
A. Yes.

Q. What are the key quality and safety performance indicators you are referring to there?
A. Those in our service agreement.

Q. So in terms of surgery waiting times; things like that?
A. Yes, and transfer of care in emergency department, et cetera.

Q. But what is the reason why that may change over the next two years?

A. Because of that step change, because we're going to need to open some more capacity, because of the presentations will get to the point that unless we take that step change, we will end up impacting on wait times in the emergency department, transfers of care. Yeah. So it is about how much you can do within the same amount of staffing.

Q. So there is limited - as we have discussed - limited levers that can be pulled to slow the activity coming through the facilities, correct?
A. In the short term, yes.

Q. There's limited or no funding available for activity performed over those targets, correct?
A. Yes.

Q. There's flow-on effects to the delivery of other services by increased activity coming through the district, such as elective surgery waiting times and the like?
A. Yes.

Q. And a number of these things are subject to key performance indicators in your service agreement; is that right?
A. That's correct, yes.

Q. Is there a tension between the number of those key performance indicators?
A. Yes, there is. That's right. And I guess every day we're balancing the need to ensure that we continue to provide quality care to our community, strive to meet our key performance indicators and do that with an efficient delivery model.

Q. One of the examples you give in this paragraph is that the measures the district is having to implement will likely have an impact on overdue planned surgery waiting times?
A. Yes.

Q. One of your KPIs?
A. Yes, that's correct.

Q. You then tell us that alternative strategies are being put in place to mitigate the impacts?
A. Yes.

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

the Ministry of Health is funding us - it's close to $4 million - to put in an expert team to do inreach into residential aged care. So that includes a clinical nurse consultant, some other expert nurses in partnership with advanced care paramedics, and so referral from the residential aged care provider will channel through a different - whatever routes to that team. It is a virtual urgent care service. And then that urgent care is despatched into the residential aged care provider.

So the funding - we're effectively the fund-holder for that service, and we contract, in this case, the aged - sorry, the advanced care paramedic as partners with our team to do that. So it's complimentary - I will come back to my earlier comments; complimentary scopes, aligned vision and values, established referral pathways, inreach into a home, keeping people well at home, and that has definitely - I can't remember the number, but I can tell you after this, the number of avoided ED presentations - there certainly has been a number of avoided ED presentations as a consequence of that.

THE COMMISSIONER: Q. Sorry to interrupt you, but the term "urgent care service", should I understand that that is a state NSW Health service, not a Commonwealth service?
A. Commissioner, so both the State and Commonwealth have funded urgent care services.

Q. Yes.
A. The model that I've just described is unusual insomuch as it is virtual.

Q. Right. Is it funded only by NSW Health?
A. Yes, that's correct. Yes.

MR GLOVER: Q. Do you see a scope for that type of approach to commissioning of services and funding to be rolled out more widely?
A. Yes, I can use an example from New Zealand, if that's helpful. So in Canterbury, where I was working, there was a model run by Pegasus which is the primary health organisation equivalent to PHN here. They ran a service where they contacted community nursing a general practice, home care supports, allied health with the support of the ambulance service, and then they would dispatch care teams to homes for a wide variety of conditions. The local health district funded that - district health board.

Sorry, the district health board funded that in partnership with some funding directly from the government, as well as from partnered-in-practice team.

So it is a pooled funding model, but Pegasus did that on behalf of a range of providers. So they were a funding model. They had an integrated technology system, a shared care record. So whichever provider was providing that care, they could input into that shared care record. And just before I finished in that role, the residential aged care providers were also contributing into that shared care record, and so that continuity of care element made a material difference to the care that those patients were receiving.

THE COMMISSIONER: Q. Sorry to interrupt you. I am told, because of an industrial issue, we have to be fully vacated the building by 4.00, and I am told that to allow everyone enough time, particularly those assisting us to get out, we have to finish in effectively five minutes. Just in relation to that, as I said in my note, in terms of Ms Maisey - sorry, can I just ask you, I don't think Mr Glover is going to finish in five minutes. Do you need to go home tonight? And before I say that, it will make no difference to us if you do, because we can adjourn your evidence part-heard and finish it remotely if that's more convenient to you?
A. I am booked to fly home in the morning, yes.

Q. Right. What time in the morning? Early? Yeah. I think what we will do then is not inconvenience Ms Maisey. We will adjourn her evidence part-heard and we will find a day and time that is convenient to finish it off. It will probably be an hour at most, or whatever. It doesn't matter. But we will do that at a time that suits you as well as us, but doesn't mean you don't get home tomorrow morning.

MR GLOVER: Can I use the five minutes?

THE COMMISSIONER: You can, but I've got something else to say that we need to sort out within the time that we've got.

Dr Grotowski - I hope I have said that right. Did I? Yes. Sorry. Dr Grotowski is scheduled to start at 9.30 tomorrow morning but has to be finished at 10.30. Does

that mean we should start earlier than 9.30? 9.15?
MR GLOVER: 9.15.

THE COMMISSIONER: All right.

THE WITNESS: Commissioner, I'm happy to change my flight.

THE COMMISSIONER: No, no. I think that's crazy; you need to get back to work. I am not going to have you miss a flight for 20 minutes or an hour's evidence, so we'll - you're - no, you want the rest of the four minutes?

MR GLOVER: Yes.

Q. Just very quickly, and we might return to this next time we see you, but in paragraph 130 and again in 131, you describe funding models that are outcomes-based?
A. Yes.

Q. In the three and a half minutes we have left, what do you mean by an outcome-based funding model?
A. So, easiest if I use the example I've just given you?

Q. Yes. Yes.
A. And so that funding model which the district health board funded Pegasus to coordinate that care, the service level agreement that we had with them had a range of indicators within it, input/output outcome, and so the outcome was around avoidant transfers to the emergency department. It was around the clinical care that was provided and readmissions. It was also around our patient reported outcome measures, PROMs. It included a range of financial outcomes. Our expectation was that service delivery model was avoiding future cost, and so there was some economic analysis done around if those patients had come to hospital, the likelihood of them being admitted and the likely costs. So it was avoiding - it wasn't necessarily cash savings, but it was avoiding future cost.

Q. So the funding was delivered to those services based on the outcomes that were likely to be achieved; is that how it operated?
A. It was - to be fair, it was a mix of an input and an outcome based funding model, yes.

MR GLOVER: We will explore this further next time.

THE COMMISSIONER: All right. Thank you very much for your time today. We are very grateful. You are not released, but you are excused for now, and we will make arrangements for a convenient time to finish your evidence remotely, so thank you. We will otherwise adjourn until 9.15 tomorrow morning. So we will adjourn until then.

<WITNESS STOOD DOWN

AT 3.45 PM THE HEARING WAS ADJOURNED TO 9.15 AM ON THURSDAY, 19 SEPTEMBER 2024

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