Special Commission of Inquiry

into Healthcare Funding

Before: The Commissioner,
Mr Richard Beasley SC

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

Friday, 14 June 2024 at 10.00am

(Day 035)

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
Mr Oliver Jones for St Vincent's Health Australia

THE COMMISSIONER: Good morning. Apologies for being a few minutes late. I was looking at a variety of ties and settled on this one.

MR GLOVER: I'm glad you found one suitable, Commissioner.

THE COMMISSIONER: It was better than the one you offered, so.

MR GLOVER: The first witness today is Associate Professor John Preddy, and he is in the witness box.

<JOHN SPENCER PREDDY, affirmed [10.07am]

<EXAMINATION BY MR GLOVER:

MR GLOVER: Q. Can you state your full name for the record, please?
A. John Spencer Preddy.

Q. And you are currently the clinical director of paediatrics at Wagga Wagga Base Hospital; is that right?
A. Indeed.

Q. And to assist the Commission in its work you provided a statement dated 30 May 2024; correct?
A. Yes, mmm-hmm.

Q. I'll just have that brought up on the screen. It's [SCI.0011.0067.0001]. Commissioner, if you are working in hard copy, it's G33.

THE COMMISSIONER: Thank you.

MR GLOVER: Q. Have you had a chance to read the statement again before giving your evidence today?
A. I have, thank you.

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

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

THE COMMISSIONER: Thanks.

MR GLOVER: Q. If we can start with paragraph 4 of this, Professor. There amongst your many roles you tell us that you're the co-chair of the Agency for Clinical Innovation's Paediatric Network. What does that network do?
A. It's a clinician-based network with over a thousand clinicians as members, and we discuss issues that are relevant to the delivery of paediatric care across the state and also undertake specific areas of investigation. So there's a number of areas we're looking at at the moment, including outpatient services statewide in the public system, for instance.

Q. Once those investigations of that kind and discussions of that kind are held, what is the output of that work through that committee or that network?
A. Such a good question. Thank you. There is a little bit of frustration for us in that I think we draw - we put together very good submissions, but there is - there is no pathway to advance them. So it is a little bit frustrating. I think we've come up with very good ideas - obviously I do because I'm the co-chair - but it's very difficult to escalate ideas into the system.

Q. So it's an advisory body?
A. It's an advisory body. We're not quite sure who we're advising. That's part of it. That is part of the problem.

Q. Can I take you then to paragraph 5. In the second sentence there you tell us your view is it's important that the scope of roles across the delivery of paediatric care in New South Wales "is clearly delineated, optimised and coordinated in a way that takes advantage of their different strengths"; do you see that?
A. Yes.

Q. Why is that important in your view?
A. Because I think there is potential in complex systems for siloed health - well, health particularly for siloed health care to occur, and it does, and I think it's very important that we look at this system and understand ways that different parts of the system can work better together. That's how I see --

Q. And is that particularly acute in paediatric care in your view?
A. I think paediatric care is reasonably unique. We're a fairly small area of health care largely working in an

adult-focused system. So I think it's very important that we as clinicians work very clearly together, and I see that that breaks down at times.

Q. When you say it's a small area of practice in an adult-focused system, what particular challenges does that give rise to in the delivery of paediatric care across the state.
A. I think there are many. I'll just give one or two examples, if I may. One might be in my hospital, for instance, there's a large emergency department that treats everything from an unwell baby to an adult with all their variety of health issues, and it is a very hostile place for children, it's not designed for children, and with increasing pressure on the system time spent in those areas is greater and greater, and we receive immense amount of feedback from families saying, "We spent 19 hours in your emergency department. It was hell." Okay. It's not designed for children. Adult hospitals are not designed for children. So we've got paediatric bits, okay, and I think the focus from health care planners is they are generally overwhelmed with a burden of aged care disease. Therefore, we are much less of a priority, I think, for health care planners and budgets.

Q. And in circumstances where paediatrics is less of a focus perhaps for - I'll withdraw that. That observation you just made about health care planners being overwhelmed with increasing aging population, we've heard some evidence about the increase of chronic disease in aging population. I take it from the last observation you made that presents a particular challenge in the delivery and planning of paediatric care in that context?
A. It does, and I think largely it comes down to relationships, actually, like a lot of planning does, and I enjoy a very good relationship with my executives in my town. Others do not. So I think I'm in a much better position than some.

Q. Does it also create challenges in securing funding for paediatric care?
A. Unquestionably. There's challenges securing funding anywhere but I think particularly in the preventive space. You know, preventive health for us is we'd like to prevent old people having problems by treating young people at a younger age. The investment is a 50-year investment. It's not seen as a priority in the system.

Q. Can I ask you some questions about how the system operates at the moment before coming to your observations about how it might be improved?
A. Mmm'hmm.

Q. I might show you a document. It's the "Paediatric Service Capability (Paediatric Medicine and Surgery for Children) Guideline". We'll bring it up on the screen. It's [MOH.0002.0144.0001] and, Commissioner, it's G106.

THE COMMISSIONER: Just before you go on.

MR GLOVER: Yes.

THE COMMISSIONER: I tried to do this subtly by sending a message on Teams, but Teams isn't working. I can't get the running transcript up on - I assume everyone else is getting it so it's just me, but --

MR GLOVER: I don't have it either.

MR MUSTON: I was informed yesterday afternoon, Commissioner, that the two individuals who have been taking the transcript before us so valiantly and effectively over the past few weeks --

THE COMMISSIONER: I knew that, yes. No, you don't - I know that. Is that why it's not live?

MR MUSTON: It's being dealt with remotely, but that means that we don't have a live stream today.

THE COMMISSIONER: Right. Okay.

MR MUSTON: So the transcript is being recorded but we don't have access to a live stream today.

THE COMMISSIONER: All right. So it's not me. When I sent my Teams message it said it would be delivered on Saturday at 8 am, which would make it fairly useless. But maybe that's linked to that. I don't know.

MR MUSTON: I don't think it is.

THE COMMISSIONER: There's no reason to further interrupt this evidence, so let's proceed.

MR GLOVER: Q. The document is on the screen to your right, Professor. Is this a document with which you are familiar?
A. It is.

Q. Can I take you ahead in the document to internal page 0012, and there under 2.1 do you see, "Clinical care and interhospital transfers for infants, children and adolescents are delivered through a statewide system of networked care." See that --
A. Yes.

Q. -- in that first paragraph? And then a little bit lower, last sentence of that same paragraph, "Services are linked through local networking arrangements"; do you see that?
A. Yes.

Q. Can you just tell us as a practical matter what are those networked arrangements?
A. I think when it comes to escalation of very sick children there's a very clear networked arrangement, which is we as a receiving hospital might talk to the newborn emergency transport service, have a discussion about optimising care locally and have a discussion about managing care prior to transfer to and thereafter in a children's hospital. That's a very well-oiled system. It works well. It's incredibly important. Okay.

I think the other thing I'd say about role delineation is it's very important we understand what various paediatric roles need in terms of services. What it does not do is examine optimising scope of practice and providing better care particularly in larger level 4 centres, which is where - something I'm very interested in. So if we treat every centre the same then what you're then doing is treating everyone to the lowest common denominator, because you have to, okay, whereas I think health care doesn't work like that. So for me part of providing care is optimising care delivery in the various facilities we have across the state, and that might --

THE COMMISSIONER: Q. Sorry, just for the purpose of the transcript can you just define level 4?
A. So a level 4 service is the service that I would run in Wagga, which is - has a dedicated children's ward,

dedicated paediatricians, paediatric-trained staff and allied health support and investigative support to provide a whole range of services. That would be level 4. Level 6 would be a children's hospital with a much higher scope of services and practice.

Q. Now, I interrupted you. Hopefully you haven't lost your train of thought?
A. Completely lost it.

Q. Yes, of course. And we can't read the transcript back.

MR GLOVER: We can't read transcript.

THE COMMISSIONER: Sorry about that.

MR GLOVER: Just to perhaps close out the answer to the Commissioner's question, if we go ahead in the document to internal page 0023. Professor, in this section of the document it identifies and defines the levels of care from 2 and then through to 6, and then the same for surgery later in the document; is that right?
A. Yes, with respect, I don't think it actually defines level of care. I think it defines the services that are available to deliver care, and the two things are different.

Q. In what way?
A. Well, I mean, I think that the care scope that we deliver in my town, for instance, would be very different from another level 4 unit in a smaller town, yet the facilities in terms of the levels might be the same. So what the levels talk about is what facilities you have, not what scope of practice you have.

Q. And is that - well, with that limitation to this guideline and the role delineation through levels, is that one of the reasons why you perceived there needs to be a more clear role delineation for facilities across the state?
A. I think what there needs to be is a mechanism for providing higher level of care within a level 4 structure. So that's what, for instance, I talk to my team about, how do we optimise care, how do we deliver world-class care in my town knowing the limitations, and my limitations will be different from other places. So where you have a document

that says, "You're all going to be this," it doesn't allow for individual facilities to up their scope safely.

Q. How might that be facilitated?
A. Well, I think it's genuinely a discussion where each of us should be responsible for saying how do we deliver a certain level of care, how do we make sure that's delivered safely - and when I say "each of us" I'm talking about clinical directors of facilities - how do we keep that safe, how do we keep it world class, how do we maintain connections with level 6 facilities to facilitate us to do that; does that make sense?

Q. Yes, it does.
A. Okay.

Q. Would that be facilitated by a statewide strategic and operational plan for the delivery of paediatric care across New South Wales?
A. Unquestionably, if it allowed that flexibility to take place, yes.

Q. Just before I leave the policies, you mentioned in an earlier answer that the arrangements for the transfer of patients for specialised care work well in your view; have I understood your evidence correctly?
A. What I stated was emergency care is very well dealt with at a state level.

Q. I see. And you draw a distinction with more specialised care, do you?
A. I draw a distinction with a situation where I might be managing a patient and I need more specialised care at some point in that patient's journey. That's more problematic. There is no statewide approach to that.

Q. Can we just bring up another document. It's the "New South Wales Paediatric Clinical Care and Inter-Hospital Transfer Arrangements". It's [MOH.0002.0146.0001]. Next page, please, Operator. This is a document that you're familiar with?
A. Perhaps not as familiar as I should be, looking at it.

Q. Well, that might follow the challenge, perhaps.

THE COMMISSIONER: It will come back to you.

MR GLOVER: Sorry?

THE COMMISSIONER: I said it will come back to the witness when you take him through it.

MR GLOVER: Yes.

Q. If we have a look under the summary at policy requirements, just perhaps read, if you wouldn't mind, the first three paragraphs to yourself and let me know when you've done that.
A. Yep, I think I've speed read them.

Q. If you need to go to any other part of it let me know, but this policy directive describes the type of arrangements for the transfer of patients into more specialised care. How does that work in practice at the moment?
A. It doesn't work in practice as stated in the first three paragraphs in this document. In practice, if I wish to rather than transfer care but involve care from subspecialists it generally means that I would phone somebody on call, I'd phone a friend, I'd phone a junior doctor as part of a team and discuss the care needs. Sometimes it would involve emailing, sometimes it would involve sending a referral, and often it would involve barriers and wait.

Q. And from that do I take it that you perceive that those arrangements rely significantly on relationships between clinicians?
A. They do. Not entirely. There is always in kids' hospitals someone on call for particular services with whom you can speak some of the time.

Q. If we go back to your statement, please, and to paragraph 9. Some of the challenges you've been describing in your last answers, do they feed into the conclusion you reach in paragraph 9?
A. They do very much. I often think of health care as being like a gearbox. You've got gear number 4, which is where I work, and gear number 4 has to work closely with gear 5/6, and it needs to be oiled and there needs to be a very good collaborative system between those people. They have different jobs, but they work in the same system, and what I see is that there's a breakdown in collaboration often between level 6 care and level 4 care, and if we

better utilised level 2/level 4 care there will be less pressure on level 6 care. That's how I see it. So if I can up my scope of practice, if I can look after patients in my town well with the assistance of subspecialists either by phone, by video or even transfer for periods of time then that would give a much better level of care, I believe, to individual patients, if that makes sense.

THE COMMISSIONER: Q. When you say a breakdown in communication, can you give us an example and an opinion about the cause of it?
A. I can give you an example quite easily. I had a child recently who clearly had an inflammatory bowel disease, which is inflammation of the colon --

Q. Yes.
A. -- and what I needed was for a specialist gastroenterologist to undertake some investigations and give me some advice about management, and it probably took six months for that to happen.

Q. A specialist at either Westmead or Randwick?
A. Yes, as it happens this was in Melbourne.

Q. Right.
A. But that's because the family had connections in Melbourne.

Q. Right.
A. But trying to navigate my way through a system where it was clear what I needed --

Q. Yes.
A. -- it was clear that I wanted to collaborate with somebody --

Q. Yes.
A. -- but it just couldn't happen. It wasn't happening. I couldn't talk to the right person, and there were a number of --

Q. But why not? Why not?
A. Because sometimes the system is almost designed to prevent that from happening. I know that sounds a bit whiny but --

Q. In what way?

A. That I'll make a phone call, I'll be directed to a secretary, to a junior doctor as part of a team.

Q. Right. There's no clear route?
A. There's no clear route.

Q. Right.
A. There's no clear responsibility for people to say, "That guy in Wagga needs my help. This is what I'm going to do."

Q. Yes.
A. You know, and one of the things I think in health care is we all need to understand what we give to the system, but we need to understand our responsibility, and I think - and accountability, and I think sometimes that breaks down.

Q. So a solution for what you're identifying for someone like you that's head of paediatrics at a large regional hospital but needs to at least consult a specialist because a child has a particular health problem is - let's call it a network - a network where there's a clear direct route where you can easily and quickly get in contact with that specialist, discuss the case, work out whether the child can be safely treated where the child is, in your hospital, regional hospital, or, "This looks more serious, might need a transfer to a quaternary hospital," that sort of thing?
A. Those things plus, "Looks like I need you to do this" --

Q. Right.
A. -- "and when you've done this, I'm happy to then collaborate with ongoing care."

Q. Again, yes.
A. And those things break down.

Q. Like a form of case management; yes?
A. Yes. Exactly.

MR GLOVER: Q. Building on that last passage of answers, if we go ahead to paragraph 22 of your statement, perhaps directly to the heart of the proposition, this is where you describe you can see the system operating in an optimal way; correct?
A. Yes.

Q. Aside from the barriers that you've described to the Commissioner in terms of a look of a pathway to achieve that type of system, are there any other barriers to achieving what you've set out in paragraph 22?
A. Look, I've reflected on this, and I think one part of this piece of evidence is a little impractical. I think there should be a statewide children's, if you like, website or electronic facility so that I can go on there and say, "Oh, at Westmead so and so is on call for gastroenterology, and this is how I contact them," so that would be very helpful for me, and, similarly, to have on the same server, if you like, all of the protocols and procedures I need to manage children effectively, that would be very helpful.

In terms of bed management, which is included here, I don't think it's practical to have bed management stuff on a website. I just don't think it would work. But I think services that are available, how to contact those services, who is on call, procedures and policies, all of those things in one place across the state would be very helpful.

Q. All right.

THE COMMISSIONER: Q. Sorry to be difficult, but if someone can get this for me. This is no doubt my fault, but I obviously have an earlier version of Professor Preddy's statement because I don't have a paragraph 23 and what's in paragraph 22 is in my paragraph 20. So if someone can just grab that for me now I'd appreciate it. But keep going. Keep going.

MR GLOVER: Q. All right. So from that answer we understand that the suggestion of a centralised database with real-time referral is one that you've reflected on and perhaps see some challenges in implementing?
A. I just can't see it being practical. It sort of came out of the moment, but I can't see that being updated. But I think processes, who to speak to, how to speak to, et cetera, would be very helpful.

Q. I take it then that you remain of the view that, to the extent that a patient requires subspecialty opinion, discussions should occur between the general paediatric service and the appropriate subspecialist?

A. Hundred per cent.

Q. And that ability to identify who that might be at any given point in time of day or night is something that would be very helpful to you?
A. Without question, and I think it's a two-way conversation.

Q. Yes.
A. Okay. And as a two-way conversation it can't happen with someone who's not in control of the service.

Q. And then a collaborative care plan should be drawn up, including appropriate use of children's hospital beds; correct?
A. Yes.

Q. And would that include plans to return the patient to your care if it were you?
A. Absolutely. Absolutely. I mean, it's very frustrating, as a paediatrician sometimes I send a child for an opinion, to find them three years later having active treatment that we could deliver safely and effectively local. It's a very frustrating thing to see in the system.

Q. To facilitate this type of approach, do I take it that you would agree that there's benefit in there being a statewide operational plan that identifies this approach and sets out roles, responsibilities, expectations and the like?
A. Absolutely. I think what we have statewide is a number of plans which are a series of aspirational statements. They are not plans on how to deliver care. So your comment about operational planning is really important.

Q. At paragraph 14 of the statement - and this perhaps goes back a step in the pathway that we've just been discussing, but there you describe a lack of consistent referral pathways from general practitioners to specialists, et cetera. Can you just describe what in practice that looks like?
A. Yes, look, I have quite a strong view that GPs have a very difficult case load. They manage people from babies through to 97 years of age or whatever, and there are times when they need the help of paediatricians, and my view is

that GPs should refer to their local paediatric service. It's our responsibility to then see those patients and, where necessary, refer them for quaternary care in a children's hospital. That's how I believe the system should work. Often times, for a variety of reasons, GPs will refer directly to children's hospitals' subspecialists, and I think that's inefficient and what it does is it clogs up quaternary services with tertiary services, which is my domain, if you like, and I think what that leads to is kids' hospitals that are overwhelmed with patients that are unsorted, if you like - that's a bad word, it's a bit medical, but not thought about, if you like, and it just clogs their systems up, and a better system herefore does that. They refer to see me and my team, we sort that out and then where necessary we escalate care with an agreed care plan. That's how I think - it's more - it's more about using what we have more efficiently, okay?

The other major advantage of that is most families don't want to travel five hours every second week to see someone about their health care, most families actually want to stay where they live, and understand they can get as good care locally as they can by travel.

Q. You see there being great benefits to patient care in it being delivered close to home?
A. In ways that I don't think are really obvious. So there's clearly an advantage in terms of using services more effectively. But if I have a child in my hospital their grandparents can visit, their siblings can be part of care. As they improve I can send them home and deliver care at home, okay, which might be 500 metres down the road, okay? So from a regional centre we can deliver care much more effectively. It's better for physical outcomes, it's certainly better for family outcomes and it's undoubtedly better for mental health outcomes for patients and their families. We know there are restrictions to what we can do, and that's when we would say, "We need to escalate care. But when it is appropriate we will accept care back again."

Q. Is this, what you've set out in paragraph 14, perhaps the first step - that is, the referral pathways from GPs to someone like you or someone in your department who can then determine whether escalation is required, is that perhaps the first step in achieving a system in operation that --

A. I think that's one of the first steps because that - that is a first step, but it goes hand in hand then with much better collaborative care, which means that if I'm now a gastroenterologist in a kids' hospital and say, "I've done my bit. Now we're going to share doing ongoing care." So I think both of those things are needed.

Q. Are there any barriers to achieving the situation that you describe in paragraph 14; that is, GPs effectively coming to general paediatricians first and then the decision to escalate being made from there?
A. I think there are barriers in that some general paediatricians are so overworked that's troublesome. But so are our subspecialty colleagues, okay, and so I think our job then is to receive that, look at the referral, speak to the GP and make sure we provide right care at the right time in the right place. So that's a barrier. Other than that, it's really about good communication, and good communication often does break down - good communication, good clinical hand-over.

Q. Is there anything that can be done at a system-wide level to advance the aim that you identified in paragraph 14?
A. I - which one's paragraph 14?

Q. Having a clear referral pathway from GPs to general paediatricians and then --
A. At a system-wide level I think that would depend on my subspecialty colleagues saying, "With respect" - to a GP - "you should refer that patient to your local paediatric service. They will do what they need to do initially, and then send them on to our care if they need to." So it would require everyone in the system to have the same level of thinking, okay, and say, "No, that child is not appropriate for our service. It is more appropriate to see your paediatrician in Dubbo," or Tamworth or wherever, "first, and maybe only."

Q. Again, something that might be dealt with in a statewide operational plan for the delivery of paediatric care?
A. Hundred per cent.

THE COMMISSIONER: Q. The sort of things you've just been discussing with Mr Glover, are they discussed at the paediatric network, at the ACI, or is that a different --

A. No, no, sometimes we do discuss these issues, and I think the issue is - the problem for us is there's no easy way to escalate that to a solution.

Q. I see.
A. So we can talk about it, and then we --

Q. You talk about it, you agree with each other and then it goes nowhere?
A. Correct.

Q. Okay.

MR GLOVER: Q. I'm going to take you to a slightly different topic. Are you familiar with what's described as the Alexander review?
A. I am.

Q. I'll bring up the report. It's [SCI.0010.0004.0001]; Commissioner, G17. Can I take you straight to page 20, please.

THE COMMISSIONER: 20 of the report?

MR GLOVER: Yes.

THE COMMISSIONER: Yes. Does the witness have a copy?

MR GLOVER: It's on the screen.

THE COMMISSIONER: Right, okay.

MR GLOVER: Q. Here are a series of recommendations that the expert panel made in June 2019. You indicated in answer to my earlier question that it's a document - you were familiar with the review. In what circumstances have you become familiar with it?
A. A number of - a number of times - I think this was published some four or five years ago, so I would have read through the recommendations, and I wasn't involved in the report in terms of giving information, and I would have read through that more recently. Unclear why, actually. Probably in relation to the Henry review, which I was involved within to some extent.

Q. I just want to ask you about a few of the recommendations that were made and get your views about

them. Recommendation 1, paragraph 1 there on the screen, the first part of it recommends a continued networked approach between the hospitals at Randwick and Westmead. It then goes on to say that approach continue within a clearly articulated strategy for paediatrics in New South Wales which provides direction for the range of paediatric providers in the state. I take it from the answers you've given today that that is something with which you agree?
A. Absolutely agree.

Q. And it was clear to the reviewers in June 2019 that it was required. Why is it clear to you today that it's required?
A. I think it was clear in 1966 it was required, and I say that deliberately because there was a review of children's health services in 1966 and when you read it it says largely the same as reviews today, okay, so the issue has not resolved. I think there are a couple of contradictions in the recommendations, but I think having a statewide plan, operation plan, for delivering care is extremely important if we are to be efficient.

Q. When you say you think there are a couple of contradictions within the recommendations, what do you have in mind?
A. Well, I think in this particular document it was stated that there should be - the network should be renamed and it should focus on kids' hospital quaternary level care. I entirely agree with that. But then it says - and then it almost says it should be a broader network across the state. I think the two things are slightly different. They're connected, and I do think that kids' hospitals should really focus on delivering quaternary care well and collaborating with other services in the state, and that should be part of a broad operational plan. So I think the contradiction is the network is a couple of kids' hospitals with some bolt-ons, right? But then there's a much larger network which requires some cohesion.

THE COMMISSIONER: Q. I think you've probably got to read these recommendations together --
A. Yes, I think that's --

Q. -- and then they're perhaps not contradictory, but --
A. I believe that's true.

Q. But, yes - isolated, yes.

MR GLOVER: Q. Yes, and perhaps if we come to recommendations 4 to 6, which are on pages 21 and across to 22. Just have a read of 4, 5, and then when you're ready let us know and we'll have the operator turn over to 6?
A. Yes. No, I am familiar with these and --

THE COMMISSIONER: Q. 4 is the core recommendation, I think?
A. Pardon?

Q. 4 might be the core recommendation, I think, 4 and on?
A. Yeah.

Q. Creating a New South Wales paediatric care network.

MR GLOVER: Q. Operator, if we can turn over the page, please, thank you, and then into 6. Do you see that?
A. Yes, I was familiar with that.

Q. Are they concepts with which you agree?
A. Yes.

Q. And one way perhaps to read the report is to say, well, the panel recommended that the children's hospitals remain connected, they focus on highly specialised care, but that in parallel a New South Wales wide network in the true sense be developed along the lines of 4, 5 and 6; would you accept that as a reasonable reading of the recommendations?
A. Yes, I do, and I think that fits nicely with the statement that I have made, actually.

THE COMMISSIONER: Q. It seems - you'd agree that those recommendations are consistent with the matters you've been discussing with Mr Glover so far in your evidence?
A. Absolutely. I do.

MR GLOVER: Q. You mentioned earlier the Henry review, and we might turn to that now. Bring up the report. It's [SCI.0010.0001.0001]. I think in answer to an earlier question you said that you had some involvement in this review; is that right?
A. I have.

Q. What was that involvement?
A. Well, the ACI was tasked with investigating several of

the recommendations for implementation.

Q. Any in particular that come to mind?
A. There are some. There was a recommendation around about rehabilitation services. There were recommendations around prescribing medication for children with ADHD. There were recommendations around level 4 hospitals providing outpatient services and how to coordinate those things. There was also recommendations with respect to developmental assessment of children, who should do that and how that would relate to the NDIS.

Q. Can I take you in the report to page 43, please. Here Professor Henry observes about halfway down the page under the heading "Children, young people and family committees" that at the stage in his review and report there are over 60 committees and networks related to child, youth and family services, et cetera; do you see that?
A. Yes.

Q. And then there's a rather complicated diagram that follows?
A. Yes.

Q. And then over the page under that next diagram, "An overarching formal statewide committee for children, young people and family services does not currently exist"; do you see that?
A. Yes.

Q. Is that still the case today?
A. Look, I think we've made progress. I don't think it's ideal. I think forming an executive level committee to oversee paediatric health care has been helpful. I - so that's the Children, Young Persons and Families Executive Steering Committee - it's a mouthful - and I'm a member on that committee. So I do see that as helpful. I think it is difficult for elements within the system to escalate concerns to a point of action. I think that still exists, and I think committees probably are larger than they perhaps could be, and I think they're overrepresented at times by the ministry and from quaternary children's hospitals, and underrepresented from other services. That's all I would say. But I think there has been - there has been some moves made that are helpful. But there are more things I think that could happen, particularly if we reflect back on the Alexander report saying there should be

a system - an organisational plan at a state level, and I think in that report it mentions involving LHDs more. So, for instance, my LHD, which is Murrumbidgee, might be involved saying, "Okay, how are we going to run a paediatric service well," for instance.

Q. In that answer you mentioned that it was difficult for people to escalate issues, concerns. Is that because there's no clear point at which those can be escalated to a decision maker?
A. I think that's one of the reasons, yes --

Q. What are the others?
A. So, for instance, the ACI clinical network which I co-chair, we have, as I said, over a thousand clinicians involved with that. I think we come to some very clear and evidence-based proposals. I don't know where to take that. The system doesn't allow me to ring or to communicate with a higher committee to say, "These are things we need discussion for implementation."

Q. If we go back in the report to page 0005, please.

THE COMMISSIONER: Is that actually page 5?

MR GLOVER: This one does match, yes.

THE COMMISSIONER: Yes, okay.

MR GLOVER: Q. And you'll see a heading about halfway down the PAGE "MOH structures and governance"; do you see that?
A. I'm getting there.

Q. Operator, we might see if we can make it a little larger.
A. So this is "MOH structures and governance"; that's this one?

Q. Yes.
A. Okay, yes.

Q. And then there's a first subheading "Issue" and then some blue text headed "Recommendation 9"; do you have that?
A. Yes.

Q. If you could read down to the end of the blue text in

recommendation 9 and let me know when you've done that, please.
A. Yes. Yes, read that.

Q. The first proposition that Professor Henry makes is there's no systemic approach that drives decision making and provides focus for direction for children, young people and family health services; would you agree?
A. I would have agreed. I think that has been partly addressed by forming the CYPFESC committee that we spoke about earlier.

Q. When you say partly, what more work is to be done?
A. If you read through the rest of the recommendation it says, "Okay, reconfigure" - tick, done. But the other things, develop standardised guidelines, [indistinct] statewide policy and planning, I don't believe has been done and I don't believe the committee really has the time to focus on that. Community representatives are present on the committee.

Q. What about its role as a peak decision-making body? Is that its function at the moment?
A. I think it's its function, yes.

Q. In what way is it a decision-making committee as opposed to an advisory committee?
A. That's a good question. I think one of the issues with decision making from that committee is it's not empowered to make a decision. It's empowered to recommend, and then it's unclear to whom they're recommending. So, for instance - and this gets a bit complex, I think - we might recommend things to the ministry, the ministry often can't in and of itself enact those recommendations because in truth LHDs need to enact some of those recommendations, and LHDs are largely independent bodies. So let me give you an example of that.

If we state that paediatric rehabilitation for children with major brain injuries should occur close to home, which is a sensible recommendation, okay, then that would require LHDs to employ and have facilities to do that locally. So it can be recommended that that be done but actually doing it is an LHD responsibility.

Q. Well, if the recommendation was made to the ministry and the ministry accepted it, would it not then be the

ministry's function to ensure the LHDs had the resources available to them to comply?
A. Possibly. But I think - I mean, the ministry can make a recommendation to an LHD. The LHD - my LHD is $25 million in the red at the moment - will say, "We don't have the resources to do that," and that's where the conversation may end, unless the ministry says, "We'd like you to do this. Here's the money to do it."

Q. Right. I'll just take you to the terms of reference of the Children, Young People and Families Executive Steering Committee - I cannot pronounce the acronym in the way that you did; perhaps in the world of acronyms there might be a better one - [MOH.9999.3132.0001]. Commissioner, I think you might have been provided with a hard copy. It's a relatively recent document.

THE COMMISSIONER: I'm sure I was, but whether I can lay my hand on it. I can see the screen. It's here somewhere.

MR GLOVER: Q. These terms of reference have been approved only last month, so relatively new. Are you familiar with them?
A. Yes.

Q. Turn over the page, please, to the responsibilities of the committee. Prior to these terms of reference being adopted what was the function and responsibility of the committee?
A. I think the function is the same as it was when these were adopted. I mean, obviously when we first met we had a discussion about, "Okay, what are we here for," and it was clear from the outset that we needed to provide guidance to the system. It was unclear perhaps how that was going to happen, but it was clear what we were trying to achieve, and I think with time it is now - the instruments to recommend change are becoming clearer, okay, from a committee perspective. Actually doing that on an organisational basis is less clear. But the instruments are clearer, what are we going to discuss, what power do we have in the system to get things looked at, and that's coming together, I would say.

Q. And once that work is done, looking at the issues, looking at the areas of focus, do I understand your evidence to be at the moment there needs to be more work done on what is the next step, where does that go, who is

the recommendation being made to --
A. Yes, I do believe that, and I think one of the issues in health care is everyone wants more all of the time, but I think if we're a responsible committee what we would say is, "How do we do more with the same," and I think that's what we should focus on. Does that make sense?

Q. It does.
A. So how do we work the system better is really what we should be - I think we should be focusing on.

Q. I just ask you about the fourth dot point:

Provide direction and leadership to ensure the achievement of outcomes in priority areas.

Firstly, how are those priority areas to be identified?
A. I think we have a list of or a number of priority areas that had been identified by the committee. Particularly looking at Indigenous care, remote care for children are high priority areas for us. Developmental strategy and early intervention is a high priority area for us.

Q. So these are priority areas identified by the committee?
A. Correct.

Q. And how do they come to the committee?
A. I'm not quite sure. I think people raise them.

Q. But there's no - it's an informal organic process, is it?
A. Yes, I believe so.

THE COMMISSIONER: Q. When you say work the system better with the same, I perfectly understand that. You might be able to make recommendations where things are re-arranged and the cost is the same but the outcome is better --
A. Yes.

Q. -- because you're doing it in a different way. But the other example you gave of, for example, rehabilitation of children with brain injuries closer to home of course is one where if closer to home there's no funding or FD for an

appropriate clinician, that's where either a reallocation of funding might be needed or extra funding is needed?
A. Yes, look, I think that's true. I think reallocation is important, and I often believe if we use technology better sometimes then kids' hospitals, children's hospital clinicians could better support remote care.

Q. Yes.
A. And that is being done to an extent.

Q. Yes, sure.
A. Okay? But I think we could do better.

MR GLOVER: I have no further questions for this witness, Commissioner.

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

<EXAMINATION BY MR CHIU:

MR CHIU: Q. Dr Preddy, could I take you back to the evidence you gave earlier about what's missing in the system at the moment, which is a system for shared care between the general paediatrician in the district and the more specialised paediatrician in the Sydney Children's Hospitals Network?
A. Mmm'hmm.

Q. And you gave the example there of where you have a patient who probably ideally should remain in your facility but you need that assistance from a specialist somewhere else. Is it correct to say that at the moment the system operates reasonably well with transferring patients, so from a facility to another facility? I think that was your evidence earlier?
A. I think it depends which you look at. If you're looking at incredibly sick children, yes. If you're looking at children who have subacute problems, then the transport is not an issue. They catch a plane, a train or a car. That's easy. It's the system that's the problem --

THE COMMISSIONER: Q. By "incredibly sick children" you mean children that need the sort of highly specialised care that is provided at Westmead or Randwick?
A. Intensive care facilities, yes.

MR CHIU: Q. But in the less sick children the difficulty is then to get that assistance from someone else you have to transfer the patient to another doctor?
A. Yes.

Q. That patient then goes away from out of your sight, the patient may or may not come back at some other time?
A. Correct.

Q. But there's no capacity for shared care across facilities?
A. Well, it's not - there is capacity. It's just not done --

Q. It's not done; right.
A. -- okay, and I think, you know, we have - it's interesting in health. We have strange incentives for the system not to work well. So if I make myself into a tertiary care doctor based in a kids' hospital it is easier for me sometimes to say, "Come back to see me next month", "Come back in two months, and we'll put you in the ward and give you this", "Come back in three months and we'll see you again," rather than say, "Do you know what, a lot of this care can be delivered locally."

Q. Yes.
A. There are models for that. So if you look at oncology services, for instance, in Victoria they now have a very clear shared care model for kids' cancer treatment.

Q. Right.
A. And what that needs is subspecialists in kids' hospitals to say, "We are part of this system. We believe in it. We're going to do it." There's - or if they don't believe in it, if they don't want to engage in it, it will not happen.

Q. Could it potentially be facilitated by direct agreement arrangements between districts and the sick children's hospital network.
A. I think it could be facilitated by that.

Q. Yes.
A. I think ultimately it will come down to good communication. But definitely facilitated by it.

Q. Thank you.

THE COMMISSIONER: Nothing arose out of that? Thank you very much for your time, Professor. We're very grateful.

THE WITNESS: My pleasure.

THE COMMISSIONER: You're excused.

THE WITNESS: Thank you.

<THE WITNESS WITHDREW

MR GLOVER: The next witness, Commissioner, is Dr Paul Craven.

THE COMMISSIONER: Dr Craven, good morning.

<PAUL DAVID CRAVEN, affirmed: [11.01am]

MR GLOVER: Q. State your full name, please?
A. Paul David Craven.

Q. Amongst a number of roles, you are the executive director of children, young people and families, medical services of - networks - I'll withdraw that and start again - the executive director of Children, Young People and Families, Medical Services and of Networks and Streams, Hunter New England Local Health District?
A. I am. I'm the executive director of Children, Young People and Families, but separate to that the executive director of Medical Services, Networks and Streams for Hunter New England.

Q. We'll unpack that in a moment. To assist the work of the Commission you've made a statement dated 7 June; correct?
A. That is correct.

Q. Have you read it again before giving your evidence today?
A. I have.

Q. Are you satisfied that it's true and correct?
A. I am.

Q. Bring it up on the screen. It's [MOH.9999.1289.0001]; Commissioner, it's G95.

THE COMMISSIONER: Mmm'hmm.

MR GLOVER: Q. If we start with the roles that you've identified in paragraph 2, come back to director of Children, Young People and Families, what is the role of executive director of Networks and Streams?
A. So the executive director of Networks and Streams, we have eight networks that work across the whole of Hunter New England. One of those is Children, Young People and Families, but the others are women's health and maternity, chronic disease network. We've got a palliative and end-of-life care network, a procedural network, and a critical care network as well. So I'm the executive director of all of those networks together, but they would have managers and medical leads within those networks as well.

Q. And these are networks within the LHD?
A. They're networks within the LHD.

Q. All right. In paragraph 3 you tell us that you host the New South Wales Child Health Network Northern; do you see that?
A. That's true, yes.

Q. What is that network?
A. So within New South Wales we currently, and it is changing, have three children's healthcare networks, the northern, the southern and the western, and they are children's healthcare networks too that work between different LHDs. So the northern incorporates northern New South Wales, the Mid North Coast, Hunter New England, and is in transition to incorporating the Central Coast LHD as well, and we employ medical leads, nursing leads, allied health leads and administrative staff, and within each of those local health districts we have nursing leads, a clinical nurse consultant, and we work in a networked fashion to ensure that we provide high-quality care throughout New South Wales.

The northern network is hosted by John Hunter Children's Hospital, and the other two networks are hosted by one of the - Sydney Children's Hospital, either Westmead or Sydney Children's Hospital in Randwick at that stage, and we are, following the Henry review recommendations, in transition at the moment from three networks in New South

Wales to a single network in New South Wales.

Q. We'll come back to that in a moment. But in that answer you said within these networks, currently framed --
A. Yep.

Q. -- those involved work together to deliver care across that region. How does that happen in practice?
A. In practice those networks are relatively small networks with limited staffing in those networks. So it would be more of a strategic view of health care. So it will be either looking at how to standardise some of the practice we perform across the different LHDs in that region. It would be looking about trying to standardise some of the guidelines that we have in that area, some of the education we have, some of the quality improvement and potentially some of the research we perform in that region as well. So it wouldn't be direct patient care we're providing through that, but we are trying to coordinate the care we provide for the children, young people and families in the north of the state through it.

Q. And the Henry review made some recommendations about those networks; correct?
A. It did.

Q. And part of the function of the Children, Young People and Families Executive Steering Committee has been to review those networks; is that right?
A. That is correct, yes.

Q. And in an earlier answer you were about to tell us that there's going to be some change to that structure?
A. I think that the three children's networks were set up 21 years ago, and probably the original terms of reference for those children's healthcare networks have been a bit lost within the system over 21 years, and so in review in 2020/2021 there was recognition that potentially what those were established to do is not currently required and the function of the networks needs to change.

Following the review and wide consultation across New South Wales it was recommended a single network was formed and a change in the actual structure of the network, but really looking at the functions was still to provide high-quality and coordinated and integrated care across New South Wales. So there is going to be a single network,

which is in consultation at the moment about that network, there will be coordinators within that network --

Q. Just pausing there. I'll come to the detail in just a moment --
A. Sure.

Q. -- but the review that you've spoken about of the three developing into one, that was work done through the Children, Young People and Families Executive Steering Committee; correct?
A. That is true.

Q. Building on the recommendations in the Henry report; is that right?
A. That is true.

Q. All right. So building to what the - that structure will look like in the future, accepting that it is out to consultation and perhaps hasn't been finalised, but where is it heading?
A. It's heading to be a single network for New South Wales. There will be a --

Q. "Network" is used a lot. What does that mean?
A. It's going to - it's the - so in New South Wales the strategic planning network or steering network in New South Wales or committee is Children, Young People and Families Executive Steering Committee, as you have alluded to. You alluded previously to a lot of committees with children, young people and families in New South Wales, and we now have identified probably five lead committees in New South Wales which will report up to the Children, Young People and Families Executive Steering Committee.

Q. Five that exist or five that will exist?
A. Five that will exist.

Q. And that is a rationalisation of - Professor Henry nominated 60, but the numerous that are currently in existence; is that right?
A. That is right, and there will be five lead, but there will be some subsidiary committees reporting to those lead committees, so there is a structure for children, young people and families in New South Wales, and the new children's health network, what we were talking about originally, is called the Children, Young People and

Families Healthcare Network for New South Wales. Just a single network. There's a lot of networks in New South Wales, and this is a single network which is an operational network of decisions made - the strategic decisions made by the executive steering committee will be operationalised through the children's healthcare network that is being developed.

THE COMMISSIONER: Q. Which recommendation of Henry does that come from?
A. That will be under the children's healthcare network reviews from Professor Henry. Sorry, I don't know exactly which number.

MR GLOVER: Perhaps if we go to the Henry report to build in the Commissioner's questions.

THE COMMISSIONER: Yes. It's under the heading "Children's healthcare networks", is it?

MR GLOVER: Yes, it would be. [SCI.0010.0001.0001].

THE COMMISSIONER: So, "The Children's Healthcare Network Northern Region be expanded to include Central Coast"; that alone doesn't sound like one network is being created. Where's the --

MR GLOVER: Operator, page 6, please.

THE COMMISSIONER: I think it starts at, yes, recommendation 17. Yes.

MR GLOVER: Q. So there's the recommendation 17 and 18 was one that you've referred to in your statement and it's one that caused some concern?
A. Yes.

Q. Is that no longer being pursued, I take it, in this current model?
A. I think that within that recommendation 17, "The Children's Healthcare Network Northern expand to include the Central Coast", within the body of the Henry review there was recommendation that services that are required, some of the tertiary services required, for the Central Coast will be sought from John Hunter Children's Hospital in the future, where previously they may have been sought from the Sydney Children's Hospitals Network. So that

still needs to be pursued at that stage because that is about care that we're providing to the children of the local region. So we are looking at the opportunities to provide some of those tertiary services for those children in those regions. Incorporating the children's - Central Coast into the Children's Healthcare Network Northern is not going to be possible because we're going to have one single network working together for the children of New South Wales --

THE COMMISSIONER: Q. What I'm struggling with is to work out where that comes from Henry. Is it 9?
A. I think it may --

MR GLOVER: If I can assist, Commissioner, page 44 and following of the Henry review report --

THE COMMISSIONER: Yes.

MR GLOVER: There's a section that deals with these networks. As I read it, there's no express recommendation in Henry that says, "You should have one, not three."

THE COMMISSIONER: No, I can't see that either. That's why I'm asking the question. There is in the Alexander review. I can see that. But I can't see it in the Henry review.

MR GLOVER: I might be able to explore it with Dr Craven in this way.

THE COMMISSIONER: Sure.

MR GLOVER: Q. After the Henry review there was an implementation committee stood up; is that right?
A. There was, yes, that's right.

Q. And you were a member of that?
A. I was.

Q. And then that implementation committee turned into the Children, Young People and Families Executive Steering Committee; is that right?
A. That was one of the recommendations of the implementation plan, to develop a peak leadership committee for New South Wales for children, young people and families.

Q. And that committee was stood up?
A. It was.

Q. And you're a member?
A. I am.

Q. And you remain a member?
A. I am the co-chair of that committee.

Q. And part of the --

THE COMMISSIONER: This is the committee you were asking Professor Preddy about; yes.

MR GLOVER: This is the one with the very long name and --

THE WITNESS: Yes, that's right.

MR GLOVER: -- unpronounceable acronym.

Q. The immediate function or one of the early functions of that committee was to oversee the implementation of the Henry review recommendations; is that right?
A. That is correct.

Q. And is it the case that in the implementation of the Henry review recommendations that committee also undertook a review of the operations of the children's healthcare networks that are set out on pages 44 and following of the Henry review report?
A. That is correct.

Q. And is it the case that in that process of review the committee determined that there should be a new model of, one, not three?
A. That is absolutely correct, yes.

MR GLOVER: Does that assist?

THE COMMISSIONER: Yes.

MR GLOVER: Q. Now, before we got to that passage we were exploring what the new structure will look like and how it will operate, and I asked you some questions along those lines, so if we just revisit that. Once established, accepting that it's still under review and consultation,

but what is the vision for that single network across the state?
A. The vision for that single network for the state is to operationalise the strategies identified by the Children, Young People and Families Executive Steering Committee, and they will only be operationalised by working in consultation with all of the 15 local health districts and the two specialist health networks in New South Wales.

Q. When you say operationalise recommendations from the committee, the committee as it currently stands isn't a decision-making body; is that right?
A. The committee has identified two strategies within New South Wales that we would like to roll out at the moment. One of those strategies is the service capability framework, so mapping the service capability framework and identifying issues within New South Wales; and the second one is to look at outreach services, something we've talked about through this process, and how we provide outreach services from tertiary children's hospitals to paediatric services around New South Wales.

Q. So once the committee does that work, makes its recommendation, what is the process or what will the process be for it then to become operationalised through the forthcoming network?
A. The network - the children's - the new Children Young People and Families Healthcare Network will work with the local health districts and will work with identifying members within every LHD and specialist network in New South Wales to implement and map the service capability, and that will be the responsibility of each of the local health districts, and the Children Young People and Families Health Network, the new network, will also help map the current outreach services that exist within New South Wales Health. They will then - because they are built from medical, nursing and allied health representatives within that network, they will look for what would be necessary for New South Wales and they will look for where the gaps exist in New South Wales from what we provide to what would be ideal at the moment, and they will make a recommendation back through the Children's Healthcare Network to CYPFESC, and obviously one of the principles of CYPFESC is to escalate problems to the minister of health about --

THE COMMISSIONER: Q. What should I understand to be the

differences between the network proposed and what Dr Alexander, Dr Steer and Ms Peter recommended in their review regarding the paediatric care network? Are there any differences, or is it the same thing with a different name?
A. I would have to take that on notice because I'm not sure about what the initial recommendation in the Alexander report was.

Q. Well, we can get that up.
A. Yes.

MR GLOVER: [SCI.0010.0004.0001], at page 20, please.

THE COMMISSIONER: Q. So drop down to 4:

> *To review and consolidate existing committees to create a streamlined and coordinated New South Wales paediatric care network to provide advice on.*

And then I'll let you read the rest.
A. Yes.

Q. But what's there in 4, 5 and 6 seems something like what you're telling me as distinct from at least what I can read and understand from the Henry review?
A. I read what number 4 is saying as we have identified the Children, Young People and Families Executive Steering Committee.

Q. Yes.
A. Which is doing and performing those functions that are outlined there.

Q. Yes.
A. The new Children Young People and Families Network is trying to operationalise the plans being made by that committee.

Q. Yes.

MR GLOVER: Q. When you use the word "operationalise" what do you mean?
A. There are lots of strategies in New South Wales and there's lots of plans which we'd like to implement through 15 LHDs and two specialist health networks. The -

"operationalise" for me is actually ensuring what we say we are going to do gets done in a local LHD; so, you know, when we have 77 recommendations in the Henry review how do we know that those recommendations are filtering down to the LHD and occurring in every single site where those recommendations are pertinent to that region.

Q. So building on the practical examples you gave us earlier, the capability mapping exercise, so it's the case if the committee says, "Well, this is something that" - oversimplified significantly, tell me if we go astray, but the committee says this is something that we - should be done and should be done within a certain time?
A. Yes.

Q. And then it will be the function of the network to ensure that it is done?
A. Yes.

Q. And then fed back to the committee for consideration and then recommendation?
A. That's right.

Q. Is that a fair summary?
A. That is a fair summary, yes

Q. And is that the way you envisage it working in all areas of the committee's work?
A. Yes, it is. The network will function in collaboration with the LHDs. The --

Q. Why do you put that qualifier on it?
A. Because the network has got - the network employs two coordinators, one nurse lead, one medical lead and one allied health lead. They are never going to be able to implement very complex recommendations in every LHD, and with a devolved governance system in New South Wales we need to work with those LHD because it's partly their responsibility to actually enact those plans as well.

Q. I take you back to your statement, please. Just a point of clarification in paragraph 9. So it's, "Within Hunter New England LHD, John Hunter Children's Hospital operates at the centre of the CYPF Network"?
A. Mmm-hmm.

Q. That's a network within the LHD, is it?

A. Yes, I can see where it's going. So Hunter New England is a local health district. Within the local health district we have a children's hospital which is funded by the local health district.

Q. Yes.
A. Different to the Sydney Children's Hospitals Network. We work as a networked service. So we are the level 6 provider, and within our own LHD we have to obviously provide services to our local population as well, and so we work, as previously discussed, as a network service. We provide level 6 services, level 4 services, but we also support our services within Maitland, Tamworth, Armidale and the region as well. So that's how that Children Young People and Families Network works in Hunter New England and the children's healthcare network works beyond Hunter New England for the north of the state.

Q. And, to the extent that there's level 6 services being provided at John Hunter Children's Hospital, that's not limited, of course, to those people within the district?
A. Absolutely.

Q. That's a statewide service; correct?
A. It is a statewide service, and it truly is statewide. You know, we will have transfers in from the whole of the state, and some of our services in fact from Newcastle and from the John Hunter Children's Hospital will provide services for southern New South Wales and Murrumbidgee. But the majority of our tertiary services are provided to the Central Coast upwards.

Q. I take you ahead to paragraph 11. There you tell us at the start of the paragraph that the "John Hunter Children's Hospital is within the clinical governance structure of the ... LHD and does not form part of Sydney Children's Hospital Network". Does that provide any challenges for the operation of the children's hospital?
A. It does provide challenges.

Q. In what way?
A. I think that as a - to talk about the history of John Hunter's Children's Hospital, it evolved as a paediatric ward in a large hospital, John Hunter, and so the children's hospital was established in 1995. So it's been a children's hospital for nearly 30 years, but it's grown up within a large tertiary hospital which is an adult-based

hospital and within an LHD which provides both adult and paediatric services, and I think we've heard this morning some of the complexity from our point of view is there are many pressures on the healthcare system at the moment and there are many pressures at a local health district level as well. Some of those are about service provision, some of those are about the KPIs we have to meet and some of those are financial pressures as well, and so trying to run a tertiary children's hospital within a large adult-based LHD does come with its challenges.

Q. You were here when Professor Preddy gave his evidence?
A. I was.

Q. And you heard him describe some of the challenges of operating a paediatric service in - I hope I accurately quote him - a adults-focused planning process. Would you agree with his observations?
A. I agree with the challenges we're facing. We have an aging population, we have some significant challenges in the flow of patients coming through our emergency departments and getting surgery done in New South Wales at the moment, and a lot of attention is naturally and quite rightly on those challenges we're facing. And the aging population, 70 per cent of our growth is over 70. So trying to advocate for really important paediatric preventative, early intervention services when there's an aging population is extremely difficult, and I think what John alluded to is saying that, you know, if we do intervene early we actually prevent some of the things we're treating later on in life as well. And we do have some processes where we are working on early intervention at the moment, but a focus on paediatrics sometimes gets a little lost in a large LHD with some other pressures.

Q. Does it still get a little lost, to pick up your term, when you're operating a specialist children's hospital within the LHD environment?
A. It does. I have great support from the executive of the LHD. But it is funded as an LHD; it's not funded as a tertiary children's hospital in the same terms as potentially - in the Sydney Children's Hospitals Network, that's a purely children's healthcare network, whereas in Hunter New England obviously the funding is for both adults and children at that stage, and it's also in a local health district, and we're then providing services beyond that local health district as well.

Q. Are you aware if there's been any consideration as to whether the John Hunter Children's Hospital should remain within the LHD or form part of the wider perhaps Sydney Children's Hospitals Network?
A. Look, I am aware and I can see it has been reported in the Alexander report in the past about considerations. Personally, the Sydney Children's Hospitals Network is two children's hospitals in Sydney, and we are Newcastle children's hospital, and I don't think anywhere in the world you would have a children's hospital in another city called under the Sydney's Children Hospital - grouped with another children's hospital in another city. I do think, however, the concept of thinking about how three children's hospitals work together is a concept we should think more about and how we plan some of the tertiary services we provide together.

Q. Building on that answer, accepting your view that you would not deem it as practical or appropriate that the children's hospital in Newcastle be put together with two children's hospitals in Sydney. Building on that then, how does one overcome the challenges that you've described earlier about operating a specialist children's facility within the LHD environment and the challenges that brings?
A. I think there has been - there's definitely been examples of how we've overcome that in recent years, and there has been some planning around some specialised paediatric services that we've introduced in the last couple of years, and I'll talk about gender services, palliative end-of-life care services for children and some of the virtual care services we're providing for children as well. Some of those have been coordinated and funded as a three children's hospital model, and it doesn't need to just be children's hospitals, and I apologise just for talking about children's hospitals at that time. But they have been funded together and we collaborate together as three children's hospitals at that stage. The problem at the moment is some of the historical services we have provided for a very long time aren't worked in the same way, so --

Q. What do you mean by that?
A. So we would have many tertiary services. So at the moment we're funding gender services and palliative end-of-life care and virtual care, and money is provided and we're staffing those services within our three

children's hospitals and working together in that system. We've historically got other tertiary services, such as immunology, cardiology, gastroenterology, oncology and the list goes on, and I think that we now in New South Wales are providing more specialist paediatric care than we've probably ever provided before and, you know, there was a time I think probably a lot of that care was provided by general paediatricians. Those services now are provided by three children's hospitals and also some larger level 4 services, but I'm not sure we have coordinated provision of those tertiary services well in New South Wales at this stage.

Q. Is that why in an earlier answer you mentioned there's scope to look at how the three children's hospitals work together?
A. I think - yes, absolutely. I think it's - we've got some what's called super-regional services which we - you know, neonatal intensive care, paediatric intensive scare. So it's coordinated for the state. We've got some specialised services that have come onboard, and they seem to be coordinated for the state at the moment. But we do have some historical services that are not coordinated and I think would benefit from being coordinated centrally.

Q. What improvements can be made to the way that the three hospitals, that is the three children's hospitals, work together, in your view?
A. I mean, I think we have - we have an excellent relationship between us. We meet on a regular basis. We have a heads of agreement between us about how we will work together, some guiding principles of how we work together. I do think - I think that if we could have some service planning around some of those tertiary services for New South Wales and consider where the services are required in New South Wales, who should provide those services, where they should provide them and where the funding would come from in that situation I think that would really help us work together collaboratively.

Q. Statewide operational and services planned for the delivery of paediatric care which includes how the three hospitals work together; is that what you had in mind?
A. Absolutely --

THE COMMISSIONER: Q. Also more than how just those three hospitals work together; how paediatric departments

in other LHDs work?
A. And I was just going to say, for me, I'm talking about three children's hospitals because that's what we talk about, but the reality is it doesn't have to be provided in children's hospitals. The whole emphasis is providing care close to home.

Q. Yes.
A. So how can we think about providing, in John's situation, good paediatric care and good community care, but how do we provide tertiary care, and of course for me at the moment it's providing tertiary care, because there's great demand for tertiary care and we have long waiting listing for children wanting to access tertiary care, because at the moment with a lack of some planning it's difficult to meet the demand.

MR GLOVER: Q. I take it from that answer that you would adopt Professor Preddy's point about there being benefit in clear role delineation and pathways for referral into specialist facilities like yours and then back to level 4 facilities like his?
A. Absolutely. I think we have got some good - I think we have got some good systems. We've got some good systems of how GPs could refer effectively. I'm just not sure it's consistent across the state, so I think some consistency with our primary healthcare providers. I think there will be some consistency and there is some suggestion around what a children's hospital should provide, would be good to continue some work on at the moment at that stage, and I think some consistency around who and where we should provide good outreach services would be a sensible approach, because bringing children into children's hospitals is not the right thing to do. Keeping them up close to home would be a much preferred system.

MR GLOVER: Is that a convenient time?

THE COMMISSIONER: It is. Yes. We'll adjourn until 11.50.

SHORT ADJOURNMENT

MR GLOVER: Q. If we can turn back to your statement and to paragraph 11, building on some of the evidence before lunch, halfway down that paragraph you tell us there's no centralised planning of tertiary paediatric services in New

South Wales; do you see that?
A. Yes.

Q. We've touched on that already. What I want to explore with you is what improvements you see could be made in a formalised sense to overcome that lack of centralised planning?
A. I think that we have done some really good planning. So I will state that I think with some of the newer services that have been introduced recently we've had a really good look at where services need to be provided, by whom, how, and have looked at the staffing of what we would require to provide those services. That's been excellent, I'd have to say.

So I think maybe what I'd say is maybe learn from some of our successes to think about retrospectively applying them to some of the things which we're currently providing but maybe struggling to provide within New South Wales. I think like services such as - John Preddy and myself have both talked about gastroenterology services, but it will be the same for most paediatric subspecialty services at the moment, so gastroenterology, oncology, immunology, the list could keep going on at that stage, and maybe a staged approach to how are we going to provide these services, where are we going to provide these services, and who is going to provide those services as well.

Q. So at the end of paragraph 11 you tell us that joint meetings are important to ensure the three children's hospitals work collaboratively.
A. Mmm'hmm.

Q. Is a more formal structure for joint planning across those three facilities required, in your view?
A. Look, I think at the moment they are quite informal meetings, the three children's hospital meetings, and they are only the three children's hospitals. And we've learnt this morning that so much work occurs beyond the three children's hospitals, and we have to be really cognisant of that. So I think maybe we have to be aware that maybe just the three of us trying to sit together and think about what we're going to do together you might end up with the same answer every single time, and I think maybe broadening where those conversations and who is orchestrating some of those conversations will be a good thing as well.

Q. Accepting that planning for paediatric care across the state must necessarily involve those who deliver it across the state, what I'm really focusing on though is the particular type of care that is delivered through the three children's hospitals. Is there scope for more formalised coordination and planning across those hospitals?
A. There's definitely scope, and I think we're making some good progress already. I think we have looked at the governance of children, young people and family services across the whole of New South Wales as well at the moment, and I think we're making some good progress.

I think that formalising some of that planning would be a good opportunity. I think the service capability framework, when we've mapped it we will know where some of the gaps are. So I think that's an important opportunity. It is important to recognise, however, that the service capability framework doesn't really map tertiary services provided. So that is very much around some of our general paediatric and community paediatric services provided, not tertiary.

Q. When you say there's been good progress made in this direction where do you see that ending? What's the end goal of that progress?
A. I mean, I think there's a recognition through the Children Young People and Families Executive Steering Committee. I will say that that committee is very much focused on the Henry review, and there are 77 recommendations in the Henry review and there's been an incredible amount of progress in trying to achieve many of those actions.

I guess one of the things I reflect on is the Henry review was 2019. And so the issues that were pertaining in 2019 have changed. We know that health care has changed, especially post-COVID at that stage. So maybe understanding some of the newer challenges we are facing across New South Wales is one of the elements of that committee is now doing, and the first two things we're going to look at operationalising at the moment is that service capability framework and also the outreach services. So it is very much similar to what we're actually - what I'm outlining here to trying to plan some of those tertiary services.

THE COMMISSIONER: Q. What are the key newer challenges

that you were just referring to?
A. I think challenges at the moment is how - the models of care. So I think, you know, we've had this very traditional, "Doctors have to see a patient; should be in a children's hospital." So I think virtual care is really, you know, pertinent for the future. I think we have to think about workforce. We've got many challenges, and I think the challenges are disproportionate with our rural and regional colleagues at the moment. So I think we should be thinking about where we provide services, how we provide services, but most of all who should provide those services because what we've historically done we shouldn't probably do for the future.

We've currently got some excellent models of care, and it is coming out of the Henry review still, but we've been looking at models for ADHD. John Preddy, you know, referred to models for rehabilitation care. We've been looking at models for complex health care, how do we coordinate that better. So there are really good things occurring in New South Wales at this moment in time, and I think what we need to think about is when we've got the evidence that something's working how do we spread it and make it consistent across the system.

MR GLOVER: Q. You were here when I took Professor Preddy through the paediatric service capability document?
A. Yes.

Q. And the inter-hospital transfer arrangements document; correct?
A. Yes, I was.

Q. Is part of the review of service or the mapping of service capability that the committee has suggested and will be operationalised by the new single network when it's up and running, what's the vision for the endpiece of that work? What is it going to be used for and where do you see it developing the network structure across New South Wales?
A. Look, I think when we map the service capability we will - that service capability outlines the minimum level of care that's to be provided between levels 1 and 6 at that stage. And I think there are services in New South Wales now that would be declaring they are providing a level of service that when we map them they won't be able to do. And so I think it will give us a realistic

impression of what services are being provided, where they're provided, and ensuring that they are provided safely at all times. And I think that will then allow us to identify the gaps, where they exist. And then I think behind that there are some models that we have to consider, and I think that's that work that Professor Preddy is working on at the moment, looking at new models of care and how we can spread those across the system. So I think it's good we'll have a baseline of where we sit at the moment and it will be good to have a baseline of where maybe some of those gaps exist, and therefore we can try and adapt the system.

Q. What about putting some more formal structure around the networks that are referred to in those two policy documents? Is that part of that process?
A. Can I ask which networks you're --

Q. Well, that's a good question. If we go to the paediatric service capability document.
A. I apologise.

Q. [MOH.0002.0144.0001], page 12. You see there under the first paragraph the policy tells us that clinical care and inter-hospital transfers for infants et cetera are delivered through a statewide system of networked care; and then later in that paragraph services are linked through local networking arrangements. Can you assist on what those networking arrangements are?
A. I can in my own district. Look, I can really say that for the north of the state. I guess when we map the service capability we're mapping the minimal level of service they've all provided at that stage. Within that document there is a process of identifying how you will escalate care between different services. And it might not all be moving them to a children's hospital. It would absolutely be moving them from a lower level of care to a higher level of care and ensuring you have the back transfer, once the patient is improving, move them back again.

I think some of those networks are probably formalised in some areas and I think some of them are based on relationships. So I think formalising some of those and ensuring we have them documented would be very useful.

Q. Because would you accept that it's important that

arrangements like that are not heavily based on relationships between particular clinicians but are rather part of business as usual?
A. I think in the past we have had a lot of networking based on relationships, and I think things are changing at the moment based on many things. We've got quite often a newer workforce at the moment and a different workforce. So I think formalising some of those networks would be very important.

Q. Is that part of the work of the committee, that is the Children Young People and Families Executive Steering Committee, at the moment?
A. Yes, it is because it is part of the service capability framework to ensure that within that document we not only ensure that we have a mapping of what service they can provide; it is actually ensuring that we have an education framework and a transfer framework and a framework of supporting smaller services by larger services.

Q. I take you back to your statement, please, and to paragraphs 14 and 15. We've discussed already today some of the challenges that might arise from being a specialised children's facility within a LHD structure. I just want to touch briefly on paragraph 15 where you describe some of the challenges associated with securing funding. In the second sentence of paragraph 15 you tell us that:

> *... growth in activity should translate to increased National Weighted Activity Unit allocations [that the] funding is incremental which creates challenges for investing in services and growing the workforce ... to provide such services.*

Do you see that?
A. Yep.

Q. Can you just explain what you mean by that?
A. At the moment the majority of our - as I said before, a lot of what has previously been service provided by a general paediatrician potentially is now becoming a very specialised paediatric service provided by dedicated specialists.

I think within the John Hunter Children's Hospital

certainly we have grown that specialised workforce incrementally and slowly, and so we have extremely small teams of specialists. So we often have anywhere from one specialist in a team trying to provide service 24 hours a day, seven days a week, and even some of our larger specialist services have got very little FTE to provide that service at the moment.

We find ourselves getting to a situation where we would work those services when we have two people to the maximum, and we just can't generate any more activity with two people at that moment in time. So as much as we could say if we did more we might be able to generate more activity and more funding that we could reinvest at that stage, I think we've shown by new models coming in and specialised services coming in having funding up front to establish a service is really important. I don't know how a hospital is started, but most hospitals have teams at the beginning, and I think trying to grow a team from nothing is very difficult to try to provide a service.

Q. And is part of the challenge in growing a team to be able to then increase activity and it becomes somewhat circular perhaps; correct?
A. Absolutely. I mean, I think that we want to provide the service to the children. The most important thing we want to do is provide a service to sick children in the north of the state. We recognise that. I think it's extremely frustrating for clinicians to be able to provide part of that service and know that they have got children waiting to be seen, who need to be seen, but when there's one or two people it's just impossible to get to them. And so we do have children waiting for a long period of time.

Q. Is part of that challenge heightened by the fact that within the LHD environment those services compete for funding with the range of other services provided with the LHD?
A. We do, and we advocate for all our services, and we advocate for all our services with our colleagues advocating for adult services, community services and various other services across that area. And it is a very difficult time at the moment to try and advocate for some of those services. So I recognise the pressures and I recognise how frustrating it is for some of the clinicians to try and provide and meet the expectations of the population we're serving. And that expectation is not

only within the LHD; it's outside the LHD as well.

Q. When you say it's difficult at the moment to advocate for those services what do you mean?
A. I think it would be fair to say at the moment there are some financial challenges in many areas of health care at the moment and everybody at the moment is asking for more. We recognise at times we have to be realistic. So I think what we said earlier is we have to try to think about what we do with what we've got and try to do it better with what we've got at that stage.

THE COMMISSIONER: Q. There's a health acronym which is CFE that we keep getting told about: challenging financial environment.
A. Yes. I like to be consistent.

MR GLOVER: Q. When you use challenging financial environment what do you mean?
A. Look, I think I recognise there's areas that I believe - I have looked at every which way to try to provide a good clinical service. We could re-design the service. We have used new models of care. We have looked at different staffing models to try to provide that service. But at some stage there's a recognition that the only fix for that service is you actually do need more people to provide it, and there are some of our services where we have reached that situation.

Q. And to provide more people do I take it that you need more funding?
A. I would need more funding to provide that service. But I equally understand that all my colleagues are doing the same thing and advocating for the patients they care for at the same time.

Q. I take you ahead to paragraph 22. There you summarise the challenges, and we've covered all of them in your evidence today. What I want to explore with you is whether statewide approach to operational and service planning that we've discussed might assist you in meeting some of those challenges and, if so, in what way?
A. I think it has shown - I think we have already demonstrated with some of the specialist services where we have already planned on a statewide level that we are providing excellent care for the patients and we are providing it in the right locations by the right people,

and those services have been funded, and I think we have some good models where we could reflect on in that situation. I do --

Q. Just pausing there, do I take it you agree then --
A. Yes, I do.

Q. -- that there is benefit in a statewide approach across the board rather than just in relation to specific services --
A. I feel some statewide planning from some of the specialised services we provide would be very sensible. I think when there are services provided - for example, in the Hunter New England region we provide some services to the local population which every LHD provides, and I understand that we will continue to provide those services as part of a LHD. But when you're providing tertiary services, providing very few centres in New South Wales with a very limited workforce, I think some planning around how we use that workforce effectively would be good and I think that would be good centrally.

Q. And how that service and workforce is then linked to other paediatric care provided across the state, as you mentioned earlier?
A. Absolutely. And, as I said before, it may be to provide it not in a tertiary service.

Q. Would that approach also assist in advocating for funding for paediatric care?
A. I think we have shown already we've advocated for funding for some of our specialised services that have been very effective.

Q. By that do you mean where there's been statewide planning for certain services that has assisted in securing funding for them?
A. We have shown that where we plan for intensive care for beds, for neo-natal or paediatric intensive care we allocate funds to where the activity is increasing at that stage, and we have had some very good specialised services which have been funded statewide. And I think about the gender services, palliative and end of life care, and currently the virtual care we're providing for children in this state where we're providing some urgent care virtually for children, and that has been centralised planning.

Q. And has that centralised planning assisted in securing funding for those services?
A. It has.

Q. And do you see benefit in more wide-ranging centralised planning also providing a greater strength to advocate for resources being allocated to paediatric care more broadly?
A. I think centralised planning then allocates the funding to where it's required at that stage. It will be remiss of me to say that obviously, you know, we have to recognise that there are things in health care potentially that we will stop doing as well. As a service we have to think very carefully about the models that we have employed in the past and could we do things better and what do we stop doing to actually start doing things we want to do as well.

Q. And part of that process - that process would commence with assessing the needs across the state, would it?
A. Absolutely. I think assessing needs.

Q. And then determining the resources available to meet that need across the state?
A. I think assessing needs, assessing models is really important as well because we shouldn't just keep replicating what we've always done; I think assessing where we should be putting models at that stage; and really building it that way and then advocating for funding for tertiary care or community care where it's provided.

MR GLOVER: I have no further questions for this witness.

THE COMMISSIONER: Thank you. Mr Chiu?

MR CHIU: No questions, Commissioner.

THE COMMISSIONER: Thank you very much, Doctor. We're very grateful for your time.

THE WITNESS: Thank you very much.

<THE WITNESS WITHDREW

MR GLOVER: Dr Lyons is the next witness, Commissioner.

<NIGEL JOSEPH LYONS, sworn: [12.12 pm]

<EXAMINATION BY MR GLOVER:

MR GLOVER: Q. State your full name again for the record?
A. Nigel Joseph Lyons.

Q. And you're still a special adviser to the Ministry of Health?
A. I am.

Q. And to assist the Commission in its work you have provided a statement dated 7 June; correct?
A. I did.

Q. [MOH.9999.1870.0001], G105. Did you have a chance to read it again before giving your evidence today?
A. I have.

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

MR GLOVER: It will form part of the bulk tender, Commissioner.

THE COMMISSIONER: Yes.

MR GLOVER: Q. May I take you to paragraph 3, Dr Lyons. There you tell us that between October '16 and August '22 you held the position of Deputy Secretary, Health System Strategy and Planning, and then at the end of that paragraph that that included responsibility for the direction of child and family health policy; do you see that?
A. I do.

Q. Just focusing on the responsibility for child and family health policy, what was the scope of your role in that position?
A. So I was responsible for the health and social policy branch, which had responsibility for child and family health. That was brought back into the ministry following New South Wales Kids and Family dissolution in 2015. But my involvement actually goes back longer. We've talked about paediatric networking a lot today. My initial

involvement in paediatrics and its networking was in the year 2000 when I was actually seconded into the ministry, the then Department of Health, to write the plan to establish the three paediatric networks which people have talked about today. So that was back in 2000.

The issues around networking have existed, as we heard, from the 1960s onwards. They are the ongoing challenge. And how we actually support the appropriate networking of services within districts across networks, specialty health networks, and across the state is an ongoing challenge which we've heard lots about during this hearing.

Q. Coming back to that. Since leaving the deputy secretary role and your specialist advisor role, I take it you're still up to date with issues in this area?
A. Somewhat, but not to the level of detail of others who have been directly involved in those meetings. So Dr Craven, for instance, has been part of some of those discussions. I haven't been directly involved in those since I left --

Q. So you were on, for example, the Children Young People and Families Executive Steering Committee for a time?
A. At that stage it was actually the Henry review implementation group. So it involved, I think, into the executive steering committee subsequently. But I did co-chair it.

Q. And that role for you ceased in about August 2022?
A. That's right. That's right.

Q. If I ask you a question that is now beyond your knowledge, feel free to say so. Touching on the networking issue, coming back to your time in the ministry when the children's health networks were being revised and implemented, do you recall what led to that development within the New South Wales health?
A. The purpose of the paediatric networks was to recognise, as we have heard today, that the care of children needs to be supported and needs to be supported in a way which allows the care to be delivered as close as possible to where they live, and that is a challenge because you need to have the workforce in place but you need to have the workforce supported by access to advice and higher levels of care when that's required, and for

those things to be provided in a way that enables the child to get the care they need where they are, but if the care they need is beyond where they are that there's an easy way for that referral for the transfer to occur; or, alternatively, for the clinician who's involved in delivering that care locally to get the advice to be able to deliver the care safely in that place. So those things were recognised and have been recognised.

The way to achieve that is, you know, through the really important role that our tertiary and quaternary services play and the expertise that they have being made more available to the people who are actually providing that more general care. I think the challenge of that has increased over the last few years, and we've heard about the increasing subspecialisation. That's occurring in every sphere of medical care. It's occurring in paediatrics. It certainly has created increased challenges because what was previously done by a general paediatrician in a level 4 unit often now is needing to have the referral or back -up of those subspecialties.

I think what's highlighted over the last few days of evidence and listening to witnesses is that issue around the connection between the subspecialties that exist and how they might better support what is happening across our local health districts in terms of provision of paediatric care is probably something which we really need to focus on now as the next phase of, you know, the priorities for service support, planning might need to be put around that and there might need to be some more definition and clarity around how that is supported across the state.

Q. What is it about the delivery of paediatric care in the last few years that you've mentioned that has perhaps brought that into sharper focus than might have been previously?
A. Well, I think every area of subspecialty medicine has grown because of the depth of knowledge that now exists; the capability to do things that weren't able to be done before, the application of technologies to support that; and the need for those to be done in a highly specialised environment with a team with skills and capability around you. So that shift has inevitably meant that patients are being transferred more into the Sydney Children's Hospitals Network. As we heard today, even referrals for outpatient care, those are often to specialists in those setting.

So what that means is how do you create the connection so that access to that advice, that care and support is appropriate, but how do you then support the transfer of care back to somebody who can actually deliver that, whether that's a specialist paediatrician locally, a generalist, or even to general practice in some cases because there won't be a specialist paediatrician in those environments. So how do we create that networking and that support for the overall care of the patient and their family, because the family are an important component of that, and how is that done in a way that enables everyone who needs to be a part of that to be aware of what's going on and to play their part appropriately.

Q. You were here while Professor Preddy and Dr Craven gave their evidence?
A. I was.

Q. And I took Professor Preddy in particular to the "Paediatric Service Capability (Paediatric Medicine and Surgery for Children) Guideline"?
A. Yes.

Q. I can take you to it if you need, but that document I took Dr Preddy and I think Dr Craven through refers to networks in a variety of senses.
A. Mmm'hmm.

Q. Do I take it from the answers that you've just given that you would agree that there is now time to perhaps put some more structure around those networks, more clarity about how they operate, without of course interfering with clinical decision-making?
A. Absolutely. We should not interfere with clinical decision-making and nobody should interfere with that, and I think referral patterns will always occur between clinicians. It's about how the system supports the appropriate networking and arrangements between clinical services to enable clinicians to access easily that support and make those referrals where required.

Look, I think, on reflection, the Northern Child Health Network, as came out in the Henry review, was probably more mature in terms of how it's operating. And on reflection, you know, the changes that occurred in the governance of the two children's hospitals in Sydney with

the establishment of the Sydney Children's Hospitals Network probably disrupted the networks that used to occur at Randwick and Westmead for the southern and western parts of the state.

Q. Why do you say that?
A. Because I think there became a focus on - very importantly a focus on how the two hospitals were brought together which created a more inward-looking focus of the executive management and the clinicians, and the whole idea of the paediatric networks was to be more outward-looking. And so by necessity through the establishment of the Sydney Children's Hospitals Network the outward-looking didn't get as much focus as perhaps occurred in John Hunter through the fact that that wasn't disrupted by that change.

Q. Dealing with that issue directly, perhaps, I'll take you to what's been described as the report of the Alexander review at [SCI.0010.0004.0001]. That's up on the screen, if you have it there. Are you familiar with this document?
A. I am.

Q. And were you involved in the commissioning of this review?
A. I wasn't involved in the commissioning but I was consulted as part of the consultation process with the panel and was involved after the report was received.

Q. What was your understanding of the purpose of this review?
A. It was really focused around whether or not the decision that was made - if I step back to the Phillips review actually. Ron Phillips actually did a review in 2012 which was subsequent to the last Special Commission of Inquiry where there were recommendations made around the establishment of a new quaternary hospital and a new basis on which children's services should be sort of centralised and coordinated across the state.

Ron Phillips, who was a previous Minister for Health, was commissioned to actually undertake a review and provide advice to the department/ministry around what was the appropriate course of action, and there were a range of options considered around how that would be supported, one of which was to have the Sydney Children's Hospitals Network take the leadership role for the state from a network perspective. But ultimately there was a decision

made to establish an authority within the ministry or a separate pillar, actually, with its own board which would have the responsibility called New South Wales Kids and Families. So that was actually set up but subsequently disbanded in 2015.

The Children's Hospitals Network, which was established during that time or just before that time actually, had been set up with the view that it should look to how the services that were provided at each of the hospitals in Sydney could be better coordinated and managed and look at that linking of them to more effectively provide services for not just metropolitan Sydney but the state, and during --

Q. As opposed to Commissioner Garling's recommendation of a single hospital --
A. Yes. So I think it was done in recognition of that need to bring services together, whether that was physically or through an organisational arrangement. So the decision was made to create the network. There was certainly a lot of unrest and disquiet around a particular service: cardiothoracic surgery.

Q. What was the unrest and disquiet?
A. It was around the fact that the service had historically been provided at both sites and, internationally, there was a trend towards consolidating these services because of issues around volume and outcome and the need to have a skilled workforce to provide the service and a certain number of patients to be actually cared for to enable the skills to be maintained.

Q. And is that a trend that exists not just in that particular field but across specialist medicine generally?
A. It happens in other areas as well. It's a trend that's actually, yes, occurring everywhere. The fact, you know, two hospitals trying to provide 24 hours, seven days a week cover, 365 days a year, meant that there would be needing to be a minimum of three, probably, surgeons on each site to cover an after-hours roster. There wasn't enough work to enable all of those surgeons to be maintaining all of their skills.

So there's a need to think about how the service was delivered differently, but that created a lot of concern which played out publicly. And there was actually

criticism of the network in that process, that the network wasn't resolving this, the network hadn't delivered any benefits. And so the secretary and I think through the board chair of the network commissioned this review to assess was the networking of the services still the right way to go in terms of governing them.

Q. In addition to the disquiet that you've described about that particular service, were there also challenges in bringing the two hospitals together given that they had existed separately perhaps with their own cultures and approaches and philosophies?
A. Absolutely. So they were very - and they are amazing services at both ends, and with really passionate people with huge skills, and they're very dedicated to their sites. This is not uncommon in health. People really are passionate about what they do and where they work. And bringing people together to be part of something bigger and different without having a sense of losing things is a challenge.

And so I think, you know, the history was that they were very strong, both of those hospitals, in terms of their internal culture and in some ways you could argue were in competition with each other. And so to come together as one network and to work as one service was incredibly challenging to deliver.

Q. Aside from those two issues, were there any others that prompted the commissioning of the Alexander review as far as you're aware?
A. I think they were the major drivers for it, as I understand it. The other issue of course would be that as with all - and we've heard about it today - there would not be one service across the state that I'm aware of that wouldn't argue that they should do better if they had more resources. So there would have been I think a sense coming out of the network and the hospitals that perhaps the resources had not been provided to enable it to be successful. So I think that will be another driver that would have been behind the review.

Q. I think in an earlier answer you said once the review had been completed you had some role in considering it, did you?
A. I was the deputy secretary who had responsibility for child and family health. So it was concluded and had a

series of recommendations which probably went beyond the initial envisaged scope of the review because --

Q. We might just go to the recommendations on that topic. They start at page 20. Just refresh yourself on them generally and then go to the scope of the review. I'll ask the operator to scroll down slowly.
A. Mmm'hmm. So it's when we come to the recommendations that start talking about the statewide reform program and the need for that more expansive --

Q. That's where you --
A. Yes.

Q. All right. If we go to the terms of reference of the review, which are on page 27.
A. Mmm'hmm.

Q. So there there's the subheading "Advice sought":

The advice for the Panel is sought to identify the most effective governance of [the network] to maximise the benefit --
A. Yep.

Q. Then it goes on.

... including advancing local service accessibility and excellence as well as improving the integration of paediatric services across levels of care and across the State.
A. Yep.

Q. So in what sense do you perceive that the recommendations made in the Alexander review went beyond the scope?
A. In that they were not referencing the role of the network in relation to those things; it was more a general statement about what the state should provide in terms of the overall care of children. So I think the intent of that advice sought was initially around how the network should have a role in supporting that rather than those broader recommendations around --

Q. Go back to the recommendations and I want to ask you about a couple of them. Back to recommendation 1. Before

I do that, so once the report was received what was your role in considering the recommendations and then moving forward?
A. I was not actively involved in the decision. I think that was more a discussion between the secretary at the time, and the minister certainly had been appraised of the review. And I've seen correspondence that went back to the acting board chair of the network at the time providing the report and indicating that at that stage there was not a desire to progress the recommendations that were beyond the network.

So the specific recommendations that related to the network, the executive management and the board and the governance of the network, were handed to the board for consideration. But there was a decision made not to progress the other recommendations. And my understanding was that that was because at the time this whole issue of the need for a statewide planning process and review of paediatric services generally had come to the fore, and it was being envisaged that there would be a review commissioned to look at those things, and that's where Professor Henry was subsequently appointed to undertake that review. It was almost within a few months of this report being received that that one was initiated.

Q. Well, from a timeline perspective when do you recall that the Alexander review was first commenced?
A. I thought it was in late 2018/early 2019, that sort of timeframe.

Q. And the report itself was delivered in June 2019.
A. Correct.

Q. Is it the case that in February 2019 then Minister Hazzard announced the Henry review?
A. There was - I don't know that he announced the Henry review. He announced that if the government won the election there would be a review of services. He didn't indicate who would undertake it.

Q. I see. And are you aware of the catalyst for that announcement?
A. My recollection is that it was because there was a lot of consultation going on around the cardiothoracic surgery issue, including having roundtables with lots of clinicians and people involved and stakeholders involved in delivering

child health care and paediatric care, and there was certainly a view expressed that there needed to be an overall review of what was happening across the state. So I think that was the genesis for the committee to a broader review.

Q. Who had expressed the review that there needed to be an overall review of what was happening across the state?
A. I think the roundtables; it was coming from the clinicians involved in providing care that there was needing to be further review undertaken.

Q. Was that a recommendation that came from your directorate?
A. No, it wasn't something that we initiated. It came I think from that feedback that was coming from clinicians involved in the roundtables.

Q. Were you consulted about the announcement made by Minister Hazzard in February 2019?
A. I was aware that that was being committed to.

Q. You were told; is that right?
A. I was aware that that was being committed to.

Q. Do I take it that you weren't asked before the decision was made?
A. I don't recall being involved in a conversation about whether or not there was - what my opinion was about the need for it.

Q. All right. And is it the case then that the announcement having been made in February 2019 work - I withdraw that. Once the announcement had been made, did you have any involvement in what became the Henry review thereafter?
A. Yes. I mean, I was involved in developing the scope and terms of reference for that review; was involved in appointing Professor Henry to undertake the review; was involved in regular meetings with Professor Henry as he undertook the review; was involved in establishing a reference group to support him in that work. So all of that was my direct responsibility.

Q. And do you recall whether the scope for the Henry review was developed after the Alexander report had been delivered?

A. It was around the same time, and we certainly were aware of the recommendations in the Alexander review which were broader in nature, and it was considered that those should absolutely be part of what Professor Henry's review should consider.

Q. In an earlier answer you gave some evidence that, once the Alexander report was delivered, a decision was made that to the extent that those recommendations extended beyond governance within the children's network they were to be parked, for want of a better term, pending the subsequent review; have I understood you correctly?
A. That's my assessment of things, because the timing was so close. It was almost within a matter of months that the other review commenced. And there was a sense that the Henry review would be a broader consultation than that had occurred with the Alexander review, which had been relatively narrow by comparison.

Q. Who made the decision not to action the recommendations made in the Alexander review that it extended to statewide issues?
A. It certainly was not at my level that decision was made. So I don't know whether it was at the secretary or minister level, but it was some point above where I was operating that the decision was made not to progress them.

Q. After the Alexander report was received was there any formal response to it by the ministry?
A. The only documentation I've seen is the letter that went back to the acting board chair of the Sydney Children's Hospitals Network. I haven't seen any other formal documentation, and we've reviewed the correspondence at the time and can't find any evidence of there being any formal documentation around the response other than to the network.

Q. In hindsight, this review having been commissioned by the ministry, do you consider that there should have been a formal response to it by the ministry?
A. I think that's a matter for the people who commissioned the review as to what they do with the review. It's a review commissioned by them for their use. So I'm not really in a position to answer whether there should or shouldn't have been. It was certainly --

Q. Well, let's take it outside of this scenario. Would

you accept that where a review is commissioned by the ministry with public funds it is appropriate that, once that review is received, some formal response to it indicating whether the recommendations are accepted or rejected and why should be given?
A. I would put it this way, that I think the recommendations that related to the governance of the network, which was the critical issue, were certainly acted on and the people who were responsible for that were asked to provide feedback and be involved in making the changes.

The broader recommendations, my sense is that there was a view that there needed to be further testing of those recommendations for the broader constituency. Now, the question is whether you go out and say you're responding to those by not responding and having this further review undertaken. The timing of things is the issue there. I don't know that the timing meant that that really occurred in the way that was enabling that formal response to be given. The commitment to a further review was made in February. So it was anticipated this further review was likely to be undertaken. So I'm not sure as to whether or not a formal response was required and to whom it would have been given.

Q. It might have been given to those who were consulted in the Alexander review or the authors of the report perhaps?
A. And I don't know the answer to whether or not they were provided with any of that. There's no formal evidence of it, though, that I've seen.

THE COMMISSIONER: Q. Frequently with government reviews, royal commissions, those sorts of things there's usually a government response to them indicating what's accepted, what's not, what's going to be done to implement what's accepted, that sort of thing. That wasn't something that happened with the Alexander review that you're aware of?
A. No, and I would say that in terms of it being a review it was not so much a public review for the consumption of the broader community but more to provide advice to the secretary around whether the governance arrangements that existed were still appropriate. And so I don't think it's unreasonable that it wasn't more broadly communicated, the response, to the recommendations that were in it.

MR GLOVER: Q. I take you back to the recommendations, which are still on the screen. I just want to ask your view about them from your experience. Recommendation 1:

> *To maintain the networked approach to governance of paediatric services across the two hospitals.*

What I want to ask you about is the next passage:

> *... within a clearly articulated strategy for paediatrics in New South Wales which provides direction for the range of paediatric providers in the State.*

Do you see that?
A. Yes.

Q. You would have heard some of the evidence about those matters today. Is that a proposition that you would agree with?
A. I would, yes.

Q. Why is it important, in your view?
A. Well, it's really important to understand how the relationship occurs between the services that are providing care to children, whether that's within a district, across districts or across the state. I would say to you that there was a lot of documentation to support that, because we've already noted there were role delineation documents that exist which define levels of care. We know that local health districts have a primary responsibility to provide paediatric care and child health as a core responsibility of their roles as local health districts. They do clinical service planning. They define how those services are provided across their sites that they're responsible for.

There was a lot of work done to support how that's delivered. The development of the paediatric capability framework was one such effort to actually assist the districts to assess how they should provide that care and what appropriate support should be in place to deliver that safely and effectively. There were guidelines about inter-hospital transfer to make sure that the care was safe and escalated appropriately. These things were part of a statewide strategy.

I think the issue here is specifically around the role of the Sydney Children's Hospitals Network in the context of that statewide strategy. That's the thing which I think people are pointing to as being required.

Q. And further than that, though, isn't it, the identification about how all those parts work together across the state?
A. Well, you could argue that within a local health district and across many local health districts they do work. They don't always work easily, but they work.

Q. I wasn't intending to suggest they don't work but rather that there's a need, isn't there, for a overarching statewide operational and delivery plan for the delivery of paediatric care which includes things like clear role delineation, how the various services across the state will operate together in a cohesive way to deliver the care that's required?
A. So I think, you know, if we go back to the fact that role delineation defines that, being always in place, the districts were clear of what the role delineation of all the services were across the state. There's a statewide compendium of all of the services and the level that they are provided at. There is documentation --

Q. There's more to that than just saying, "Well, that service can be provided safely in a particular hospital," isn't there?
A. So that's what the paediatric capability framework was about as well. I think the question here is - and there was the development of paediatric networks which were established in the year 2000 with an aim to start to create the links between the three children's hospitals, the two in Sydney and John Hunter Children's Hospital, and the area health services at the time that referred patients to them to create those connections to support that care being delivered.

So it's not that these things didn't exist. I think it's a fact that, you know, they did exist. It's a need to strengthen them up and make sure people are also - as things changed that the evolution of those changes, people are aware of those and that they're refined and further developed as time goes on.

Q. And, consistent with some earlier answers, you

perceive that need to have been heightened in recent years with developments in how care is provided, including increased subspecialisation?
A. I think that's the critical driver. The subspecialisation is certainly a major factor driving the need for that to be redefined, as we've heard in evidence this morning. The other thing I would say is that the establishment of the paediatric inpatient unit at Campbelltown I think is another driver for us to start to redefine that for the purposes of understanding its role in relation to the Sydney Children's Hospitals Network.

Q. Why do you say that?
A. Because the relationship is going to be key and the relationship between the services, and there may need to be cross-appointments and agreements about what level of care is provided at different sites. That might need to be reassessed with the establishment of a 100-bed inpatient unit at Campbelltown. And I think it's important as those service changes occur that we revisit how things are delivered to ensure that we've got the right care being delivered in the right place and that people understand how those relationships will work and that there's some documentation to support that.

Q. So some planning and analysis of how that facility links in with the existing children's hospital --
A. Correct.

Q. -- facility both in Sydney and in Newcastle?
A. Correct. And how it will relate to the services that exist in the districts, because they may start to refer into that hospital rather than to one of the other hospitals.

Q. I take it from the answers that you've just given that you don't disagree with the proposition that there is benefit in developing a strategic and operational plan for the delivery of paediatric care across New South Wales that covers quaternary and tertiary hospital care as well as local paediatric care within the LHDs?
A. I think the local paediatric care within the LHDs is well covered by the LHDs. I mean, I think we've got to be really clear about what we want this plan to deliver for us. We have a lot of plans in New South Wales Health and --

Q. Understatement of the century.
A. -- a planning process doesn't necessarily deliver the outcomes that people are looking for. They'll point to a planning process as a solution. I think there's a need to define up the relationship between those tertiary and quaternary services and what is provided at the local health districts. And I think we heard in evidence from the Sydney Children's Hospitals Network earlier in the week that they are establishing agreements between themselves and the districts about how those things will actually work in practice. That's good practice and I commend them for having done that. It is one of those things that provides that clarity and establishes quite clearly the relationship between the various services and how the services on the ground will operate.

The issue in the statewide planning process is trying to do that on a state when issues in each of the districts are different and the level of capability of the service will be different. And it will change over time often due to changes in workforce availability. So a paediatrician or two might leave a certain district, and then they struggle to provide the level of service that they previously used to. And we know that, increasingly, it's difficult to attract general paediatricians and it's more challenging to attract paediatricians into rural and regional environments. So it's a dynamic state of affairs that a planning process of itself will not resolve.

So I think we do need definition. We do need clarity. We need to delineate those things and agree on how they are going to operate at this point in time. And we need to have an ongoing process for assessment and review that they're actually operating effectively.

Q. If we scroll down to the next page, Operator, I want you to have a look at recommendations 4 and 5. Just let me know when you've read them.
A. Yep.

Q. They're the sort of principles and concepts that could be included in a statewide plan for the delivery of paediatric care across the state, aren't they, without unduly limiting the ability of the LHDs to deliver the care that is needed in their regions?
A. There's elements of what's in there which you would certainly incorporate into a process to establish the

definition around things I've just talked about. Whether or not that needs to be a broad statewide plan - the risk is it will be so high level that it actually won't deliver the solutions to the issues that people have been raising. No-one will disagree about having principles that underpin things. But actually how that translates into the care of a patient when someone's got someone in front of them that they need to access, you know, a higher level of specialist advice or referral, the principles won't necessarily fix that.

Q. Is the starting point then determining how paediatric - I'll withdraw that. Is the starting point then identifying the vision for paediatric care across New South Wales, where it is to be delivered and how it is to be delivered, and go from there?
A. I have a vision for that which is that we should be --

Q. I'm not suggesting you don't, but is that the starting point?
A. Well, it is already a given that where we want to provide care is firstly in a primary care setting, secondary care - specialist as close as possible to the home so that families, you know, are provided the best possible care as close as possible to where they live. Those things are enshrined in everything we do. I think we've got to be really clear that some of these things in here, yes, you would argue you could put into a process at the state level that will assist us in defining what we do, and others of them won't necessarily make any difference.

Q. Won't make any difference because they are high-level concepts; is that what you mean?
A. That's right. And I think we have plans that have a lot of these principles and high-level concepts. It's the translation of the plan into what it means for clinical care and service delivery that is the critical issue. And my view would be that, you know, having established better governance across the state, the Children Young People and Families Executive Steering Committee will be starting to look at these issues and think about how they could be applied in practice.

Q. You express some caution in the development and utility of a statewide plan. What is the source of that caution? What is the risk that you are guarding against?
A. Well, it consumes a lot of people's time. It's

another process which will take significant effort and resource to complete. And the benefit - I mean, I've been involved in a lot of planning processes over the years. They of themselves don't necessarily lead to a better outcome around the issues that people are expressing a concern at the moment. I think it can be of some support, but not necessarily the only answer to the issues that are before us.

Q. You've followed the evidence on these issues over the week and today, you've been here; correct?
A. Yes.

Q. You've heard some of the challenges in the delivery of paediatric care being described by witnesses; correct?
A. I have.

Q. Are there other mechanisms, other than the statewide plan that has been suggested by a number of witnesses, that you would see as being capable of being deployed to meet those challenges?
A. I would use the example of the Northern Child Health Network as an example of what could be done, which is where the relationships between the children's hospital concerned and the referring districts and the support for agreement around how the care is delivered across those services, what the access points are, what the referral pathways are being documented and clearer, who is available to provide advice to the clinicians on the ground when that advice is required, having those agreements documented and clear as a part of the networking arrangements could actually address some of or many of the issues that have been raised today. A statewide plan may also do that subsequently, but it of itself won't necessarily deliver it.

THE COMMISSIONER: Q. Do I get the impression that - I think one of the things you said about the statewide plan is they can be so high level that their practical utility might be a question mark. But your preference is and you alluded to the heads of agreement that have been agreed between the network and particular LHDs being perhaps a better way because they're more bespoke to the needs of that LHD which might, for example, be a regional LHD; would that be right?
A. That's correct. That's what I'm alluding to, Commissioner. And I think those were negotiated directly between the parties. So the clarity around those is

contemporaneous and relevant to the circumstances.

Q. And the benefit of that sort of heads of agreement and then developing more detailed agreements is that those agreements talk to the population needs of that LHD, what's already available as services, what might be desirable to develop?
A. Correct.

Q. All those sorts of more detailed nitty-gritty type plans?
A. Absolutely. As we've heard this morning from Professor Preddy, how can the general paediatric unit in that district be supported by the subspecialties to have care transferred for there to be ongoing involvement of the care of those children who need enduring and ongoing care with chronic conditions. Those --

Q. Noting the size of what the Wagga base serves, the health needs of the children there et cetera that might be slightly different to another LHD?
A. That's correct.

Q. Yes.
A. That's correct.

MR GLOVER: Q. Can I just explore that with you a little. Professor Preddy gave some examples this morning of challenges he faces in providing care in Wagga and referrals in and out of the children's hospitals. Do I take it from the answers that you've just given that you see those challenges being met by bespoke arrangements between the LHD and the network?
A. They need to be tailored to the local circumstances because what is available in the environment that Professor Preddy works at won't be available necessarily in the environment that somebody in Tamworth or Lismore has in place. So it does need to be in some respects bespoke to the circumstances.

And I think the relationships - we heard about relationships today. We should never underestimate the criticality of the relationships. In my experience of establishing networks and having effective networking relationships both the referring party and the person who receives the referral need to have trust and confidence and an ongoing and enduring relationship about how they provide

care for their patients. That's why referrals often occur to individuals that have a relationship already.

When you're trying to organise that at the system level you've got to create the enablers around that that enable that to occur no matter who's in the role. And, in part, that needs to be done by the services accepting that they have a responsibility to that. They need to be aware of what's available. They need to know who is there and is capable of delivering care. So on both ends there needs to be a knowledge and an awareness and a commitment that, "If we're going to make this work, we are in it together."

Q. All the networks that are referred to in documents and all the committees and all the policies, what currently exists to provide that structure for people like Professor Preddy and his colleagues?
A. Well, I think as I said, you know, the whole concept of the paediatric networks which were established 24 years ago was to establish that process. It's occurred well in one part of the state. We need to replicate that in the other parts where it doesn't currently exist. It's at a variable level. And, if it's working well in one part of the state, what is the reason why it's working well in that part of the state that we need then to transfer to the other parts where it's not working.

Q. And I appreciate you're no longer a member of the Children Young People and Families Executive Steering Committee, but is to your understanding part of the work in that area the development of the single network that Dr Craven told us about earlier today?
A. I think that will assist, but it needs to go beyond just having a network overarching. It needs to get into the agreements that need to be in place to support that occurring and how those relationships and referral pathways will be maintained and sustained; how they'll be monitored and managed in an ongoing way; and, where there are issues where things aren't working well, how and where they'll be escalated to for resolution.

Q. Can I perhaps try and summarise what I think is the substance of your answers, that you accept that there's a scope for structures and the identification of support mechanisms to be done at a system level, but the individual arrangements should be able to be dealt with at a district level to meet the particular need and service availability

in that area?
A. You've said it much better than I did.

THE COMMISSIONER: Q. For the issue that Professor Preddy raised concerning a better route to assistance, a bespoke agreement between the Sydney Children's Hospitals Network and the paediatric department of Murrumbidgee would be far more useful to him than an overall state plan. There might be some benefit in an overall state plan, but to directly address the needs and the desirability of the change that he's talking about it's that lower level more detailed whether it's a plan or a network structure individually to that LHD would be better?
A. That's my view.

Q. Yes. And also a state plan just won't talk to or is unlikely to talk to - it maybe have some worth, but it also won't talk to the kinds of demographic changes we're seeing in regional and rural New South Wales that might cause needs for different health services, including different health services for children or different workplace problems as people seem to be gravitating to the bigger regional centres and for various reasons leaving the smaller rural towns, which could be driven by a number of things including not least climate change. But, having individual plans that can be constantly updated, those sort of bespoke plans we're talking about would be far more useful; do you agree with that?
A. That's my view, Commissioner.

MR GLOVER: Q. Supported perhaps by some guidance from the system as to the development of those plans?
A. Yes.

Q. The identification of roles and responsibilities in delivering those plans?
A. Yes.

Q. Such that if one day when Professor Preddy retires his successor can slip into that role seamlessly?
A. Correct.

MR GLOVER: No further questions.

THE COMMISSIONER: Q. Can I just ask your opinion on one thing, and it is just a curiosity. Please don't think I'm about to recommend that there should be a new single

children's hospital costing $5 billion in New South Wales. But when you were talking about - I'll take it this way.

We all know Justice Garling, Commissioner Garling at the time, recommended the one hospital. But I think in the Henry review there's a discussion about there's not much political will for that and, secondly, "We've spent all this money on infrastructure at two sites, and so it just might not be feasible to unpick." But you talked about the trend towards subspecialisation and also with highly specialised services, and I think you mentioned - the example you gave was cardiothoracic and the need for volume and constant use of skills to get the best health outcomes.

If in an impossible situation we were starting again and planning again - and I've read papers, and I can't remember which one it is but it talks about cities and populations up to 10 million it's better to have the one quaternary children's hospital for the reasons I've just discussed and you gave in your evidence. If you're starting again, in your opinion would it be better just to have the one big children's hospital in Sydney serving the metropolitan area for those sort of highly specialised treatments?
A. It would be I think advantageous to have the one tertiary quaternary hospital.

Q. Yes.
A. Not providing secondary care. I think the --

Q. No, I didn't mean that.
A. Absolutely. And I think then you would look at what the other hospitals did in relation to secondary care. The issue for Westmead in particular, I think, that occurred once it opened was that people voted with their feet. They thought they were getting better quality care if they took their children to Westmead Children's Hospital. So they bypassed all the local hospitals. So the work that was previously done in a lot of the paediatric units around that reduced. And that has not been a good thing either for The Children's Hospital or for the surrounding services.

So I think having a clearer understanding of what the role of that service would be, how it's accessed and ensuring that the secondary and tertiary care that could be provided locally was done and that it actually had a very

clear role. The challenge for the Children's Hospitals Network at the moment is it's doing a whole lot of secondary care as well, and that's putting pressure on its services.

THE COMMISSIONER: Thank you. Mr Chiu?

MR CHIU: Commissioner, I have no questions. On Tuesday you asked me about some matters arising from the Alexander review and the Henry review.

THE COMMISSIONER: Some of it's been clarified. I asked a question about - and feel free to explore it if you want to. What I said was, from my reading of the Henry review in relation to the governance issue, I thought - still think - that there's been a misinterpretation of what Dr Alexander and her colleagues recommended regarding an expansion of governance of the Sydney Children's Hospitals Network. That's my view. If there's any more clarity - we don't need to explore that if there's --

MR CHIU: I don't think there's anything I can get out of Dr Lyons that would assist on that. I also don't --

THE COMMISSIONER: I'm happy to hear from Dr Lyons if I've misread or I don't understand. But, if it is what it is, it just is what it is and we don't need to go into --

MR CHIU: That will ultimately be our position. It is what it is and we can't explain it without --

THE COMMISSIONER: Yes. I don't think there's any need to explore it with Dr Lyons.

MR CHIU: Yes.

MR GLOVER: Q. There's just one question arising not from that but the last answer Dr Lyons gave, the issue of children's hospital - whether it should be limited to quaternary care or secondary care and the example you gave of people attending at Westmead because they felt like they were getting better care for their child. Could that risk be alleviate if specialist quaternary children's hospitals did not have the emergency department at which people could present?
A. If the quaternary service that was established as a standalone didn't have an emergency department, it could

be. However, I don't think that's an option in our current environment.

Q. Why?
A. Because the Westmead service has been built around having the emergency department services as well as all of the other components, and I don't think we could change that now.

Q. Is it also because there's --

THE COMMISSIONER: Q. When you say you don't think we could change it, is that we could change it but there might be some political problems --
A. I think it might be a step too far, Commissioner.

MR GLOVER: That follows up the last question I have, Commissioner

THE COMMISSIONER: Okay. Anything come out of that?

MR CHIU: No, Commissioner.

THE COMMISSIONER: Thank you very much again for your time, Dr Lyons. We're very grateful. You're excused.

THE WITNESS: Thank you, Commissioner.

<THE WITNESS WITHDREW

MR GLOVER: Commissioner, we're just finalising some tender bundles and some non-publication orders relating to some --

THE COMMISSIONER: The ones the other day disappeared.

MR GLOVER: There are. But there are some issues with some particular documents which we're working through. We propose to deal with that in chambers, if convenient.

THE COMMISSIONER: Yes.

MR GLOVER: Otherwise that completes the evidence for this hearing block.

THE COMMISSIONER: Dealing in chambers I take it means that everyone is in agreement as to what should happen?

MR GLOVER: I think we are, but I just want to be clear about it because I haven't had myself the opportunity to review it.

THE COMMISSIONER: Okay. Is that it then?

MR GLOVER: That's it for this hearing block.

THE COMMISSIONER: I have no idea when we're adjourning to. When are we adjourning to?

MR GLOVER: Someone will tell me.

THE COMMISSIONER: To a date to be confirmed?

MR GLOVER: Yes. Sine die. To a date to be confirmed, Commissioner.

THE COMMISSIONER: I've actually got 24 June.

MR GLOVER: Yes. Thank you.

THE COMMISSIONER: We'll adjourn, unless corrected, to 10 am on 24 June.

MR GLOVER: Thank you, Commissioner.

THE COMMISSIONER: Sorry, just before we adjourn, do I need to say anything about the one extra witness that we haven't called? That can just be --

MR GLOVER: I think that can be managed in the next round.

THE COMMISSIONER: All right. We'll adjourn.

AT 1.06PM THE SPECIAL COMMISSION OF INQUIRY WAS ADJOURNED TO MONDAY, 24 JUNE 2024 AT 10AM

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