Special Commission of Inquiry

into Healthcare Funding

Before: The Commissioner,
Mr Richard Beasley SC

At Level 2, 121 Macquarie Street,
Sydney, New South Wales

Tuesday, 11 June 2024 at 10.00am

(Day 032)

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

Also present:

Mr Hilbert Chiu for NSW Health

THE COMMISSIONER: Good morning.

MR MUSTON: Thank you, Commissioner. We are commencing this short hearing block, which over the next four days will examine three fairly discrete issues. The first is the Sydney Children's network, which will be examined today and Friday. St Vincent's Hospital we will be looking at on Wednesday, and the Hawkesbury District Health Service, which has been operated most recently by St John of God under a PPP, will be looked at on Thursday. In respect of the latter, we note that it is shortly to be handed back to the state.

In terms of the children's network, we're not going to look, during this hearing block, at what have been described in some of the submissions and statements provided as the "inadequacy or unsuitability of ABF funding" for the recognition and funding of complex paediatric services. That's not because we're not going to look at them, but it's because we think it's probably more appropriate to defer them to the funding hearing block a little bit later in the year.

We are going to examine how the network operates and whether, as some have suggested, it's really a network in name only. And it is important for us to develop an understanding of the potential benefits of a properly networked system of paediatric care across the state and, to the extent that we don't currently enjoy that, what might be done to better facilitate it.

In this respect, we anticipate that we'll probably see some similar themes emerging to those which rattled out of the evidence given in relation to the spinal care or spinal injury services and the catastrophic brain injury services a little bit earlier in the Commission, where the benefits of a properly networked system were identified and some of the challenges presented by the absence of a good and functioning network similarly were identified.

Turning then to St Vincent's and Hawkesbury District Health Service, these are probably, we anticipate, likely to raise some similar issues to those which emerged from evidence given by Royal Rehab, Tresillian and Karitane. There are some subtle but important differences, though. St Vincent's is a networked AHO, I think the only networked AHO, which means it has its service agreement directly with

the ministry, as opposed to those other entities which have their service agreements entered into with LHDs. We'll examine the benefits and disbenefits of that.

We're also then going to look at the arrangements under which St John of God has operated the Hawkesbury service. As I mentioned a moment ago, that has been in the nature of a PPP. The contractual arrangements that St John of God have had in respect of the arrangements of that service have been with the Nepean Blue Mountains LHD, not the ministry, so it's a subtle difference between them and St Vincent's. More importantly, we're going to explore with the witnesses called in respect of that facility the reasons that they have chosen to bring that arrangement to an end.

Ultimately, though, we anticipate that both St Vincent's and St John of God will raise issues about the extent to which the funding provided under their respective arrangements is sufficient to meet the costs of the delivery of the services that they are required to deliver under those agreements. As each are private entities and not LHDs or part of the state, the drivers for them and the consequences of funding deficits are obviously very different.

Finally we anticipate exploring with both St Vincent's and St John of God the extent to which they are involved or they have been involved in the planning of health services in the wider catchments that they operate, that is to say, whether there is any particular long-term strategy or planning around the particular services that each of those facilities offered relative to facilities within that wider catchment.

We've discussed and heard evidence throughout the Commission about the way in which the delivery of health care is a patchwork of services which pulls together to, as best as possible, cover all of the needs of the community. It has been identified for us that there is a real importance to ensure that there is no overlap and, similarly, that there are no important gaps. We are interested to explore with St Vincent's and St John of God the extent to which they are involved, if at all, in that process of identifying what the landscape looks like and exactly where they fit in it with a view to minimising any gaps and avoiding any overlap.

Without further ado, we'll turn to the children's network. Mr Glover is going take those witnesses.

THE COMMISSIONER: Just before we do, just so everyone is aware of what I've been looking at, other than obviously the witness outlines, two of the things I've read are the "Final report of the expert panel" regarding "Review of governance for the Sydney Children's Hospitals Network" - I think the shorthand for it is "the Alexander review" - and the "Review of health services for children, young people and families within the NSW Health system", the shorthand for which is "the Henry review". The Alexander review is June 2019. The Henry review is December of that year.

One of the things Professor Henry says he was asked to do - sorry, I will go back a step. I would like to know with clarity what, if any, of the Alexander review recommendations were accepted. I would like to know - I think I already do - about Professor Henry. Someone has told me that all of the 77, I think, recommendations were accepted and some have been implemented.

The things I don't understand are why Professor Henry was asked to address a review that was six months before his own. I could be misreading it, but there are aspects of Professor Henry's review where he comments on what the Alexander review found, that I think are - they don't seem to be correct. They seem to be misinterpretations of the Alexander review, which concerns me if the Henry review recommendations have all been accepted.

There are also some references to these reviews in the witness statements that I don't completely follow. I won't take that up now, but I would like it explored in the evidence.

MR MUSTON: These are matters that will be explored in the evidence, and otherwise it may be for my learned friends to enlighten your Honour in respect of some of the motivation questions that --

THE COMMISSIONER: I thought I would say that now so that people are aware of what I've been looking at and what's confusing me.

MR MUSTON: Thank you, Commissioner.

MR GLOVER: The first witness is Dr Alexander.

THE COMMISSIONER: For clarity, a different Alexander than the "Alexander review"; correct?

MR GLOVER: Yes. I laboured under that misapprehension for a short while.

<SHIRLEY MARIE ALEXANDER, sworn: [10.08am]

<EXAMINATION BY MR GLOVER:

MR GLOVER: Q. Dr Alexander, could you state your full name, please?
A. Shirley Marie Alexander.

Q. You are a staff specialist at the Sydney Children's Hospitals Network; correct?
A. I am.

Q. You have been in that role since July 2008; is that right?
A. Yes. I've actually worked there since 2007 but as staff specialist since 2008.

Q. You are currently the head of department of the Children's Hospital Institute of Sports Medicine and Weight Management; correct?
A. Correct.

Q. And you have held that role since about October 2016; is that right?
A. Correct.

Q. For the purposes of giving your evidence today, you made a statement on 6 June; is that right?
A. Yes, I think so.

Q. It is on the last page.
A. Yes, yes, that's right.

Q. I will bring it up on the screen for you. It is [MOH.9999.1286.0001]. It's just up on the screen there to your right, although if you have a hard copy, feel free to use that. Have you had a chance to read the statement

again before giving your evidence today?
A. I have, yes.

Q. I understand there is one correction that you wish to make to paragraph 11; is that right?
A. There is.

Q. In the last sentence?
A. Yes, it should be, "If referrals are not accepted, services should find appropriate or instigate appropriate alternative treatment routes" --

THE COMMISSIONER: Q. I'm sorry, I've just missed that. What line are we at?
A. The very last line in paragraph 11.

Q. So it should say?
A. "If referrals are not accepted", apologies for that, "services should find appropriate alternative treatment routes/suggestions for the referrer to action."

THE COMMISSIONER: The statement I've got, that was put in my folder, differs from this. Is that a problem?

MR GLOVER: Well, yes.

THE COMMISSIONER: I will change that. That is a problem.

MR GLOVER: That is a problem. I need to correct that, Commissioner.

THE COMMISSIONER: There have obviously been some changes made to the statements since they were provided to me.

MR GLOVER: I'm sorry.

THE COMMISSIONER: Does that apply to many or all of the statements?

MR GLOVER: It does, some. I now can't immediately recall whether the other two for today, but, Commissioner, you should have the right version.

THE COMMISSIONER: I was given a hard copy, which I have worked on. It is possible that a different version was emailed to me, but I've assumed that there have been no changes and kept the hard copies because that's what I've

highlighted and got notes on.

MR GLOVER: Yes, all entirely sensible.

THE COMMISSIONER: I can probably live with what's on the screen at the moment.

MR GLOVER: All right. I think if you are happy to proceed in that way, we can manage it for this witness.

THE COMMISSIONER: Yes. Perhaps I should just ask, ballpark, really - lots of fundamental changes to the statements or only minor?

MR GLOVER: To about three or four paragraphs and nothing that altered the substance of the evidence, is my recollection.

THE COMMISSIONER: Let's live with what's on the screen and what I've got, but I would like a copy of the actual witness's statement at some stage.

MR GLOVER: I'm sure that would be very helpful.

Q. All right, Dr Alexander, none of that is your fault --

THE COMMISSIONER: Obviously, moving forward, when there are changes to witness statements and I've been given a hard copy, people will let me know and give me the new updated version?

MR GLOVER: I'm sure they will.

Q. Now, Dr Alexander, in paragraph 6 of your statement, there you tell us that one of the benefits of the network structure is that it supports greater coordination and collaboration across clinical services in both hospitals; do you see that?
A. Yes.

Q. When you were referring to the "network structure" in that paragraph, you're talking about the two facilities that sit within the Sydney Children's Hospitals Network; correct?
A. Yes.

Q. In paragraph 7, you tell us that since the development

of the network, more services have collaborated and shared knowledge processes to support each other. So by that, do we understand that since the development or the implementation of the network in about 2010, more and more services, over time, have collaborated and coordinated their services; is that a fair summary of those two paragraphs?
A. Yes, that's my perception, yes.

Q. Are you aware of services that haven't done that - that is, haven't collaborated and integrated their services?
A. Not specifically.

Q. Are you aware of any barriers to that collaboration and coordination of services within the network?
A. Not specifically. I mean, barriers would potentially be more maybe on a departmental and individual level.

Q. What do you mean by that?
A. In terms of where interests of head of departments or staff lie as to, you know, where their special interests are.

Q. When you say "the interests of head of departments and their special interests", does that mean that there may be a disconnect between the interests of a department at one facility versus the interests of a department at another facility? Is that what you are describing?
A. There could be.

Q. Could be? When you say --

THE COMMISSIONER: Q. Could we just go back a step. Sorry - no, you finish that question, because I am interrupting you mid-flow. I will wait.

MR GLOVER: Q. When you said "could be" to my last question, is that something that you actually have any knowledge of, or is it just a potential?
A. It's just a potential, not that I have specific knowledge.

THE COMMISSIONER: Is that a convenient time?

Q. Can we just go back a step and perhaps look at paragraphs 2 and 3 of your statement. In paragraph 2 you

have introduced what we call the Sydney Children's Hospitals Network, and from then on, you are referring to the network and, as an example, in the last sentence of 3 you are saying, "Having a Network has enabled ...", et cetera. Do you see that?
A. Yes.

Q. "Sydney Children's Hospitals Network" is just a title. When you make a reference to the "network", how would you define it? What does it involve?
A. To me, the network is looking at - it's two separate hospitals but one entity, with the aim of providing optimised care for the children from a tertiary and quaternary perspective of New South Wales, and also for their local population, from the secondary care level, and --

Q. Is it networked at that secondary level?
A. Is it networked at the secondary level? Sorry.

Q. Well, when you are talking about local populations, is that part of the network? Do you mean serving the local populations, that Randwick services the east and south-eastern suburbs and Westmead the western suburbs, I suppose; is that what you mean by that?
A. Yes.

Q. Is that part of the network, though?
A. It is to a degree part of the network, but secondary level care is --

Q. To what degree is it part of the network?
A. In the sense that you're still looking at the best - the optimised care for your local population as well as the New South Wales population, and, you know, if, for example --

Q. How is the Randwick Hospital networked to the Westmead Hospital for the purposes of doing that - taking the word "networked" to mean joined in some way, collaborating in some way?
A. Yes. So, for example, some of the ambulatory care services, even though they are - they're working at both levels, at a tertiary and a secondary level, and if you're looking at secondary level, if that service, which is a networked service, such as hospital in the home - if, for example - but they have staff at both sites - if they are

understaffed at one site and maybe have more patients that they have to go and visit, for example, and the other site has less visits booked in for that day and more staff available, they share services, and that could be at the sort of secondary level, patient level, but also they can do that for the tertiary. So there is a melding, you know. Because the hospitals both are - they are secondary and tertiary/quaternary, that can sort of be a grey area. So it's - you're networked on all levels, I think.

Q. Sorry, what do you mean by "grey area"?
A. Well, if you're at other, for example, some metropolitan hospitals, rural/regional hospitals, they are secondary level care and they won't provide tertiary level care, whereas because both sites, Sydney Children's Hospital and Children's Hospital Westmead, provide both secondary and tertiary level, there can be a little bit of a blurring of the --

Q. I see. All right. Does that cover - I'm obviously not asking you to go down to the detail, but in terms of the big picture, that's what you mean by "network" or what your understanding is, it has a network?
A. Yes, well, overall the network is to work both collaboratively - both sites collaboratively and coordinatedly, but also networking within the LHDs within New South Wales from that sort of tertiary level.

Q. And how does that work?
A. So, for example, there have been new services set up, like virtualKIDS, which was - it's a remote monitoring service. That was commenced during COVID, and that has now become - it's expanded and it's now become a service that actually services the whole of New South Wales. During COVID, it was mainly for the two sites, and then we got asked to, you know, support some of the other rural/regional areas that were having challenges, and then it's now become a network - a New South Wales statewide service.

Q. Just because we're on paragraph 3, can I ask you some questions that are just out of curiosity but completely different to what we were just exploring?
A. Yes, sure.

Q. In paragraph 3 you talk about the increase in the prevalence of, first of all, obesity. Obviously, these are

obesity rates in children or people under 18?
A. Yes.

Q. Off the top of your head, are you able to help me with what the increase is and what the levels are?
A. Well, one in four children, school-aged children, in New South Wales have issues with overweight or obesity. The overweight prevalence has levelled off, but obesity has increased from about 6 per cent to 8 per cent.

Q. I just missed what - my computer's down, I can't see the running transcript. You said "all weights", did you?
A. Overweight. Overweight.

Q. Tell me the difference, the medical difference, between overweight and obesity?
A. Overweight is related to the body mass index of a child, which will be between the 85th and the 95th percentile on age and gender/sex-specific growth charts, BMI charts; and obesity is above the 95th percentile, and obesity basically is when excess adipose tissue in the body starts to create health problems.

Q. And when you are talking about increase in prevalence of obesity, can you give me an idea about what that increase has been over a time period, or --
A. So over about the last 10 years, it's increased from about 6 per cent to 8 per cent, but the severity of the obesity - so those at the severe end of obesity have increased even more. So, for example, when I first started working in the area, we rarely got children that were over 100 kilograms. Now we have children up to 250, 280, 300. So that severity has increased.

Q. Is the concern for that not just immediate health problems but health problems into adulthood, I imagine?
A. Yes. I mean, there are health and psychosocial problems involved in that.

Q. The extension of service you mention in paragraph 3 with the dietician weight management clinics, what does that involve? What are they exactly?
A. We now have a position which we call a network dietician position, so the dietician works two days at one site, two days at another site, and prior to that - so that's been about 12 months. Prior to that, there was no specific weight management service at Randwick. Now --

Q. Sorry, has this been set up because of the increase in prevalence that you have been talking about, the concern that --
A. Yes, we've been working on it for a little while --

Q. Yes, yes. Sorry, I interrupted you. Keep going.
A. No, that's all right. And so even though the prevalence of obesity is less in the eastern suburbs, because obesity tends to be a higher prevalence in lower socioeconomic areas, there is still a need for weight management services in that area. And also the Aboriginal population has a very high prevalence. So we felt that we've been sort of working towards having a network service to provide intervention for children affected by obesity at both sites.

Q. And the last question on that, obviously - well, perhaps not obviously, but my assumption is that the purpose of the weight management clinics is to have improved health and lower weight. How is that done through the clinics? What is actually done?
A. So the dietician will give dietary advice on how to - it's really looking at lifestyle goals around nutrition and also some physical activity. If the young person involved has more health concerns or more severe obesity - so the dietician-only clinics look at children with less severe obesity, then the dietician liaises with the team overall, because we all meet on a regular basis, and would be referred to our multidisciplinary team that's based at the Children's Hospital at Westmead. The ultimate goal would be to have both services across both sites, as in dietician and also a multidisciplinary team, but the dietician at the Randwick site has access to the full expertise of the team.

Q. The ultimate goal you just referred to obviously requires that ultimate goal to be funded?
A. It would require resourcing and --

THE COMMISSIONER: Yes, okay. Sorry for that diversion. Go ahead.

MR GLOVER: Q. Dr Alexander, if I could take you back to your statement and turn to paragraph 9. There you tell us that, "One of the limitations of the network structure is the cultural impact caused by the creation of the network itself." Do you see that?

A. Yes.

Q. I think from your earlier answers, you were employed in the service, which is now the network, both before and after its creation?
A. (Witness nods).

Q. So you have seen the transition firsthand, I take it?
A. Yes, yes.

Q. What do you mean in the first sentence there about, "One of the limitations of the network structure is the cultural impact caused by the creation of the network itself"?
A. So my observation, having not worked at - so I was originally employed at the Children's Hospital at Westmead, but it was only a couple of years before the network was put in place. However, you know, I've worked in a number of hospitals across both Australia and the UK, and my understanding is that people that have worked at both sides for a long time, for example - and over the years and decades, each site has developed its own culture, its own sort of personality, its own way of working, and they can be quite different in some areas, and I think whenever you have a change and a merging of entities together, there will be some that will be early adopters of change and there will be some that are more resistant to the change. And there is also a feeling of, even though we are a network, we still want to maintain that sort of individuality of the culture at each different site. Just because we can coordinate and collaborate together doesn't mean to say that you need to lose that sort of cultural identity.

Q. I will break that up a little bit. Some of the issues you have described in that last answer create a barrier of sorts to the integration and collaboration of services that you described earlier in your evidence; is that right?
A. Yes.

Q. Is that something that persists today, or has it all been overcome, to your observation?
A. I think some of it persists today and it's a work in progress. I think overall what we are - I mean, ultimately what we all aim for is to do the right thing by the right patient at the right time at the right place, you know, optimise health care, and people, some people, might want

to do it in slightly different ways. I think whenever you have a collaboration together, you've got to take into account other people's ideas or ideals. For some that might be easier, and for others it might take a bit longer, and so I think it's still a work in progress.

Q. We're now almost 15 years down the track. What initiatives, to the extent you are aware of them, have been put in place to finally close that loop?
A. Well, I think during COVID there was a lot of collaboration. We worked together very well, made changes very quickly, as they were needed during COVID. I think, based on that, there has been a lot of good work, a lot of trust built up and a lot of collaborative projects and services built up, like virtualKIDS, that have come from that. So I - sorry, I have lost train of your - just ask me your question again.

Q. I will ask a different question. To the extent that these issues still persist today, what do you think could be done to overcome them?
A. I think for most people, when you are looking at change and doing something that might be different from the way that they've done things before, it's to do with communication, being heard, feeling like you are part of the process of change and that you can give input to the process and then seeing that what you have suggested or your ideas and your input is being acted upon.

Q. Can I take you to paragraph 10, please. This touches on some of the answers that you gave to the Commissioner earlier. I just want to make sure I have understood what you say in paragraph 10, and then I will ask you some further questions about it. In paragraph 10, you tell us that the network operates to provide support for regional and rural communities through virtualKIDS and outreach clinics but is not always best placed or resourced to deliver paediatric services across the state. By that, do we understand it that the network provides support to paediatric departments in LHDs across the state, who will then have primary carriage of the care for children in those services; correct?
A. Yes.

Q. But the network itself will not be the primary care deliverer. Is that what you mean?
A. Yes.

Q. How does that operate on a day-to-day basis, that sort of approach?
A. So overall, and again particularly since COVID, there's been the - telehealth has accelerated, and so that's enabled many services to do, if you like, virtual outreach clinics and support, so the local clinician can connect with someone in the network for their expertise and support, and they can do that either with their patient connecting with the expert and then the expert or the network person connecting with the local clinician, or they can do it with the local clinician being in the room, so there's many ways that the network clinicians can support local services at regional/rural areas, by joint care, joint coordinated care.

Q. Is this something that your department does?
A. We do more and more of that now, yes, because regional and rural areas don't have weight management services.

Q. Perhaps let's use your department as an example.
A. Yes.

Q. Take me through how the process would work. So there is a paediatrician in Wagga, who has a presentation of someone who needs the services of your expertise.
A. Yes.

Q. How would they go about getting the support from the network that you described in paragraph 10?
A. So they would refer to our service and then we would liaise with them as to whether or not the patient meets the referral criteria, for example. Then we would also - depending on how far they are away, our clinical nurse consultant would discuss with the family as to whether or not they would want to actually come up for a physical examination and interview or consultation in our service. If not, then what we would do would be, we would liaise with the local clinician to do the physical examination, but we would link up with the family to do a consult via telehealth. Often that's the family on their own. Sometimes it's with the clinician in the room with them. And then we devise a plan of how often to connect with the family or the clinician.

Often what we encourage is local facilities, so, for example, we might get the local dietician to connect with

the family and the local paediatrician, and then our dietician would also liaise with that local dietician to give support and advice as to how to move forward with the family, and then the local dietician, local paediatrician, would see the patient more frequently and then we would see them on a monthly or a three-monthly basis to connect up and give further support. And then obviously we're available for queries from the local services. They might email us, might phone us, as to further advice as to what to do or interpret results, et cetera. So that's the way it would work, and I suspect many other services do that.

Q. Are there any formal plans or pathways that identify how support from a regional clinician through to a service like yours can be obtained?
A. So we have different pathways, our service has different pathways. We are in the process of formalising a model of care for regional/rural support. It's not finalised as yet, but, yes, that would be the way we would do it, would be sort of a clinical pathway that the clinicians could follow.

Q. In providing support of the kind that you have just described, would there be benefit, in your view, to there being a high-level overarching plan for the delivery of paediatric care across the state?
A. I think a higher overarching plan across the state would definitely be helpful in terms of developing services as evidence-based and need. There would have to be I think the facility to look at specific areas, so that different areas would - you know, they will have different needs, different requirements, different, you know, population prevalence with that condition, so you would need to build in to that overarching plan or policy, or whatever, to be able to be flexible with the different areas and the different sub-specialties.

Q. Is what you are suggesting that there needs to be an assessment of the needs for paediatric care in different parts of the state as part of that planning process?
A. Usually that's what you would do. You would do a needs analysis to see what specifically is needed in what area.

Q. And as part of that plan development, would there be benefit in identifying clearly the types of services that, for example, the network would provide and the types of

services that ought to be available in the LHDs across the state in relation to paediatric care?
A. Yes, I think so.

Q. And would there be benefit in clearly identifying the support that the network could give to paediatric units in the LHDs across the state and the mechanisms by which that support could be obtained?
A. Yes, I think so.

Q. Does any of that exist at the moment, to your knowledge?
A. Yes, I think in virtualKIDS, for example, with that going statewide, they have - you know, there is a definite remit, there are definite pathways for clinicians and families to follow, and it's also expanding into different areas. You know, they've got the - they're looking at new models of care as to how virtualKIDS can support patients and families and clinicians to avoid admission to or presentation to emergency or enable discharge home more safely and more early.

Q. So that's an example of a particular service having a pathway and a plan; correct?
A. Yes, yes.

Q. Is there anything, though, to your knowledge, that covers the delivery of paediatric care across the state in a holistic way?
A. There are - so I'm not at high enough level to know --

Q. That's okay.
A. -- what there is across everything. However, I can say that there are certain areas that I do know have developed or are in the process of developing models of care to coordinate care across the state. For example, rehabilitation, paediatric rehabilitation medicine - they have developed a model of care that is across the whole state, so it includes services in John Hunter Children's Hospital. It's - they are sort of in an implementation phase, I think, and they've got, you know - and this is a good example of the two hospitals working together, where rehabilitation medicine at each site have come together to support the employment of a project officer, for example, to help implement some of the model of care.

Q. Can I take you to paragraph 12. There you tell us

that, "The challenge around outpatient referrals, which occurs across all LHDs, has been identified by NSW Health", et cetera. Do you see that?
A. Yes.

Q. What's the challenge around outpatient referrals that you are referring to?
A. So my understanding is that different services will have - and this is not just in paediatrics; it's in adult care as well - they will have different referral criteria, which for those who are referring patients might be confusing or they might not know, there's sort of no central repository of where they can look to find the referral criteria, and so to help standardise that and support referrers and also the clinicians that are receiving the referrals, they are piloting statewide referral criteria across both adult and paediatric medicine to clarify the process for those involved.

Q. Will that process or that clarification overcome the challenge that you describe in paragraph 11 about there being what you call a grey area around whether patients should be referred in to the network?
A. Yes, I think that will go towards clarifying that significantly. What I was saying in that paragraph, and one as well, is that with both hospitals having separate - having emergency departments, you can't overcome the fact that some families will choose to come to the two children's hospitals' emergency department rather than potentially going to their own local health district emergency department.

MR GLOVER: Thank you, Dr Alexander. I have no further questions for this witness, Commissioner.

THE COMMISSIONER: Mr Chiu?

MR CHIU: No questions, Commissioner.

THE COMMISSIONER: Thank you very much, doctor, for your time. We're very grateful. You are excused.

THE WITNESS: Thank you very much, Commissioner.

<THE WITNESS WITHDREW

MR GLOVER: The next witness is Dr Ging. Someone is

looking - we're slightly ahead of time.

THE COMMISSIONER: Yes. I might just adjourn for five minutes. I will come back in five minutes.

MR GLOVER: Yes, thank you.

SHORT ADJOURNMENT

THE COMMISSIONER: Mr Glover?

MR GLOVER: Thank you, Commissioner. The next witness is Dr Ging, who is in the witness box.

<JOANNE MAREE GING, sworn: [10.50am]

<EXAMINATION BY MR GLOVER:

MR GLOVER: Q. Could you state your full name for the record, please?
A. Dr Joanne Maree Ging.

Q. You are the executive director of clinical operations for the Sydney Children's Hospitals Network; correct?
A. That is correct.

Q. You have held that role substantively since about November 2020?
A. Yes.

Q. And acted in it from about February 2019, prior to that; is that right?
A. That's correct.

Q. For the purpose of giving your evidence today, you made a statement; is that right?
A. Yes, I did.

Q. I will just have it brought up on the screen. It's [MOH.9999.1292.0001]. It's there on the screen, but if you have a hard copy with you, feel free to use that. Have you had a chance to read it before giving your evidence today?
A. Yes, I have.

Q. Is it true and correct to the best of your knowledge and belief?
A. Yes.

MR GLOVER: Commissioner, that will form part of the tender in due course.

Q. In paragraph 2 of your statement, you give us a general overview of your function, but I just want to explore with you a little bit more about what it means in a day-to-day role. When you say you direct and manage the clinical operations of the SCHN across a broad spectrum of health service delivery settings, et cetera, what does that mean on a day-to-day basis?
A. So I'm responsible for the clinical functions of both the Children's Hospital at Westmead, Sydney Children's Hospital at Randwick, Newborn Emergency Transport Service, or NETS, Children's Court Clinic, and Bear Cottage at Manly.

Q. So you sit across both the facilities, the two main facilities in the network; correct?
A. That's correct, yes, and I regularly visit NETS and Bear Cottage.

Q. As part of your function, when you say you are responsible for the clinical operations, what do you do in performing that function?
A. So the clinical operations are the care that we provide to children. It's not corporate services, such as cleaning and linen and pathology; it's more of the clinical services that I oversee, although at Westmead we do have a pathology service as well, not at Randwick. So it's all the clinical staff we have in the network, our nurses, doctors, allied health staff and others, such as perfusionists and technologists and all those - they all fall into my directory of clinical operations.

Q. So responsible for the clinical workforce?
A. Yes.

Q. What about for clinical planning?
A. Yes, although there's a team, we have a team, an executive team, who look at planning across the board, but on a day-to-day basis, yes, I'm responsible for clinical planning.

Q. Does part of that function include coordinating services across the two sites?
A. Yes, it does.

Q. We'll come back to that in a moment. Just before we turn to some of those issues in relation to the network, in paragraphs 9 to 11 of your statement, you refer to the John Hunter Children's Hospital?
A. Yes.

Q. Which is not part of the network at the moment; that's right?
A. Yes, it is.

Q. Are you aware of why it's not part of the network?
A. No, I'm not sure that that was considered at the time, but it is part of Hunter New England area health, or it was the area health service; it's now the LHD.

Q. Has there been any consideration, to your knowledge, of whether it should be formally part of the network?
A. Not to my knowledge.

Q. In paragraph 9, you say although the John Hunter Children's Hospital doesn't form part of the network, the Sydney Children's Hospitals Network works closely with it on service delivery and there are joint partnerships. Do you see that?
A. Yes, that's correct.

Q. What sort of work is done with the John Hunter Children's Hospital in relation to service delivery?
A. So we have several services that are statewide services - of those, palliative care, and the other one is virtualKIDS, our urgent care service, which is a statewide service. We also have gender services, which are part of a statewide service for gender services as well.

Q. So when you say you work closely with John Hunter Children's Hospital on those particular services, what sort of collaboration and coordination is done?
A. They're slightly different for each of them. So the palliative service, we run a statewide on-call service for the palliative care. So the palliative care specialists are in contact on a daily basis and provide that care. For virtualKIDS Urgent Care Service, that is an absolutely integrated service; they meet multiple times a day virtually and provide care seamlessly. If calls can't be answered in one site, the call is answered on the other site. The governance is combined. There is a manager

across both sites. And the finances - it is a complete joint service that we set up. Gender services are a little different, but I'm happy to go into that detail if you would like.

Q. Aside from the statewide services, is there coordination between John Hunter Children's Hospital and the network in relation to other care that is delivered through either the network or John Hunter?
A. Yes. So in multiple ways. We meet - I think I'm online with John Hunter Children's Hospital at least every couple of days and sometimes multiple times a day. It can be over just a patient, where we need to collaborate to make sure that that child receives the best care that can be provided, or it's planning services that we need to provide for other parts of the state, or we're looking to ensure that the right services are available in each site. So we do provide some specialists, because we have the full range of sub-specialists, and some of those sub-specialists go to John Hunter to provide care.

Q. Can I take you to paragraph 19, please. I'm sorry, before I do that, doctor, I wanted to take you to paragraph 13. There you tell us that the LHDs, of course, provide paediatric care through their own facilities?
A. That's right.

Q. Then about halfway down the paragraph, in the fourth line, you say:

> *We meet regularly with paediatric leaders in each LHD to develop a work plan for future collaboration.*

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

Q. What does that work plan involve?
A. So it depends on the LHD. As I said, we have heads of agreement with many of the LHDs, and we now have a signed one with ACT as well, because there's children's services provided in the capital territory as well. We also then meet with each of these districts at different times. Depending on their level of population or their level of need, it varies between monthly to quarterly. At those meetings, we develop a set of priorities for which we want to collaborate, and it differs for each of the LHDs,

because of course the priorities are different, and then we steadily just work through them so we can make sure that we provide the best care for children in that LHD, either by putting things together that are, you know, written, as in documents, or is it staff, or is it just strategy, work planning strategy for their strategy in different areas. So it is a - we develop a work plan for each LHD with what we want to accomplish within the next 12 months.

Q. So the starting point is what does the LHD need from the network?
A. Correct, that's right.

Q. Correct?
A. Yes.

Q. And then the plan, if I've understood you correctly, identifies how the network will support the LHD; is that right?
A. That's right, yes.

Q. Does it go into detail about referral pathways, things like that?
A. Yes. It depends on the LHD and what the issues are. So, yes, it can do that, yes.

Q. And I think you said perhaps staffing support as well?
A. Sometimes, yes.

Q. What might that look like?
A. So we have developed a joint position with South West Sydney to provide neurology services to Campbelltown and Liverpool Hospital, and that's a joint position and a joint person who works for us to ensure that they keep their really sub-specialty high-level skills as well as working with the number of children that live in the South West Sydney area. For the example I gave there, Western New South Wales, it's different, and that's a virtual service where we provide support to clinicians in usually small hospitals through Western New South Wales, to support the paediatricians in particularly Dubbo.

Q. Now, if we go ahead to paragraph 19, please --

THE COMMISSIONER: Q. Just before you do, in paragraph 13, second sentence, "We have heads of agreement with many LHDs" --

A. Yes.

Q. What does "many" mean?
A. I've listed most of them. We have a few more and we're working on a few more. It just takes a little bit of time to go through the legal processes. My aim will be that we have a heads of agreement with each LHD, but we're just steadily working through them.

Q. When was the first heads of agreement entered into?
A. From memory, 2022.

Q. So this is a very recent process?
A. Yes.

THE COMMISSIONER: Are these heads of agreement in the evidence?

MR GLOVER: No, they are being collated and they will be in the tender bundle, yes.

THE COMMISSIONER: All right. Thank you.

MR GLOVER: Q. Paragraph 19 --

THE COMMISSIONER: Q. Sorry, perhaps I will just ask, what was the thinking and purpose behind entering into the heads of agreement with the LHDs?
A. So I really felt that the network needed to look outwards to providing the best care for all of the children in New South Wales, not just within our two hospitals, and so to do that - and having worked both rurally and in metropolitan Sydney, I've worked as a paediatrician in other areas, so I wanted to make sure that we actually had something that documented the collaboration, and the aim is to have the heads of agreement and then to have different SLAs. And so now, with several of the LHDs, we now have SLAs to actually define what happens, so that if something was to happen to me, it's not just based on a relationship; it is actually documented, so that everyone else can see what it is, that it is clear, and that the funding is also clearly documented about where it's coming from.

Q. Right, okay. Tell me if this is wrong, but the heads of agreement are between the LHDs and who - the Sydney Children's Hospitals Network is the other entity?
A. Correct. That's correct.

Q. Is it a means of creating a bigger network?
A. I hadn't thought of it like that, but, I mean, networking is really - we are a network between the two hospitals and our other entities, but what we actually do throughout the state is we network with all of the other paediatric clinicians, be they medical, nursing, allied health throughout the state, and so this is a way of formalising that and just making sure that we're all seeing things from the same point of view, and it does enable, as I said, the service level agreements to get down to the detail to --

Q. One of the things you said was that you wanted to make sure that we actually have something that documented the collaboration --
A. Yes.

Q. -- which I understand in the heads of agreement, but collaboration is another way of networking, isn't it?
A. Yes. It depends how you view the word "network".

THE COMMISSIONER: Yes. Yes, it does, I think.

MR GLOVER: Q. I might come to that now. In paragraph 19, you refer to the Alexander report --

THE COMMISSIONER: Sorry, there is another question that occurred to me.

Q. The genesis for the idea of entering into these heads of agreement, did it come from any of the reviews, like the Alexander review or the Henry review, or was it independent of those?
A. No, I think it was between myself and our CE, Cathryn Cox.

Q. Your CE - chief executive?
A. Yes.

Q. How did it emerge that the sort of discussion - you felt there was something missing?
A. Yes. I think we - we do a lot of work outside the network, but it's not documented. We provide a lot of what are currently called outreach clinics.

Q. Was this a means of formalising what was already being

done and putting it in a documented form?
A. Yes, yes, but also the - it was to also open up the opportunities for the new ways of working, and I think that's been actually more of what we've actually realised than just documenting what we're doing, but seeing where the opportunities are to do further work with the other LHDs.

Q. So two goals, two notions: one is, document what we're already doing?
A. Yes.

Q. But, two, for these heads of agreement, to provide an agreement, a documented agreement form of perhaps broadening collaboration?
A. Yes.

THE COMMISSIONER: Okay.

MR GLOVER: Q. If I can take you to the report of what has been described as the Alexander review, it's [SCI.0010.0004.0001]. I will have that brought up on the screen to your right there. This is a document that you are familiar with?
A. Yes, I am.

Q. If I can take you to page 4, please, I will just invite you to read to yourself the first paragraph on page 4, and let me know when you have finished and then I will ask you some questions about it.

THE COMMISSIONER: Which paragraph at - is it page 4?

MR GLOVER: Page 4, Commissioner, of the Alexander report.

THE COMMISSIONER: The whole page?

MR GLOVER: The first paragraph.

THE COMMISSIONER: The first paragraph, okay.

MR GLOVER: Q. There are a few concepts in that paragraph, but we will take them one by one. The first, in the second sentence on the second line, the author says:

> *There remains an opportunity to strengthen governance and support for paediatrics*

across NSW, more broadly, to improve quality and access to the right care in the right place at the right time.

Do you see that?
A. Yes.

Q. Do you agree with that?
A. Absolutely.

Q. Does it remain the case today as it was to the author in 2019?
A. Yes.

Q. Is part of the process of the memoranda of understanding or service level agreements between the network and the LHDs directed to that aim?
A. Yes. Yes, absolutely.

Q. Are there any other steps that you think could be taken to further that aim?
A. Look, I think - and I have put that in my statement, I think to actually look at a statewide plan for paediatrics, not just a strategic plan, to ensure that we have healthy children and they live their healthiest lives, but operationally we can look at this, is something that I think would be very beneficial.

Q. That's the very next proposition in the paragraph, that the author of the report considered that a clearly articulated strategy at state level, which informs operational plans at service levels, is required; do you see that?
A. Yes.

Q. That's the sentiment that you were referring to in your last answer?
A. Yes.

Q. We might go to that issue now. In paragraph 31 of your statement, in paragraph 31(a) you identify the need or the potential for such a plan, and you say it needs to include quaternary and tertiary hospital care, local paediatric care, community and early childhood services and outpatient care that is planned and integrated. Do you see that?
A. Yes.

Q. How, in practical terms, do you see that coming together?
A. So I think that we have amazingly passionate clinicians for paediatric care in New South Wales, and if we asked them what they think should happen, I think we could come up with a plan that would be very workable. I think there is a great level of collaboration between all the paediatric clinicians in New South Wales that I see regularly in what I'm doing. I think what we need to do, though, is to ensure that equity - there are some places that don't have the services that we would like to do, and I think if we had a better plan, we would actually be able to achieve that in an appropriate way with the appropriate - again, I haven't written that there, but right care, right place, right time, with the right people to do it, closest to home - as close to home as possible, is absolutely what we're all trying to achieve.

THE COMMISSIONER: Q. The heads of agreement that you have entered into, they are not obviously a kind of overarching strategic and operational plan that you are referring to in 31(a), but I imagine they are a step in the process of creating that; would that be right?
A. I think they could be used as a step in the process.

MR GLOVER: Q. In that last answer, you referred to the need to address equity?
A. Yes.

Q. Equity of access to paediatric services; is that what you had in mind?
A. Yes.

Q. How might that be achieved through the planning process that you refer to in paragraph 31?
A. So I think the only thing that has probably changed since Alexander and Henry is the use of virtual care, and if we actually plan that and have either a virtual first or a hybrid where we can make sure that children have either appropriate virtual care with the right specialist or local clinician or they work together and they do things together either virtually or face-to-face, I think we could actually provide that equity to all parts of New South Wales.

Q. In addition to ensuring equity of access, what other benefits to the delivery of paediatric care across the

state would flow from a plan like this, in your view?
A. I think we'd actually see better outcomes for children. It's hard, because - measuring that, we often don't see healthy children until they get into adulthood, so it's going to take a long time to realise some of those goals. But, for example, we did a large project in looking at diabetes care, and if we were to network that, both with virtual and face-to-face and a real plan for making sure that every child has the same access to a dedicated level of care, we should be able to improve their diabetic outcomes, and that's a big project that we've been working on for the last year and a half or so.

Q. So would a plan like that, then, to your mind, be used to identify service levels in particular facilities across the state? Is that what you have in mind?
A. So the paediatric service capability framework is already a document that is there, and we are looking through the child, youth and family and young people's network to implement that in the next - and that's in the work plan for this 12 months, for the new entity called CYPFN.

Q. I think that was a poor question. What I am really driving at is the plan, a statewide overarching plan, would it then seek to identify the particular types of services that will or ought be available in LHDs across the state and how they will then feed in to the particular specialist services available within the network?
A. So as I said, there is already - the capability framework is there and we have different levels of different services and they are very clear, from level 1 through to 6, but it is how they all work together, I suppose, with the plan we'd then look at, because I think once they're determined, it's then how they all actually collaborate and work together and that there is a flow through the levels and back through the levels.

Q. And ensuring as best as possible each of the services are available in each of the LHDs where they are needed?
A. That's right.

Q. In 31(b), you then say:

> *The system can then provide a tiered, hybrid model with appropriate children accessing virtual care ...*

Do you see that?
A. Yes.

Q. This is the model that you see flowing from the plan that you refer to in 31(a); is that right?
A. That's right.

Q. When you say a "tiered, hybrid model", what does that mean in practice?
A. So hybrid is both - because New South Wales is a very large state and it's really challenging for families to travel very large distances, it's also very challenging for clinicians, sub-specialists, to travel to multiple areas, it takes a lot of time, just because of the vast distances, some things can be done in a hybrid way, which would be virtual, but some will need face-to-face, and the same child may need a combination of both at different times through their journey.

Q. That's the hybrid. What's the tiered aspect of it?
A. Tiered - so that you have the quaternary services that may be provided, but you also have support for secondary services. So what do I mean? If you had a nurse in a small level 1 service in Western New South Wales, they may need the support of our CNC and our virtualKIDS line, but we may send our cardiac specialist to Dubbo to do an echocardiogram and do a clinic in Dubbo. So it's a tiered service for the different requirements for different places and for different children.

Q. And support from one tier being provided to the other?
A. Yes.

Q. Can I take you back then briefly to the passage of the Alexander report that I was at, just to the last sentence. Then, building on those answers, doctor, the author of the report says this:

> *The network of paediatric services is much broader than SCHN and without a State-wide approach, Local Health Districts ... and other important elements of the broader network of care will not get what they need from the [network].*

Do you see that?

A. Mmm-hmm.

Q. Would you agree with that?
A. I think that we do need a statewide approach. I think we're already providing that in many areas, but I think there are still opportunities for improvement.

THE COMMISSIONER: Q. Where it says further down on that page - if you look at the paragraph commencing "The change management process", if we could just go to the bottom of that paragraph, the authors say:

> *There is also insufficient formal engagement with LHDs and other organisations providing care to children.*

The heads of agreement process you've been going through is a means of responding to that?
A. Yes.

Q. Even if it wasn't your intent to respond directly to Alexander, that would be something that you're trying to achieve through that process?
A. Absolutely.

MR GLOVER: Q. Can I take you over to page 5 of this report, and the second - well, the first full paragraph on that page, commencing "In relation to"; do you see that?
A. Yes.

Q. Would you just read that to yourself and let me know when you have finished. I just want to ask you a couple of questions about it. Does the overarching statewide plan for the delivery of paediatric care that you envisage in paragraph 31 of your statement extend to the identification of where statewide services would be delivered?
A. Look, that's a challenging question and I think that - we want to make sure that the children receive the best care that they can, no matter where they live, and then we need to provide a system that enables that. So yes and no. I think that the network - we've done a lot of work in the last period of time since the Alexander review, and this was in response to that, really to look at the structure of what we provide, and so that is just being implemented at the moment.

So over the last 12 months, I've done a clinical

restructure of the clinical operations directorate to ensure that we have the right structure to have two really well-supported with strong site based leadership at Westmead and at Randwick, and then we also have a matrix service where we have our clinical streams that go across the network in all of the major areas, such as medical, surgical and anaesthetics, priority populations, connected care and diagnostics, and that ensures that we can actually see where the services are required, for which children, in what area.

THE COMMISSIONER: Q. Sorry, just pausing there with that answer, where you said "and then we also have a matrix service where we have our clinical streams that go across the network", should I understand "the network" there to be limited to Randwick and Westmead or --
A. Yes.

Q. It is?
A. Yes.

THE COMMISSIONER: Okay, thanks.

MR GLOVER: Q. We might come to that work that you have just mentioned directly. In paragraph 20 of your statement - I will have that brought up on the screen, thank you, operator - you tell us that the network has undergone a restructure of clinical operations due to be completed this month. Do you see that?
A. Yes.

Q. What is now being - what will be different to what has been the case in the past under that restructure?
A. So firstly, we've got a really strong site based leadership team. So unlike other hospitals, the two hospitals, until this year, have not had a general manager equivalent. We've called ours the director of clinical operations just because of the differences in corporate services on our two sites, but we now have a director of clinical operations for Randwick and for Westmead, and they have a director of nursing. We've got new directors of allied health on each site, and we also have - they are supported therefore by a corporate services manager, and therefore it's forming a sort of a site based - and, sorry, a director of medical services. Those positions are all, except for the directors of nursing, fairly new, and the directors of nursing positions have also changed in their

operational responsibilities. So we've taken the two hospitals to being similar to other hospitals in New South Wales with the structure that they have, so that it's now more - it's like an LHD, where then the two hospitals come under one sort of district governance with those two strong site based teams.

Within the streams, some of them were already networked and some of them weren't; some of them were site based. So now, at the moment, we're trialling medical and surgical, which contains the majority of the doctors and a significant number of the nurses, as network streams as well.

THE COMMISSIONER: Q. Can I just ask you about paragraph 19 of your statement, where you say, "In 2019, the Alexander review recommended the networked approach to the governance of specialist paediatric services across Sydney Children's Hospital and Westmead remain, within a clearly articulated strategy for paediatrics in New South Wales." If we could just go to page 20 of the Alexander review and drop down a bit, please - yes, "Recommendations". So recommendation 1 is what you are referring to in that first sentence of paragraph 19; correct?
A. That's correct.

Q. Can I just ask your opinion about this, because - this is not a criticism of the authors at all. It's probably my lack of knowledge, but I'm not quite sure what's meant by one of the recommendations, and I would like your opinion about it. If we go to the next page, it's - sorry, let's go back. I should have kept it. So 1 is picked up in 19 of your statement?
A. Yes.

Q. Then 2, let's not worry about whether there should be a name change. I don't want to get too caught up with the meaning of the word "network".

But if we go to the next page now, please, I don't want to ask you about 3. But 4, I'm not quite sure what I should understand by this, and I would like your opinion, "Review and consolidate the existing paediatric committees to create a more streamlined and coordinated NSW Paediatric Care Network". Pausing there - and feel free to look at (a) to (f) - is it your understanding that what was being

recommended here was: we'll still do 1, that is, there will be the network approach between Sydney Children's Hospital and Westmead, but there should be created a broader paediatric network involving not just those two hospitals but all of the LHDs that provide paediatric services. Was that your understanding?
A. That's what the review says, yes.

Q. Do you agree with the recommendation 4? You might have parts you disagree and parts you don't or whatever. You feel free to tell me.
A. So there is quite a lot in this and there are significant issues.

Q. The first concept is, "Let's have a paediatric care network that involves a network that's greater than just Randwick and Westmead but, I assume, involves all of the hospitals and LHDs that are providing paediatric services. Is there anything wrong with that as a concept?
A. No, and I think that's what I've been trying to achieve by collaboration rather than necessarily a governance structure.

Q. That's part - part of your heads of agreement process is at least part of that?
A. Yes.

Q. Probably not the whole thing?
A. Correct.

Q. Because you've also talked about the need for the broader plan in paragraph 31 of your statement, but it's part of it. And it's certainly not inconsistent with it. Probably, it's consistent with it. Agreed?
A. Correct.

Q. Do you have any comments or views about recommendation 5? It would be all part of the strategy - they would all be dealt with in the strategy you have talked about in 31, wouldn't they?
A. Yes, definitely, yes.

Q. And then in 6, which is on the next page, to establish a membership of the network which includes Randwick - well, sorry, Randwick and Westmead in (a); (b) John Hunter; (c) the local health districts providing paediatric services; and (d) those other statewide services. So it's

just more detail in relation to recommendation 4. Is there anything, in principle, that you wouldn't agree with in that?
A. Only that the statewide services, down the bottom, except for the NSW Pregnancy and Newborn Services Network, which currently does not exist - it doesn't exist any longer - they are all actually part of SCHN.

Q. Yes. But otherwise, in principle, no disagreement?
A. No disagreement to us all working together.

Q. Do you think it is a good idea?
A. I think the more that we collaborate together and we break down the barriers between the different levels of care and anyone in different hospitals, I think that is better for children's care.

Q. Please don't think I'm being difficult, but do you agree - do you think 6 is a good idea? Is what you just said a way of agreeing that you think 6 is a good idea?
A. So I think that if we are all working together, I think that will provide - I do agree, yes.

THE COMMISSIONER: Thank you, all right. That's what I wanted to ask, thank you. You go ahead.

MR GLOVER: Q. Can I take you to paragraph 23.

THE COMMISSIONER: Of Alexander?

MR GLOVER: I'm sorry, of the witness statement.

THE COMMISSIONER: Paragraph 23.

MR GLOVER: Paragraph 23, I'm sorry.

THE COMMISSIONER: Right, thanks.

MR GLOVER: Q. There you tell us there have been some challenges in developing the network structure. Again, to be clear, that's the network structure within the Sydney Children's Hospitals Network; correct?
A. Yes, yes.

Q. The one you identify is the fact that not all children who are unwell and seriously unwell live in Sydney.
A. That's right.

Q. What are the other challenges that you had in mind, if any, in paragraph 23?
A. So I think it's taken us some time. As I said, we've just now got the, what I would say, the structure in a way that we can actually work towards that formally. I think also, change is always challenging. It has taken a year for me to implement the change in structure, and we will finish it this month, to get everybody aligned. So I think change is always challenging between different places, and I think that they are mainly the challenges - they've come with the changes that have occurred.

However, there have been so many changes in health over that period of time as well. Some of those have helped, particularly through COVID, but I think there are still going to be challenges to come as the health landscape continues to change.

Q. The restructure that you have described as coming online at the end of the month, was that directed to a particular challenge in the development of the network structure over the last almost 15 years?
A. So it is ensuring that we have the correct site based leadership, correct professional leadership and alignment with professional leadership, and until recently, the nursing staff reported through to the clinical operations directorate, not necessarily through to nursing, which was something that was just within the Sydney Children's Hospitals Network. We've now made that align, as with allied health.

So all of those things have taken time to arrange and it required a great deal of consultation with the - there's over 4,500 staff in our clinical operations directorate.

Q. The challenge of change that you are referring to, driven by the fact that the two facilities were once entirely separate, run in different ways with different people and perhaps different cultures, and bringing them together, creates problems - or challenges, I should say?
A. Yes. I don't think they are insurmountable and I think - I should just reflect on the fact that because I manage the network every day and I have a view above all of the services, I can actually see how being a network actually works so well to provide better care for that child, in making sure that all our services work together,

and although there have been challenges, I think the benefits outweigh those challenges.

Q. Have all those benefits been realised at the moment, in your view?
A. Oh, not completely. I think, as I said, we're always working to improve and working towards new opportunities. So I think there are certainly many, many more that we can actually achieve as we work together, but they're - certainly, on an everyday basis, I see the network working to provide better care.

Q. Is the work to develop the network structure that you refer to in paragraph 23 something that you see continuing beyond the implementation of the restructure at the end of the month?
A. Absolutely. So we're doing a lot of change management in the background as well and, actually, we have a plan, we have evaluation that will start in July, as we will then formally be finished getting everybody aligned, and as we do the evaluation, I have no doubt that there will be some things that we will need to change to reflect where - what things are working and what things are not and to further strengthen the network.

Q. When you say "get everybody aligned", what do you mean?
A. Oh, just - sorry, that's - my apologies. To do these changes we had to change, in HealthShare and StaffLink and all our back-end systems and finance - 4,500 people had to be realigned into this structure, so that's the reason for the delay at the moment, is just getting all of those cost centres and everything all aligned with the people, with the correct line management.

Q. In the last sentence in paragraph 23, you say:

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.

A. Yes.

Q. Can you just describe that work, please?
A. I think I've already discussed some of that, but advocacy at a state level - so there's always multiple

different projects that are happening and we want to make sure that all the LHDs and staff in those LHDs are available to be able to support whichever project that might be occurring.

Q. Advocacy to ministry; is that what you mean?
A. Look, it depends. Ministry, we - I sit on many ministry working groups or committees to ensure we are looking at paediatric care. Paediatrics, in comparison to adult medicine, is a very small portion of the health care in New South Wales, and in many LHDs, the paediatric care can be a very small part of what they actually do, so it often helps for them, if they are - and also, most of the clinicians, as they report to me regularly, are extremely busy. Therefore, it does help to be able to work together and all come together to actually - it gives paediatrics a louder voice, for a specialty that is actually very small in number.

MR GLOVER: Thank you, doctor.

I have no further questions for this witness.

THE COMMISSIONER: Q. Can I just ask a question about paragraph 24 --
A. Yes.

Q. -- and the first sentence. Before I do, perhaps if I lay this groundwork: please don't think this question is either a direct or implied criticism of you, it is not, so put that aside, and it is not necessarily a criticism of anyone. Where you say, "meeting with rural paediatricians to get an understanding on how we can share care better", the network I think commenced in 2010, and we're in 2024. Would it be unfair of me to think that there has been perhaps a leisurely approach to getting that understanding about sharing better?
A. So there are two things I'm meaning here. So it's communication, so, as I said, we've got a weekly - we had a weekly group, it is now a monthly group, where all paediatricians can join. It's actually on at 2 o'clock this afternoon. But also - what I'm talking about there is sharing care. So what we are trying to achieve - and I've got another group that we're meeting with as well at the moment - is to ensure that we have appropriate communication coming from local districts and general practitioners as well, not just local paediatricians,

through to the network, but then back with that information back towards the LHDs and the general practitioners, to make sure that there's - I think I've mentioned integrated care, so we make sure that everyone, whether it be a local allied health clinician, everyone can be kept into that.

That's quite challenging with the number of children that come through, so sometimes we could do that better. So we are working at the moment - and that is a cultural change, too - to make sure that we really keep them - instead of them being part of the journey that we don't see, to actually be able to share that journey better. So that is a live project at the moment, to try and see if we can do that in a better way.

Technology does assist, but as you may know, the network has an EMR that we can see everything between the two hospitals --

Q. Yes.
A. -- which is extremely beneficial for children who have care across our entity, but we don't/can't share with other districts. So we can't see theirs and they can't see ours. So until we have a single patient digital record, we actually require to do this communication in a better way. So that's what I meant by that.

THE COMMISSIONER: Thank you for that.

Just one further thing - and this isn't a question for you, doctor. From paragraph 25 onwards - I did hear what Mr Muston said about funding. The witness has got some observations and opinions about ABF, et cetera, from paragraph 25 onwards. My assumption is that that is something that's going to be explored at the later funding hearings, and it may be that Dr Ging has to come back then, if there is a decision made that she needs to?

MR GLOVER: It may be or it may be that you --

THE COMMISSIONER: But there is more than one witness that is saying the same thing.

MR GLOVER: Quite, yes.

THE COMMISSIONER: All right. Mr Chiu, do you have any questions?

MR CHIU: No questions from me, Commissioner, thank you.

THE COMMISSIONER: Thank you very much for your time, doctor. We're very grateful. I won't say you are excused. You might have to come back regarding the challenges of ABF that you mention in your statement, but someone will let you know about that.

THE WITNESS: Thank you.

<THE WITNESS WITHDREW

MR GLOVER: The next witness is Ms Cox, who is scheduled for 2pm.

THE COMMISSIONER: She has been told 2 o'clock, has she, so we will adjourn until 2? Is that what you want me to do?

MR GLOVER: Thank you, Commissioner, yes.

THE COMMISSIONER: All right. We will adjourn until 2 o'clock.

LUNCHEON ADJOURNMENT

THE COMMISSIONER: Yes, Mr Glover.

MR GLOVER: Thank you, Commissioner. The next witness is Cathryn Cox and she's in the witness box.

<CATHRYN PATRICIA COX, affirmed: [2.02pm]

<EXAMINATION BY MR GLOVER:

MR GLOVER: Q. Could you state your full name, please?
A. Cathryn Patricia Cox.

Q. You are currently the chief executive of the Sydney Children's Hospitals Network?
A. Yes.

Q. You've held that role since about August 2020; is that right?
A. Yes.

Q. You made a statement prior to giving your evidence today; correct?
A. Yes, yes.

Q. I'll just have it brought up to the screen. It's [MOH.9999.1869.0001]. There is a screen to your right, but if you have a hard copy, feel free to use that.
A. Thank you.

Q. Have you had a chance to read the statement again before giving your evidence today?
A. Yes.

Q. Is it true and correct to the best of your knowledge and belief?
A. Yes.

MR GLOVER: Commissioner, that will form part of the tender in due course.

THE COMMISSIONER: Thanks.

MR GLOVER: Q. Can I come directly, Ms Cox, to paragraph 12. There you tell us that the Sydney Children's Hospitals Network is not responsible for overall governance of paediatrics across New South Wales; do you see that?
A. Yes.

Q. Is there a body or group or person that does have that responsibility?
A. Paediatric services are also the responsibility of the local health districts that have a responsibility for the geographic catchment area, which obviously includes children.

Q. Is there a peak oversight body or position, though, for the delivery of paediatric services across the state?
A. No. There is a chief paediatrician.

Q. What's the function of the chief paediatrician?
A. As an advisory role to the Ministry of Health.

THE COMMISSIONER: Q. Advising about what?
A. About issues to do with children and young people and families.

Q. But not governance issues?

A. No.

THE COMMISSIONER: Thank you.

MR GLOVER: Q. And not service delivery issues?
A. Could include service delivery issues.

Q. In what sort of way?
A. So, for example, during COVID, the chief paediatrician, say, worked with the network in that regard in relation to encouraging COVID vaccination for children.

Q. Do you know where within the ministry the chief paediatrician sits?
A. Health and social policy branch.

Q. In paragraph 14, you tell us that the network --

THE COMMISSIONER: Do you mind if we go back to paragraph 9, because I will forget unless we --

MR GLOVER: We might be going back there, but yes.

THE COMMISSIONER: Well, I will ask it, anyway.

Q. In paragraph 9, you say that the network does not provide primary health services for children but may partner with other government or non-government services to provide specialist support and expertise where this may be needed. What do you mean to convey to me about the partnering in that second sentence?
A. So I will give an example, if that's okay. So we've got a project in Western Sydney which is around vulnerable populations, and that's called Kids - the Kids Early Years, and what we do there is we partner with education, police, justice, so that there is basically no wrong door for those families, and so the network is part of that collaborative partnership, so that if we identify a family that we might be seeing the child in our hospital, we actually make sure that there is a consolidated and very integrated response to that family.

THE COMMISSIONER: I see. Okay, thank you.

MR GLOVER: Q. In paragraph 14, you tell us that the network brought together the Westmead and Randwick hospitals?

A. Yes.

Q. In the second sentence, you say:

There has been an ongoing process of change and evolution due to the history of SCH and CHW operating as two separate hospitals prior to the establishment of the network.

Do you see that?
A. Yes.

Q. What's the particular issue that you are drawing attention to in that sentence?
A. So two stand-alone hospitals coming together into a network just means that you need a process of change management to support that. Sydney Children's Hospital was part of the South Eastern Sydney Local Health District, and so there are a number of shared services on that particular campus. For example, we share our theatres. We use the Prince of Wales Hospital theatres. They provide our imaging services. So there is a process, when you bring those two hospitals together, how you disentangle some of those services, but also respectful of very strong relationships that might happen at the individual sites. So I think with COVID in 2020, that really gave us an opportunity and a real call for action, I guess, to really come together as a very cohesive entity to support also across the state.

Q. So the network was established in 2010?
A. Correct.

Q. Well before your time in the role, obviously?
A. Yes.

Q. Since you have taken the role, have you been able to identify any reason why it wasn't until COVID in 2020 that provided that catalyst to come together in the way that you have described?
A. I think it's a complex process and people have had time to actually understand what that looks like. As I said, the relationships that Randwick in particular - because that was embedded into the Prince of Wales Hospital - that is complex to actually then work out how those services should operate and come out. Westmead was its own stand-alone children's hospital, so it actually

hadn't been part of that sort of structure. So to bring them together, I think it's not an easy undertaking. So that took a long time. And then, realistically, conflict over services such as cardiac certainly meant that there was quite an internal focus, and I think there was probably conjecture as to whether the network would stay. And so in 2019, that was quite important, because the two reviews confirmed that the network should stay as a network, because there were lots of advantages to that arrangement.

Q. In that answer, you referred to there being an internal focus.
A. Mmm.

Q. By that, do you mean an internal focus within the two facilities that formed the network?
A. Internal to each hospital and probably internal about the relationship between each other, yes.

Q. And you referred to the two reviews. We'll come to those, but that's what's described in your statement as the Alexander review and the Henry review; is that right?
A. Correct.

Q. Was it the case that prior to those two reviews, there was some doubt as to whether the network would remain?
A. I wasn't in the network, obviously, prior to 2020.

Q. Yes, but from what you've come to understand since assuming the role?
A. Possibly.

Q. Both reviews looked at that very question, didn't they?
A. The reviews I think - well, Alexander was much more about sort of operationally, how could that come together certainly from the network's perspective. There were other issues that that review looked at, but certainly it was how could the operational management of the network be optimised.

Q. The Henry review made an express recommendation to maintain the network structure?
A. Correct, yes.

Q. The development of the network that you have referred to in paragraph 14, is that an ongoing process today?

A. Yes.

Q. What pieces of work are under way or in the pipeline to further develop it?
A. So we did a new strategic plan. We did that through 2021/22 and we published that in '23. And then out of that process, we've then started probably the most significant change that has happened over that period, which was a restructure of our clinical operations directorate, and we moved them into clinical streams. So that's provided an opportunity to do that across the network. That's been a longer process, to make sure that we did lots of consultation and had those discussions. So that is just - essentially our last piece of that puzzle has just gone into place.

The other piece that we have been doing is also getting a structure whereby each hospital has an executive team, so that is now in place, and then they will continue, as we look at services, that process of how we work together and then how we then also work with our LHD colleagues.

Q. We'll come back to some of those concepts in a moment, but if we go back to paragraph 4 and following of your statement, please, there you tell us a little bit about the network and in paragraph 7 you tell us about the core function of the network?
A. Yes.

Q. Just stepping back one level, is the network intended to operate effectively as a mini LHD or is it a children's hospital service spread across both sites, or is it a combination or something different? How do you see it?
A. So, sorry, an LHD - what was the second suggestion?

Q. I will try it in a different way.

THE COMMISSIONER: Q. Does it operate as a mini LHD or is it a children's hospital service spread across both sites, or is it a combination or something different? That's the options you've got. Maybe take it one at a time. Go to the LHD and then move on to the others.

MR GLOVER: Q. What I'm really exploring with you is the strategic purpose of the network, as you see it.
A. Mmm-hmm.

Q. Do you see it as operating as its own mini LHD directed to the provision of specialist paediatric care through the two hospitals, or is that oversimplifying it?
A. No, look, I think it functions like an LHD. We've obviously got the two hospitals, but we also have other services that sit within the network, so we have our hospice as well. So I think really the only difference to an LHD is just that issue around a defined geographic catchment, but, yes.

Q. Within that service, or the network, is it intended that the hospitals operate like stand-alone hospitals or that they are really delivering the one service across both sites?
A. So the two hospitals both have a management structure, now, that you would see in other hospitals, public hospitals in New South Wales, in an LHD. They have similar services but not identical, and then they also have that other role which is specific to the community in which they are located.

Q. Just the last part of that answer, the other role which is specific to the community in which they are located, what are you referring to?
A. So Prince of Wales Hospital obviously doesn't have a paediatric unit, so we provide - so the Sydney Children's Hospital would provide emergency services for that geographic proximate location there, as would Westmead, because Westmead adult hospital does not have a paediatric unit.

Q. Thank you. In paragraph 15 of your statement, that is where you have referred to the two reviews that we have mentioned, the first being the Alexander review, and I will have the report brought up on the screen. It is [SCI.0010.0004.0001]. This is a document you are familiar with, I take it?
A. Yes.

Q. I'm going to ask you a few questions about it. Can we turn to page 4, please, and the first paragraph on page 4, commencing "The Panel observed that". Do you see that?
A. Yes.

Q. Just have a read of that paragraph to yourself and let me know when you have finished.

A. Yes.

Q. There are a few concepts in that paragraph. I'm just going to break them up and ask you about them. In the second sentence on the second line, the authors or the panel state that there is an opportunity to strengthen governance and support for paediatrics across New South Wales, more broadly, to improve quality and access to the right care in the right place at the right time. Do you see that?
A. Yes.

Q. Do you agree with that?
A. Yes.

Q. And so sitting where we are today in 2024, there are opportunities to strengthen governance in those areas?
A. Yes.

Q. What might be done to do that, in your view?
A. So I think from the network's perspective in relation to the services that we provide, we've got a process of working with our LHD colleagues in relation to particular service challenges that they might be having, and so that gives us an opportunity to work with them.

So if - there are examples in my statement in relation to Far West Local Health District, for example, that need child developmental assessments, and they're obviously a very small district, they don't have those resources available to them, so we are able to partner with them so that we can use our expertise to make sure that children in Broken Hill get child developmental assessments. So I think having those sorts of agreements is actually all about making sure that children across New South Wales get access to the specialty services that the network provides.

Q. And is that a program that's supported by a service agreement between the network and that particular LHD?
A. So what we've done is - because there's always lots of informal networks in health, certainly we've been going through a process of doing heads of agreement, just to put some structure around that, and being able to be clear for both the LHD and for the network, the roles and responsibilities and how we'll work together in those circumstances.

Q. I might just show you an example of a heads of agreement. Operator, it is [MOH.9999.1676.0001]. I have some hard copies, Commissioner, for you, a working copy, and one for the witness, if she would prefer. This is a heads of agreement between the network and the Hunter New England Local Health District?
A. Yes.

Q. Is this the type of heads of agreement that you were referring to in the last answer?
A. Yes.

Q. And if we turn to internal page 3, please, 0003 at the top right-hand corner, Ms Cox, if you are following along on the hard copy, under the heading "Background", the purpose or the rationale for the agreement is stated in paragraph C, "To formalise a mutual collaboration regime and to record the parties' intentions, roles and responsibilities relating to the delivery of health services"; do you see that?
A. Yes.

Q. The approach to entering into these types of agreements commenced after your appointment, did it?
A. Yes.

Q. What was the catalyst for the move in this direction?
A. As I said, there are a variety of informal service networks that operate across the system. My view was that these sorts of arrangements are managed appropriately through having a structure and a governance process so that both the chief executives knew that these were being discussed and we had a process where we could mutually collaborate, and so for me, it's important to have that governance structure.

Q. So this is a method of putting some formality around the interactions, the roles and what could be expected of each other --
A. Yes.

Q. -- in the interaction between the network and the LHD; correct?
A. Yes.

Q. Is the purpose of agreements of this kind merely to set up that structure rather than identify particular

initiatives that might be entered into between the network and the LHD?
A. So the heads of agreement really is, as you say, setting out the structure in which the collaboration will occur, and then what then happens is we might have a much more specific service level agreement in relation to an individual service, such as the one I described for the Far West, for example.

Q. And the collaboration is intended to occur, under this regime, through the steering committee that's set up at page 7 and following; is that right?
A. That's right, through - just let me come to that bit. Yes, as outlined at 4.1.

Q. And this particular agreement was entered into - it has a date on the front of December 2020.
A. It's 2020, yes.

Q. In practical terms, how does the steering committee process work under this particular heads of agreement?
A. So under the Hunter New England one, we have a monthly meeting with the parties, as described there at 4.1, so we do that on a monthly basis. The other - I think it sets a foundation, though, for working together much more collaboratively. So with the urgent care service that was rolled out across New South Wales, we make sure that any of those sorts of initiatives we do in partnership with Hunter New England, with the John Hunter Children's Hospital. Palliative care is another one that we plan collaboratively together.

Q. In that answer, you mentioned John Hunter Children's Hospital. Is this the platform through which collaboration and coordination occurs between the network and that particular facility?
A. It provides the structure for that, and then there's obviously those informal relationships and discussions that would - that occur all the time.

MR GLOVER: Commissioner, I might mark this document. It's not in any bundle at the moment. I just want to keep track of it.

THE COMMISSIONER: Okay, so MFI --

MR GLOVER: We're up to 9.

THE COMMISSIONER: Okay.

MFI #9 HEADS OF AGREEMENT BETWEEN THE SYDNEY CHILDREN'S HOSPITALS NETWORK AND HUNTER NEW ENGLAND LOCAL HEALTH DISTRICT, DATED DECEMBER 2020, [MOH.9999.1676.0001]

THE COMMISSIONER: Q. The background is that the parties have entered into an agreement to formalise a mutual collaboration regime --
A. Mmm.

Q. -- and to record intentions. The objective is to work in partnership to develop specialty paediatric services in Hunter New England. There is a steering committee, and the network has responsibilities for services that it is required to provide under the Act, and the LHD has responsibility for services that it is required to provide under the Act. I mean, obviously the intent of this is very high level?
A. That's right, yes.

Q. It's not to get into any of the specifics regarding what the actual paediatric services might be. That, I assume, is a matter for discussions at the steering committee level; would that be right?
A. That's right, and then if we want to enter into a specific service level agreement that might have resourcing implications, then that's obviously agreed between the two chief executives. So it just - it's important to have, as I said, that foundation, to have those discussions and everyone knows that they're happening.

MR GLOVER: Q. If we could go back to the Alexander report, please, and in that same paragraph that I directed your attention to earlier, the next proposition I want to draw your attention to is in the fourth line of that paragraph, where it says:

> *The Panel considers that a clearly articulated strategy at the State level, which informs operational plans at service levels, is required to address barriers to the integration of care ...*

et cetera. Do you see that sentence?

A. Yes.

Q. Is that a proposition with which you agree?
A. Yes.

THE COMMISSIONER: Q. These heads of agreement are the first step in that process, I imagine, are they? They're not --
A. They would support that overarching strategy.

THE COMMISSIONER: Yes.

MR GLOVER: Q. To the extent that you consider that there should be a clearly articulated strategy at the state level, which then informs operational plans, what might that look like, in your view?
A. So for me, it is actually defining what paediatric units in other hospitals are expected to do, and there is a process of role delineation which talks about the sorts of levels of services that you see in public hospitals. I think in terms of, though, being very clear about what are the services that LHDs can expect to be providing from their hospitals and then what are the expectations around the network in working with them, what will we do, you know, what will they do - I think that would be really helpful.

Q. So what you are describing is building on the current role delineation policies that exist, which set out what particular services can be provided at certain hospitals; correct?
A. Yes.

Q. And then building on that to go deeper into, well, what can be expected to be provided, not just what might safely be provided?
A. Yes, and I think in terms of understanding the roles and responsibilities in that system, because, you know, paediatrics is a small part of a very big health system and I think just that extra level of clarity would certainly help.

Q. And as the Commissioner raised with you earlier, the heads of agreement and the service agreement process that you have implemented with the LHDs is part of that process; correct?
A. Yes.

Q. But I take it you still see benefit in there being a more formal structure across the whole of the state?
A. Yes.

Q. Can I take you, then, ahead in the report to page 9. Do you see the heading "2. There is an opportunity", et cetera; do you see that?
A. Yes.

Q. And then in the third paragraph under that heading, there is a paragraph that commences "There is a consistent view that"; do you see that?
A. Yes.

Q. In the second sentence in that paragraph, the panel expresses the view that to provide consistent and coordinated care for children across New South Wales, the interdependence - that is, between services provided in the LHDs and those of the network - must be acknowledged and supported within a decision-making framework broader than the network or an LHD. Do you see that?
A. Yes.

Q. Do you agree with that?
A. Yes, I think it's the same conversation that we were just having.

Q. And the acknowledgment of that interdependence through a planning process - would that, in your view, extend to the identification of appropriate referral pathways both into the network and then back to the LHDs?
A. In terms of referral, there are obviously clinician referrals and those sorts of pathways. Is that the referral pathways that you mean?

Q. Yes.
A. Yes, I mean, clinicians will make clinical judgments as to who is the appropriate referrer, and then there would obviously also be referral mechanisms from general practice to paediatricians in local health districts and then potentially into the network.

Q. Would a clear identification of the particular services that are available and can be expected to be provided within the LHD and then those that can be expected to be provided within the network assist in the efficiency

of that referral pathway?
A. It would probably, yes, assist referrals in terms of where they can send children and families.

Q. Can we go ahead in the report to page 20, please. Towards the bottom of that page, there is a series of recommendations?
A. Yes.

Q. Are you familiar with the recommendations, at least in a general sense?
A. Yes.

Q. I appreciate the report was delivered before your appointment, but are you aware of whether any of these recommendations were taken up by the ministry?
A. So in relation to 1, I think the fact that the network is still there is probably that 1 is still in place. The name change hasn't occurred.

Q. Perhaps I will do it in a different way.
A. Do you want me to keep working through or --

Q. I take it you agree with the proposition in paragraph 1 that the network structure that exists today should be maintained going forward?
A. Yes, I do.

Q. If we go, then, ahead to recommendation 4, just refresh your memory about recommendation 4 and then I will ask you some questions about it.
A. Yes, I know this one.

Q. Leaving aside the labels and references to committees, that recommendation is really calling for the type of overarching plan and governance coordination that we've referred to earlier. Would you accept that?
A. Yes, and there has been a governance review of all the paediatric committees.

Q. What's the outcome of that review, to your knowledge?
A. So the child, youth and family executive steering committee has been established and has - that's been conducted by the health and social policy branch.

Q. We'll come back to that committee in a moment. Would you agree, though, that in general terms, each of the

priorities or issues reflected in subparagraphs (a) to (f) are matters that should be the subject of statewide coordination and consideration?
A. Yes.

Q. If we turn, then, to recommendation 5 --

THE COMMISSIONER: Q. Is there currently anything that equates to a New South Wales - that is, statewide - paediatric care network?
A. Not in - not a statewide New South Wales paediatric care network. There is certainly, as I said, the child, youth and family executive steering committee which provides an overarching governance.

MR GLOVER: Q. Whilst we're on that committee, I might just take you to a different document. Operator, it is [SCI.0010.0005.0001].

THE COMMISSIONER: What is the document? I've got the number.

MR GLOVER: It is the Henry review implementation plan.

THE COMMISSIONER: Okay.

MR GLOVER: If we turn ahead to page 44, 0044, this is the terms of reference for the Children Young People and Families Executive Steering Committee. Is this the committee that were referring to in your earlier answers, Ms Cox?
A. Yes, it is, but that's been subject to a governance review.

Q. The committee itself has been subject to a governance review?
A. Yes. Yes.

Q. When was that governance review?
A. So it's - what are we now? It would have been early - '23/'24.

Q. Earlier this year?
A. Yes.

Q. And were any particular changes to the structure or purpose of the committee flowing from that earlier review?

A. I'd have to go and look at the terms of reference again.

Q. The terms of reference have changed, have they?
A. They were - they've been reviewed.

Q. In general terms, leaving aside what might be the outdated terms of reference on this page or what might be the new ones, just describe to us the general purpose and function of this committee?
A. So that's really a peak committee that is managed by the Ministry of Health. So I'm a member of that committee, along with a number of other stakeholders. As I said, it provides an overarching governance, which then has a variety of committees that sit under that, around the spectrum of child and young people's health care, of which, like I said, I provide tertiary and quaternary acute services, and it's got a much broader remit, so it will have the vulnerable families. So the prevention of violence and neglect, for example, would sit under this umbrella.

Q. When you say that the committee provides overarching governance, what do you mean by "overarching governance "in that context?
A. As in, I think, making recommendations to the secretary about priorities and directions for health of children and young people and families.

Q. So it is an advisory role, not a decision-making role; is that right?
A. Yes, I think it's the best way to describe it.

Q. Thank you. If we go back to the Alexander report --

THE COMMISSIONER: Q. Does it generally have the functions and the responsibilities that are outlined on page - you are on page, what is it?

MR GLOVER: Internal page 44. It's 42 of the PDF, 44 of the doc ID.

THE COMMISSIONER: Q. Does it generally have those functions and responsibilities?
A. Yes, Commissioner. I just would need to cross-check it against the current terms of reference.

Q. And what about, if we can go to the next page, membership and terms of office - does it have generally membership in accordance with what was outlined there or is it something different?
A. No, that, from my recollection, is pretty much the membership.

Q. So there is something called a central system focus?
A. So that's ministry representatives.

Q. And then there is the local system focus, which has one LHD chief executive; is that right?
A. A metro and a rural representative.

Q. And one rural.
A. Yes.

Q. And the others are mentioned. So it's high-level. It's not, for example, a particular rural LHD specific; it's at a higher level?
A. No, it looks across the spectrum.

THE COMMISSIONER: Okay, thanks.

MR GLOVER: Q. Can we just go back to page 44, 0044. Do you see under "Functions and Responsibilities":

> *2.1 Agree, communicate and oversee delivery of the annual action plan ...*

A. Yes.

Q. Is that a function that the committee has performed since you've been a member?
A. Yes.

Q. Just in general terms, what type of things do the action plans cover?
A. So most of it was in relation to, as it says at 2.1.1, really recommendations arising from Henry, which again was much broader than the network.

Q. And still ongoing, the implementation of Henry review recommendations; is that right?
A. Yes. I would have - you would have to get a status report from the ministry. That's --

Q. So is it the case, then, that the action plans that have been developed by this committee in accordance with clause 2.1 on that page have largely to date been directed to the implementation of recommendations from the Henry review?
A. Mmm.

THE COMMISSIONER: Q. I assume, is it really going to be called the CYPFESC committee, or has it got a different name?
A. CYPFESC.

MR GLOVER: Dr Lyons might have a word for it on Friday.

Q. If we go back to the Alexander report please, thank you, I've taken you through recommendation 4. I just invite you to read recommendation 5.
A. Yes.

Q. Would you agree with the sentiment of that recommendation?
A. Yes.

Q. Is there any work being done, to your awareness at the moment, to achieve those aims?
A. Certainly from the network's perspective, those sorts of principles are reflected in our strategic plan. They are certainly what we strive to deliver.

Q. And what about at a wider state level for the delivery of paediatric care?
A. I think they would be principles that everyone would support.

Q. Finally in this document, I will take to you recommendation 6 over the page.
A. Mmm-hmm. Yes.

Q. Is that a recommendation that you would support?
A. In some respects, the CYPFESC, to use that term, would basically be that membership.

Q. Sorry, the --
A. The Children Young People and Families Executive Steering Committee.

Q. Oh, the committee, yes.

A. Yes. Sorry.

THE COMMISSIONER: Q. Sorry, so I understand your evidence, there are aspects of the committee we were discussing that can be seen in recommendation 6; is that --
A. That's right, because recommendation 4 is essentially around a committee-type structure.

Q. And equally - tell me if you disagree, but in relation to recommendation 4, there is at least the beginnings of something like that with the heads of agreement process you are going through with LHDs; correct?
A. I think in certainly the way to look at (d) and (e) for us, that's sort of a heads of agreement process.

Q. Yes, it's high level; it's not the detail of this?
A. Yes, but it would be.

Q. But it is kind of a step?
A. Yes.

MR GLOVER: Q. Although the committee to which you have referred draws membership from many, if not all, of the entities in recommendation 6, that committee doesn't have a role in planning for paediatric services across the state, does it?
A. No, because planning for the services is actually a responsibility of the network for me and would be part of the requirements of an LHD to plan those services.

Q. Do you see there being benefit in a statewide plan for the delivery of paediatric services extending to service delivery?
A. Yes, it's along the lines of that plan that we talked about earlier.

Q. I will take you back to your statement, please, and if I can take you down to paragraph 35. Some of these issues we've touched on on the way through, but we will step through them. These are a number of areas in which you see the delivery of paediatric care across the state could be strengthened or improved; correct?
A. Yes.

Q. The first one we've discussed, a statewide paediatric services plan to assist in delineating service scope, roles and responsibilities. We've discussed some of the benefits

of that already, but to your mind, why is that something that would strengthen the delivery of care for children and young people across the state?
A. Because for me it provides a foundation for discussions around funding and how we actually make those services operational.

Q. In what way will it provide a foundation for discussions around funding?
A. Because if we've got a statewide services plan for paediatrics which is clear about the responsibilities of the network in providing those quaternary and tertiary services, it means that we can look at funding approaches and funding strategies, because often we may start a service through an outreach or identify a service gap, but we don't do that in a sustainably funded way, and so a plan that is clear about roles and responsibilities lets you have those funding discussions and formalise those arrangements.

Q. When you say "a sustainably funded way", do you mean there is not long-term funding in the pipeline? Is that what you have in mind?
A. So there are not good funding mechanisms for paediatrics to reflect some of that care that we provide outside the network, and so, for an example, we may start an oncology service that we have provided for many years that goes to Wagga or another LHD, and that builds over time, there is unmet demand, but we actually don't have a funding mechanism that lets you grow that service, because, you know, it's an outpatient service and it's not well reflected in ABF, for example.

Q. Would the plan of the kind that you have discussed today also assist the LHDs in the identification of the paediatric services that they would provide but also secure funding for those services?
A. That's right, and I think that's why it's a partnership, because it's got to be a service need that the LHD identifies that we can then work together to say, "Actually, who is best placed to do that?" You know, we understand that workforce is challenging for some rural LHDs and it's often a bit easier for the network to attract those staff because they have that variety of other paediatric work, because it's a small workforce and it's a small volume. So there are ways that you can configure services to make that easier for staff, to support those

lower volumes.

Q. And as part of that planning process, there would need to be an identification of the demand for particular services across the state; is that right?
A. That's right, and because they are low volume, it's often difficult to have enough work to actually duplicate that service locally. It's not a very efficient way to do that.

Q. And is that another reason why a coordinated statewide plan for the delivery of care, be it through the network or through the LHDs or a collaboration between both, is important, in your view?
A. Yes, it is, because I think we're all working to make sure that children and young people across New South Wales all get access to the same level of care.

Q. In paragraph 35(b), you have raised consideration of different models of services, and an example you give is paediatric medical imaging. Do you see that?
A. Mmm.

Q. Can you just give us some practical context to that example?
A. Yes. Look, it's - again, an issue for specialised paediatric care is often, again, the volume and the highly specialised workforce. So medical imaging is an example where having sufficient paediatric radiologists is challenging, and we often have clinicians who are working both in the network, who might be working up at John Hunter Children's as well, and so that is a big demand on a very small workforce, and I think there are options that we could really explore, certainly around imaging, whether a statewide approach would make sure that all children get access to that paediatric expertise, and because we've got technologies now that let us do that, that would seem to be one that would be good to pilot.

Q. In 35(c), you refer to the need to continue to develop partnerships with the LHDs. We've covered that fairly significantly in your evidence today, but is there anything in addition to what is in your statement or the answers you have given today that you would wish to add in relation to that initiative?
A. I'd just add that, again, technologies like virtual health give us the opportunity to make sure that the child

in Orange can get the same level of care as the child living in Randwick. So I think we can use those technologies to really work with our LHD colleagues to provide access to that specialist care, without expecting children to have to travel to Sydney to access that.

Q. In paragraph 35(d), you highlight the challenges associated with workforce, and by that do we take you to mean the limited availability of paediatricians, particularly outside metropolitan areas?
A. Paediatricians, but also just the surgeons and physicians who support the very complex care that we provide, you know, like liver transplants and - you know, they are a very small workforce. So I think in terms of how we can network better to support that staff as well, I mean, we train a lot of the paediatric workforce.

Q. When you say there are opportunities to network more closely with John Hunter and paediatric services at Campbelltown Hospital, what do you have in mind?
A. I think certainly imaging that we've talked about with John Hunter Children's, whether there are some opportunities we can do there. We've got good examples with palliative care where John Hunter and ourselves support the after-hours palliative care roster, to make sure that clinicians are having a roster that's actually not too onerous. So I think they are sorts of examples that we can build on to continue to work really closely, and that's why we've certainly got heads of agreement with Hunter New England and South Western Sydney Local Health District.

Q. What about with LHDs outside the Sydney and Newcastle area, are there opportunities to provide work force support to those LHDs for the delivery of paediatric care in their regions?
A. Yes, we do that significantly. So we're just doing an arrangement with Western New South Wales Local Health District to support child developmental assessments for them; oncology services, do lots of outreach services across New South Wales; our cardiac service goes to Bega, to Canberra, to Tamworth, to Armidale. So we do fairly significant statewide coverage. Our neurology services also provide that type of support.

Q. Part of the heads of agreement process that you have implemented is to formalise those networks --

A. That's right.

Q. -- that grew organically?
A. That's right, and to set them up to be sustainable. I think that's a really important underlying objective.

Q. Finally, in paragraph 34(f) [sic], you refer to the continued and accelerated focus on sustainability.

THE COMMISSIONER: 35(f). You said 34. It is 35, unless I've got a different statement.

MR GLOVER: No, I am sorry. That was definitely my mistake. I am sorry.

Q. 35(f), sustainability, and you refer to the adverse effects of climate change. This was a topic that featured in the network's submission to the Commission, and I just want to invite you to tell us what you have in mind in that paragraph?
A. So we've committed to net zero by 2035 for our scope 1 and scope 2 emissions. It's something that our children and young people and families have told to us that they expect the network to lead on, because it is of critical importance to them. Children are disproportionately affected by climate change. So we take that very seriously, and, really, I personally feel, and I know the network does, that we need to lead by example in the sustainability space.

MR GLOVER: Thank you, Ms Cox. Thank you, Commissioner, I have no further questions.

THE COMMISSIONER: Q. Can I just get you to help me with something, if you can - and you are allowed to tell me you can't. At paragraph 15 of your statement, you have referred to the Alexander review, which Mr Glover has taken you through, and also the Henry review, and Mr Glover has gone to the implementation plan of the Henry review. Could we just get the Henry review? I don't have a document number.

MR GLOVER: Yes, Commissioner. It's [SCI.0010.0001.0001].

THE COMMISSIONER: Again, I'm not going to be able to give the computer page number, but if we can go to - it's 41 of the actual review.

MR GLOVER: I think they align in this document.

THE COMMISSIONER: Yes, that's it.

Q. So there are some reflections on governance by Professor Henry. Then if we go to the next page, can you help me with this, the first paragraph:

> *There were many solutions suggested by Alexander and her colleagues. One was to broaden the role of the SCHN.*

Do you see that?
A. Yes.

Q. Just keep that in mind. And then the next paragraph, third line:

> *The Reviewer found no evidence and no opinion that supported the concept that expanding the role of the [network] would make it more outward looking. Rather, a common view was that if the [network] remained in its current form, it would take a decade for the "wounds to heal".*

Next paragraph:

> *The decision about the role of the [network], or indeed its continued existence, should not be determined by a popularity contest.*

Accepting that, unless the popular view is correct, but leaving that aside:

> *However, the Reviewer did not believe that the broader role for the [network] canvassed in the Alexander report was acceptable to the LHDs or to the [ministry].*

What my question is, if you can help me - can you tell me where in the Alexander report a broader role for the network was canvassed or recommended? Is that your understanding of the Alexander report?

A. No. No. I --

Q. You see, I think the recommendation in Alexander is almost the opposite. It's: we should maintain the network, which is recommendation 1 that Mr Glover took you to, but rather than expanding the governance role of the network, recommendation 4, which Mr Glover took you to, is the creation of a new paediatric care network that is statewide. Do you remember that?
A. Yes. But, as I said, I read that recommendation 4 as being about the sort of committee structure and how that type of governance approach is, rather than a service governance that this --

Q. And again, second-last paragraph, still on this Henry report at 42, second-last paragraph:

> *Whatever decision is made about the continuation of the [network] --*

and I think you have agreed the network should continue, and that was recommendation 1 from Alexander --

> *this Review does not support an enhanced governance role for the [network] across the state.*

Again, that's not something that you perceive as being recommended in the Alexander review?
A. Not in terms of a governance role. I do think there is an importance for the network to continue to work in partnership and collaborate, to get that equity of access for children and young people. I really believe that.

Q. So wherever you are, if you are a child in the state, if you have got a particular health condition, you should get the same treatment for that, wherever you are?
A. That's right, and the network should be part of that process and part of delivering that.

THE COMMISSIONER: Thank you.

Mr Chiu, anything?

MR CHIU: I have no questions, thank you, Commissioner.

THE COMMISSIONER: All right. Thank you very much for

your time, Ms Cox. We're very grateful. You are excused.

THE WITNESS: Thank you, Commissioner.

THE COMMISSIONER: Can I just raise something before we --

MR GLOVER: Yes.

THE COMMISSIONER: -- temporarily adjourn. This is for Mr Chiu. Are you able to help me regarding the Henry review, because it seems to me - and I could be wrong, so I'm happy to be persuaded otherwise - but it seems to me on this crucial area - there is a whole lot of recommendations in the Henry review that may well be great recommendations but are probably not necessarily relevant, at the level of detail they are, to this Inquiry, but the overall governance issue is important, and it just seems to me that what Professor Henry, with respect - and I appreciate he's not here, and neither is Dr Alexander, and maybe they will have to be here - but it just seems to me that what is said at 41 and 42 of the Henry review is a misinterpretation of Dr Alexander.

MR CHIU: Commissioner, there does seem to be a disconnect between the notion of expanding the governance role and expanding some kind of a service delivery role.

The person who could potentially give the best evidence that's available is Dr Nigel Lyons. He has provided a statement, but he's also available on Friday, and I've been in conversations with Mr Glover about potentially having him answer your questions. I would prefer not to take on the role of a witness --

THE COMMISSIONER: No, I don't want you to and I'm not asking you to, but perhaps take this on board: at 42 of Henry - can we keep it on the screen? - at 42, the paragraph commencing, "The decision about the role" - do you see that paragraph?

MR CHIU: Yes.

THE COMMISSIONER: It is the last words, "was acceptable to the LHDs or to the ministry" - I don't know what has happened, but the fact that he is saying "The Reviewer did not believe that the broader role for the network canvassed by Alexander" - pausing there, I don't think Alexander did

recommend a broader role for the network - when he said "was acceptable to the LHDs or the ministry", it looks as though, one view of that paragraph is, that the LHDs and the ministry are playing, potentially, a role in this misunderstanding, in that he is certainly saying, "In my opinion or my belief, the broader role canvassed, suggested by Alexander, is not acceptable to the ministry" - so I would like to know what has happened there.

MR CHIU: Yes.

THE COMMISSIONER: Can I also just raise one other thing, because this is important to the governance term of reference - and I don't require an answer from you right now, but I would like it by Friday.

MR CHIU: Yes.

THE COMMISSIONER: There is no criticism of Professor Henry in this. Whether or not he has made a misunderstanding of Alexander is one thing, and leave that aside. There is no criticism of the fact that Professor Henry undertook the review he was asked to do; he is just doing what he has been engaged to do by the ministry. But I would like some response to why I shouldn't think it's not great practice to have a taxpayer funded review like this one - ie, the Alexander review - which on governance says, let's just call it, "Do A", and then, seemingly without a response from the ministry saying, "We don't agree with A for these reasons", have another review that says, "Do the opposite of A". Because what you are obviously left with is two reviews coming out the same year saying opposite things, without at least a middle step of the ministry - and maybe there is this document that exists and maybe it's been published, in which case that will be the answer to my question - but it seems as though best practice would be, if there was some disagreement at the ministry level to the recommendations made by Dr Alexander, Dr Steer and Ms Peter, that you would say, "Thank you for your service. We don't agree with the recommendations and here is why." And then you might have another review to see how it might be tweaked or whatever. But the two reviews dealing with the same issue of governance - and I appreciate Professor Henry's dealt with a hell of a lot more --

MR CHIU: Yes.

THE COMMISSIONER: -- but that doesn't seem best practice.

MR CHIU: On that specific issue. I will take that on board. There may not be a good answer, but I will see if there is one.

THE COMMISSIONER: Did anything emerge out of that from you, Mr Glover?

MR GLOVER: No, Commissioner.

THE COMMISSIONER: Sorry, if I didn't say you are excused, you are excused. Thank you very much.

<THE WITNESS WITHDREW

THE COMMISSIONER: And do we adjourn until 10 tomorrow?

MR GLOVER: We do, Commissioner. Ms Cox's statement also dealt with issues of funding, but as we discussed earlier --

THE COMMISSIONER: Same approach?

MR GLOVER: It's the same approach.

THE COMMISSIONER: All right. Thank you. We will adjourn until 10 tomorrow.

AT 3.04PM THE SPECIAL COMMISSION OF INQUIRY WAS ADJOURNED TO WEDNESDAY, 12 JUNE 2024 AT 10AM

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