



LEGISLATIVE COUNCIL

BUDGET AND FINANCE COMMITTEE

Watarru Room, Old Parliament House, Adelaide

Monday, 11 February 2019 at 10:05am

BY AUTHORITY OF THE LEGISLATIVE COUNCIL

WITNESSES

DWYER, LESLEY, Chief Executive Officer, Central Adelaide Local Health Network	443
MARTIN, CHRIS, Administrator, Central Adelaide Local Health Network	443
MENTHA, MARK, Administrator, Central Adelaide Local Health Network	443
REID, MICHAEL, Deputy Chair, Central Adelaide Local Health Network Transition Board	443

MEMBERS:

Hon. K.J. Maher MLC (Chairperson)
Hon. J.A. Darley MLC
Hon. J.E. Hanson MLC
Hon. D.G.E. Hood MLC
Hon. F. Pangallo MLC
Hon. C.M. Scriven MLC
Hon. T.J. Stephens MLC

WITNESSES:

DWYER, LESLEY, Chief Executive Officer, Central Adelaide Local Health Network
REID, MICHAEL, Deputy Chair, Central Adelaide Local Health Network Transition Board
MENTHA, MARK, Administrator, Central Adelaide Local Health Network
MARTIN, CHRIS, Administrator, Central Adelaide Local Health Network

3525 The CHAIRPERSON: Welcome to this meeting today of the Legislative Council's Budget and Finance Committee. The Legislative Council has given authority for this committee to hold public meetings. A transcript of the evidence you give today will be forwarded to you for examination for any clerical corrections. Should at any time you wish to present confidential evidence to the committee, please indicate and the committee will consider your request. Parliamentary privilege is accorded to all evidence presented to a select committee; however, witnesses should be aware that privilege does not extend to statements made outside this meeting.

All persons, including members of the media, are reminded that the same rules apply as in the reporting of parliament. Further, I remind the camera operators that, as in the chamber, they are to focus on witnesses or members speaking and not film other members of the committee or those in the gallery. I will introduce the members of this committee for you. On my left are the Hon. Clare Scriven, the Hon. Justin Hanson and the Hon. Frank Pangallo. On my right are the Hon. Terry Stephens, the Hon. Dennis Hood and the Hon. John Darley.

In just a moment we will get into questions proper. It is a very large subject matter to cover. I think most members will want to ask questions, so we will move quite rapidly through them. If a member feels that you have answered a question, they will probably let you know and move on to the next question. They are not being deliberately rude, but there is a lot to get through and we will try to move on to as many questions as possible. Firstly, can you introduce the people sitting at the table and any other officers from the health department or from KordaMentha who are with us in the gallery today.

Ms DWYER: I will make a start. I'm Lesley Dwyer. I'm the Chief Executive Officer of the Central Adelaide Local Health Network, known as CALHN. To my left is Michael Reid, who is the Deputy Chair of the CALHN board, which has been constituted by way of a steering committee for our recovery program. This is Mr Mark Mentha and Mr Chris Martin. They are KordaMentha recovery partners. I am going to have to turn around, if that's okay, to find out who I have here. We have three colleagues from KordaMentha. Do you want to know their names?

3526 The CHAIRPERSON: Yes, that would be useful.

Ms DWYER: Sophie Gibbons, James Wagg and Noah Jacobson. Looking around here, I have Helen Rodwell. Helen is our company secretary and corporate governance person. From the department, we have Hayley McDonald, who is part of our comms team.

3527 The CHAIRPERSON: Hansard records everything that's said. I know you're turning around to look at who's here, but make sure you speak into the microphone so they can properly understand.

Ms DWYER: I'm sorry. Helen Rodwell is our board secretary and corporate governance person, and Hayley McDonald is from SA Health's media team.

3528 The CHAIRPERSON: We usually afford witnesses appearing a very brief opening statement if there is something you want to say at the start. Bear in mind, as I said, that there are lots of questions, so we would ask if you could keep your statement very brief.

Ms DWYER: I will go as quickly as I can then. Thank you very much for allowing us to come and present to the Budget and Finance Committee. As many of you would know, I commenced at CALHN as the chief executive at the end of November last year. That was the same day that we began our recovery journey and launched the CALHN Organisational and Financial Recovery Plan, which we call our recovery plan.

For me, the release of the diagnostic review and recovery plan was a very significant turning point for CALHN in that it brought to light just how broken we had become. It sent a very clear message that our current state is preventing us from meeting the standards that we, the community and, most importantly, the patients that we care for expect of us.

As outlined in the KordaMentha diagnostic report, without meaningful intervention CALHN was forecast to incur a cost overrun of \$300 million. That includes statewide services for the 2018-19 financial year. Where we are right now means that our poor performance is systemic and unsustainable and we do need to do better.

I said in my first week in the role that I would not have taken the role if I thought that recovery was an impossible task. I have seen organisations perhaps not of the scale of CALHN but certainly organisations that I would term had been broken and where ownership of those organisations—the staff themselves—saying there was something that we needed to change has made a significant difference. Having successfully led these organisations, I do know that it's possible, but I also know that it's not possible without help.

As administrators, Mark Mentha and Chris Martin have been employed by CALHN—by me—as public servants. Both report to me as the chief executive. They have no involvement in clinical care. It is self-evident that our doctors, nurses and allied health workers are continuing to be in charge of all clinical decisions.

At the heart of my role as chief executive is patient safety and improving the quality and effectiveness of the care we provide. The governance structure is very clear. The administrators report to me. Together, we have adopted the one program, one team approach and this is all about ownership. This is not KordaMentha's recovery program—it is all of ours within CALHN. I often refer to a motto. I write a letter to the staff every Friday where I always end it with, 'If not us, then who?' That's about us picking up this challenge and saying that we can make a difference and I think it really does resonate with the challenges ahead.

Further, the CALHN transition board, as I mentioned, under the extremely capable chairmanship of Raymond Spencer and the deputy, Mick Reid, who is here today, will provide governance and oversight during the implementation of the recovery plan until the board officially commences in July 2019. Raymond has extensive business experience and Mick has been a director general in both New South Wales and Queensland. Mick is considered to be an expert in the delivery of public health services in Australia. KordaMentha is also well known to South Australians through its important work in the recovery of the Whyalla steelworks.

After coming onboard, not only Mark and Chris but the whole KordaMentha team have become an integral part of the organisation. Leading from the front, they are discharging their duties professionally and with considerable insight and empathy. This type of skill set has not been a feature within CALHN, or I could say within health overall, and we did need a different approach.

To strengthen the knowledge and ongoing skills in CALHN, we have seconded almost 20 of our own staff to work on the program and have adopted an approach whereby all work streams, specific activities and programs are co-sponsored by both KordaMentha and a CALHN representative. This is really important to make sure that we build both the capability and the capacity

for additional skills and experience and that they will be embedded within CALHN. At the end of the day, KordaMentha will leave us in a better state, but then we need to continue the recovery program.

The recovery plan has one simple aim, which is to reposition CALHN as a high performing and accountable healthcare network that operates to Australian benchmark standards across all domains. We know that this can be done, and I, in particular, know it can be, as many of the CALHN's national peers are operating at higher levels across a range of clinical performance indicators and accepted benchmarks. Whilst the recovery program is at a very early stage, we are picking up the pace.

I am pleased to inform the committee that there are several organisational recovery green shoots or performance improvements that are already evident. In particular, CALHN's use of agency staff reduced significantly at the start of this year. Agency nursing peaked in January 2018 at 7.7 per cent of our workforce; that is extremely high. It has now dropped to a low of 1.4 per cent in the fortnight ending 4 January, during which, historically, we have had a high agency use. It continues to track at under 2 per cent, which is much closer to where you would want it to be.

Significantly, the organisational recovery team have invested considerable time and effort in ensuring that patient medical coding is being completed in an efficient and timely manner. Importantly, the backlog of uncoded separations inherited by the administrators and myself is being reduced, with the expectation that the full backlog will be completed in coming weeks. This is in addition to the newly embedded controls on appointments and procurement, which are long overdue, and I spearhead both of those. It is what you would expect in an organisation—that we have (and pardon me for using an NHS term) sufficient grip and control in what we are doing.

It remains clear that capacity and access to hospitals and treatment remain major issues for us. It is a priority area and we need to look at different ways to create better patient journeys across our sites. Over many years, our hospitals have been choking, meaning that we lack the capacity to deal with surges, such as flu season, or to bring down our elective waiting lists. It is absolutely not good enough to accept that hospitals are always full and that ambulances will always ramp. It is absolutely my job as the chief executive to create the breathing space required to meet demand, to bring down waiting lists and to create capacity and access to flow, and that's exactly what I intend to do.

It has been well recorded, particularly in the last few days in the media, that January 2019 was the busiest month on record for emergency department presentations, both at the Royal Adelaide and at The Queen Elizabeth. The Royal Adelaide emergency department is now averaging 237 presentations per day, whereas before it had been 215. While you might be thinking that almost an extra 20 patients a day does not make a difference; for a hospital that is unable to have flow consistently, it makes a big difference, particularly to the number of people who can get through our front door.

There are many lessons that we can learn towards better planning, and this week, on Thursday, we are holding a summit to stop ramping, bringing together staff from across the network, including our Ambulance Service colleagues, community health professionals and also borrowing a couple of international experts who happen to be in town, to find solutions with real action that will relieve this pressure. I am the first to say that ramping is not okay, and I know that one gathering won't solve the problem, but it is an important first step in working together towards improving South Australia's health services to ease pressure on our emergency departments. It is something that you will not see to the degree that we do and we have normalised. Ramping is not good for patients, it's not good for staff, it's not good for the health system.

I often refer to the term, 'What you walk past, you accept,' which goes back to addressing the cultural issues across CALHN. I introduced a whistleblower hotline in November 2018, and to this date there have been 40 calls from CALHN staff. This does not take away the other routes for people to raise concerns. I do want to get to a position where I will not need a whistleblower hotline and that people will feel supported to be able to raise issues. The majority of these complaints, though, through the hotline, have been related to bullying or work health and safety concerns, which goes to the cultural issues that have been allowed to grow over many, many years.

As I stated earlier, I'm encouraged by the number of green shoots that have emerged both operationally and financially that reflect the early efforts of the recovery program. Furthermore,

I am most encouraged by the early response of the vast majority of the CALHN team who have evidenced an enthusiasm for change and who continue to deliver care to our patients and the community we serve. Thank you.

3529 The CHAIRPERSON: Thank you for that opening statement. Mr Martin, are you appearing here today as a public servant or as an external consultant in your role as a liquidator?

Mr MARTIN: We are appearing here in both capacities. We are employed, in my case, as 0.8 of an FTE, and in Mr Mentha's case it is 0.4, and we have also received the authorisation of the chief executive to conduct external employment under KordaMentha.

3530 The CHAIRPERSON: Is that a feature of what you do? Are you doing everything you do in both capacities: there's no delineation between when you are a public servant or when you are acting as a liquidator?

Mr MARTIN: To correct the record, I am not liquidator; I'm a qualified solicitor and chartered accountant and have considerable experience in business. That's just to be clear about my professional standing. No, I think it would be a mischaracterisation to say that everything we do is in both capacities.

3531 The CHAIRPERSON: When are you a public servant and when do you act in your role as an external consultant with KordaMentha?

Mr MARTIN: We have been provided with certain delegations in our capacity as administrators of CALHN reporting to the CEO. When we are exercising those delegations we are acting in the capacity of a public servant, otherwise we are acting in our capacity as partners of KordaMentha.

3532 The CHAIRPERSON: So only at the time that you are exercising delegations do you consider that you are a public servant; at all other times you consider that you are an external consultant—is that what you are telling us?

Mr MARTIN: No, obviously at all times I am a public servant. As a matter of fact, based on the employment contract, there's a question of the notional allocation of time and responsibility. KordaMentha, as you are no doubt aware, has a separate contract with SA Health which also requires KordaMentha to deliver a range of professional services which we are also providing.

3533 The CHAIRPERSON: I'm a little bit confused. You said today you are here as both, so are you charging time as a consultant to be here today?

Ms DWYER: Perhaps I could help.

3534 The CHAIRPERSON: That would be good, but I have asked Mr Martin what is his understanding and I'm sure that if you want to add something after he answers that would be great.

Mr MARTIN: The position, I guess, as opposed to my understanding, is that Mark Mentha and I are receiving a salary in our capacity as South Australian public servants which has been deducted from the KordaMentha contract value. Effectively, as far as the state is concerned, there is no higher or lower cost in terms of whether or not I'm appearing here as a public servant or appearing as a partner of KordaMentha.

3535 The CHAIRPERSON: Are there different responsibilities and obligations that you have in those two roles?

Mr MARTIN: Could you be more specific? Clearly, as an employee of KordaMentha—

3536 The CHAIRPERSON: I might get to both of those things in a moment. Just to confirm: you have signed a contract with the chief executive of SA Health as an executive in the public sector. At what level is that?

Mr MARTIN: That is at the same level as the chief executive of CALHN.

Mr MENTHA: It's at level 2 under the status of South Australia's executive services contract—so level 2.

3537 The CHAIRPERSON: Yes, and perhaps both Mr McGowan and Mr Martin, when you were appointed were you interviewed for the position and do you know whether others were interviewed in competition with you for these positions?

Mr MENTHA: In reference to our employment, I would have to defer to the CEO.

Ms DWYER: There was a tender process for the current arrangements. I do need to be clear that that occurred before I started but SA Health ran that procurement.

3538 The CHAIRPERSON: Mr Martin, for your employment was there a formal interview like most other people go through for a job interview? Do you recall?

Mr MARTIN: There was a formal and very public procurement process, yes.

3539 The CHAIRPERSON: Were other candidates interviewed? Was it a merit-based selection process for the level 2 public sector job that you have, or were you it, basically?

Mr MARTIN: You would have to ask the individuals who conducted the procurement process.

3540 The CHAIRPERSON: You are not aware of a merit-based selection process where interviews occurred with other people and referee checks were conducted?

Mr MARTIN: I'm not aware of any of the details that were undertaken in respect of the procurement process, as would be appropriate for me not to be aware.

3541 The CHAIRPERSON: We talked about your employment as a public sector employee; I think it is section 10.1.3 of your contract foreshadows that you could be reappointed at the end of this year for a term of up to three further years. Is that correct?

Mr MARTIN: I could check my contract, but I am prepared to take your word on that matter.

3542 The CHAIRPERSON: And I think you said your public sector contract is a 0.8 FTE.

Mr MARTIN: Yes.

3543 The CHAIRPERSON: The other 0.2 of your working time, what is it that you do with that?

Mr MARTIN: Well, I'm spending all of my time working on the organisational and financial recovery of CALHN.

3544 The CHAIRPERSON: What's your remuneration for the 0.8?

Mr MARTIN: Would you like me to look that up or would you—

3545 The CHAIRPERSON: I just want to check: if it is page 3, schedule 5 of the service agreement, the daily rate is a bit over \$5,000. Would that be your rate, Mr Martin?

Mr MARTIN: No, that is not correct. I just need to find the reference.

3546 The Hon. T.J. STEPHENS: Chair, isn't 0.8 of a—what was it?

3547 The Hon. J.A. DARLEY: Level 2.

3548 The Hon. T.J. STEPHENS: Isn't that public information that you can look up yourself?

3549 The CHAIRPERSON: I'm not sure. That's why I have a couple of questions that will get to that—whether it is a public sector rate or whether it is the contract rate.

Mr MARTIN: It's a public sector rate.

3550 The CHAIRPERSON: The financial arrangements on schedule—and you might have it before you, the service agreement, I think it is page 5 of 10, schedule 3, financial arrangement, at pages 5 and 6; on page 6 it talks about the total professional fees for the 12-month KordaMentha contract being \$13.9 million over 13.5 FTEs. So am I right in saying that each FTE for the year that the contract is for is costing a total of about \$1 million each?

Mr MARTIN: I'm sorry. There are a number of questions in that question. Could I first of all ask you to show me which document you are referring to so that I can have a—

3551 The CHAIRPERSON: There is a services agreement between CALHN and KordaMentha that outlines at schedule 2—I think it is affixed to the contract—specifications of the services agreement. Are you familiar with that?

Mr MARTIN: If I could have the document identified to me.

3552 The CHAIRPERSON: I can pass this up to you and you can pass it back so I can refer to it, that might help you.

Mr MARTIN: Yes, thank you. Yes, I am familiar with that document.

3553 The CHAIRPERSON: So the table there on page 6, at the bottom of the table it talks about the total professional fees—that is, the fees for individuals from KordaMentha who are contracted—being \$13.9 million, and it says that is across 13.5 FTEs. So it might not be what the individuals are getting in their pocket, because of course some will go back to the company, but in effect it is costing the taxpayer \$1 million per person, isn't it?

Mr MARTIN: That is not how I would characterise the contract. When KordaMentha is engaged on a highly complex, difficult turnaround such as the one that faces us at CALHN we allocate a number of staff specifically to the engagement, which we have allocated here, but in addition to that our clients, in this case SA Health, have full access to all of the resources and capability of KordaMentha. So in addition to the 13.5 staff that are allocated, SA Health and the other relevant stakeholders have access to the full resources of KordaMentha as required in order to complete the organisational and financial recovery.

3554 The CHAIRPERSON: And the total cost of the contract is about \$20 million, isn't it, when you include everything else?

Mr MARTIN: I think it's a fraction under that.

3555 The CHAIRPERSON: Eighteen point something plus GST, so around \$20 million.

Mr MENTHA: If I can just correct you, Chair, it's \$18.9 million.

3556 The CHAIRPERSON: And GST on top of that?

Mr MENTHA: Yes.

Ms DWYER: Yes, it is.

3557 The CHAIRPERSON: So a bit over \$20 million when the GST liability is included. So the \$13.9 million is part of that, and that is professional services, which includes 13.5 FTEs, and then there is another \$5 million or so on top of that. What does that buy the state government?

Mr MARTIN: As per the contract, which I understand has been released some time ago, in addition to the dedicated KordaMentha staff and the additional KordaMentha resources we have brought in a range of external industry experts who are working both with KordaMentha and CALHN.

3558 The CHAIRPERSON: Getting back to your employment contract, you are remunerated at a level of the executive level 2 for your 0.8.

Mr MARTIN: Yes.

3559 The CHAIRPERSON: And then any additional payment is as an equity holder in the company that earns fees from this contract? You are not paid extra as a consultant on top of your executive level appointment?

Mr MARTIN: I'm not sure I understand the question but, to the extent I do, the answer is no.

3560 The CHAIRPERSON: Are you paid anything more for your work except that of an executive level 2 public servant?

Mr MARTIN: I am paid my salary by my employer, in this case KordaMentha.

3561 The CHAIRPERSON: And part of that comes from the state government contract?

Mr MARTIN: KordaMentha is a very large organisation with hundreds and hundreds of live engagements, so I think that would be a mischaracterisation of the derivation of my salary from KordaMentha.

3562 The CHAIRPERSON: Who do you report to in terms of this contract and your role as a public servant? I understand you have had trouble delineating when you are a public servant or when you are an external contractor, but let's say they are the same thing and you have the same duties and responsibilities: who do you report to?

Mr MARTIN: I don't think I've had any difficulty delineating. In terms of my appointment as administrator it is quite clear that both Mark and I report to the chief executive officer, being Lesley. In terms of my KordaMentha employment, I refer to the principal of the firm, Mark Mentha.

3563 The CHAIRPERSON: In your role in the health department, what level of financial sign off do you personally have?

Mr MARTIN: Again, to correct the record, I have no role in the health department. I am appointed as an executive reporting to the CEO in CALHN, and we have been given financial delegations as would ordinarily be expected with a person in that position, which we can provide a copy of to this committee if need be.

3564 The CHAIRPERSON: That would be useful, if you're happy to do that. As 0.8, do you envisage you will be undertaking other work besides your work for CALHN over the next 12 months—or potentially four years, as the contract envisages?

Mr MARTIN: Again, to correct the record, the plan envisages a three-year financial recovery plan, not a four-year plan, and no, I do not envisage undertaking any other paid work.

3565 The CHAIRPERSON: Are you required to seek permission, as a public servant, to undertake any further work or have you been given a blanket permission to do that if you wish?

Mr MARTIN: We are required to seek permission from Lesley, being the CEO, in order to undertake any additional work. That approval has been sought and received.

3566 The CHAIRPERSON: That is for both you and Mr Mentha?

Ms DWYER: Yes, it is.

3567 The CHAIRPERSON: So you are able to do your work for CALHN and then undertake any other work that you desire to do and you do not have to get permission to do that, there has been a blanket permission already granted. Is that what you're saying?

Mr MARTIN: No; that is most definitely not what I'm saying.

3568 The CHAIRPERSON: What are you saying?

Mr MARTIN: I am saying that permission has been sought and granted.

3569 The CHAIRPERSON: To undertake what other work?

Mr MARTIN: To maintain our employment with KordaMentha in order to discharge the contract with SA Health in respect of the financial and organisational recovery of CALHN.

3570 The CHAIRPERSON: I think I haven't been clear in my question. Are you able to do work outside of that for CALHN, work for other companies or other organisations around Australia or internationally?

Mr MARTIN: Theoretically, I suppose, yes. However, given the hours that the broader KordaMentha and CALHN team are making I think that is a very unlikely set of circumstances, and not one that I would be anticipating occurring.

3571 The CHAIRPERSON: And if you do that, do you have to seek permission do that?

Mr MARTIN: Yes.

3572 The CHAIRPERSON: Just to be clear, that is not already granted in your contract, that you have permission to do that outside work?

Ms DWYER: Not within the contract, it's not; that is my understanding. I have to formally be requested, what that work would be. I don't need to know the commercial arrangements per se, but I then need to give permission.

3573 The CHAIRPERSON: So for any outside work, you need to give permission to do it? Okay. In terms of undertaking your work, Mr Martin, are you required to comply with the public sector Code of Ethics?

Mr MARTIN: Yes.

3574 The CHAIRPERSON: What does that mean in relation to if you wanted to do outside work in terms of conflicts that you may have with your work here?

Mr MARTIN: I refer to my earlier comments that I'm a public servant in respect of 0.8 of my available employment allocation, and 0.2 for KordaMentha. It says nothing in respect of my ability to redirect the time in respect of the 0.2 KordaMentha other than to say that all my time is currently being clearly directed to the financial and organisational recovery of CALHN.

3575 The CHAIRPERSON: What is your email address when you are doing this work? How do people contact you by email?

Mr MARTIN: For this work, there are two emails addresses: one is in respect of my KordaMentha email address, which is obviously an email address that I have had for many years, and have had in my employment as KordaMentha; and the second email address is an SA Health email address.

3576 The CHAIRPERSON: Have you received any emails about SA Health matters to your KordaMentha email address?

Mr MARTIN: That is a very broad question. Can I ask: what matters over what time frame from who?

3577 The CHAIRPERSON: Since your engagement as a member of the SA public sector, have you received any emails to your KordaMentha email address that deal with CALHN matters?

Mr MARTIN: There are a range of CALHN matters that would be entirely appropriate for me to receive emails on, such as the contract between KordaMentha and the state. I will have to take that question on notice.

3578 The CHAIRPERSON: What do you understand are your responsibilities under the State Records Act and the Freedom of Information Act in relation to correspondence and emails?

Mr MARTIN: We have received a briefing in respect of the relevant FOI legislation in South Australia, and we are aware of our obligations under that legislation.

3579 The CHAIRPERSON: Are you able to give a summary of what you understand them to be?

Mr MARTIN: I am not a qualified solicitor, so I don't think it would be appropriate for me to do so.

3580 The CHAIRPERSON: As a public servant, and your reporting duties to the Independent Commissioner Against Corruption, do you have an understanding of what your responsibilities are?

Mr MARTIN: Yes, not only do we have an understanding but we have met with the commissioner and several of the commission staff and expect to do so on a regular basis.

3581 The CHAIRPERSON: Given that you have a good understanding of those, do you want to outline what you understand them to be?

Mr MARTIN: I think it's inappropriate in this forum, given that I am not a qualified solicitor and we are receiving legal advice, for me to attempt to summarise what is a very important and complicated body of law.

3582 The CHAIRPERSON: I will take you to a document that's an attachment—the industry participation plan. Are you familiar with that part of the contract?

Mr MARTIN: Yes.

3583 The CHAIRPERSON: It's mentioned in there—and I am happy to pass up this piece of paper—that the tender value is some \$43 million. Was that in anticipation of future work to be done? Are you able to explain what that figure relates to?

Mr MARTIN: Absolutely. Under the industry participation guidelines, it is a requirement that any prospective tenderers, if the contract duration is unknown or potentially to be extended, put an estimate in terms of the longer dated value of that contract in the event the contract was extended.

3584 The CHAIRPERSON: That's what you estimate the contract could be worth to KordaMentha—\$43 million?

Mr MARTIN: Based on the initial 12-month contract, that is a reasonable estimate at this point in time.

3585 The CHAIRPERSON: So we have the \$18.9 million, plus GST, contract for one year. Is that \$43 million on top of the \$20 million or inclusive of the \$20 million?

Mr MARTIN: As per the industry guidelines, it's inclusive of the initial year.

3586 The CHAIRPERSON: What you would envisage, should you keep doing work, is a contract that's in total worth \$43 million to KordaMentha?

Mr MARTIN: Subject to information available at the time and the knowledge had at the time, yes.

3587 The CHAIRPERSON: And this formed part of the industry participation plan? Are you aware of the South Australian government's industry participation policy in terms of local participation in government tenders?

Mr MARTIN: In part.

3588 The CHAIRPERSON: Are you able, off the top of your head (or I can give you the three or four pages near there), to say what KordaMentha put in their tender for local industry participation; that is, how many local people will be employed as part of this potential \$43 million contract?

Mr MARTIN: Well, it's an \$18.9 million contract, with no guarantees or—

3589 The CHAIRPERSON: No, that's why I did say 'potential'; I didn't say 'actual'.

Mr MARTIN: So, no, I would like to look at the document you are referring to, please.

3590 The CHAIRPERSON: I will pass that up. You will see that under a number of them there are questions about engaging local business or local components.

Ms DWYER: While Mr Martin is looking at that, I will perhaps remind you, as I said in my earlier statement, that it's been terribly important for us that we have our own staff who are working alongside KordaMentha. Currently, we have 20 of those.

3591 The CHAIRPERSON: I appreciate that. I know that when there's an actual contract of \$20 million, and a potential contract of \$43 million, I'm sure many would hope or expect there's some benefit directly from that contract to South Australia. Is it the case that there's not a single South Australian being engaged as part of this current \$20 million and potential \$43 million contract by KordaMentha?

Mr MARTIN: That's a different question to the question you proposed prior to handing me the document.

3592 The CHAIRPERSON: Well, I'm asking that question.

Mr MARTIN: At present, CALHN are receiving the benefit of some legal advice from a high-quality, South Australia-based legal firm.

3593 The CHAIRPERSON: In terms of the KordaMentha side of it, are there any South Australian individuals engaged, or is it all interstate people flying in and flying out of South Australia?

Mr MARTIN: Do you mean currently—

3594 The CHAIRPERSON: Engaged by KordaMentha.

Mr MARTIN: When you talk about South Australians, though, do you mean individuals born in South Australia or individuals currently residing in South Australia?

3595 The CHAIRPERSON: Individuals currently residing in South Australia.

Mr MARTIN: The KordaMentha team is, by and large, currently residing in South Australia.

3596 The CHAIRPERSON: Are they full-time living in South Australia, not flying in on Monday morning and flying out Thursday or Friday?

Mr MARTIN: Thinking through the individuals, I think the majority, if not all the individuals, are currently conducting a fly in generally on a Sunday night or a Monday morning and flying out.

3597 The CHAIRPERSON: So, to the best of your knowledge, everyone KordaMentha is engaging directly is coming out from somewhere around the country, flying in to Adelaide to work during the week and then flying back out.

Mr MARTIN: As was outlined in the tender document and response and the South Australian industry plan, yes.

3598 The CHAIRPERSON: Is the cost of that travel included in the \$20 million, or is that in addition to that?

Mr MARTIN: Again, it's an \$18.9 million 12-month contract and the cost of all travel is included.

3599 The CHAIRPERSON: Included in that?

Mr MARTIN: Yes.

3600 The CHAIRPERSON: How do most people fly? Do they fly economy or business class when they come into South Australia?

Mr MARTIN: All individuals fly economy unless those individuals elect to use their frequent flyer points, if available, to upgrade.

3601 The CHAIRPERSON: Where do most of the people in your fly-in fly-out team stay when they are here?

Mr MARTIN: We stay in a range of serviced apartments located throughout Adelaide and the inner suburbs of Adelaide.

3602 The CHAIRPERSON: Are you able to provide an approximate cost—I will let you take it on notice to provide the exact cost—of how much that's costing the South Australian taxpayer, flying people in and out every week and putting them up in serviced apartments, as compared with if everyone was actually resident in South Australia?

Mr MARTIN: That question contains a fundamental misassumption in terms of how the contract price was developed and negotiated. It was developed and negotiated on the basis that it was an \$18.9 million capped arrangement for 12 months—

3603 The CHAIRPERSON: Indeed, but—

Mr MARTIN: —so there are no details available in terms of the individual components of individual expense items.

3604 The CHAIRPERSON: You're not prepared to look at how you internally account for the cost make-up of your contract? You would have that. Are you prepared to let us know what that is?

Mr MENTHA: With respect, sir, I think it's an issue for KordaMentha in the way they priced the contract.

3605 The CHAIRPERSON: Well, Mr Mentha of KordaMentha, are you able to let us know what component of that \$18.9 million is flying people in and out?

Mr MENTHA: I don't think it's relevant, in that we have provided a contract—

3606 The CHAIRPERSON: Indeed, but I'm sure—

Mr MENTHA: —and the starting point of that contract was far in excess of the current contract we have contracted out. So, in many respects, KordaMentha have absorbed the cost of the travel and the accommodation to meet the price point that was negotiated by South Australian procurement. It is our cost to KordaMentha, not to the state of South Australia.

3607 The CHAIRPERSON: Are you happy to take on notice and provide what the costs, then, you say you are absorbing are?

Mr MENTHA: I'm saying they are costs of KordaMentha and—

3608 The Hon. T.J. STEPHENS: It's none of your business.

Mr MENTHA: —they're part of our business, not the business of what I would have thought was this committee's. Further, having lived in Whyalla for 18 months, I almost feel like I am a South Australian, and when I wake up and read decisions that we have made in Whyalla, formulating sponsorship of Port Adelaide overnight—

3609 The Hon. T.J. STEPHENS: That could be a tragedy. Don't go down that path.

Mr MENTHA: Well, it's one of many tragedies that we are dealing with here in South Australia at the moment.

3610 The CHAIRPERSON: Can I ask, Mr Martin, with the previous contract before the most recent appointment, was cost included? In every contract you have had with SA Health or CALHN over the last 12 months, have travel costs been included in that, or in some of them has that been extra to the contract?

Mr MARTIN: I'd have to check that.

3611 The CHAIRPERSON: Are you able to check that and bring back an answer to that?

Mr MARTIN: Yes.

3612 The CHAIRPERSON: My understanding is that in the original contract to do the scoping work, travel was extra on top of that.

Mr MENTHA: I believe that to be the case.

3613 The CHAIRPERSON: In that case, are you able to let us know how much that cost the South Australian taxpayer, given it was an extra cost and wasn't factored in to the overall cost of the contract?

Mr MENTHA: All our contracts have been fully transparent and the make-up of those costs are available, and we would be happy to provide them to the committee.

3614 The CHAIRPERSON: We'd appreciate that. The recovery plan report identifies the Treasurer is a key oversight person for the implementation of the plan. I'm wondering, Mr Martin, to what extent has the Treasurer been involved in the discussions and implementation of this plan?

Mr MARTIN: I think we have met the Treasurer on a couple of occasions. There are certainly no regular meetings, there are certainly no regular updates. There are no discussions, no direction. SA Health has procured the services of KordaMentha and we are getting on with the job.

Mr REID: Mr Chair, just to re-emphasise, the question is about implementation and the implementation is the responsibility of the CEO. So I think those questions about implementation, which KordaMentha are not responsible for as they are employees helping to deliver, would probably be better handled as a conversation with the Treasurer which might be more appropriate with the CEO and the head of the agency rather than KordaMentha as employees in this case.

3615 The CHAIRPERSON: I appreciate that.

Mr REID: That's distinct from the diagnostics. The diagnostics were for the external contractors, KordaMentha, who are doing it. At this stage, they are employees.

3616 The CHAIRPERSON: Mr Martin, yourself, how many times have you met with the health minister?

Mr MARTIN: I would need to refer to my diary.

3617 The CHAIRPERSON: Very approximate.

Mr MARTIN: Three times.

3618 The CHAIRPERSON: A similar number of times with the Treasurer as with the health minister would be a reasonable thing to say.

Mr MARTIN: Yes.

3619 The CHAIRPERSON: All the other KordaMentha staff involved in this contract, do they have access to hospital sites? That might be something for the chief executive to answer.

Ms DWYER: To hospital sites, yes.

3620 The CHAIRPERSON: Do they have access to hospital procedures?

Ms DWYER: Could you elaborate on what you mean?

3621 The CHAIRPERSON: Do all members of the KordaMentha team have access to what the procedures are at hospitals? I would have thought—

Ms DWYER: You're not talking about clinical procedures. You're talking about—

3622 The CHAIRPERSON: How hospitals operate, do they have access to that sort of information?

Ms DWYER: Yes, they do in an aggregated form.

Mr REID: Except insofar, Chair, that they do not access individual medical records, so they are not part of that, if you are encompassing the word 'procedures' to include individual medical records.

3623 The CHAIRPERSON: I'm wondering, and this might be for all the witnesses, has there been any contact from the Auditor-General in relation to this or any other contract with KordaMentha over the last 12 months?

Ms DWYER: I can only speak during my tenure and I have had no contact with the Auditor-General.

3624 The CHAIRPERSON: Mr Martin or Mr Mentha? Have you had any contact with the Auditor-General over your time?

Mr MARTIN: Not that I'm aware.

Mr MENTHA: Other than referencing his report in our diagnostic, we haven't had any relationship with the Auditor-General.

3625 The CHAIRPERSON: Mr Mentha, this might be better addressed to you. Are you able to very quickly outline the structure of KordaMentha? Is it a public company? How does it operate? Who owns KordaMentha?

Mr MENTHA: KordaMentha is a corporation. Its two principals are my business partner, Mark Korda, and me. We have approximately 400 staff in Australia and through South-East Asia. We conduct a business that is best known for corporate restructuring but it is very broad in that we have a property group that transacts about \$1 billion of property a year. We have a private equity group where we are involved in numerous small businesses and mid-sized businesses. We have several property trusts. We have a forensic business that brings skills, both in digital and court matters, in terms of expert testimony. We have a corporate business which is the business that has been engaged in South Australia.

3626 The CHAIRPERSON: This might be for Ms Dwyer, or Mr Martin might be best to answer it. In relation to this current engagement, the \$18.9 million with the potential for a \$43 million contract, does that require KordaMentha to maintain its current corporate structure to maintain that engagement? Can KordaMentha change, split up, be sold and still have the contract, or does it require the current corporate structure to remain in place?

Mr MENTHA: The current contract runs through to the end of its term in November and it has been procured through KordaMentha Pty Ltd with the state of South Australia. We have milestones to meet and, should we meet those milestones, we will be reconsidered when the time comes for a renewal of that contract for its potential long-term outcome.

3627 The CHAIRPERSON: But if the way KordaMentha is owned as a company, who owns it or how it is structured changes that doesn't affect the contract at all? There is no provision in there?

Mr MENTHA: I think the only specified people in the contract are myself and Chris.

3628 The CHAIRPERSON: So you two have to stay on the contract for it to remain valid?

Mr MARTIN: The contract is public, so we can check the terms of the contract and provide an answer on that specific legal question.

3629 The CHAIRPERSON: Okay. For example, if KordaMentha was sold to a Chinese state-owned entity, would that invalidate the contract or would SA Health still be required to follow through with the contract even if KordaMentha was sold and then owned by an overseas government?

Mr MENTHA: I think we will just have to take that on notice—

Ms DWYER: We will take that on notice.

Mr MENTHA: —but as a principal of KordaMentha, we have no intention of being sold to a Chinese state-owned enterprise nor are we in any negotiation to sell any part of our business currently.

3630 The CHAIRPERSON: So no-one from KordaMentha has been in discussions about selling some or all of what KordaMentha does to overseas firms?

Mr MENTHA: No, not at all.

3631 The CHAIRPERSON: So there have been no discussions with any overseas firms about selling KordaMentha?

Mr MENTHA: We pride ourselves on our independence and in the world of the big four, we see ourselves as having a market opportunity of being independent. In a world of conflict of interest, we believe we are an attraction too. We are a very highly capable resourced firm capable of bringing in the likes of people like Chris Martin, who has a very broad industry background.

3632 The CHAIRPERSON: So you can assure us, Mr Mentha, that while you are doing work for CALHN KordaMentha will not be sold to an overseas firm?

Mr MENTHA: I know Mr Gupta is buying most things around South Australia. He hasn't approached me as yet, but I can categorically state that KordaMentha is not for sale.

3633 The CHAIRPERSON: Did you have some questions, Clare, and then we might open it up a bit? I have a few more, but I'm conscious—

Mr MENTHA: But if you have a price in mind, sir, I would be more than happy—

3634 The Hon. C.M. SCRIVEN: My questions are initially for Ms Dwyer. It has been 10 weeks now since your contract began, I understand, and you said when you started about the importance of developing the detailed implementation plan quickly. So, 10 weeks later, is there a plan for the implementation?

Ms DWYER: Yes, there is.

3635 The Hon. C.M. SCRIVEN: Has that been released publicly?

Ms DWYER: The implementation plan that KordaMentha developed is now our plan and that has been released.

3636 The Hon. C.M. SCRIVEN: Released publicly?

Ms DWYER: Yes.

3637 The Hon. C.M. SCRIVEN: Were clinicians consulted in the development of the plan and, if so, which ones?

Ms DWYER: We have many clinicians who have been part of the development of that plan, but, more importantly, we want a wider group of our clinical staff being part of the implementation. I referenced now twice that we have many of our own staff working as part of the one team for our recovery plan—

3638 The Hon. C.M. SCRIVEN: Yes, you mentioned that, thank you.

Ms DWYER: —but we are also setting up—

3639 The Hon. C.M. SCRIVEN: Sorry, before you move on, in terms of those who have been consulted so far, who have been consulted?

Ms DWYER: When we released the diagnostics and the plan, we spoke to over 1,000 of our staff and, given the way that we provide our services, they are all clinically-based staff. Our administration staff are part of that team.

3640 The Hon. C.M. SCRIVEN: So that's the diagnostic plan, but the implementation plan?

Ms DWYER: Regarding the implementation plan, as we now start to work through the detail of exactly what that looks like, we are already having many of our staff from all of our wards, which includes not just our nurses but also our multidisciplinary team, undertaking some support and some training right now in the way that communication will be better. They will know that as a huddle and that is a normal way that we do business, but this is actually about talking. What will it take to get people home when they are no longer requiring clinical acute care?

3641 The Hon. C.M. SCRIVEN: So the plan that you are referring to as being released was released in December, I take it, but there was no level of detail about implementation, so will there be a further report with more detail about the implementation?

Ms DWYER: Absolutely, and to that end we are establishing a clinical reference group and design team, but we have many clinicians that are part of the development of that plan.

3642 The Hon. C.M. SCRIVEN: When will that plan be released?

Ms DWYER: That plan needs to be released over the next few weeks, but, as I said, we are already living that plan.

3643 The Hon. C.M. SCRIVEN: You are already what, sorry?

Ms DWYER: We are already living that plan, so much of what we are doing is within that plan already.

3644 The Hon. C.M. SCRIVEN: So there's a plan that is already being implemented, but you haven't released that; is that what you are saying?

Ms DWYER: Staff are asking for much more detail, but what they are asking for is, 'Where do I fit in to this? How will I know what I'm going to be expected to do?' Part of that plan—and I referred to them in my opening address—is around some of the controls that we have in place, particularly around recruitment and procurement, and also around our performance.

I really do need to establish CALHN as an accountable organisation, one where performance is not an option, that in fact we look at our performance, we compare it to others, but we always try to do better. We have implemented a new performance framework. I am part of that. My job is to make sure that people are given the level of support and information to do their job better.

3645 The Hon. C.M. SCRIVEN: The plan doesn't include any detail about FTEs. Do you have outcomes in terms of FTEs as yet?

Ms DWYER: Can you rephrase that question? Do I have a number of FTEs that should not be in the organisation, is what I think you are implying?

3646 The Hon. C.M. SCRIVEN: That is one part of the question, but in terms of FTEs, what is in the plan?

Ms DWYER: CALHN is a very large organisation and it has benchmarked with others that might say that we have FTEs that you may not see. I understand that during the move there were additional FTEs put on; however, what I think is important for the committee to understand is that we have a large number of staff who are casual, who are agency staff, who are on short-term contracts. We know that we use an inordinate amount of overtime. I think, as far as FTEs are concerned, we may see that our substantive staff number grows because I know that I want to have people who are committed to that organisation, who are there full time if they can be, part time and absolutely committed to the success of CALHN.

3647 The Hon. C.M. SCRIVEN: How many FTEs do you think that would envisage, then?

Ms DWYER: Until we have managed to go through the organisation and look at our service re design and efficiency—and, again, we are using benchmarks, but we are also using the expertise that our staff have—I think that is too difficult to actually answer.

3648 The Hon. C.M. SCRIVEN: I understand the contract said that the operational design of CALHN would be finalised by the end of March. Is that still on track to occur?

Ms DWYER: Yes, it is.

3649 The Hon. C.M. SCRIVEN: So that will be part of the implementation plan that will be released—that will be clear?

Ms DWYER: Yes, it will be.

3650 The Hon. C.M. SCRIVEN: Has KordaMentha devised a revised budget for CALHN?

Ms DWYER: No.

3651 The Hon. C.M. SCRIVEN: Will that be occurring?

Ms DWYER: We already have a target of savings for this year, and that's what we are working towards.

3652 The Hon. C.M. SCRIVEN: So you are not envisaging that that will change?

Ms DWYER: No.

3653 The Hon. C.M. SCRIVEN: Is there any indication that the \$41 million of savings, which were identified to be achieved by June this year, will not be achieved?

Ms DWYER: No.

3654 The Hon. C.M. SCRIVEN: You are confident that the \$41 million in savings will be achieved by 30 June?

Ms DWYER: We have had savings targets provided to us. We need to do everything that we can to achieve those.

3655 The Hon. C.M. SCRIVEN: Are you confident that that \$41 million will be achieved by 30 June?

Ms DWYER: I think 'confident' is always a very difficult term. As I said, there is a lot of work that needs to be done. The baseline on which we are starting is a very low one, but we know what we need to achieve and we are already seeing some things that we are doing having a positive impact on that.

3656 The Hon. C.M. SCRIVEN: What I am hearing is that you are not confident that \$41 million in savings will be achieved by 30 June; is that correct?

Ms DWYER: No, that's not what I said. As I said, we have \$41 million of savings that we need to deliver.

3657 The Hon. C.M. SCRIVEN: So you can't say that you are confident, but you can't say that you are not confident; is that what you are saying?

Ms DWYER: I think we are already seeing some very early signs that would give me confidence. Work that we are doing around coding—coding is the lifeblood for any—

3658 The Hon. C.M. SCRIVEN: Yes, sorry, you did mention coding in your opening statement, thank you.

Ms DWYER: —organisation, and for an organisation to have not had the coding up to date over a long period, we know that we have more income that that organisation should be receiving. We also know that without coding and without the quality of coding that the acuity—we do not know how sick our patients are. By way of example—

3659 The Hon. C.M. SCRIVEN: That's alright, I think I do understand coding so that's fine, thank you so much. Is there any indication as yet that the \$270 million in savings that is required by 30 June 2021 won't be achieved?

Ms DWYER: Just by way of clarity, because people do refer to them as savings—and I'm not playing semantics here—that 270 is the overspend that CALHN has, so we need to find ways to become a more efficient organisation. We know that rework and not treating patients in time and not having flow established in that organisation creates a very inefficient organisation.

Mr REID: If I can just add to that because I think it's a very important question. I think one of the important elements of that is that if those overruns are not rectified then progressively, given the nature of funding of hospitals in Australia at the moment, where you are funded according to an activity-based price, if we go forward carrying those overruns and they are somehow picked up internally then the moneys that the state can expect to receive from the commonwealth proportionally will decline. It would be a really terrible outcome for the state if progressively, over time, this issue wasn't addressed and that you have a reduction in funds from the commonwealth as a result, which would be the outcome.

3660 The Hon. C.M. SCRIVEN: Given that FTEs are about 60 per cent of the budget, as I understand it, how are you envisaging to increase FTEs whilst still making up to \$270 million of savings?

Ms DWYER: By way of an earlier answer I gave the example around agency but also overtime. We know that when we have staff who are undertaking a lot of overtime—what I would much prefer to do is to look at: is that the work that is required? Is this what we are funded to do? And then set about having permanent staff appointed. It is not my intention to have staff working inordinately long hours. We need to make sure that we create a safe environment. That is by way of example, which really, I think, predicated my comment that we may see permanent FTE increase.

3661 The Hon. C.M. SCRIVEN: So you can guarantee that FTEs won't decrease.

Ms DWYER: I think we need to make sure that as we go through this program we eliminate those areas where we know that if we had permanent staff we would have a much more efficient organisation. Whether or not the overall—because our FTEs are also made up of contracted workforce as well—our aim by the end of this recovery program is to say, 'This is the FTE we need to run CALHN against the national efficient price.'

3662 The Hon. C.M. SCRIVEN: So is it that you can guarantee that FTEs won't decrease?

Ms DWYER: I think the FTE environment is a very highly charged one. As I said, our aim is to make sure that we have permanent staff undertaking the work that CALHN needs to do. We know that some of the work that we do should really be done in a community setting and so those staff may no longer be with CALHN but they may be with community partners. However, until we have the plan in its detail completely sorted out at that level of granularity, it's not a question that I think I can answer.

3663 The Hon. C.M. SCRIVEN: That's referring to the privatisation of some aspects that are currently done by CALHN; is that right?

Ms DWYER: No, not at all; absolutely not about privatisation at all. We currently run community-based programs but 10 years ago it was absolutely well recognised, not just here in South

Australia but across Australia and internationally, that the way to be able to run an efficient health system is to create a community expertise and capability so that patients who no longer require acute care can be supported in their home and we can actually have earlier intervention.

Unfortunately, that is not as strong as it needs to be here in South Australia so many of us in the acute setting, in the hospital-based setting, have actually started community-based programs. I'm looking for good partners to work with. That is very different to privatisation but unless there's—

3664 The Hon. C.M. SCRIVEN: Will those staff providing those services still be employees of CALHN or SA Health?

Ms DWYER: I don't know quite what that employment framework will look like but our plan is to become partners. I do not need to give away any staff whatsoever. What I do need is to make sure that they are in the areas where their skills are valued and they are making a difference and having an impact on South Australian health lives.

3665 The Hon. C.M. SCRIVEN: In terms of nurses currently employed by CALHN, how many are there?

Ms DWYER: There's around about 1,000 nurses—a bit more than—

Mr REID: About 4,000.

Ms DWYER: Sorry, 4,000.

3666 The Hon. C.M. SCRIVEN: And how many do you expect to be there at the end of the three-year administration?

Ms DWYER: Again, until we have gone through and been very clear around what our service redesign what looks like. However, as I said earlier, we are currently using agency staff. We have got it down to a level, but there had been a high use of agency. I believe that nurses—

3667 The Hon. C.M. SCRIVEN: You did mention that. So, in terms of this plan, this is the one that will be available by 30 March; is that correct?

Ms DWYER: That's what we are working towards.

3668 The Hon. C.M. SCRIVEN: So that's when we would know each of those details. I have some more questions, but if—

3669 The CHAIRPERSON: I think Dennis had some, then Justin, then John.

3670 The Hon. D.G.E. HOOD: Ms Dwyer and colleagues, thank you for appearing before the committee today. My question is to you, Ms Dwyer, and I would like you, if you wouldn't mind, to give us some insight into your experience. In your broad experience, have you ever seen an overspend of this magnitude as you are currently dealing with?

Ms DWYER: No, I haven't. I need to put that in the context of—many organisations both nationally and internationally really do have challenges around: can it live within its means? I have had experience both within Australia and also now in the UK of undertaking both a quality but also a financial turnaround, and I know that the people I need to actually assist me will be within CALHN, but for whatever reason something has got in the way of the way that we have organised it for them to step forward.

But the amount of money that we are talking about—and to the staff during our release of the diagnostics we said the overspend that we are currently incurring year on year is the equivalent of another Queen Elizabeth rebuild, so not just once but continuing on in perpetuity. We know that it is actually about the equivalent of three city high schools.

So there is I think no sense that this is something that can continue, and the staff themselves say that—that they know it is time for change, that they will not be bailed out. And in actual fact they haven't been bailed out because, in fact, South Australia is incurring this debt.

3671 The Hon. D.G.E. HOOD: Thank you. I guess the obvious follow-up question to that would be: what are the implications for the system if this overspend isn't brought into line with expectation?

Ms DWYER: Health becomes the—sorry, do you want to do this?

Mr REID: I'm happy to answer this. There are several implications. There are a number of hospitals around Australia which are experiencing significant budget overruns as we talk. You can go to Royal Hobart, you can go to Cairns, you can go to Westmead, you can go to Princess Alexandra in Brisbane, you can go to Canberra health services, Austin in Melbourne.

But the question, which is your first question, goes to the implications: what are the differences between here and there? The major difference is that the level—the quantum—of the overrun is significantly greater than those by far. The quantum is a major issue in a jurisdiction which already has an inefficient health system by comparison to other jurisdictions. So we've got a combination of problems which are confronting us.

We also know that in those other jurisdictions you still get ramping, you get elective surgery waiting time, you get emergency department pressures, those types of things which are experienced here, but those hospitals are actively now bringing their budgets into constraint, and they are doing it in a way which reflects the fact that they are driven much more these days, given that the commonwealth provides so many funds directly to the health system, by the notion of an efficient price. Hospitals get funded by the notion of what is an average price around the country. It is not really efficient; it is an average.

What happens here is that you've got a current budget overrun, you've got a poor efficient price by comparison to other jurisdictions, and the implication of that—to go to the heart of your question—is that if that's not addressed you end up with the commonwealth funds becoming significantly less as a proportion of the total funds which are provided to the health service over time. And that will have ongoing implications to the state in terms of how it funds health services itself, if the state is going to pick up that differential. All jurisdictions are actively engaged in this. The real issue that stands out here, as the CEO said, is the quantum.

I think the reasons are in the KordaMentha diagnostics: 10 CEOs in 10 years, poor leadership, a poor culture. What is really pleasant about the current CEO, which is very much supported by the incoming board, is that she is addressing the cultural issues first because the culture is such a an important determinant of strategy and leadership and how you employ and take on staff.

I think one of the benefits of having a significant budget overrun goes to your question, which is the impact upon it. There is much that can be done without impacting upon the permanent staff for people who work here and still make it a happier, more productive place to work—and the level of overtime, the level of part-time employees, the level of FIFOs, the level of those additional costs is very, very significant to how it works.

So I think the extent to which you can achieve a lot of budget savings by protecting the permanent staff and possibly even, over the years, growing that—and as the CEO said, that is a question to be determined—it becomes a better way of approaching this in a way that doesn't affect quality of care. In fact, it probably enhances quality of care but, more importantly, it enhances culture.

3672 The Hon. D.G.E. HOOD: Just two final questions, if I may, Ms Dwyer. You mentioned green shoots in your answer previously, and I didn't feel you had an opportunity to really expand on what that is. Can you give us an indication of what you were referring to and why you are positive about those developments?

Ms DWYER: I might pick up from what Mick has just said around the level of engagement and the culture. I have been in public health a long time—I've just celebrated my 40th year, and my background is nursing, so I do think I understand the clinical area as well as what it is like to work in organisations, both those that are challenged and perhaps those that are in a much more high performing area—and this is the first time in my career that I have had to establish a whistleblowing hotline.

As I said earlier, that is not to take the place of other forms where you would expect staff to be able to raise concerns, but whatever has happened at CALHN has done so. I gave a commitment to staff on my very first introductory talk to them; we went to every site across CALHN over the first few days when we released the diagnostics and the recovery plan and talked to them about how I would work quite differently with them, that bullying would not be tolerated and that we

would follow through. One of the worst things you can do in an organisation is to set up an expectation that you can raise concerns and then you never hear what has happened to them.

We have started a very different way of communicating. We call out behaviours; it comes under 'what you walk past you accept'. But we also need to start making sure that the organisation has an optimism that it can be different in the future. So we applaud the good things that make up CALHN. Obviously we are having to deal with some specific issues but, in fact, it is a good organisation in parts. We have got some brilliant services that the South Australian people should be very proud of.

However culturally, in some ways the 'retrospectroscope' for me in my last role in Medway is that I would have loved to have started on the culture program first, but there was a set of circumstances that was about the quality of care that needed to be addressed as harm was being done.

3673 The Hon. C.M. SCRIVEN: If I can just follow up on that whistleblowing line. If staff wish to make any commentary or any complaints about KordaMentha staff or consortium team members, are they able to do so through that line?

Ms DWYER: Yes; they are.

3674 The Hon. C.M. SCRIVEN: Do you know if any have?

Ms DWYER: Nobody—no, that's not quite true. In the first instance there was somebody who asked a question around the cost of the contract, which was public anyway. But no, they have not.

3675 The CHAIRPERSON: Just on that as well, will the administrators have any access to the information from the whistleblowers line? If they are charged with turning around the organisation, will they have access to what CALHN staff see as some of the problems?

Ms DWYER: The way we have set up the whistleblowing hotline is that it goes to an independent group of people. Any issues that are raised that need instant action, that goes through our own Executive Director of Human Resources.

3676 The CHAIRPERSON: Do KordaMentha staff have any access to those?

Ms DWYER: No, and they will not see the names. We have absolutely given our commitment to our staff that this is anonymous. Occasionally staff may have asked me or told me that they have done that, but that is a one-to-one—

3677 The CHAIRPERSON: But will the complaints be forwarded on to KordaMentha if they are charged with fixing the system?

Ms DWYER: KordaMentha is not charged to the degree that we do not do that. That is our job, that is absolutely our job. If I need support from KordaMentha, if there is something quite specific that they can do, then I will ask that help.

3678 The CHAIRPERSON: If it's a systemic complaint that someone has made to the whistleblower hot line, you won't talk to KordaMentha about how major—

Ms DWYER: If it is something that's part of our recovery, absolutely I would, but I would not—

3679 The CHAIRPERSON: But they may or may not have access to the whistleblower hotline. Did you have another thing, Dennis, you wanted to add?

Mr REID: I should just emphasise, Chair, that you might have left that with an implication that there will be an identification of a person.

Ms DWYER: And there's absolutely not.

Mr REID: That is clearly not the case in this circumstance.

3680 The Hon. D.G.E. HOOD: Last question, Mr Chairman. You also mentioned the investigation or opportunities that coding presents for the organisation. I wonder if you would not mind giving us an outline of exactly where that is at and what you hope to achieve.

Ms DWYER: CALHN had fallen behind by over about 8,000 separations. That's when we discharge a patient. That goes to the absolute core of the way that our revenue is calculated, and, as Mick said earlier, this is when we can know that we are getting less money from the commonwealth than we should. There had been a decision taken, for whatever reason, not to code in the way that you would expect. We have used some support through our recovery partners, KordaMentha, to try to get some industry experts to come and help us design a better system.

By way of example, when you look at the acuity, which is what I was about to say earlier, of the Royal Adelaide Hospital, which is the state's tertiary quaternary high-end hospital, you could actually be forgiven for thinking that you are talking about Mount Gambier, so when you do not code efficiently your income is not going to reflect the work that you do. We are now seeing some absolute more than green shoots. We know, and our coders are saying, that this is the best they have been able to work for some time, and we are well on the way to eliminating that backlog, again by the end of March.

When we asked our coding team some months ago, when I first started, how long they thought, doing what they do now, it would take to be able to clear that backlog, they were not even getting to this financial year. This is critically important for the state's negotiations with the commonwealth for the amount of funding we will be getting, and we are not talking small amounts of money—we are actually talking about many millions of dollars that we expect, that we are currently not providing the evidence for the work we are doing.

3681 The Hon. J.E. HANSON: Mr Martin, you're a qualified solicitor, aren't you?

Mr MARTIN: Yes. I no longer hold a practising certificate but, yes, I was qualified.

3682 The Hon. J.E. HANSON: In regard to that role, you lead a team of people I think at KordaMentha Corporate; is that correct?

Mr MARTIN: Sorry, in respect of which role?

3683 The Hon. J.E. HANSON: For instance, what you are doing now.

Mr MARTIN: Yes, I am the service line leader for KordaMentha Corporate; that is correct.

3684 The Hon. J.E. HANSON: And you are acting in that capacity now in regard to being administrator for CALHN?

Mr MARTIN: Well, no, as we previously discussed, 0.8 of my time is as per an employment contract with SA Health, reporting to Lesley; 0.2 of my time is as an employee of KordaMentha.

3685 The Hon. J.E. HANSON: How many of the team you have at KordaMentha Corporate are assisting you in your role in what you are doing now?

Mr MARTIN: The organisation recovery team comprises approximately 18 KordaMentha staff, approximately 10 industry experts and 17 or 18 CALHN secondees.

3686 The Hon. J.E. HANSON: How many of them are you aware to be qualified solicitors or legally qualified?

Mr MARTIN: I'm not sure that anyone else in the team has that.

3687 The Hon. J.E. HANSON: Has legal qualifications? No problem. As part of the project of KordaMentha being brought in to do the role you are doing now, my understanding is that they have, as part of that, external legal advice; is that correct?

Mr MARTIN: CALHN is receiving the benefit of external legal advice, yes, that is correct.

3688 The Hon. J.E. HANSON: And CALHN is not using the Crown Solicitor for that advice?

Mr MARTIN: CALHN is using a number of solicitors, including the Crown Solicitor.

3689 The Hon. J.E. HANSON: What is the breakdown of that, Ms Dwyer?

Ms DWYER: In particular, what we are using the external legal experts for is around industrial relations advice, whereas we are still obliged to use Crown for other matters.

3690 The Hon. J.E. HANSON: How is using a commercial lawyer for that purpose better than using Crown?

Ms DWYER: Can I just clarify that I'm not using a commercial lawyer. I'm using an external legal firm, one of which is based here in South Australia, to provide expert advice to me around any HR issues.

3691 The Hon. J.E. HANSON: Just let me explore that a little. You have multiple external lawyers you are using; is that correct?

Ms DWYER: We are currently using two legal firms.

3692 The Hon. J.E. HANSON: Who are they?

Ms DWYER: Arnold Bloch Leibler, which are Melbourne based, and EMA Legal, based here in South Australia, through one solicitor.

3693 The Hon. J.E. HANSON: Who are the lawyers from Arnold Bloch Leibler who are assisting you in that regard, do you know? Who are the partners?

Ms DWYER: Bridget Little, and from EMA, Kaye Smith.

3694 The Hon. J.E. HANSON: Why use interstate lawyers?

Ms DWYER: I think it didn't matter where they came from. What we needed to do was to have expert advice to try to navigate what had become a very difficult environment for CALHN, whereby a lot of our time was being spent in discussions and appearances before the commission. I needed to try to get a different view around how we tackle some of the very longstanding issues that CALHN was facing. It was taking up an awful lot of time. We are respectful at all times to any process that we are meant to follow, but I needed to test exactly why I have ended up in this situation where we had several issues that had not been resolved, despite everybody's best intentions, for a long time.

3695 The Hon. J.E. HANSON: Who performed the procurement process to hire the lawyers? Was that done by CALHN, by KordaMentha, or by KordaMentha in their role as acting for CALHN?

Ms DWYER: The latter: KordaMentha acting in their role for CALHN.

3696 The Hon. J.E. HANSON: What was the procurement process, Mr Martin?

Mr MARTIN: I think I would just like to slightly clarify that. The procurement process, as I understand, had commenced prior to Lesley's commencement as chief executive officer. That procurement process was conducted through the office of the Crown Solicitor.

Ms DWYER: Sorry, I stand corrected.

3697 The Hon. J.E. HANSON: When was the procurement process completed? Was that while you were acting, Mr Martin, or was that before you came on board?

Mr MARTIN: You would have to ask the Crown Solicitor that.

3698 The Hon. J.E. HANSON: So you had no involvement with that matter?

Mr MARTIN: We had no involvement in the procurement of Arnold Bloch Leibler, no.

3699 The Hon. J.E. HANSON: What is the expected cost of interstate lawyers?

Ms DWYER: I think I would have to take that on notice.

3700 The Hon. J.E. HANSON: In regard to what you mentioned, that it doesn't matter, I think you said, Ms Dwyer. I don't want to put words in your mouth, but I think that's what you said in regard to that it doesn't matter where they come from.

Ms DWYER: That was not a decision to say that I need to go interstate, per se. It was around that I wanted the best advice available.

3701 The Hon. J.E. HANSON: So using South Australian lawyers wasn't a part of the procurement process?

Ms DWYER: EMA is South Australian based.

3702 The Hon. J.E. HANSON: I'm aware that EMA is, but they are only performing part of the contract, I understand. Arnold Bloch Leibler are to be performing a substantial part of the contract, too. They are an external, interstate firm, so I'm just wondering did the role of South Australia and getting South Australian lawyers form a part of the procurement process guidelines or not?

Ms DWYER: As Mr Martin has said, the procurement was done through the Crown Solicitor's Office and predated my arrival.

3703 The Hon. J.E. HANSON: In any way did KordaMentha recommend Arnold Bloch Leibler to you in regard to the use of them for external legal advice?

Ms DWYER: As I said, that procurement had commenced before I started.

3704 The Hon. J.E. HANSON: Are there not South Australian lawyers who are the equivalent of Arnold Bloch Leibler? Why do we have to get them in regard to what you mentioned as the best advice? Why can't we just use EMA for all roles?

Ms DWYER: Again, I started on 27 November and this process had started. I haven't worked in South Australia for almost a decade and so I imagine that there are extremely good lawyers here, hence us using EMA, but as you know as a part of SA Health we have been required to use the Crown Solicitor for some time now.

3705 The Hon. J.E. HANSON: Was there a tender process as part of the procurement process? Did it go to tender?

Ms DWYER: I'm happy to take all of this notice but, as I said, you are asking questions for which I do not have the level of knowledge.

3706 The Hon. J.E. HANSON: Sure, that's fine. You can take those on notice and get back to me. Is there a contract which has been signed with Arnold Bloch Leibler and a separate one for EMA?

Ms DWYER: Yes.

3707 The Hon. J.E. HANSON: Are those contracts public?

Ms DWYER: I don't know. But again, I can take that on notice.

3708 The Hon. J.E. HANSON: That would be much appreciated, thank you.

Ms DWYER: The contract is with Crown.

Mr REID: I think in some ways, Chair, these are questions which we are not the initiator of these answers. You are asking us questions which really would need to go to Crown.

3709 The Hon. J.E. HANSON: Nevertheless, you are the people I have now, so I can ask the questions now and you can say you will take them on notice and then provide that to me later on. That's absolutely fine. I guess what I'm driving at in regard to this, and what confuses me a little bit in regard to the questioning and the answers that I do have, is that I'm not quite clear on how the use of what essentially are interstate lawyers, some of whom have international clients, is useful in affecting and what impact it might have on the terms and conditions of employment and provision of local services by nurses and doctors here. I'm just not sure how that advice is actually better than, for instance, what you might get locally with a local understanding of those conditions.

Ms DWYER: As I said, CALHN has found itself in a rather extraordinary position with the number of disputes and matters before the commission. I have never seen that in an organisation which was taking up a lot of time but more so creating, I think, a level of disaffection and frustration from both the staff, who have raised those with their industrial bodies, the unions themselves, and certainly CALHN.

I would have to make an assumption, correctly or incorrectly, that if we had been able to resolve those earlier, they would have because some are of a longstanding nature. What we needed was a different approach. But I also need to be very clear that we are not using any legal advice, whether it be Crown or from any external parties, which will impact on the terms and conditions of our individual staff. Those enterprise agreements are set at a state level, not at a CALHN level per se.

3710 The Hon. J.E. HANSON: So what is the scope of work—in particular, you mentioned industrial work—that Arnold Bloch Leibler is providing to you then? What's the scope of the work?

Ms DWYER: They provide advice to us.

3711 The Hon. J.E. HANSON: Yes, I get that. A bit more specific than that is what I'm after.

Ms DWYER: I'm obviously not going to be talking about individual cases. That's not appropriate for me to do that here.

3712 The Hon. J.E. HANSON: Sure. I'm not asking you to do that. What I'm asking is: you said, for instance, they won't be altering their terms and conditions of employment because they are covered by state agreements. Okay, cool. So we are getting in these external people with an external view coming from interstate. You said you required it. What is the scope of that advice that they are providing you? What do they bring that EMA can't?

Ms DWYER: They are bringing an expertise into our organisation of the way that we manage disputes, of the way that we provide the interaction with our industrial bodies. Just seeing the position that we inherited could not have been useful for both the unions, CALHN itself, but more importantly the staff. So what we are trying to do is find a new way of working together but to make sure that the things that we have that are live and active within the commission, we are now setting about resolving, instead of having a view that they can be ongoing without an end date in mind. We absolutely need to resolve that for our staff and, more importantly, to give us some of that clear air where we have a different level of conversation with our staff.

3713 The Hon. J.E. HANSON: Just to be clear on this, you don't think EMA Legal can do that?

Ms DWYER: EMA Legal are doing that.

3714 The Hon. J.E. HANSON: Then why do you need Arnold Bloch Leibler?

Ms DWYER: They are working together.

3715 The Hon. J.E. HANSON: I'm sorry, I'm confused. EMA Legal have been around in South Australia for quite some time. EMA Legal do all the things you just said you need Arnold Bloch Leibler for. What is wrong with having the South Australian experience and South Australian legal team that are provided by EMA to assist you with those disputes that you have outlined? I'm just confused as to why you need Arnold Bloch Leibler.

Ms DWYER: Again, we have sought advice from a firm that is extremely experienced, and also in other states, because we need to make sure that we are doing what you would expect to see in any other organisation that is the size and complexity of CALHN.

3716 The Hon. J.E. HANSON: With respect, you have Crown law and you have EMA Legal. Why do you need another external third party lawyer? What scope are they providing that those two sources of legal assistance, which are very significant, are not providing to you? I just don't understand. You haven't provided any actual reason why you need them. What is the reason?

Ms DWYER: Again, we have inherited longstanding issues that have not been able to be resolved. I needed some fresh eyes to look at things and say, 'How have you ended up in this position and what can you do to try to resolve these longstanding issues?' I'm very confident that by using the Crown, EMA and Arnold Bloch we are going to get the best advice that will set up CALHN to have a very different way of behaving with our staff and also with our industrial colleagues.

3717 The Hon. J.E. HANSON: I will move on from that because I don't think I'm getting anywhere. Are KordaMentha now sitting in on all negotiations with the unions and workplace industrial representatives?

Ms DWYER: Are you talking about our internal CALHN ones?

3718 The Hon. J.E. HANSON: Yes.

Ms DWYER: We would have experts from the KordaMentha team there with us, yes.

3719 The Hon. J.E. HANSON: When it comes to when you might end up in the industrial commission—hopefully, you don't but when you might end up there—do KordaMentha staff represent CALHN at that body as well?

Ms DWYER: KordaMentha staff do not represent CALHN. CALHN is represented by CALHN and our legal advisers.

3720 The Hon. J.E. HANSON: In their capacity with CALHN—so that I understand the 0.8 that you are acting for CALHN—do KordaMentha staff represent CALHN at the Industrial Relations Commission when they are representing CALHN?

Ms DWYER: They don't take the lead in representing CALHN. CALHN is represented by CALHN, but there are experts within the KordaMentha team around HR and industrial relations that we do rely on.

3721 The Hon. J.E. HANSON: And they attend?

Ms DWYER: I have only been in a situation where we have sought permission once for somebody from KordaMentha to attend.

3722 The Hon. J.E. HANSON: But they do, so that's a yes?

Ms DWYER: On the one occasion that I have seen that happen.

3723 The Hon. J.E. HANSON: It's not a trap, it's literally a question. It's a binary statement. Do KordaMentha staff sit in on any disciplinary hearings or performance management meetings and other human resource meetings in regard to their capacity in acting for CALHN?

Ms DWYER: As I said, there are experts within the KordaMentha team who our own staff, particularly our HR staff, will seek advice from. There may have been an occasion where they have asked for that expertise to be with them when they have had a discussion.

3724 The Hon. J.E. HANSON: I'm sorry, but I don't think that was an answer to my question. Do they sit in on disciplinary hearings, for instance?

Ms DWYER: You are asking a very blanket question and my answer is that where it has been appropriate they may have done so and I can think of one example where it has.

3725 The CHAIRPERSON: I think that's a yes, sometimes.

3726 The Hon. J.E. HANSON: It's a yes, okay.

3727 The Hon. D.G.E. HOOD: Mr Chairman, we have three other members who haven't asked any questions yet. I wonder if we might move on.

3728 The Hon. J.E. HANSON: Sorry, Mr Hood. I just had a great deal of difficulty in getting answers to my questions. Do they sit in on performance management meetings?

Ms DWYER: At an individual level?

3729 The Hon. J.E. HANSON: Again, it's a binary thing. Are they sitting there or not?

Ms DWYER: No, it depends on what you are asking because when you use the term performance management meetings, I think that you are asking about individuals. I explained earlier that we have introduced a new performance and accountability framework, which is exactly what you would expect organisations to do, and certainly KordaMentha are there.

3730 The Hon. J.E. HANSON: And that then applies to individuals?

Ms DWYER: I'm hearing your questions, but perhaps you could clarify around disciplinary procedures. I don't know if that is what you are getting to.

3731 The Hon. J.A. DARLEY: Ms Dwyer, earlier you emphasised the point that the implementation of this program is the responsibility of yourself, your staff and CALHN. Can I ask the question: is the \$41 million savings target accepted by your organisation, or is it a target set by Treasury?

Ms DWYER: I inherited the target, so I don't actually know who set it. What I do know is that in the diagnostics that number is around where other benchmarked like-peer organisations should be able to find that level of savings. But we certainly own it and the organisation is prepared to find those savings.

3732 The Hon. J.A. DARLEY: The reason I ask that is that in a lot of cases with organisations that I have been associated with, if the staff and everyone within the organisation don't accept that the target is theirs and you don't meet the target, then at the end of the day they will say, 'Well, it's your target, not ours.'

Ms DWYER: I think that is a really fair comment and I have certainly seen where that has happened. Soon after the diagnostics were released, we undertook a pulse check survey of the organisation and in particular there were some things we wanted to find out. One was: did the staff by and large accept that there was change that was needed, and overwhelmingly they said yes. Disappointingly, they felt that the leadership of the organisation probably didn't have the skill set—and they were referring to people like myself, I imagine—to do that.

Overwhelmingly, the organisation has accepted that we are spending more money than we can earn and certainly more than what other peer organisations would. Nobody has said to me that is unrealistic. What they have said is that it will be difficult and that it will require the whole organisation working together.

3733 The Hon. J.A. DARLEY: So they accept that the target is possible and they will endeavour to achieve it?

Ms DWYER: Yes.

3734 The Hon. T.J. STEPHENS: Before I ask a couple of quick questions of Ms Dwyer, Mr Mentha, as a Whyalla born and bred person, thank you. I have never had the opportunity to thank you for everything your organisation did up there. I say, on behalf of so many of my friends, that I am really proud of what you have done. Ms Dwyer, you talked about the whistleblowing procedure, and, of course, in cultures and organisations if the staff think that they are being ignored or not heard and no action is being taken, it's a downward spiral. Can you give us a couple of examples of the 40-odd whistleblowing calls you have had as to the sorts of things that the staff are telling you that are wrong?

Ms DWYER: Obviously, I will only speak in a matter of themes that are emerging—bullying, harassment, where people feel that they are not in a safe environment to speak up, that there would be retribution. There have been financial issues, of which we have been obligated to take action against. There have been issues in regard to individuals feeling that they may have been overlooked for advancement, where, in fact, process may not have been followed.

Also, I think, of those 40, some have taken the opportunity to readdress issues of which they have had no follow-up. That does not necessarily mean that the organisation did not do something, but if you don't know, as far as you can, that action has been taken, and you don't see a difference. It's not my intention. We had the initial contract for six months, and I think it was a modest cost—just under \$7,000, about \$6,700. Again, I have worked in organisations where we have established other ways of providing support to staff.

In the NHS, trusts are required—trusts being LHNs—to train people and to support people who are peers around speaking up safely. It would be my intention to do something similar. Again, I don't expect the staff to say, 'We now trust the new management of CALHN.' I have to earn that respect, but what I do need is that they have many avenues in which to raise issues.

Mr REID: If I can just add to that because it is an important question, I have just chaired a committee of inquiry into workplace practices in ACT health services—and I actually sent the document to the CEO and it's on the public record—showing evidence which is now going to be

much more public around Australia. For example, in that hospital in Canberra health services, 65 per cent of staff witnessed bullying or harassment of staff on staff in the previous year, and 35 per cent experienced it. One in 10 had witnessed violence or inappropriate sexual behaviour.

I am not saying those figures are high here, but part of trying to change the culture is trying to address that so that things are addressed at a much lower level. For example, as the CEO said, things are escalated to HR, things are not dealt with at the workplace, there are inappropriate recruitment practices—all those things are experiences which we are seeing throughout the health sector of Australia now. The specialist colleges, in terms of accreditation, are much more prevalent. You may have seen recently that some of the colleges have restricted accreditation programs of some hospitals in Australia because of witnessing the bullying and harassment programs.

One of the fortunate things for the very unfortunate situation of such a significant budget deficit is that you can use this process of how you start to actually try and bring the staff along around the values of the organisation, around trying to address and identify bullying and harassment processes early and addressing them readily. I am really pleased in terms of the CEO. One of her strengths, which people have already commented upon, is the way she communicates and talks to staff around what she is doing and what needs to be done and the way that there is a re-emphasis on values.

Whilst this is a \$300 million overrun problem that we are addressing, it's also at the core an issue, as I said earlier, of poor leadership—10 leaders in 10 years—poor adherence to values, enabling of that bullying and harassment process to take place at all levels of the organisation—clinical and non-clinical, throughout the organisation—and not addressing that. Hopefully this process of trying to do what the staff want—remember what the CEO said: people feel it is appropriate that we take action now.

In terms of the funding of South Australia, it is critical that actions are taken now. Part of doing that is actually to use it as a way of how you do impact upon culture. Poor culture is expressed by casuals, overtime, inappropriate work practices. We saw evidence in some states of inappropriate overtime for junior medical officers. Those poor practices of how staff are employed go to the culture, and addressing those is going to be very significant for CALHN, for all the hospitals in CALHN and I think, in a funny kind of way, the size of the problem presents an opportunity.

3735 The Hon. T.J. STEPHENS: Mr Reid, while we are engaging, can you tell me, in your experience, what is the best example of a turnaround that you have seen with regard to a health organisational system? Is there somebody we can aspire to be like with regard to what they have done to turn things around?

Mr REID: I think the first thing, to go to some of the questions, is that it has to be done in a way that is a South Australian way and reflect the people and the culture of the people in South Australia. I think the first thing is that where you would look to for best practice is where this problem doesn't occur. How do other hospitals act in a way that doesn't require a complex diagnostic and a complex implementation strategy to address a very significant budget overrun?

One of the things that the current head of SA Health, Chris McGowan, is doing now, which I think is very positive, is introducing a mechanism of early warning of budget positions across all the health sectors within South Australia. This brings out early the fact that a hospital is getting to a difficult position. It might just be reflected through small metrics of how you measure that, but this should never be allowed to get to a \$300 million problem. Where you see best practice is where you see the early calling out of this data.

I think the other thing that goes hand in hand with that is what data you have which enables you to monitor that. Where we are seeing best practice around the world now is in hospitals that use live or predictive data to run their health service, so that you know in, let's say, theatres and recovery that the input into the emergency department is going to place pressure on the theatres and hence in your recovery room and hence on your beds, and this is what needs to be done.

Many of the hospitals in Australia and indeed in this state are still running using retrospective data. That's just something you wouldn't countenance in an organisation that takes 10 per cent of the gross domestic product of this country. I think those organisations that are moving to live and predictive data are the ones that I think are beneficial.

The third point of the three that I think is really important is exactly what the CEO is doing—that the constant focus on focusing on the small things, and reinforcing the values and the cultural change, is what needs to occur to impact upon the budget change. Best-practice organisations focus on values, focus on culture and focus on integrating those values and culture in how they employ people, how they performance manage people and how they undertake their strategy development.

3736 The Hon. T.J. STEPHENS: Can I just finish with my last question to Ms Dwyer. International experts re ramping—who are international experts on ramping? Where are they from?

Ms DWYER: I should say they are international experts on flow.

3737 The Hon. T.J. STEPHENS: Okay.

Ms DWYER: Ramping is a symptom of not being able to have the right patient being treated in the right environment for the right amount of time, and then not all patients require supportive care, but increasingly more and more do. NALHN, for example, does not ramp and has not done so, I understand, for some time.

There is an expert from the NHS and, without going into a lot of detail, he is a geriatrician by background who has been working with the emergency care improvement program in the NHS for some time, which is around how an organisation responds when they have got an increased demand to be able to ensure that people are being treated in the right place. It just so happens that he was in town, so we have borrowed him from NALHN.

Also Chris McGowan has asked that he talk to all of the LHNs, and it will not be exactly the same, but in fact my experience is that most times the principle is around: how do you prepare somebody for discharge from the moment that they are admitted? Most patients want to know what is happening to them. It should not be a surprise and a miracle the day that you are actually ready for discharge. Most people should be able to say to their relatives, 'In three days' time I am expecting to go home,' so that everybody then wraps around getting that person home.

Sorry, it was not quite a short answer, but there are people around, and there is also practice to look at because ramping is not okay.

3738 The CHAIRPERSON: I've just got a couple of quick questions. I will go through them very quickly and, if there are just very short answers, then the Hon. Frank Pangallo I think has a couple of questions. I note where we are and the media attention around this morning and the ramping and the presentations to emergency. Some time ago, is it correct that 25 beds closed at Hampstead Rehabilitation Centre?

Ms DWYER: My understanding was that those beds had been opened for last winter and they closed towards the end of last year.

3739 The CHAIRPERSON: Do you know what date they closed? Were you on board, Ms Dwyer, when they closed, and did KordaMentha or any of the administration staff have any input into that decision?

Ms DWYER: I may not be able to give you the right date because I believe it was happening around about the time that I was being onboarded, but I just need to be really clear that the clinical decisions of that organisation remain that of the organisation. I can come back to you with the exact date.

3740 The CHAIRPERSON: So, to your knowledge, there was no input whatsoever from KordaMentha on the decision to close those beds down.

Ms DWYER: No.

3741 The CHAIRPERSON: I think the minister said that those beds would be available to open if there was sufficient demand. I remember in parliament he referred to them as 'flex beds'; is that correct?

Ms DWYER: I think that's the term that South Australia uses when you have some beds that you can use when you have surges in demand if they are the correct beds.

3742 The CHAIRPERSON: Is there a reason, if they are beds that can open for surges in demand, or flex beds, as the minister refers to them, that at record presentations to hospitals these beds still remain closed?

Ms DWYER: I think you have to go back to: what is the reason we are not able to deal with surges of demand? The reason for that is that we are not discharging people in the way that we need to.

3743 The CHAIRPERSON: I agree, and these are good, long-term goals and systemic things to work on but, given where we are now, is there a reason those 25 flex beds at Hampstead remain closed?

Ms DWYER: These are rehabilitation beds.

3744 The CHAIRPERSON: So they can't help with the overall system.

Ms DWYER: In getting people into the emergency department, they may be helpful, but in fact you always have to have a plan to be able to close those beds again in quick term. CALHN operates at almost 100 per cent bed occupancy.

3745 The CHAIRPERSON: These beds at Hampstead that are now closed but that can be opened may be helpful in the current situation we are in, yet we still keep them closed and ramping occurs. That doesn't make a lot of sense. Maybe you can take that on notice—

Ms DWYER: I can take that on notice, because it is a complex answer. I'm very happy to do that.

3746 The CHAIRPERSON: But that's what you said, isn't it, that they could help with the situation we are in, but we choose to—

Ms DWYER: Only if we are looking for people who need to be stepped down into a subacute environment.

Mr REID: Can I just add a really important point here? You indicated that the other issues are long-term issues, but they do have some medium- and short-term impact. For example, we know there are 22 conditions now that the Grattan Institute found which constitute about 8 per cent of beds that are currently being used in this state which are preventable.

We know there are about 2 per cent of beds occupied by people who need maintenance in some way; that is, they need to be better located in another facility, not in an acute hospital setting. We do know—and this is a skill base of the incoming head of the health agency—that there are many things that can be done in the home and the community which offer far better care, and they are short and medium term—

3747 The CHAIRPERSON: I understand, but that is a reasonable discussion for another day when we have much more time. The organisational and financial recovery plan that KordaMentha put together indicates an intention to reduce the number of bed days by 65,000 patient bed days a year, or an average of 178 beds per night. Is that what is being aimed for? When do we expect that to be completed?

Mr MARTIN: That is not the intention, nor is it stated—

3748 The CHAIRPERSON: I think it is page 33: 'This equates to an estimated reduction in the average length of stay of 1.5 days, which would free-up approximately 65,000 Occupied Bed Days ...per annum'.

Mr MARTIN: Yes; I understand your question. You refer to documents, and I would like to refer you to page 32 of that document, headed 4.1—Indicative 3-year financial recovery path. I would like to quote from that (which is in front of you, for those who have it):

The Recovery Plan will drive cost reduction and financial performance improvement across four key areas:

1. Reducing length of stay to national benchmarks
2. Undertaking all activity efficiently and managing appropriately
3. Improving management of CALHN workforce so as to maximise patient facing time...

4. Control and accountability

As part of the diagnostic, what we did then was assess the performance of CALHN relative to its national peer groups. At no stage in the report have we said, nor is it our intention, that the mathematical examples that have been included in the plan are, in fact, the plan for CALHN. That is a misinterpretation—

3749 The CHAIRPERSON: It is the intention, though, to get to national weighted averages on a lot of these things, and to get to that you would need 65,000 occupied bed days to be closed.

Mr MARTIN: No; there is a mischaracterisation of the problem and of the plan—

3750 The CHAIRPERSON: So we won't be closing any beds at all as part of this?

Mr MARTIN: We are certainly not closing any beds that are required.

3751 The CHAIRPERSON: I think that is a very interesting qualification. Will any beds be closed as a result of what KordaMentha are looking at doing?

Ms DWYER: Can I firstly just answer by giving a different metric, a different mathematical argument? The strongest evidence between bed block and what you see in the ED, which is people not able to get in, is when you have 35 per cent or more of your beds filled with people who have a length of stay of greater than seven days. It is an NHS metric—

3752 The CHAIRPERSON: Okay, so—

Ms DWYER: Just let me finish, please, if you could. CALHN currently has almost 50 per cent of its beds with people who have been there for more than seven days. So no matter how hard those staff in the emergency room work, they are not going to be able to get people through, and so getting the length of stay down is critically important—

3753 The CHAIRPERSON: I understand what you're saying: getting the length of stay down would reduce the beds and reduce the occupied bed days and you'll be able to close beds. I understand you are saying that is because people stay too long in hospital. Is there any chance we will see wards at The QEHL or Royal Adelaide closed once we can introduce things to get the bed stay down?

Ms DWYER: I think what we will see, during the implementation period but also with the work we are going to be doing around flow, is that we will know how we can get our bed occupancy down to 92 per cent so that we have available beds should we need them.

3754 The CHAIRPERSON: Is there any possibility wards will be closed at the Royal Adelaide or The QEHL if you can implement everything you want to?

Ms DWYER: If we can implement everything we can, we are going to be able to say with confidence how many beds we will need.

3755 The CHAIRPERSON: Will you guarantee all wards as they currently are will stay open, or are you not prepared to give that guarantee?

Ms DWYER: With the length of stay we have that is well outside national benchmarks, I don't think I am in that position.

3756 The CHAIRPERSON: So you can't guarantee that you won't close wards at QEHL and Royal Adelaide? Will you be keeping Hampstead Rehabilitation Centre open—can you guarantee that?

Ms DWYER: I think that the work that is done at Hampstead will continue. We absolutely have to develop—

3757 The CHAIRPERSON: Will work at Hampstead continue—

Mr REID: Chair, with the greatest respect, we would be grateful if you would allow the CEO to answer the question, rather than put words in her mouth at the end of it, with the greatest respect.

3758 The CHAIRPERSON: Two very simple questions: can you guarantee that Hampstead will stay open, not that the work that it does may go somewhere else? Can you guarantee

that Hampstead, in its current form, will stay open, and can you guarantee that St Margaret's Rehabilitation Centre in its current form will stay open?

Ms DWYER: I don't think I am in a position to guarantee—

3759 The CHAIRPERSON: That's fine. I think the Hon. Mr Pangallo has some questions.

3760 The Hon. F. PANGALLO: Thank you, Chair, are you sure we have time today?

3761 The CHAIRPERSON: We will go over, Frank, if we need to get through.

3762 The Hon. F. PANGALLO: Thank you for coming today. You are talking about the record presentations, first, at the new Royal Adelaide Hospital. Can I ask you what is the breakdown in terms of the type of patients they are, in other words, elderly, and is that presenting a problem for you?

Ms DWYER: Obviously, we look at who is attending our emergency department, and the greatest number of patients are those who would fit within a general medicine. A fair proportion of those are what I would term 'frail elderly'. So it is incumbent on the organisation to start developing different models to care for those people, and some of those will extend beyond our four walls, being able to support, particularly when we look at the data, particular areas where perhaps a greater level of support is needed. Many of our clinicians are really keen to do that.

For example, on that day of extreme heat we knew that we were likely to get people presenting who needed a different form of care, and our geriatricians determined that they would go down and work in the emergency department. That was quite successful with them being able to connect people to community-based care, to the point now that one of our senior geriatricians is working with our clinical lead within the emergency department to say, 'How can we make that sort of thing happen every day?', because when we have a fair proportion of elderly people we need a different level of resource at the front door.

3763 The Hon. F. PANGALLO: Can I say that late last year, about the same time that beds were being closed down, I had reason to be at Hampstead, and while I was there on another matter I was approached by clinicians there who were quite concerned that beds had been closed down, particularly acute beds for the aged. That is one of their concerns. Is that what happened?

Ms DWYER: I know that that was a concern raised with me. I have also seen where we have had acute beds, because I think that's a really important term, where you have an expertise right at the beginning of somebody's stay, and that makes a huge difference. I certainly saw that in my last organisation, where in fact we put not just geriatricians but acute care of the aged in the emergency department, but also created an area where we could quickly assess people, provide the level of expertise and connect them to where care is.

3764 The Hon. F. PANGALLO: Concerns were raised before the last state election that the future of Hampstead was limited; in fact, there were talks about its being closed down. Have there been other discussions since then that Hampstead may well be closed down?

Ms DWYER: I know that with The Queen Elizabeth redevelopment we are really keen to increase the number of rehabilitation and subacute beds on that site. When we look at the demographic of that population, we can see that they would add a real value. As far as any future around all of our facilities, we need to make sure that they are fit for purpose in the future, but what we are not talking about is diminishing the clear focus and value we place on rehabilitation and subacute beds.

3765 The Hon. F. PANGALLO: What are you saying about Hampstead then, that you are looking at shifting what they do to The Queen Elizabeth Hospital—is that the end plan?

Ms DWYER: Some of the work that is done at Hampstead—we know that the future of The Queen Elizabeth Hospital through the redevelopment will pick up some of those beds, but in fact I think your specific question is something I can't answer.

3766 The Hon. F. PANGALLO: That's something for the minister, perhaps.

Ms DWYER: Perhaps.

3767 The Hon. F. PANGALLO: Mr Mentha, I will give you something to say. In your report, the plan of action, you say you will not tolerate personal or departmental fiefdoms, and agree that unacceptable behaviours should be called out. Have you called out any?

Mr MENTHA: I think we have put in place a process around the whistleblowers, as evidenced by the CEO's evidence. That, in itself, has enabled those persons in the organisation to speak up around behaviours that are not respectful or breach guidelines in terms of hospital policy. They are being called out. KordaMentha doesn't have privy to the whistleblower hotline, but we do know, through the CEO's evidence today, that over 40 responses to that hotline are being actioned.

3768 The Hon. F. PANGALLO: 'Fiefdoms' is a pretty strong word. It sort of implies that there are little kingdoms that are being set up within a kingdom.

Mr MENTHA: Yes. We have, prior to our appointment, identified in our diagnostic, and continue today, fiefdoms within the CALHN network.

3769 The Hon. F. PANGALLO: But they are there?

Mr MENTHA: They are there.

3770 The Hon. F. PANGALLO: And you know which ones they are. How are you planning to dismantle those fiefdoms?

Mr MENTHA: We are working with the CEO. Perhaps she can speak to the organisational change program that we are currently helping her with.

Ms DWYER: 'Fiefdoms' is an interesting phrase, but in fact, it's one that the staff themselves talk about. I said in an earlier answer that there are some real pockets of just sheer brilliance, exactly the sorts of services you would want. I often go to those areas and say to them, 'How did you manage to do that while the rest of the noise around CALHN was so negative?' Often, they say, 'It's because we turned our back on the organisation.'

They talk about having an ambition, and I describe that as also a bit of a fiefdom, which is, 'We now need you to step back out and contribute to the broader picture.' The organisational change around fiefdoms is that we are all part of the problem and we are all part of the solution. What we can't have are those individual units creating an environment, a culture, whereby people are excluded or there are poor practices around recruitment. We are expecting everybody to actually open themselves up and work on behalf of and as part of CALHN.

3771 The Hon. J.A. DARLEY: And if they don't?

Ms DWYER: If they don't, part of my role is to say, 'You are very welcome to join us on this program, but what you cannot do is undermine it.' We absolutely have to address that. I think that, for a number of years, poor behaviour has not been called out and it has been very destructive for that organisation. It will not be tolerated.

3772 The Hon. F. PANGALLO: Mr Mentha, and perhaps Mr Martin could also answer this, have you uncovered matters in your investigations that may need to be referred to the police or integrity bodies?

Mr MENTHA: We have identified breaches of what would be a policy within the CALHN network and they have been referred to the appropriate authorities.

3773 The Hon. F. PANGALLO: Integrity bodies?

Mr MENTHA: Yes.

3774 The Hon. F. PANGALLO: Are we talking about misappropriation as well?

Mr MENTHA: We are talking about, as the CEO spoke to, matters that speak to the respectful behaviours policy at CALHN. There have been issues identified around procurement, which raised questions as to integrity of process. There have been other matters, but I don't think I'm at liberty to talk about some of those things here today without breaching my obligations under the public service act.

3775 The Hon. F. PANGALLO: But you have found things that are quite serious that need to be referred?

Mr MENTHA: Yes.

3776 The Hon. F. PANGALLO: Particularly in the procurement area. When we are talking about procurement, what areas of procurement are we talking about? Equipment?

Mr MENTHA: To help you with your question, both Mr Martin and myself have been embedded in the procurement process at CALHN. In the main, that is why we carry South Australian Public Service delegations, so that we can be a part of the chain of approval for procurements that are made both on the schedule, which are negotiated by the South Australian procurement in the South Australian Department for Health and Wellbeing, and also, as identified in our report, about \$160 million of goods and services procured outside of the schedule.

It's the things outside the schedule that concerned us as to the controls that are in place, the ability for clinicians and non-clinicians to order those goods and services without the proper processes, the controls and compliance that the South Australian government has deliberately put in place in its procurement program.

3777 The Hon. F. PANGALLO: Has this been a bigger job than even you had envisaged initially in the beginning? Can you give us some specific examples of the most serious issues that you have uncovered?

Mr MENTHA: In my 40 years of experience, which also equates to the CEO's experience, this would be the most broken organisation I have ever witnessed both financially and culturally. I think in terms of the clinical and non-clinical outcomes that we have witnessed and continue to witness and benchmark against other peer hospitals, this is a failing organisation. It is a shameful waste of taxpayers' money to think that, as the CEO has represented, \$300 million can build three new high schools in the city of Adelaide, build a new QEH, too—in perpetuity, every year. Imagine what that money could do if we could put it into community care. We have people in that hospital who should not be there.

Finding ways to accommodate them in a community setting takes them away from the risks that we have identified in the hospital on re-infection rates, on staff being treated with agency staff who are there today and gone tomorrow. When we spoke about the FTE question earlier, we have in some wards up to 15 to 25 per cent of supplementary workforce. There comes a point where that's not clinically safe, and this CEO has identified those risks and said, 'This is unacceptable.' This is why FTE might go up because we are getting rid of the expensive workforce.

At Whyalla, we put on a whole new shift when we removed overtime. We created employment, got greater efficiency, better health and wellbeing outcomes, better safety outcomes. Sometimes the obvious answer is not cuts but getting rid of the expensive workforce who can't have any consistency in their day-to-day job. So, I hope that answers part of your question.

3778 The Hon. F. PANGALLO: You mentioned Mr Gupta earlier. I'm wondering, Chair, if you'll indulge me at the end of this if I could ask you a couple of questions about Mr Gupta. Would that be appropriate?

3779 The CHAIRPERSON: Yes, or maybe put some on notice, Frank.

3780 The Hon. F. PANGALLO: Perhaps, yes.

Mr MENTHA: I'm happy to have a private audience with you, if that would be appropriate.

3781 The Hon. F. PANGALLO: Okay, that'd be good. Something else I wanted to ask, perhaps Ms Dwyer, is that there is a 16-bed ward, 5E.01. What is happening with that? It's an outpatient service, I believe.

Ms DWYER: Correct.

3782 The Hon. F. PANGALLO: Is that being occupied or is it empty?

Ms DWYER: It has been occupied as an outpatients' area. I think it would be fair to say that the planning of what would be done on that site compared to the reality where we have many hundreds more people on that site than what was planned for has created quite a bit of pressure. We know that outpatients—and it's not just here, it's across the nation and also the world—is almost the last frontier. We have a lot of people turning up for outpatients that we know we need to address

in a different way. That then gives us spaces such as the area you have mentioned that we have then an opportunity to think about the correct use for it. I know it causes angst for clinical staff to see an area that was planned to have beds in it that is being used for outpatients because we are currently seeing more outpatients on that site than what was in the original plan.

3783 The Hon. F. PANGALLO: Can you give us an update on the chest clinic?

Ms DWYER: The chest clinic has now moved down to the Royal Adelaide Hospital.

3784 The Hon. F. PANGALLO: What will happen at 275 North Terrace? Are there any plans for that?

Ms DWYER: So 275 still has our sexual health service there and we are working with that team to think about the best use of that site.

3785 The Hon. F. PANGALLO: Has KordaMentha given you any instruction in relation to getting rid of patients a lot sooner than you would normally expect? Is there any instruction in relation to the discharge of patients?

Ms DWYER: I'm sorry, but I'm a bit surprised by your question. Absolutely not. That does not take away, though, my earlier statement which is that we have to discharge patients when they no longer require acute care and that is more so for our elderly patients. We know that, by staying in an acute hospital, they increase their risk of coming to harm, particularly around functional decline. I do not need KordaMentha, with respect, or anybody to tell me what is the right thing to do in patient flow.

3786 The Hon. F. PANGALLO: Are you putting pressure on staff to discharge patients?

Ms DWYER: I wouldn't say we are putting pressure on staff other than that, when the ED is full, we need a whole of organisation response. You cannot tell me that by not discharging patients they are doing the right thing for the emergency department, but we are not putting pressure on staff. What we are doing is stopping and saying that we know there are things that you need to do as a multidisciplinary team very early in that person's stay to get them ready for discharge, so we are giving them industry expertise around how you discharge. It's that basic in that organisation. We are having to go back to that premise, which is to let us now relearn how to work together differently to make sure that people who do not need to be here aren't.

3787 The Hon. F. PANGALLO: What if it places a patient at risk? I have already raised the matter in parliament, and I have written to the Coroner about it, where an early discharge actually resulted in the death of a young patient within 24 hours when perhaps she should have remained there with the condition she had. I'm willing to give you those details. I have already raised it in parliament and I have raised it with the minister. My concern is—

Ms DWYER: I would be very interested in learning those details. I need to be very, very clear: at the end of the day, clinicians discharge patients.

3788 The Hon. F. PANGALLO: But are they being placed under pressure to get them out in a certain time, particularly the elderly?

Ms DWYER: I do not believe that they are. What we are saying is that, compared to other organisations, we are keeping people here longer than they need to. If that is symptomatic of there not being the community supports and structures that are in place that you would see in other jurisdictions, then we need to set about getting those in place. As I said, I'm—

Mr REID: To back up the CEO's point, there is an inordinate amount of evidence that inappropriate long length of stay has health consequences, in terms of infection rates and various other things. There are best-practice guidelines for certain conditions for how long they take. Clinicians make the ultimate decision, as the CEO said, but it is appropriate for a CEO to try to ensure that people are not kept too long in hospitals. There are some health consequences of that.

3789 The Hon. F. PANGALLO: I think there was a comment that was made some time ago about the long stay where somebody suggested—and I'm not sure whether it was KordaMentha—that people liked the place, treated it like a hotel and liked the views. I have been in a hospital. I'm not the sort of person who stays there for the views. That was a bit flippant, wasn't it, to suggest that?

Ms DWYER: I think that may have been a repeat of something that perhaps the staff say anecdotally. There will be people who are saying that they are not ready to go home or the family have concerns. That is not because of the views. That is actually because they have a genuine concern that we need to listen to. The rooms are lovely. They do have a nice view, but I agree with you: it is no place where people think they want to move into.

3790 The Hon. F. PANGALLO: I think that a lot of these problems in relation to capacity relate to aged care.

Ms DWYER: Yes, it does and that is being seen across the nation.

3791 The Hon. F. PANGALLO: And palliative care?

Ms DWYER: And palliative care as well. They are both areas where we need to make sure that we have the very best services that we have developed, and both of them need development.

3792 The Hon. F. PANGALLO: Okay, thank you for your time today.

3793 The CHAIRPERSON: I might seek leave of the committee, rather than read them out, to table a few further questions to save some time.

Seconded by Hon. T.J. Stephens.

Carried.

3794 The CHAIRPERSON: I know you had some further questions. Perhaps at some stage in the not too distant future you would be happy to come back. I think you saw that there is a great level of interest in the work that is being done, and how our health system functions is critically important to South Australia. If you would be happy to come back reasonably quickly, I think we would all benefit from that if we invite you back at some stage soon.

Ms DWYER: Yes, thank you very much.

3795 The CHAIRPERSON: Thank you for your time here. As I have said, you will be forwarded a transcript of the evidence to look through for any clerical corrections. Thank you for your time today.

Ms DWYER: Thank you very much.

THE WITNESSES WITHDREW



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Ms Leslie Guy
Secretary, Budget and Finance Committee
Legislative Council
Parliament House
North Terrace
ADELAIDE SA 5000

Dear Ms Guy

I write to clarify evidence provided to the Budget & Finance Committee on 11 February 2019, regarding the engagement of Arnold Bloch Liebler (ABL) and EMA Legal to provide legal advice and services to Central Adelaide Local Health Network (CALHN). I advise that while the Crown Solicitor's delegate under Treasurer's Instruction 10 approved CALHN engaging both firms, CALHN is responsible for undertaking the procurement process itself.

If you require any further assistance with these matters please contact, Helen Rodwell, Board Secretary on _____

Yours sincerely

A handwritten signature in black ink, appearing to be "Lesley Dwyer".

LESLEY DWYER
Chief Executive Officer
Central Adelaide Local Health Network

28/2 / 2019



If calling please ask for:
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18 March 2019

Leslie Guy
Secretary to the Budget and Finance Committee
leslie.guy@parliament.sa.gov.au
BY EMAIL ONLY

Dear Ms Guy

Re: Budget and Finance Committee – engagement of external lawyers by CALHN

I refer to your letter dated 18 February 2019 in which you set out a series of questions raised by the Committee in regards to the engagement by CALHN of Arnold Block Leibler and EMA Legal to provide legal services to CALHN in relation to the implementation of CALHN's Organisational and Financial Recovery Plan.

The questions in your letter relate to a number of issues pertaining to the procurement of ABL and EMA Legal. I confirm that CSO's involvement in the engagement was not to undertake a procurement process, but to consider and grant approval under Treasurer's Instruction 10. CALHN was responsible for undertaking the procurement process for this engagement.

As such, questions about the procurement process are best directed to CALHN. However, to assist the Committee, I have set out below responses to each of the questions raised:

1. *We understand that this project has involved Korda Mentha bringing in external legal advice instead of the Crown Solicitor. Is that correct?*

It is correct that external legal advisors have been engaged to provide legal advice and assistance to CALHN as part of this project.

2. *What was the procurement process to hire these lawyers? How was the procurement process followed and who oversaw it? When did it commence and finish?*

As set out above, CALHN was responsible for undertaking the procurement process for this engagement and questions relating to that process should be directed to CALHN. The CSO's role was to consider an application by CALHN for approval under TI 10 to engage external legal advisors.

3. *Were all government procurement processes for legal assistance followed when hiring these lawyers?*

As set out above, CALHN was responsible for undertaking the procurement process for this engagement and questions relating to that process should be directed to CALHN.

The CSO's role was to consider an application by CALHN for approval under TI 10 to engage external legal advisors.

4. *Are any of these lawyers from interstate? Why?*

The firm Arnold Bloch Leibler is based interstate. This firm was selected by CALHN. I understand that this selection was based on their expertise and experience.

5. *What is the cost of these lawyers? Are the costs of these lawyers part of the KM \$20m contract or are they additional?*

The total cost of engaging the lawyers will be dependent on the scope and scale of the engagement which is being managed by CALHN (under the terms of the TI 10 approval CALHN provides instructions directly to the lawyers). This question should be directed to CALHN.

6. *From who do the lawyers receive instruction and to whom do they give answers: Korda Mentha staff or CALHN staff?*

It was a condition of the TI 10 approval granted to CALHN that ABL and EMA Legal would take instructions directly from CALHN.

7. *What was the process of hiring EMA legal? What is the process for hiring Arnold Bloch Leibler? Did it go to open tender?*

As set out above, CALHN was responsible for undertaking the procurement process for this engagement and questions relating to that process should be directed to CALHN. The CSO's role was to consider an application by CALHN for approval under TI 10 to engage external legal advisors.

8. *What is the justification for not using Crown Law in CALHN?*

In relation to this matter, the lawyers were selected by CALHN which sought approval from CSO under TI10 to engage these firms. The specific reasons for this request would need to be sought from CALHN, however TI10 approval was granted on the basis that CSO did not have sufficient resources to provide assistance to CALHN as part of this project.

9. *What is the expected or anticipated or contracted cost of EMA Legal? What is the expected or anticipated or contracted cost of Arnold Bloch Leibler?*

The cost of engaging the lawyers will be dependent on the scope and scale of the engagement which is being managed by CALHN (under the terms of the TI 10 approval CALHN provides instructions directly to the lawyers). This question should therefore be directed to CALHN.

Yours faithfully



Mike Wait SC
Crown Solicitor and Crown Advocate