Special Commission of Inquiry into Healthcare Funding

Statement of Dr Joanne Ging

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1. This statement made by me accurately sets out the evidence that I would be prepared, if necessary, to give to the Special Commission of Inquiry into Healthcare Funding as a witness. The statement is true to the best of my knowledge and belief.

My role

2. I am the Executive Director, Clinical Operations for the Sydney Children's Hospitals Network (**SCHN**). I have held that role since November 2020 and had been in the acting role from February 2019. In my role, I lead, direct and manage the clinical operations of the SCHN across a broad spectrum of health service delivery settings and corporate functions to ensure the delivery of high quality and safe health services for children, young people and their families.

3. I have been a general paediatrician since 2002. I have experience working as a general paediatrician at both a network level and within Local Health Districts (**LHDs**), including rural settings. I commenced my training as a general paediatrician at the Children's Hospital at Westmead. I then worked at Manning Base Hospital in Taree for 3 years and at Hornsby Hospital for 6 years prior to returning to the network around 12 years ago.

The SCHN and paediatric services in NSW

4. The SCHN incorporates the following services, which fall within my portfolio of responsibility:

   a. The two paediatric hospitals within the network, the Children's Hospital at Westmead (**CHW**) and the Sydney Children's Hospital at Randwick (**SCH**) which provide tertiary and quaternary paediatric services;

   b. Bear Cottage, the statewide paediatric hospice service;

c. Newborn and Paediatric Emergency Transport Service (**NETs**), the statewide paediatric emergency retrieval service;

d. The Children's Court Clinic, a court assessment service; and

e. The NSW Poisons Information Centre.

5. CHW and SCH provide similar services, with the exception of quaternary services for liver transplant, cardiac surgery and transplant and severe burns management, which are provided at CHW only.

6. The SCHN has a virtual care service, virtualKIDS. Under the virtualKIDS umbrella is the virtualKIDS Urgent Care Service which is delivered jointly by SCHN and John Hunter Children's Hospital (**JHCH**). Families call Health Direct and if appropriate they are transferred to virtualKIDS for secondary triage to avoid emergency department attendance which is achieved in 2/3 of cases. SCHN may also provide ongoing virtual care to continue hospital avoidance in our virtualKIDS Short Stay Ward. virtualKIDS also provides other services including acute review for children who attended an emergency department so that they can return home, follow up care so children can be discharged earlier from hospital and do not require admission, paediatric support for clinicians in rural areas and are working on a plan to support GPs to manage children and avoid hospital.

Relationships between SCHN and LHDs

7. CHW and SCH provide local paediatric services to parts of the Western Sydney LHD (**WSLHD**) and South Eastern Sydney LHD (**SESLHD**) respectively. This is because Westmead Hospital, which is co-located with CHW, and Prince of Wales Hospital, which is co-located with SCH, do not have a paediatric unit. SCH covers the northern part of SESLHD (inclusive of Maroubra, Woollahra and Coogee) and CHW covers half of the Cumberland Shire, The Hills Shire and Parramatta. In addition to sharing campuses, there are other shared services between SCHN and SESLHD and WSLHD, including radiology and pathology services.

8. SCHN has monthly meetings with WSLHD and SESLHD for collaboration regarding paediatric services. We also have Heads of Agreements and Service Level Agreements with both LHDs, which set out KPIs, how we collaborate and work together as well as funding of shared services.

9. JHCH is the third tertiary paediatric hospital within NSW and is embedded within Hunter New England LHD. Although JHCH does not form part of the network, SCHN works closely with JHCH on service delivery and have joint partnerships for delivery of some statewide services, including virtualKIDS Urgent Care Service, gender services and palliative care.

10. Generally, children who are based in the north of the State will go to JHCH for tertiary paediatric services and children to the south will go to SCHN. However, there are no defined geographical boundaries for referrals to the three tertiary hospitals. This is because the focus is on the right care at the right time and place rather than being service or boundary based. JHCH is also a smaller children's hospital than CHW and SCH and does not have all the subspecialties available.

11. SCHN meets regularly with JHCH, and I meet regularly with Dr Paul Craven, Executive Director of Medical Services JHCH to discuss specific patient issues but also services to ensure there is appropriate coverage. The other line managers also meet with their counterparts at JHCH to ensure consistent guidelines and practice.

12. In May 2024, the South West Kids strategy was launched. SCHN has worked collaboratively with South Western Sydney LHD (**SWSLHD**) to develop their strategy and support their services. SCHN works with them on planning services, referral pathways, outreach clinics and joint services including neurology.

13. LHDs (other than SESLHD and WSLHD) provide acute and community paediatric care through their local facilities. We have Heads of Agreement with many LHDs, including Sydney LHD, SWSLHD, and Nepean Blue Mountains LHD which set out how we will work and collaborate with the LHD based on their specific service demands. We meet regularly with paediatric leaders in each LHD to develop a workplan for future collaboration. For example, we have recently worked with Western NSW LHD to support delivery of paediatric services in their region due to a shortage of paediatricians. Some calls that the LHD's VCARE service feel need specialised paediatric care are now transferred to the virtualKIDS Acute Care Service. This will support local paediatricians in Western NSW LHD as it will reduce the demand on them for on-call services.

Interstate relationships

14. SCHN provides some national services, including cardiac and liver transplants and Islet cell transplantation. Currently only liver transplants are nationally funded.

15. I meet regularly with my counterparts in children's hospitals in Australasia, which includes the children's hospital Starship in Auckland, through Children's Healthcare Australasia.

16. For the border towns of Albury, Broken Hill and Tweed Heads, paediatric patients tend to be transferred to the most appropriate facility closest to them which will usually be interstate. This is better for the patient and their families as they are treated closer to home. For interstate transfers, NETs will liaise with their equivalents in Queensland, South Australia, or Victoria (subject to destination) regarding the transfer of the patient to ensure the right service transfers the child. NETs have governance for all transfers from NSW until the other service picks up the patient and transports them out of NSW.

17. There is a formal agreement that includes interstate transfers of paediatric patients from Broken Hill to South Australia. There is no formal agreement with Victoria for Albury or Queensland for Tweed Heads. The arrangements are regularly discussed with my counterparts as part of Children's Healthcare Australasia.

Clinical governance structure

18. There have been a number of governance reviews since the SCHN was established.

19. In 2019, Governance Review for the Sydney Children's Hospital Network (the Alexander Review) (MOH.0002.0143.0001) recommended the networked approach to the governance of specialist paediatric services across SCH and CHW remain, within a clearly articulated strategy for paediatrics in NSW. Although in practice CHW and SCH were already functioning as a network at the time of the review, services were often not seen as networked or were not referred to explicitly as being part of a network structure.

20. SCHN has undergone a restructure of clinical operations which is due to be completed this month. Under the new structure, there is a strong site-based leadership team at CHW and SCH to strengthen professional support for nursing, allied health and medical staff. As this is a matrix structure there are also speciality streams across the SCHN for Medical, Surgical, Critical Care, Diagnostics, Priority Populations and Connected Care to develop strategic priorities for the streams and ensure quality and safety. The site-based leadership works collaboratively with network stream leads. Separate business units for Cardiac Services, Oncology, palliative care and Bear Cottage, NETs and pharmacy have also been established as these are all SCHN services.

21. The benefits of the network structure are many. It ensures that the teams at different sites are aligned and share learnings. It also encourages strong professional leadership and advancement within the professions. Paediatrics is a small area, and the workforce is highly specialised. When the services all work together, service delivery is improved as there is sharing of resources and staff to ensure we provide appropriate care to a large number of children. A strong network structure eliminates unnecessary duplication of services between the two facilities.

22. Examples of benefits are:

    a. Clinical benefit example – case conference arranged by myself to discuss a child with a complex medical and surgical problem with the experts from both hospitals to develop a treatment plan which included the child going to the other site for an interventional radiology procedure and then returning for ongoing care.

    b. Flow example – meeting weekly with both paediatric intensive care nursing and medical leaders, NETS, SCH and CHW site-based leadership and the Critical Care Stream leads to change the flow of patients to ensure better spread of patient numbers in each ICU.

    c. Innovation example – sharing innovations across the SCHN and watching an innovation be rapidly introduced at the other site including a new way to plaster a baby in a hip spica to prevent discomfort, itching and smell due to soiling.

    d. Research example – setting up a team from CHW to work with the Royal Hospital for Women and clinicians at SCH using virtualKIDS to enable early discharge with monitoring for premature babies with chronic lung disease.

23. There have been some challenges in developing the network structure. The SCH and CHW are both Sydney based, although we know that not all acutely unwell paediatric patients are based in Sydney or admitted to a SCHN facility. We are currently working with the other LHDs to provide advocacy at a State level and partner with LHDs to assist in the provision of services.

24. As part of this focus, we are meeting with rural paediatricians to get an understanding on how we can share care better. Commencing in COVID, I have also held a weekly virtual paediatric group which is open to all paediatric clinicians across NSW to join. The group initially started as a way to share information related to COVID, however it now has a

broader information sharing and networking focus. Problems raised by any clinician can be escalated to look for solutions.

Funding models

25. Activity Based Funding (**ABF**) models are challenging in paediatric settings. This is mainly because the Diagnostic Related Groups (**DRG**) do not discriminate with the care that is received. This can cause a significant cost discrepancy. For example, there is a cost discrepancy depending on whether a baby is treated in the Neonatal Intensive Care Unit or Paediatric Intensive Care Unit and this is based on weight and age rather than the baby's medical issues.

26. Paediatric patients generally require more care and time than adult patients. Although there is a loading for this, it does not compensate properly particularly for more complex treatments. For example, inserting an intravenous cannula for an adult patient usually requires one staff member and takes around 5 minutes. For a paediatric patient, this same task could take three staff members (one to hold the patient, one to do the cannula and someone to secure the cannula) and can take a significant time. There is no way to capture this in the ABF model. This can also lead to worse or delayed care for children. If an adult has a head injury, they will have CT scan performed when they present to emergency. A child with a head injury who needs a CT scan may need to be moved to another facility for anaesthetic support to sedate them to keep them still. This leads to a delay in treatment.

27. The cost for drugs is different for children as there are multiple drugs that are available on the Pharmaceutical Benefits Scheme (**PBS**) for adults, that are effective for children but not approved for PBS payment for children. As these drugs can be very expensive, clinicians trial the cheaper alternatives and often the child becomes more unwell prior to commencing the more expensive non-PBS drug. Children also require medications to be in liquid form and this needs to be made up by SCHN or the more expensive liquid forms to be purchased. The financial cost for SCHN for non-PBS drugs and liquid alternatives has increased over $5 million dollars in 23/24.

28. There is a psychosocial complexity to working with children and families, however ABF does not capture this complexity. This can include complex child protection issues and may need multiagency collaboration across education, communities and justice and police.

29. Some of SCHN's services also do not lend themselves to ABF. SCHN has significant virtual services which are not adequately captured by ABF including virtualKIDS which does not currently have a clear model for ABF. Our NETs service that virtually assesses critically ill children and then transports them cannot be funded for these services by ABF despite Ministry of Health discussions with the Independent Health and Aged Care Pricing Authority and if the children are not transported no revenue is achieved. There are also other ways to measure savings. A lot of our services such as KidsGPS (care co-ordination service) provide significant societal savings, such as not having to travel, parents not having to take a day off work and sustainability but are not ABF funded.

30. SCHN is involved in new technology, including gene therapies for inherited blindness and spinal muscular atrophy type 1. Previously, children with spinal muscular atrophy would die before they reached 1 year of age, but they are now surviving with treatment. These therapies have huge patient benefits however the upfront cost of treatment is high. In addition, for children with SMA, they are now surviving however have chronic and complex conditions which puts more demand on acute care services. It is anticipated that emerging gene therapies will eventually save on acute care costs although we have not realised those gains yet.

Improvements

31. I see the following areas for further development of paediatric services:

    a. The development of a strategic and operational plan for paediatric services in NSW. This needs to include quaternary and tertiary hospital care, local paediatric care, community and early childhood services and outpatient care that is planned and integrated. It needs to ensure equity for children living anywhere in NSW being able to access the correct level of connected care.

    b. The system can then provide a tiered, hybrid model with appropriate children accessing virtual care, others accessing face to face care provided in a planned, funded way by some services that are statewide and based in Sydney or Newcastle but integrated with local clinicians including paediatricians, nurses, allied health and GPs and some provided locally.

Dr Joanne Ging	Witness: CATHERINE CRUZ
6/6/24	6 June 2024
Date	Date