Review of Governance for the Sydney Children's Hospitals Network

Final Report of the Expert Panel

Dr Kathy Alexander (Chair), Dr Peter Steer and Ms Sue Peter

Commissioned by NSW Ministry for Health

June 2019

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1. INTRODUCTION

The Ministry of Health, in conjunction with the Sydney Children's Hospital Network (SCHN) Board, convened an Expert Review Panel (the Panel) to review the current governance of the SCHN, including The Children's Hospital at Westmead (CHW) and Sydney Children's Hospital, Randwick (SCH). The Panel, Dr Kathy Alexander (Chair), Dr Peter Steer and Ms Sue Peter was asked to report its observations and recommendations to the Secretary of Health.

The Panel is extremely impressed by the dedication of the staff and stakeholders evidenced by their passionate engagement in this complex review and thanks them for their participation.

2. EXECUTIVE SUMMARY

The Ministry of Health, in conjunction with the SCHN Board, commissioned the Panel to review the current governance of the SCHN, in the context of significant changes in the organisation's operating environment which create both challenges and opportunities. Advice sought did not include commentary on specific concerns relating to cardiac services, the arrangements for which are being determined through a separate process.

The method for the review consisted of extensive consultation with internal and external stakeholders, review of documents from the SCHN and the Ministry of Health relating to the establishment, planning and/or performance reporting of SCHN and paediatric health in NSW, review of relevant international studies, review of recent literature on organizational mergers in health care, review of the Greater Sydney Commission's Three Cities Model for planning the greater Sydney metropolitan area and review of the National context and relevant benchmarks for paediatric care.

The Panel's central consideration in reviewing the governance of the SCHN is that the care required for children and young people is still a small specialty and focus in the context of the whole healthcare system in Australia, which struggles to address the needs of a larger aging population. It is therefore important to ensure that any changes to the governance arrangement do not inadvertently dilute the health care focus on children but, rather, broaden and strengthen the recognition of its importance and facilitate access to and excellence of care for children in NSW. All of the original intentions for the creation of the SCHN in 2010 are still relevant in 2019. This was confirmed by a review undertaken by the Ministry of Health itself in February 2019.

The Panel observed that, whilst there have been important advances made through the SCHN, the potential of the network governance arrangement is unfulfilled. There remains an opportunity to strengthen governance and support for paediatrics across NSW, more broadly, to improve quality and access to the right care in the right place at the right time. The Panel considers that a clearly articulated strategy at the State level, which informs operational plans at service levels, is required to address barriers to the integration of care, to ensure the highest quality of care and to provide certainty for service providers and clinicians across the whole system of care in NSW. The network of paediatric services is much broader than SCHN and without a State-wide approach, Local Health Districts (LHDs) and other important elements of this broader network of care will not get what they need from the SCHN.

The Panel observes that improvements are required to SCHN Board governance practices including a stronger focus on the development of consumer and community engagement in health service planning and development. This always assists in the development of a consumer oriented organisational culture.

The change management process and resourcing applied to the creation of the SCHN appears to have been insufficient for the complexity of the new organisation and, apparently, not monitored effectively by the Board over time. The resulting organisational structures and processes contribute to the tensions and concerns currently being experienced at SCHN. The organisation must be structured to support its core role and function to provide and support the treatment and care of children both across NSW and within its own regions and precincts. The structure must facilitate its agility and capability to support the NSW paediatric workforce in treatment and education and reflect the importance of a multi-disciplinary approach to care now and into the future. It must also more appropriately support the non-hospital services which currently struggle to get the management attention they need. The Panel considers that the existing management arrangements do not reflect the approach required by an agile, multi-disciplinary and consumer oriented organisation in this day and age and there is insufficient management support at the service delivery level. There is also insufficient formal engagement with LHDs and other organisations providing care to children.

There is now very strong evidence about health care trends to suggest that consolidation of hospital services into larger units with sufficient critical mass to ensure excellence and high quality care in a cost effective way will continue around the world. This is especially the case in highly specialised areas of care. The Greater Sydney Commission's report of October 2018 offers very clear direction for accommodating the growth of Sydney over the next 30-40 years as the population increases and the city expands to the west with a centre in Paramatta. There is a need to plan for the development of services for children across NSW to ensure that primary, secondary level and more commonly required tertiary level care can be provided as close as possible to the community in which the child lives, whilst consolidating the highly specialised levels of care in such a way that is accessible to the whole state. This will require new models and supports for training of the workforce to reduce duplication and improve quality outcomes. This is well understood by the Universities.

Financial issues appear to be contributing to and compounding the SCHN current problems. Although the management and Board have been diligent at meeting budget requirements of

the Ministry, many staff and managers are concerned that this may not be the best outcome for care and the management support required. Children's Hospitals Australasia benchmarking data shows significant differences between the Australian States in the level of funding for paediatric care, with SCHN being 14% lower in in cost than its nearest counterpart interstate. It will be important to investigate the adequacy of the NSW funding model to adequately address the particular costs of care required for children. A significant risk to be addressed as a matter of urgency is the need to adequately fund the change management and other activities associated with the capital development programs planned for both the Westmead and Randwick sites.

In relation to the future governance of the SCHN, the Panel concludes, firstly, that the SCHN is not a "network" but a service comprising essentially 2 tertiary level hospitals and a number of smaller non-hospital services which struggle to get the management and funding attention they need. Whilst there has been no attempt to create a single hospital, the management and decision making structures are, in fact, more relevant to that required by a single hospital than to separate organisations, each retaining their own brands and treatment and care relationships in different locations. Unless there is clarity about which services should be single services for the State and where they should be, this situation is bound to create uncertainty for leadership and staff in relation to their roles and responsibilities.

There is, therefore, a key requirement in the governance of paediatric care in NSW for the establishment of an overarching strategy, engaging and acknowledging the range of service providers in the broader "network" providing paediatric care to NSW, including John Hunter LHD and relevant LHDs as well as the existing separate services within the current SCHN. It is not appropriate for State-wide decisions to be made at a "service" level such as the Board of the SCHN. District relationships and service planning arrangements are appropriately governed at a Board and Executive level but these must be consistent with the State plan for paediatrics.

The Panel's detailed recommendations are outlined in Section 7.

3. TERMS OF REFERENCE

The Terms of Reference of the Governance Review (**Appendix 1)** state that, while the SCHN has achieved some significant developments in providing health care for the children of NSW and in child health research and education, the operating environment has changed considerably since it was established, creating both challenges and opportunities. These include;

- Significant health capital investment on both the Randwick and Westmead campuses
- Significant university commitment to research and education at both Westmead and Randwick
- Designation of the Randwick and Westmead sites as part of advanced health research translation centres

- Investment commitment by NSW Health to the development of paediatric services in Campbelltown
- The designation by the Greater Sydney Commission of health and education precincts and the three cities approach to planning for the growth of metropolitan Sydney.

The advice of the Panel was sought to identify the most effective governance of SCHN to maximise the benefit of these developments and build on future benefits going ahead, including local service accessibility and excellence as well as improving the integration of paediatric services across levels of care and across the State.

Advice was not sought in relation to specific concerns relating to cardiac services since the arrangements for the delivery of cardiac services across both the CHW and the SCH are being determined through a separate process. The focus of the Governance Review is on the broader governance arrangements which determine how all services, including those for rare and complex conditions requiring highly specialised care, should be planned, developed and monitored.

4. METHOD FOR THE REVIEW

1. Consultation with internal and external stakeholders

The Review Panel was assisted by a Process Clinical Consultative Group (PCCG), which provided advice on how to ensure comprehensive participation in the Review. (See **Appendix 2** Proposed Clinical Consultative Group Process and membership of the PCCG) On the basis of the PCCG advice and from management and the Ministry in relation to other key stakeholders of the SCHN, invitations were sent to 496 people to attend individual or group meetings/workshops.

The PCCG also identified the need to structure the interview/meeting questions to ensure that people understood that the focus of the Review was on the governance as it affected the provision of health care service. The following questions were considered appropriate to encourage the required focus;

- What are the most important benefits and/or achievements made possible by the existing governance structure of SCHN which should not be lost going forward?
- What are the most important obstacles to delivering excellent care that are presented by the existing governance structure of SCHN which must be overcome going forward?
- What are your views on how best to maintain the benefits and address the obstacles going forward?

The final consultation process included face to face or telephone structured interviews with internal and external stakeholders, structured group meetings for internal and external stakeholders to enable the broadest possible participation in line with the agreed framework for participation in the available time (See **Appendix 3** Resulting framework for participation as advised by the Process Clinical Consultative Group and Panel), and an invitation to all staff to provide written submissions.

The views expressed through the meetings were noted by the Panel and the data collated. Views expressed in the submissions were also collated and consistent themes from both the submissions and the interviews were reported in a paper titled "What we heard from consultation with internal and external stakeholders for the Governance Review of the SCHN." (**See Appendix 4** What We Heard)

The PCCG was presented with the paper for discussion as to whether the themes were a comprehensive list of issues to form part of the considerations of the Panel in making recommendations about the way forward and some relatively minor edits were made in line with their suggestions to better express the issues.

2 Other elements of the method were;

- Review of documents from the SCHN and the Ministry of Health relating to the establishment, planning and/or performance reporting of SCHN and paediatric health in NSW
- Review of relevant international studies quality of care and best practice models
- Review of recent literature in relation to organizational mergers in health care
- Review of the Greater Sydney Commission Three Cities Model for planning the greater Sydney metropolitan area
- Review of the National context and relevant benchmarks for paediatric care
- Formation of conclusions and recommendations

5. PANEL OBSERVATIONS AND CONSIDERATIONS

1. The potential of existing benefits of the network governance arrangement is as yet unfulfilled.

Before considering any change to the existing governance structure of the SCHN, it is important to reflect that the original intentions underpinning its creation are still relevant today. Care for children and young people is still a small specialty and focus in the context of the whole healthcare system in Australia which struggles to address the demands of an aging population. Therefore, it is important to ensure that any changes to the governance arrangements do not inadvertently dilute the focus but, rather, broaden and strengthen the recognition of its importance and facilitate access to and excellence of care for children in NSW and Australia. A review of relevant literature and

media articles at the time of the creation of the SCHN would indicate that the original intentions of the current governance arrangements were to;

- strengthen the speciality of health care for children and young people and reduce the risk that such a focus could be diluted in LHDs whose decision making relates to the needs of their broader communities and likely to be more oriented to more elderly populations
- standardise best practice care across like services where possible
- create an expert resource and support to all LHDs from a centralised expert paediatric service in NSW
- strengthen paediatric workforce development through collaborative, education and training programs
- reduce unnecessary duplication across the two specialist tertiary children's hospitals in Sydney
- improve cost effectiveness of back of house support services and of costly infrastructure in relatively small hospitals

Despite observing a number of significant problems with the existing governance structure, the Panel has also observed some real achievements, the potential of which is still unfulfilled and is at risk if the disadvantages of the current governance arrangements are not addressed as a matter of urgency. These achievements include;

- **Progress of the Paediatrio collaboration on the research agenda**. The further collaboration of both major university partners should be further encouraged both within the new organisation construct of Paediatrio and with other emerging opportunities through a broader range of paediatric services across NSW.
- **Innovation in streamlining education and training** across both the SCH and CHW to develop a standard approach to skill development and workforce development will enhance quality in a more cost effective way. This could be extended to include other paediatric services across NSW, which both refer and receive transferred patients.
- **The merging of the two fundraising entities of the CHW and the SCH** provides an important opportunity to increase strategic financial investments in critical research projects and innovations in treatment and models of care across the range of services required by a child from hospital to home. There is an opportunity to attract a broader range of donors for children's health through campaigns which recognise the state-wide role of the two major teaching hospitals in supporting its paediatric partners across NSW.
- **The outcomes of advocacy in gaining traction at a policy and funding level** for improvements in child safety and health outcomes demonstrates the power of improved partnerships and collaborations between the tertiary providers and community paediatric and child health services across NSW.
- **Improved quality and patient flow outcomes in a number of service areas** which have collaborated across the SCH and CHW demonstrates the potential to

engage clinicians from a broader range of service providers across NSW to improve the quality and cost effectiveness of care.

2 There is an opportunity to strengthen governance and support for paediatrics more broadly to improve quality and access to the right care in the right place at the right time

The current governance arrangements indicate a recognition of the state-wide "specialty" nature of the roles of the SCH and the CHW in both care and workforce development whilst also being consistent with the NSW government policy to devolve decision making. However, the success of the governance arrangement for a speciality service such as the SCHN is dependent on both the State and the Board of the SCHN agreeing on the processes for making decisions which impact the whole of NSW.

It could be argued that the SCHN is a misnomer. SCHN is, essentially, a State-wide tertiary and quaternary level service provided by two hospitals, depended upon by LHDs and other community health services for expert advice, support for workforce development, referral and retrieval arrangements and models of care which support the best access for the children they care for. There are many more paediatric services in the care network across NSW than those governed by the SCHN Board and Executive.

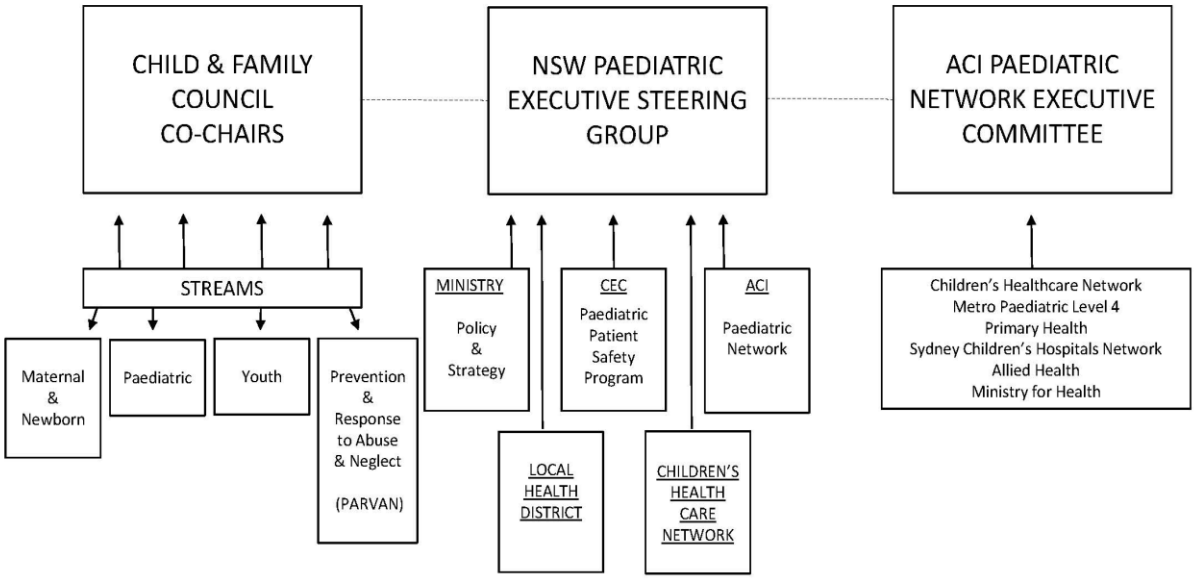
There is a consistent view that the LHD paediatric services could be more strategically engaged in decisions made at the SCHN and vice versa. To provide consistent and coordinated care for children across NSW, this interdependence must be acknowledged and supported within a decision-making framework broader than the SCHN or an LHD. Whilst service developments and arrangements could be proposed by any member of the broader network of paediatric service providers and reform agencies, the strategic decision about what type, level and location of service is to be provided and funded should sit within a broader State policy and strategy for paediatric care which is beyond the governance of the current SCHN. This is especially the case where those services are for rare or high risk interventions requiring a range of sub-speciality supports and developmental funding.

The Panel notes the work done on a NSW Paediatric Capability Framework (NSW Ministry of Health 92017). Whilst a useful guide to LHDs and tertiary hospitals in developing their services, and for the Ministry of Health to review the services across NSW, the Framework does not constitute a strategy nor does it delineate the roles and service requirements of any particular service. It is, however, a useful tool to evaluate service arrangements, as was done in February 2019 when it helped to identify variability in almost all aspects of paediatric care across the system (Paediatric Executive Steering Group (2019)).

A stronger and more accessible focus for paediatrics in the Ministry of Health would assist to provide guidance for paediatric service requirements and roles across NSW. Whilst it is acknowledged that there are some very good initiatives of various paediatric networks and collaborations with the reform agencies of the Ministry of Health relating to the Strategic Plan titled "*Healthy, Safe and Well: Strategic Health Plan for Children,*

Young People and Families, 2014-24," they appear to be developed at a service by service level rather than at a strategic system level. The diagram below outlining the interfaces of a number of roles, committees, networks and agencies in the implementation of "Healthy, Safe and Well: A Strategic Health Plan for Children, Young People and Families," makes clear why there is currently a perception of a lack of strategic alignment across the paediatric system of care.

NSW PAEDIATRIC HEALTHCARE: STATE WIDE COMMITTEE SUPPORT



----Denotes connection between committees through cross membership

Strategic decisions for the development of paediatric care must include consultation and engagement of clinicians from across SCHN and the LHD paediatric services. They should also be made with reference to clear criteria including being consistent with the broader planning requirements of the State such as "*A Metropolis of Three Cities: Greater Sydney Region Plan 2018*" as well as evidence relating to quality and safety. Their implementation must be funded and monitored to hold SCHN and LHDs to account and to ensure traction. This point is particularly relevant in view of the findings of the recent report of the NSW Audit Office in relation to the Governance of Local Health Districts (which did not include a specialty service such as the SCHN). The Report identified that whilst the main roles, responsibilities and relationships between LHDs, their boards and the Ministry of Health are clear and understood, there is some ambiguity for more complex and nuanced functions. It concluded that a statement of principles to support decision making in a devolved system would help to ensure that neither LHDs nor the Ministry "over reach" into areas that are more appropriately the other's responsibility. The report also concluded that, although relationships between system participants are collaborative, there is an opportunity to further embed this in

the system structures and processes and complement existing interpersonal relationships and leadership styles.

3 A clearly articulated strategy and evidence based operational plans are required to address barriers to the integration of care, to ensure the highest quality of care and to provide certainty for service providers and clinicians across the whole system of care in NSW.

Whilst a SCHN clinical service plan (2013 – 2017), outlined a strategic intent to develop more patient focused models of care, it did not clarify the roles of each hospital site nor delineate service roles across sites that would inform strategy for change aimed at improving quality and cost effectiveness of services. As outlined above, the Panel believes that it would be inappropriate for the Board and Executive of the SCHN, as it currently stands, to make isolated decisions about the access and arrangements for highly specialised tertiary and quaternary services for paediatrics across NSW in the absence of a state-wide Strategy and operational plans for NSW. SCHN has a mixture of approaches to service planning and configuration, including single services across CHW and SCH, or dual services - one on each site which are separately managed. The criteria used to determine which configuration is appropriate for any particular service are unclear and therefore service planning appears reactive rather than strategically developmental. Many participants of the consultation process perceive that a consensus, rather than evidence based, approach to decision-making has resulted in less than ideal outcomes. Such decisions have an impact on regional and local services but, being outside the SCHN, their views are not necessarily heard in service planning.

There is a consistent view that the governance arrangements and strategic directions of SCHN do not address the fact that both the SCH and the CHW must exist in their own ecosystems. Infrastructure and service support (such as operating theatres, medication support, diagnostic support, equipment, subspecialty availability and information systems) are different across the two sites. The existing SCHN Strategic Plan: 2017-2022 is broad and requires engagement of clinical service providers to operationalize it into clear action plans and related business plans relevant to local conditions. An important criterion for funding allocations must be alignment with this strategic approach. There is a perception, amongst both internal and external stakeholders of SCHN, that the strategic directions are not broadly understood and are not monitored by the Board. This is despite the Panel's observation that the Board members and Executive staff have a strong understanding and focus on the achievement of the strategic directions. This may indicate a lack of alignment between the governance level and the rest of the organisation and/or a lack of effective communication.

Stakeholders responsible for provision of paediatric services in the Randwick and Westmead precincts, other LHDs and state-wide services have consistent views that, contrary to the original intent underpinning the creation of the SCHN, the services now look inward with a focus on how to provide service across the campuses. They perceive that access to the support they need has reduced and is based on personal relationships rather than strategic intent.

4 Governance at the Board level could be improved

Any board is sometimes required to make difficult decisions to ensure the best for the community within the resources available. Whilst decisions require sound and relevant information from executive staff and effective consultation and engagement with stakeholders to understand all views, the debate of the Board and the decision must remain independent and in the best interests of the children of NSW and the organisation. There appear to be a relatively high number of SCHN Board members who have previous or current relationships and dependencies with either the SCH or the CHW. Whilst it can be argued that the perspectives of these people would be useful to the Board for decision making, their membership on the Board could also result in perceived conflicts of interest. It is possible for a board to be informed about the range of perspectives in relation to any decision they make through formal reports and consultation processes.

The large number of ex-officio members in attendance at Board meetings could restrict debate and influence decision-making. If it is important to receive information from a staff member, it could be provided either through a report or the staff member's attendance for a particular agenda item in a board meeting. It has been observed by some participants of the consultation process that ex-officio members often take part in debate rather than provide information to assist the Board in its independent debate.

The extent of the Board's involvement in risk management is unclear. The issue of cardiac surgery was identified as an emerging risk in 2017 through the Audit and Risk Committee and upgraded to a strategic risk. A review was undertaken in relation to how to configure cardiac services across the SCHN and a decision made by the Board. Despite both clinical and reputational risk associated with the issue, the mitigation strategy was delegated to the CEO, with apparently limited oversight by the Board, until the issue was raised in the media. This raises some questions about the nature of the Board's role in risk management and whether risk management is integrated into operational management throughout the organisation.

5 Consumer and community engagement is fundamental to achieving a consumer oriented culture and requires support at the highest level of governance

The International Association of Public Participation has identified that informed consumer participation is fundamental to effective decision making about public policy and services, especially when powerful professional voices are claiming to be advocates for consumers. Effective consumer participation requires the organisation to develop the capacity of the staff to engage consumers in strategic planning, service planning, service delivery and service evaluation. The organisation must also increase the capacity of the community and consumers to participate in these levels of planning by providing effective and accessible processes, training and support and understandable information to assist them with the complexity of health care. It must also provide

feedback to consumers to show they are listening to and acting upon consumer and community views. This requires a strategic approach and a focus at the highest level of governance and management.

The Board could benefit from the direct participation of the Chair of the Consumer and Family Council. The role of the Consumer and Family Council could be broadened to advise on and oversee the development of a strategy to increase consumer and community participation at all levels of planning. This shifts the focus of the whole organisation to increasing consumer and community power.

6 Effective change management is required to ensure the success of the SCHN in the context of its relationships with the broader network of paediatric service providers

Charles River and Associates (2018) and Deloitte (2017) observed that mergers of health care organisations and services into a single organisation or service can result in improvements in quality, range of services and costs of services but these work best when;

- Strategy is clear and certain and there are explicit financial and non-financial goals
- The change process is planned, managed and resourced well and leadership is held to account for the progress of the change process by tracking targets and milestones from day one of the transaction for a two year period at least
- Clinicians are centrally involved and clinical and functional leadership is aligned early in the process of change
- Culture is considered and addressed and people are held to account for values based behavior
- Decision making is transparent and communicated

Deloitte identified 2 steps to define the operating model. Firstly to develop a strategic rationale to anchor the future operating model by analyzing whether to collapse service lines, reduce duplicative service lines, relocate services, or vertically integrate with other service levels in order to determine what the merger will allow that could not be done if each organization stood alone and, secondly, to identify the factors that may limit future value creation from the merger. The merger's hypothesized value drivers must then be rigorously tested to inform the creation of an action plan which defines outcome metrics to be used to report to the Board during the integration process, the establishment of a project management office charged with integrating and tracking outcomes and milestones and developing a sound understanding of the culture and quality leadership to create a system wide quality approach.

There is evidence from the consultation process undertaken by the Panel to suggest that the change process following the decision to create the SCHN fell short of these requirements. The experience of the Panel in major hospital or individual service level

mergers is that a merger is more likely to succeed when most people can identify that the merged entity offers the potential for the new organization or service to be greater than the sum of its parts and when the process of integration is in line with the observations outlined above. The Panel also notes that, even when a merger is successful, cultural differences and approaches can take a long time and continuous efforts to align. Therefore it is important to continue to review and improve management change efforts for many years to maximize the potential of mergers.

Most people who participated in the consultation process for this Review still understand and support the potential of the creation of a network for paediatric care, despite the difficulties identified with the current arrangements. The Panel believes it is possible to re-imagine a more inclusive "network" within a common strategy for NSW by ensuring effective leadership and well governed change management going forward. This will require a clear evidence based strategy and goals for paediatric care in NSW, supported by a broader group which includes the Ministry and other relevant internal and external stakeholders. It will also require an organizational strategy for SCHN aligned to the State strategy, an organizational structure that provides support to the core function of SCHN, a strong brand and positioning which both creates a new symbol of the future and celebrates the best of the past. Staff must also have certainty, communication and support to understand their context, grow and develop in the new organization and make decisions about their future. Where it is clear that there will be only one service across two sites (or more), it is important to provide transport, accommodation, appropriate communication technology and required assistance to support new models of training and service delivery required by the dual site single service arrangement.

7 The organisation must be structured to support its core role and function to provide and support the treatment and care of children both across NSW and within its own regions and precincts. The structure must facilitate its agility and capability to support the NSW paediatric workforce in treatment and education.

The view of the majority of people across the organisation, including the Executive and the Board, is that the current organisational structure has not fully supported the operational and governance requirements of the 2 major teaching hospitals. Each hospital sits within its own precinct of health care and education services and requires a set of relationships and arrangements within it. They require management attention on a daily basis. Whilst it is acknowledged that the Executive staff are doing the best they can, the breadth of their roles and the depth of attention both sites require, in addition to the requirement to travel 40 kilometres across Sydney to be visible in each site, makes it very difficult for them to address the needs of each site sufficiently. There is also a view that the existing structure does not adequately support the non-hospital services within the SCHN and that, potentially, it undermines their agility and development.

There is a need to ensure a strong connection between the core clinical functions, the governance and corporate functions and the decision-making processes of the SCHN. Delegations must therefore ensure that the operational decisions are made as close as possible to the service area and that the more strategic decisions are made within a well understood process, according to clear and transparent criteria, with maximum engagement of relevant stakeholders. There should be no doubt as to the time frame for decisions, who will make the decisions, the criteria on which decisions will be made and how they will be communicated. This focus on decision-making would go some way to improving the degree of trust between the clinical staff and governance levels of SCHN.

Given the state-wide role of each of the hospitals and the state-wide services that sit within the SCHN, professional education and workforce development is a core function and must be supported accordingly. Whilst it is acknowledged that there have been effective innovations which have standardised and streamlined education across both hospitals, the resources have been stretched and this inhibits the potential to support other paediatric services, even when it is clear that there is a need for workforce development across the system. Relationship management is a core part of effective care for children. A state-wide service must relate to 15 LHDs and other primary health care services. This must be acknowledged and supported by the structure and with an appropriate level of resources.

Strong allied health and nursing leadership is fundamental to the design and delivery of best practice and efficient care in any hospital but particularly in paediatric care. These leadership roles must provide strong multidisciplinary voices at the Executive table and have the authority to ensure that professional standards are set, maintained and promoted across all service areas. The current Executive arrangement of SCHN does not provide the capacity for these roles to contribute at the level required. Executive and operational changes must be made to ensure these roles are fulfilled. This will require an increase in resources and changes to accountabilities.

8 Whilst the funding for the capital developments on both campuses is welcomed, there is an urgent need to resource the projects effectively.

Both internal and external precinct stakeholders have identified the need for an urgent focus on the change management required for the CHW project which will be on line for patient care within the next 18 months and for the SCH development. This is a significant risk area that warrants a review of the functional brief for the site developments after delineation of roles at the different sites. There are quite advanced proposals to resource the projects effectively and to ensure their effectiveness in supporting care on each site. These proposals should be funded as a matter of urgency.

9 The consolidation of health services generally and paediatric services in particular will continue on a broader scale.

Charles River and Associates conducted a study for the American Hospitals Association in January 2017 and pointed out that it is highly likely that the consolidation of health care will continue across the western world. They identified the particular need to consolidate at the extreme subspecialty end of the spectrum of care due to the need for critical mass for quality, training and skill development.

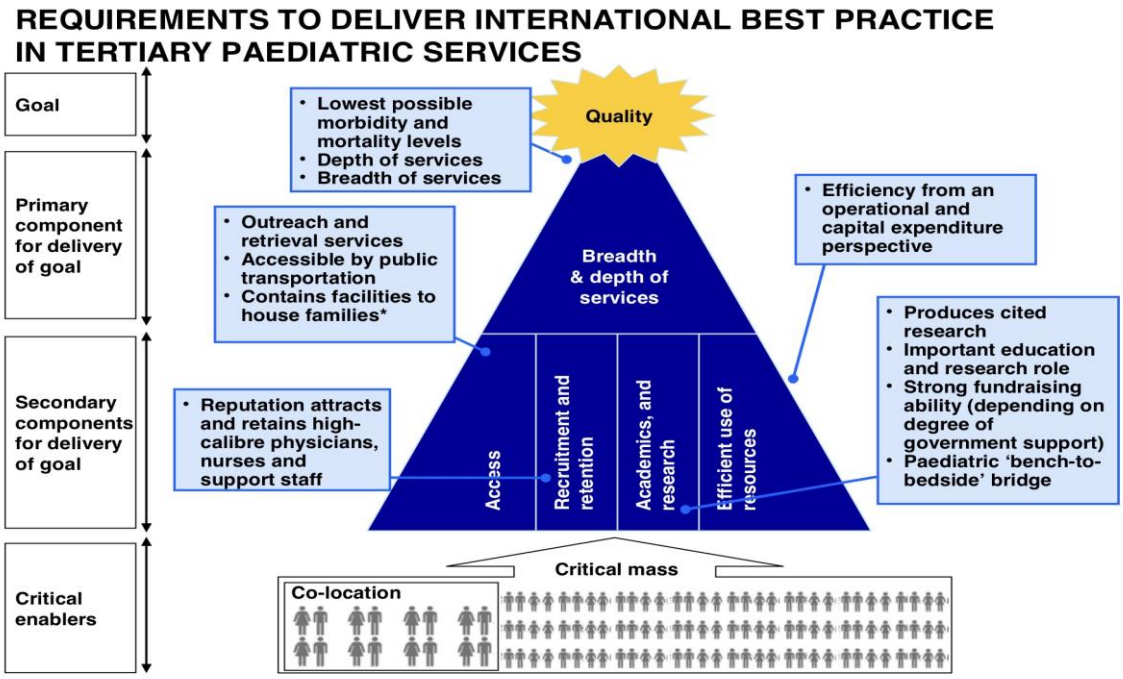
There is now substantial evidence supporting the relationship between scale/consolidation and improved outcomes in adult trauma centres, stroke centres, cardiothoracic surgical centres, ICU provision, oncology, transplant and aneasthetics. This is compounded by technological advancements particularly in diagnostics and a trend towards more sub-specialisation. Consolidation will also be important to support the opportunities offered by big data and artificial intelligence to deliver on personalized, predictive, preventive and participatory medicine and the challenges and opportunities of the genomic revolution.

There will be an increased need to create the economies of scale required to ensure cost effectiveness and affordability of the inevitable increase in expensive new technology, innovative pharma and genetic therapies and the other increased costs of treatment for rare and complex conditions. Duplication of such services would produce an unacceptable burden to the community.

Charles River and Associates pointed out that integration of services works best when integration is horizontal and vertical, ie in a network or system of care.

In the experience of the Panel, consolidation of a service can occur across a number of hospitals through management arrangements including the management of personnel, training, development of common care protocols, standardization of equipment, peer review systems, information management, data collection and service planning and other related management arrangements. This requires effective leadership and support arrangements.

McKinsey's important study of the Irish paediatric services in 2007 is still relevant today and concluded, based on international research and the plans of 14 out of 17 metropolitan areas around the world which were included in their study, that a population of 4-5 million is the appropriate base for a paediatric tertiary referral centre. Preferably it would be co-located with an adult teaching hospital, linked with other paediatric regional centres within a clearly defined integrated and multi-disciplinary service and be accessible to public transport and roads with space to expand for research and developing clinical needs. They concluded that critical mass is the driver for affordable and higher quality care through mergers across the world. The key elements of success are contained in their diagram below.



* Does not include custodial or long-term facilities (e.g., for children with severe or profound disabilities)
Source: Literature, expert interviews, hospital profiles

In addition to the issues supporting consolidation of services identified above, it must also be recognised that the next generation of subspecialists will require work arrangements which respect work/life balance. It will simply not be possible to get by with key personnel offering 24 hour on call cover or longer hours and worse conditions than would be expected in any other profession.

10 It is critical that planning for paediatric services is in line with the growth plan for greater Sydney.

The Greater Sydney Commission strategy for the growth of Sydney over the next 40 years suggests that, with an expected population of 8 million people in the next 20 years and births of 63,500 per year, there is room for 2 tertiary paediatric teaching hospitals in Sydney. However, the shape of the metropolitan area will change to the south west and west of Sydney. This change indicates the potential for a significant growth of tertiary level services both at SCH and at CHW. Paramatta will be the centre of the Greater Sydney area supported by planned transport infrastructure and cultural and economic development facilitated by the development of education, research and health services. The plan is outlined below.

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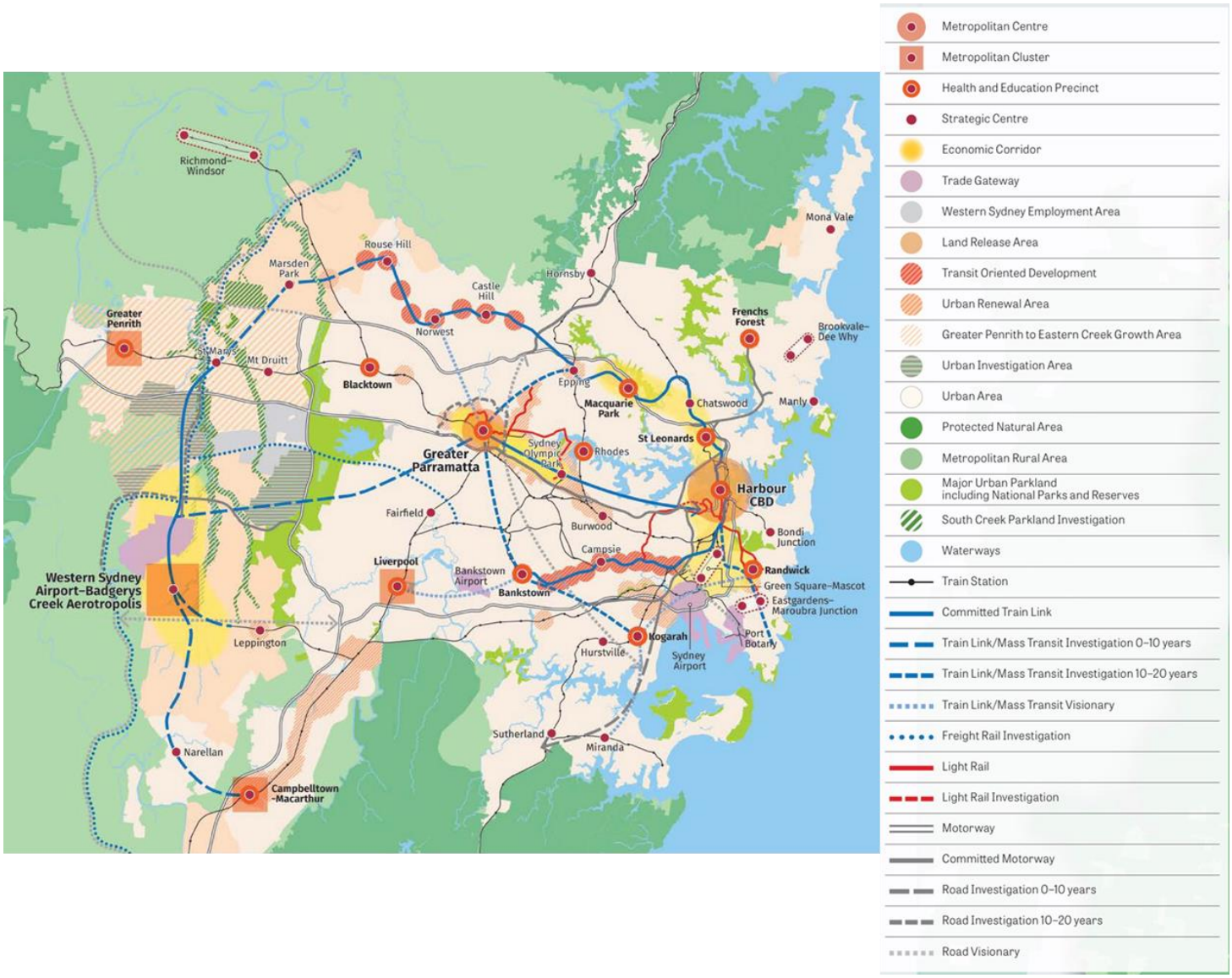

11 There is a need to ensure that the funding model addresses the particular needs of paediatric care

Paediatric care is not the same as adult care. The size and developmental needs of a child mean all elements of care are individualised and this impacts on the level of cost, care and personnel required. This includes;

- the cost of specialist care
- education for families
- the manufacture of size specific devices, nutrition, volume or dose of drugs and the requirement to hold stock for all sizes
- the availability of family and school support services

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- extra safeguards and supervision arrangements required for children who can't feed themselves, dress themselves, articulate their needs and understand treatment requirements
- costs associated with accommodating and reducing children's stress when undergoing invasive procedures by providing interventional therapies, sedation or anaesthetics and sometimes restraint

In addition to these "standard" extra costs, there is also a higher diagnostic cost of care for children. Diagnostics investigations may be required to exclude many things that have already been discovered in adults. The younger the patient the higher the cost of these "extra" to adult care requirements. This has a marked impact on tertiary children's hospitals finances when 50% of their patients are under the age of 4 years of age, highly complex and low in volume relative to adult hospitals.

National benchmarks indicate an opportunity to ensure that the NSW hospitals funding model is fair and reasonable for children by undertaking a study similar to those undertaken in other states in Australia. Based on the Children's Healthcare Australasia (CHA) benchmarking information, SCHN is the lowest cost operator for complex paediatric services of similar scale in Australasia, with its costs some 14% lower than the nearest state when additional state grants are excluded from the comparison. Other state funding models have recognised that the DRG system has limited ability to accommodate the fundamentally different clinical conditions and treatments of children in addition to the differences in care requirements outlined above. Many relatively serious childhood admissions involve a large number of investigations and fall into lower order DRGs and coding does not account for the presence of multiple complex conditions that are common with congenital abnormalities in children.

6. KEY REVIEW CONCLUSIONS

- The need for a networked approach to the delivery of paediatric care across NSW is even more relevant in 2019 than it was in 2010. This is especially the case at the extreme subspecialty end of the spectrum of care due to the need for critical mass for quality, training and skill development. It would also address the economies of scale required to take the opportunities offered by big data and artificial intelligence to deliver on personalized, predictive, preventive and participatory medicine and the challenges and opportunities of the genomic revolution and innovative pharma.
- Whilst the full potential of the current governance arrangements have not yet been achieved, there have been some benefits to date and these must be acknowledged and maintained in any future governance arrangements.
- The "network" of paediatric care must be re-imagined in the future context of a city whose population will be 8 million people within the next 15 -20 years and a metropolis whose centre is Paramatta. Such a network must facilitate a more systemic approach to ensuring quality and efficiency of paediatric care across secondary, tertiary and quaternary levels of care for the children of NSW to address

the variation in care and approach identified by the Ministry Health Care Team in February 2019.

- An effective strategy for paediatric care, which aligns resourcing, incentives and accountabilities for reform across the system, developed, supported and monitored by the Ministry of Health for SCHN and for the LHDs and other relevant state-wide services, is required to ensure excellence and equitable access to care across NSW.
- It is necessary to fully understand the effectiveness of the current funding model as it relates to paediatric care in NSW. A national benchmarking study with other paediatric services would provide insight into the real differences between the costs of paediatric and adult care.
- Effective governance by the Board of the SCHN must include developing an organizational strategy aligned to a NSW strategy for paediatrics and oversight of a change program which addresses existing problems and achieves the changes needed to be a key player in the broader NSW network of paediatric services.
- An organizational structure is required which acknowledges and ensures effectiveness in the core functions and roles of the two hospital site services both at the state-wide and local precinct levels. The structure must also provide more effective support for the other "non-hospital" statewide services.
- Organizational decision making processes must engage clinicians in effective consultation and ensure the agility and responsiveness of the support services to the core functions of the services in the SCHN.
- Governance level support is required for consumer and community participation at all levels of service planning. This will provide an important focus for cultural change.
- A significant change program is required to move forward and will require extra personnel and related resource support in addition to effective change management resourcing.

7. RECOMMENDATIONS

That the Ministry of Health;

1. Maintain a networked approach to the governance of specialist paediatric services across the SCH and CHW, within a clearly articulated strategy for paediatrics in NSW which provides direction for the range of paediatric providers in the State.

2. Change the name of the SCHN to acknowledge that;

    - the organisation's primary function is to provide secondary and tertiary level hospital care
    - it also provides a governance auspice for Bear Cottage, NSW Newborn Emergency Transport Service, Children's Court Clinic, Poisons Center, NSW Pregnancy and Newborn Services Network and a number of other non-hospital health services

- the current name is a misnomer in that LHDs and other key services are a part of the network of paediatric services providing the majority of hospital care and must be supported by the two hospitals in Sydney to do so.

3. Limit the role of the SCHN in governance of Bear Cottage, NSW Newborn Emergency Transport Service (NETS), Children's Court Clinic, Poisons Centre, NSW Pregnancy and Newborn Services Network to providing an "auspice" with separate grant funding and contractual schedules and obligations for their management set by the Ministry of Health and a direct line of responsibility from the services to the Ministry. This option would ensure that the specific care issues associated with providing care to children is not diluted in mainstream essentially adult services which might also be able to provide an auspice for some or all of the services. It also acknowledges the actual and potential importance of these organisations (not yet fully realised) in assisting in the development of relationships and models of care across the broader network of services to children and young people and their families in NSW. There is a risk with an alternative governance arrangement with organisations that do not have a specialist child health focus, that their own focus on children may be diluted.

4. Review and consolidate the existing paediatric committees to create a more streamlined and coordinated NSW Paediatric Care Network arrangement to provide advice on;

a. The development of strategic directions for paediatric care in NSW.
    i. Service development priorities in line with the strategic directions
    ii. Role delineations and coordination of care across secondary, tertiary and quaternary levels of care in LHDs and specialist children's hospitals and other state-wide paediatric services
b. A state-wide reform program
    i. to improve quality and consistency of care across NSW Paediatric Care Network
    ii. Workforce reform and development and capacity development across NSW
c. Provision of care to high risk populations
d. The framework for setting Service Level Agreements (SLAs)
    i. Key Performance Indicators for paediatric care across NSW
    ii. Monitoring of performance for paediatric care across NSW
e. Funding models and incentives to align paediatric care across NSW with the strategic directions
f. Emerging issues and risks in relation to paediatric care across NSW

5. Establish a set of principles which must underpin the advice of the NSW Paediatric Care Network. These principle should include;
a. Effective clinician and interagency engagement and collaboration across primary, secondary and tertiary levels of care
b. An evidence based approach to decision making
c. Effective consumer and community engagement in decision making
d. Effective interfaces across reform initiatives to ensure a system wide approach to improvements
e. Alignment of decisions with key policy and planning directions of government

6. Establish the membership of the proposed NSW Paediatric Care Network and include;
   a. SCHN
   b. John Hunter Children's Hospital
   c. Local Health Districts providing paediatric services
   d. State-wide paediatric services (Bear Cottage, NSW Newborn Emergency Transport Service, Poisons Center, Children's Court Clinic, NSW Pregnancy and Newborn Services Network)

7. Provide executive officer support for the NSW Paediatric Care Network to take responsibility for being a single point of contact on paediatric care issues and for proposing final recommendations to the Secretary in relation to;
   a. The strategic plan for paediatrics in NSW including role delineations and service arrangements for key strategic developments
   b. The reform program to improve quality and standards of care.
   c. The provision of care to high risk populations
   d. Funding models and arrangements for paediatrics
   e. Emerging risks and mitigation strategies
   f. Providing an annual report to the Minister of Health on the program of activity and program of the NSW Paediatric Care Network.

8. Commission a national benchmarking study of costs and funding of paediatric care to underpin a review of the impact of the existing NSW funding model on the provision of paediatric care in NSW.

9. Require the Board of the SCHN to urgently review the organisational structure of the existing SCHN and monitor implementation against agreed KPIs and time frames. The organisational design should include;
   a. The creation of an Executive Director role at both the CHW and the SCH, each to be supported by a hospital level nurse leader, hospital level medical leader, hospital level allied health leader and a business support manager. Hospital Executive Directors would be members of the Executive of the SCHN and participate on organisation wide planning and decision making whilst also managing the day to day operational decisions and requirements of the hospital for which they are responsible. The role is to ensure that decisions are based in effective engagement and awareness between the Executive and the staff of the hospital for which they are responsible
   b. A Network Director of Nursing role which is responsible for nursing standards, quality and workforce development of nursing across the SCHN and which has the authority to implement reform across the SCHN and to liaise effectively on these issues with other LHDs.
   c. Increased allocation of time for Executive Allied Health leadership to ensure workforce development and consistent standards of practice across the SCHN as well as effective input into the executive decision making
   d. Creation of a full time Director of Education to support workforce development within SCHN and liaise across the network of paediatric care providers in NSW

e. Effective corporate support services to provide hospital based support to each of the hospital leadership teams
f. Sufficient site based capital development project personnel

10. Review the membership of the Board of the current SCHN to
a. ensure it has sufficient independence, expertise and experience to oversee the proposed program of change
b. Include the Chair of the Consumer and Family Advisory Committee

11. Recognize the cost of the change process required to address the governance issues of the SCHN and the state-wide role of the SCHN in NSW

That the Board of the SCHN

12. Require the CEO to establish an organisation change program, budget, support structure and monitoring mechanism to manage and continuously report on the design and implementation of a new organisational structure as outlined above to ensure effective engagement of stakeholders in decision making and to ensure effective ongoing communication of issues and progress of the change program. The Board should consider whether there may be a role for independent consultant support on this project given the cultural and trust issues that have emerged in the organisation in recent times.

The new organisational structure should include;

a. The creation of an Executive Director role at both the CHW and the SCH, each to be supported by a hospital level nurse leader, hospital level medical leader, hospital level allied health leader and a business support manager. Hospital Executive Directors would be members of the Executive of the SCHN and participate on organisation wide planning and decision making whilst also managing the day to day operational decisions and requirements of the hospital for which they are responsible. The role is to ensure that decisions are based in effective engagement and awareness between the Executive and the staff of the hospital for which they are responsible
b. A Network Director of Nursing role which is responsible for nursing standards, quality and workforce development of nursing across the SCHN and which has the authority to implement reform across the SCHN and to liaise effectively on these issues with other LHDs.
c. Increased allocation of time for Executive Allied Health leadership to ensure workforce development and consistent standards of practice across the SCHN as well as effective input into the executive decision making
d. Creation of a full time Director of Education to support workforce development within SCHN and liaise across the network of paediatric care providers in NSW
e. Effective corporate support services to provide hospital based support to each of the hospital leadership teams

f. Sufficient site based capital development project personnel

13. Prioritise resources for the capital development projects to ensure best value and effective change management leading up to the capital projects on each site. This change management must be aligned to the proposed new organisational arrangements.

14. Provide supports such as transport, accommodation, appropriate technology etc to support new models of training and service delivery required by dual site /single service arrangements which might be necessary for highly specialized low volume services.

15. Commission a review of its public relations and reputation management framework. This should include;

a. The development of a unifying and engaging brand and associated policies and protocols and audit and reporting processes
b. Community engagement policies and strategies
c. Relationship management protocols and practices
d. Policies and systems for internal and external communication
e. Issues management and reputation management policies and protocols and training and development arrangements
f. Media policies and protocols

16. Review the Terms of Reference of the Consumer and Family Council to advise on, oversee and regularly report to the Board on the development and implementation of a consumer and community participation strategy which addresses;

a. The cultural change required for staff of the SCHN to improve their capacity to engage consumers and relevant communities in strategic planning, service planning, service delivery and service evaluation across the whole organisation in a way which is consistent with the International Association of Public Participation
b. The processes and systems required to inform and engage the community and consumers in all levels of planning and is consistent with the International Association of Public Participation

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- **Sydney Children's Hospitals Network** Terms of Reference Child & Family Health Advisory Council
- **Sydney Children's Hospitals Network** Terms of Reference Clinical Council
- **Sydney Children's Hospitals Network** Terms of Reference Finance and Performance
- **Sydney Children's Hospitals Network** Terms of Reference Health Care Quality Committee
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APPENDICES

Appendix 1 - Terms of Reference of the PCCG

EXPERT PANEL – REVIEW OF GOVERNANCE FOR THE SYDNEY CHILDREN'S HOSPITALS NETWORK

The Ministry of Health, in conjunction with the Sydney Children's Hospital Network (SCHN) Board is proposing to convene an Expert Review Panel to review the current governance model for the SCHN, including the Children's Hospital at Westmead (CHW) and Sydney Children's Hospital at Randwick (SCH)

Background: The SCHN was created as a statutory corporation in 2010 as part of the Government response to the Special Commission of Inquiry into Acute Health Care in NSW, through bringing together the two major Sydney metropolitan children's hospitals to establish a single, statewide service, to support the improvement of the health and wellbeing of children in NSW.

Objectives: While the SCHN has achieved some significant developments in providing health care for the children of NSW and in child health research and education, the operating environment has changed considerably since it was established, creating both challenges and opportunities.

These changes include:

- significant health capital investment on both the Randwick and Westmead campuses;
- significant university commitment to research and education at both Westmead and Randwick;
- designation of the Randwick and Westmead sites as part of advanced health research translation centres;
- investment commitment by NSW Health to development of paediatric services in Campbelltown;
- the designation by the Greater Sydney Commission of health and education precincts and the three city approach to metropolitan Sydney.

Advice sought: The advice of the Panel is sought to identify the most effective governance of SCHN to maximise the benefit of these developments and build on future benefits going ahead, including advancing local service accessibility and excellence as well as improving the integration of paediatric services across levels of care and across the State.

The advice should consider changes to urban and regional population, the growth planning framework for greater Sydney and the infrastructure and service investment already made by NSW Health and various universities in south east and western Sydney and the needs of regional NSW in relation to tertiary and quaternary level services. The Panel, in making recommendations should also consider the following key drivers:

- the maintenance of the high level of paediatric services offered at the Randwick and Westmead campuses;

- benefits that can be obtained through the increased synergies across the geographic sites, leveraging on the investments in the Health Education Precinct;
- changing demographics and the future health needs of children and adolescents particularly those with chronic and complex conditions;
- enhancement of broader NSW state-wide paediatric planning and service networking.

The Panel is asked to provide their advice to the Health Secretary by 30 April 2019.

Appendix 2 - Proposed Clinical Consultative Group Process and Membership of the PCCG

REVIEW OF GOVERNANCE FOR THE
SYDNEY CHILDREN'S HOSPITALS NETWORK

Proposed Clinical Consultative Group Process
Purpose

The Ministry of Health, in conjunction with the Sydney Children's Hospital Network (SCHN) Board has commissioned an Expert Review Panel to review the current governance model for the SCHN, including the Children's Hospital at Westmead (CHW) and Sydney Children's Hospital at Randwick (SCH)

- The advice of the Panel is sought to identify the most effective governance of SCHN to maximise the benefit of these developments and build on future benefits going ahead, including local service accessibility and excellence as well as improving the integration of paediatric services across levels of care and across the State.
- The advice should consider changes to urban and regional population, the growth planning framework for greater Sydney and the infrastructure and service investment already made by NSW Health and various universities in south east and western Sydney and the needs of regional NSW in relation to tertiary and quaternary level services.

Governance

The Review Panel will report to the Secretary of Health. The Review Panel will consist or Dr Kathy Alexander (Chair), Dr Peter Steer and Ms Sue Peter.

The Review Panel will be assisted by a Process Clinical Consultative Group which will meet 3 times throughout the review process to fulfil the following terms of reference;

Meeting 1

Be briefed on the proposed program of activities to achieve the purpose of the review,

Provide feedback on the proposed process to ensure an appropriate diversity of relevant views are heard

Meeting 2

Be briefed on progress of the Expert Review Panel and advise on any gaps identified in consultation process to that date

Meeting 3

As per (ii) at the conclusion of the intended interview period

The Process Clinical Consultative Group will have the following membership;

Medical perspective across clinical services
Nursing perspective across clinical services
Allied Health perspective across clinical services
Teaching/research from across the research and academic domain

Process

Draft a list of interviewees
Meeting 1 with the Process Clinical Consultative Group to seek advice on list of interviewees
Undertake majority of interviews
Review Panel to consider any potential gaps still not adequately considered through the interviews or submissions to date.
Conduct Meeting 2 with the Process Clinical Consultative Group to discuss gaps and to seek advice on a broader consultation process around these gaps.
Complete interviews and consider submissions.
Analyse data
Draft final report with recommendations and consider any unresolved gaps in information.
Conduct meeting 3 with the Process Clinical Consultative Group to consider strategies to close off any unresolved gaps in information.
Final report to the Ministry.

Process Consultative Group Members - SCHN Governance Review			
	Name	**Location**	**Position**
Nurses:	Helen Bullot	Randwick	Nursing Unit Manager
	Lisa Siladyi	Westmead	Nursing Unit Manager
Allied health:	Michael Doumit	Randwick	Physiotherapist
	Justine Trpezanovski	Westmead	Nuclear Medicine Scientist
Medical:	Sue Woolfenden	Randwick	Community Paediatrician
	Phil Britton	Westmead	Staff Specialist Infectious Diseases
	Sue Trethewie	Network	Dept Head, Palliative Care
	John Widger	Randwick	Staff Specialist Paediatric Respiratory Physician
	Steve Alexander	Westmead	Staff Specialist Nephrologist
Medical Staff Council:	Susan Russell	Randwick	Chair
	Kath Carmo	Westmead	Chair
Research:	Cate Smith	Network	Assoc Director of Research

Appendix 3 - Resulting framework for participation as advised by the Process Clinical Consultative Group and Panel

SCHN GOVERNANCE REVIEW - INVITATIONS ISSUED					
	PCCG identified Service Stakeholder Group	**No of Reps**	**Date**	**Location**	
1	**Process Clinical Consultative Group**	12	Fri, 22 March	Randwick	
2	**Diagnostics incl:** ▪ Infection Control ▪ Imaging ▪ Pathology ▪ Nuclear Medicine	 7 8 5 3	Fri, 12 April	Westmead	
3	**Allied Health**	23	Fri, 12 April	Westmead	
4	**Acute Care incl:** ▪ Emergency ▪ Transplantation ▪ Anaesthesia ▪ ICU	 5 5 6 10	Wed, 17 April	Westmead	

	▪ Surgery ▪ NETS ▪ Neonatology ▪ Renal	11 6 5 1			
	▪ David Winlaw ▪ Philip Roberts ▪ Mike Jones	1 1 1	Thurs, 18 April Thurs, 18 April Thurs, 18 April	Teleconference Teleconference Teleconference	
5	**Research** ▪ Adam Jaffe	19 1	Fri, 12 April Thurs, 18 April	Westmead Teleconference	
6	**Single Cross Campus Services incl**: ▪ Rheumatology ▪ Palliative Care ▪ Bear Cottage ▪ Cardiology ▪ Ambulatory Care / GPS / Trapeze	 2 5 1 5 15	Wed, 17 April	Westmead	
7	**Dual Services, site based not jointly managed incl:** ▪ Oncology ▪ Child Development Unit ▪ Child Protection ▪ Community Child Health ▪ Orthopaedics ▪ Nephrology ▪ General Paediatrics ▪ Respiratory ▪ Additional staff	 7 3 3 4 6 5 7 4 5	Wed, 26 April	Randwick	
8	**Nursing and Education**	16	Wed, 17 April	Westmead	
9	**Junior Medical Staff**	10	Thurs, 23 May	Randwick	3 x Apology

	Sydney Children's Hospitals Network			Westmead	
	Review Panel identified Service Stakeholder Group	**No of Reps**	**Date**	**Location**	
10	**Board** ▪ Individuals ▪ Individuals ▪ Individual incl Audit & Risk Committee Chair ▪ Chair/Acting Chair ▪ Group	 3 3 2 2 7	 Fri, 22 March Fri, 5 April Fri, 26 April Fri, 26 April Fri, 5 April	 Randwick Randwick Randwick Randwick Randwick	 2 x Apology
11	**Executive** ▪ Individuals ▪ Chief Executive ▪ Acting Chief Executive ▪ Group	 5 1 1 7	 Fri, 22 March Wed, 17 April Wed, 24 April Tues, 2 April	 Randwick Westmead Teleconference Teleconference	
12	**Non Clinical Staff**	14	Wed, 17 April	Westmead	
13	**Medical Staff Council, Executive**	11	Tues, 2 April	Teleconference	
14	**Medical Staff Council CHW**	60*	Thurs, 11 April	Westmead	
15	**Medical Staff Council SCH**	60*	Tues, 16 April	Randwick	
16	**Clinical Council**	34	Fri, 5 April	Randwick	
17	**Clinical Program Directors**	21	Fri, 12 April	Westmead	
18	**Family and Consumer Council** ▪ Network Manager - Patient and Family Engagement ▪ Patient Friend	 1 2	 Fri, 5 April	 Randwick	
	▪ Network Manager - Patient and Family Engagement ▪ Patient Representative	1 1	Wed, 17 April	Westmead	
19	**Sydney Children's Hospitals Foundation** ▪ Board Chair	 1			

	▪ Chief Executive	1	Fri, 12 April	Westmead	
	▪ Deputy Chair	1			Apology
	▪ Board Member	1			Apology
20	**Paediatrio / CRMI /CCIA**				
	▪ Chair of Paediatrio	1	Fri, 22 March	Randwick	Apology
	▪ Director of Children's Medical Research Institute	1	Fri, 5 April	Randwick	
21	**Redevelopment**				
	▪ Clinical Services Planner	1	Fri, 26 April	Randwick	
22	**LHDs - Chief Executives**				
	▪ South East Sydney	1	Wed, 17 April	Westmead	
	▪ Western Sydney	1			
	▪ John Hunter Children's Hospital	1	Fri, 12 April	Westmead	
	▪ South West Sydney	1	Fri, 26 April	Randwick	
	▪ Illawarra	1	Fri, 12 April	Westmead	
	▪ Murrumbidgee	1	Fri, 26 April	Randwick	
23	**LHDs - Children's Healthcare Network Leads/Head of Paediatrics /Paediatric Clinical Leads**				
	▪ NSW Chief Paediatrician	1			
	▪ Illawarra paediatric medical clinical leads	1	Fri, 26 April	Randwick	
	▪ South West Sydney paediatric medical clinical leads	1			
	▪ Murrumbidgee paediatric medical clinical leads	1			
	▪ Sydney LHD paediatric medical clinical leads	1			
	▪ HNE paediatric medical clinical leads	1			
	▪ Medical Lead Children's Healthcare Networks - Southern	1			
24	▪ Nursing Lead Children's Healthcare Networks - Southern	1			
	▪ Medical Lead Children's Healthcare Networks - Western	1			

	▪ Nursing Lead Children's Healthcare Networks - Western ▪ Medical Lead Children's Healthcare Networks - Northern ▪ Nursing Lead Children's Healthcare Networks – Northern	1 1 1			
25	**Ministry of Health** Deputy Secretaries ▪ Strategy & resources Division ▪ System Purchasing & Performance ▪ Population & Public Health ▪ People Culture & Government Division Secretary	 1 1 1 1 1	 Fri, 5 April Fri, 26 April	 MoH Woollahra	 Apology
26	**Universities** University of Sydney ▪ Head of School of Public Health University of NSW ▪ A/Dean of Medicine & Snr Vice Dean-Clinical Affairs on behalf of Vice-Chancellor	 1 1	 Fri, 26 April Fri, 26 April	 Randwick Randwick	
	TOTAL	**496**			

Appendix 4 –What We Heard

WHAT WE HEARD FROM CONSULTATION WITH INTERNAL AND EXTERNAL STAKEHOLDERS FOR THE GOVERNANCE REVIEW OF THE SYDNEY CHILDREN'S HOSPITALS NETWORK

KATHY ALEXANDER, PETER STEER AND SUE PETER

1. INTRODUCTION

The NSW Ministry of Health, in conjunction with the Sydney Children's Hospitals Network (SCHN) Board, convened an Expert Review Panel to review the current governance model for the SCHN, including The Children's Hospital at Westmead (CHW) and Sydney Children's Hospital, Randwick (SCH). The Review Panel, (the Panel) Dr Kathy Alexander (Chair), Dr Peter Steer and Ms Sue Peter was asked to report to the Secretary of Health.

This paper is intended to close the loop on the consultation process undertaken by the Panel to understand the views of stakeholders of the Sydney Children's Hospitals Network. The views have not been independently validated by the Panel, and so are without prejudice, but are an important element of its considerations in the review of Sydney Children's Hospitals Network governance arrangements. Other elements to be considered include relevant documents from SCHN and the Ministry of Health in NSW, literature in relation to organisational arrangements to support clinical excellence, literature in relation to critical success factors for merging health care organisations, the Greater Sydney Commission Three Cities planning framework for Sydney over the next 40 years, information from benchmark organisations in Australia, Canada and the UK and the experiences and knowledge of the Panel members.

The Panel thanks the stakeholders, Family and Consumer Council representatives and staff who provided their time and commitment to this process.

2. BACKGROUND

The Terms of Reference of the Governance Review (Appendix 1) state that, while the SCHN has achieved some significant developments in providing health care for the children of NSW and in child health research and education, the operating environment has changed considerably since it was established, creating both challenges and opportunities. These include;

- Significant health capital investment on both the Randwick and Westmead campuses
- Significant university commitment to research and education at both Westmead and Randwick
- Designation of the Randwick and Westmead sites as part of advanced health research translation centres
- Investment commitment by NSW Health to development of paediatric services in Campbelltown
- The designation by the Greater Sydney Commission of health and education precincts and the three city approach to metropolitan Sydney.

The advice of the Panel was sought to identify the most effective governance of SCHN to maximise the benefit of these developments and build on future benefits going ahead, including local service accessibility and excellence as well as improving the integration of paediatric services across levels of care and across the State. Of note this advice was not intended to address the specific issues within the Cardiology Service as these are being addressed through a separate process. This review addresses broader governance matters relevant to all SCHN services.

3. THE CONSULTATION PROCESS

The Review Panel was assisted by a Process Clinical Consultative Group (PCCG) which provided advice on how to ensure comprehensive participation in the Review (See Appendix 2) Proposed Clinical Consultative Group Process for the framework for participation as advised by the PCCG). On the basis of this advice, invitations were sent to over 496 people to attend individual or group meetings. The PCCG also identified the need to structure the questions to ensure that people understood that the focus of the Review was on the governance as it affected their service. The following questions were considered appropriate to encourage the required focus;

1. What are the most important benefits and/or achievements made possible by the existing network structure of governance which should not be lost going forward?

2. What are the most important obstacles to delivering excellent care that are presented by the network structure which must be overcome going forward?
3. What are your views on how best to maintain the benefits and address the obstacles going forward?

The final consultation process included;

- Invitations to attend face to face or telephone interviews
    - Structured interviews with internal and external stakeholders
    - Invitations to attend structured group meetings/workshops for internal and external stakeholders to ensure the broadest possible participation in line with the framework for participation in the available time (See Appendix 3 for the full list of invitations)
- Invitation to all staff to provide written submissions
- Collation of data to form this paper on key themes from the consultation
- Consultation on completeness of the themes with the PCCG

The Panel received 84 written submissions. Many of the meeting participants also provided individual submissions or participated in submissions prepared by a group. (The list of submitters is contained in Appendix 4).

Some people expressed their concerns that the group consultation meetings limited participation from some staff who may have felt intimidated to speak out. The Panel noted that both the confidential and open feedback process revealed a high degree of consistency which indicates that, overall, the method of consultation enabled people to have their say. The panel also noted that a number of people participated in submissions from a group and also made an individual submission.

Whilst the Panel is interested in the ideas of interviewees and submitters in relation to the way forward for SCHN, it has not included these ideas in this report. This is because the primary reason for the consultation was to understand the consistent issues to be addressed. Recommendations about the way forward will be based on the Panel's consideration of the other key elements as outlined in the introduction and also on the Panel's own expertise and experience in governance and management of paediatric services.

The following sections summarise the themes raised with a high level of consistency across both the interviews and the submissions.

4. PERCEIVED BENEFITS: THEMES

1. **The initial logic of the creation of the SCHN to improve and enhance clinical care for children in NSW is well understood and generally accepted.** People see that it makes sense to;
    a. strengthen paediatric care rather than to dilute it within LHDs whose main patient base is, and will continue to be older people
    b. standardise best practice care across like services where possible
    c. create an expert resource and support to all LHDs from a centralised expert paediatric service
    d. strengthen paediatric workforce development through collaborative, education and training programs
    e. reduce unnecessary duplication
    f. improve cost effectiveness of back of house support services and of costly infrastructure

2. **There is a high degree of consistency of views expressed across both sites that the full potential of the SCHN governance structure has not been achieved at this point.**

3. **Benefits and achievements of the SCHN governance structure are more likely to be articulated by the Board, the Executive Team and the Clinical Program Leads and those clinicians who have been active participants in collaborations and integration activity.** It would therefore appear that active engagement has been a strong influencer in whether or not the SCHN governance structure is perceived as beneficial.

4. **Proforma submissions were received from 84 groups and individuals, the majority expressing the view that there are benefits provided by the SCHN governance structure.** Of the 26 submissions from CHW in relation to this question, there were four submissions which identified no benefits at all from the structure. One of these submitted that there was no benefit because there was no counterpart to his service area at SCH. Another submitted that there had always been a collaborative relationship across SCH and the CHW in his service area and this was unchanged by the governance structure, but noted that the governance structure provides potential for more powerful advocacy than had been in place prior to its creation. Of the 36 submissions from SCH, eight submissions identified no benefits at all from the governance structure. It is important to note that separate to the proforma submissions process the SCH Senior Medical Staff Council expressed throughout the process that there is very little or no benefit to the Network structure. Of the three submissions from State-wide services, one identified no benefit from the governance structure. The State-wide services saw some clear disadvantages of the structure associated with the fact that the services were relatively peripheral to the interests and focus of the two hospital sites and that they were somewhat buried in the organisational management structure. This results in increased bureaucracy and slower decision-making on all levels of their operations.
   The remaining 19 submissions were received from Network staff and consumer groups.

5 **The majority of interviewees and submitters from a broad range of clinical areas across the SCHN identified some benefits to the Network structure and are consistent in views about what they are**, including;
   a. **The enhancement of research collaboration** through increased scale and critical mass in terms of both research workforce and patient cohorts. This encourages, enhances and supports the development of major collaborative research efforts. A great example of this is the formation of Paediatrio which brings together collaboration between Kids Research Institute , Children's Medical Research Institute, Children's Cancer Institute (CCI), the University of NSW and the University of Sydney and has a critical mass to rival other major international research institutions. It has attracted some $25m in funding since its inception. A broad range of submitters identified improved research collaborations as a real or potential benefit. There were some submitters who identified that there was more work to do to ensure sufficient equitable support and communication across the sites.
   b. **Advocacy at a State level from the Executive and Board has resulted in $1.2b in capital funding.**
   c. **Improved potential and efforts to streamline education and training** across the Network through sharing of grand rounds, the use of technology and the delivery of the simulation service. A broad

range of medical and allied health service submitters also identified education and training enhancements as key benefits although there were concerns expressed that nursing education and training had decreased traction primarily because of a perceived reduction in power of nursing across the SCHN and the overloading of the nursing leadership role which includes education.

d. **Health promotion and advocacy efforts** have resulted in new programs such as Zero Childhood Cancer, Injury Prevention and many more.
e. **Collaborative service planning across a number of services provided at both SCH and CHW sites.** Collaborations identified by interviewers and submitters include oncology, population health and early years programs, refugee work, ambulatory care, coordinated care planning and hospital in the home, some areas of allied health planning and models of care, palliative care and rehabilitation (300 children now have their care coordinated outside the hospitals and this has been accompanied by a large decrease in emergency presentations and 6 research articles published). Additionally, it was reported that collaborations across sites on mental health patient flow has freed up beds to accept more patients and that general surgery now has dual appointments across the sites. A broad range of submitters identified collaborations leading to service improvements such as coordination of care and enhancements such as models of care to provide care at home or by local care providers.
f. **Quality improvements through standardisation of best practice** care in a number of clinical services where there has been integration. Outcomes reported in various documents of the SCHN include halving the serious incident rate and reduced medico-legal risks.
g. **Investment in the Electronic Medical Record** at both sites will enable better care for children using both sites and support quality improvement efforts.
h. **Investment in a leadership development program** has been beneficial to culture and has now attracted its fourth cohort of leaders. The program was supported by many clinical and non-clinical people as important for the development of leaders in the Network.
i. **Synergies and cost savings in back of house services** such as payroll and other corporate support services (reduced from 3 to 1 payroll), rationalisation of many duplicated policies (eg from 1400 down to 1052), merging of a number of duplicated committees.

5. THEMES RELATING TO OBSTACLES PRESENTED BY THE NETWORK STRUCTURE

The face to face interviews, workshops and submissions yielded a high degree of consistency around themes in relation to the question "What are the most important obstacles to delivering excellent care that are presented by the network structure which must be overcome going forward?" All people who identified benefits to the governance arrangement also identified significant obstacles to progress of their work. This section describes the themes around which there was consistency of views.

1. **The vision and strategy for the SCHN has not been clearly articulated by the State or the Network itself. The vision and strategy has not engaged the hearts and minds of the organisation and its implementation is not monitored and celebrated.**

- The SCHN Strategic Plan sits outside of any state paediatric strategy or framework for child health and paediatrics in NSW. People both inside SCHN and in Local Heath Districts (LHD) have identified the lack of a single focus for paediatrics in the Ministry of Health providing guidance for paediatric service requirements and roles as an obstacle to progress. People are confused about how to get support from the Ministry. Initiatives and plans appear to be developed at a service by service level rather than at a strategic/organisational level which could be facilitated and even "required" by the Ministry.
- Whilst a clinical service plan, developed early in the life of the SCHN, outlined a strategic intent to develop more patient focused models of care, it did not clarify the roles of each site nor delineate service roles across sites that would inform strategy for change aimed at improving quality and cost effectiveness of services. There is a mixture of approaches to service planning including single services across both sites or dual services - one on each site and no clear criteria about which services should be single network services and which should remain site based. This problem goes beyond SCHN to other LHDs and the other tertiary referral centres in NSW. Service planning therefore appears reactive rather than strategically developmental. It is perceived that this also leads to SCHN trying to be all things to all people and to a level of demand that it cannot meet within its existing limited resources. It also fuels uncertainty and it is perceived by some to have compromised decision-making by facilitating a consensus based approach which has impeded the achievement of more ideal and evidenced based, but difficult, options for development.
- Although there was engagement by the Board, Executive and around 50 clinicians in the development of the SCHN Strategic Plan, it was delayed for a year and lost traction. There is a view that it is not broadly known amongst the staff and, therefore, does not inform service development. The plan is broad and requires engagement of clinical service providers to operationalise it into clear action plans and related business plans such that any new funds are aligned on an annual basis. There is not clarity that this alignment is happening. There is a view that there is little monitoring of the Strategic Plan by the Board.
- Plans do not address the fact that each hospital must exist in its own ecosystem. Infrastructure is different across the two sites (those mentioned were theatres, medication support, diagnostic support, equipment, and subspecialty availability and information systems). A clearly articulated and communicated strategy and operational plan is required to address these major barriers to the integration of care and sharing patients.
- Clinicians responsible for provision of health service in precincts, other LHDs or state-wide services have consistent views that, contrary to the original intent underpinning the creation of the SCHN, it now looks inward with a focus on how to provide service across the campuses. Access to the support they need has reduced and is based on personal relationships rather than strategic intent.

2. There has been insufficient investment in the change management required to create the new organisation from organisations with very different cultures.

- There is a view that the key change strategy was to change the structure and then to let the integration happen organically through a focus on developing joint policies and protocols for care to improve quality consistency across sites. Despite some clear successes with this approach yielding collaborations and initiatives which improved service and quality, there is a consistent view that the approach had variable success, given many other obstacles described below. Consequently, some service leaders feel their services have been forced to integrate where it doesn't make sense to them, wastes their time and

increases their sense of uncertainty and trust in the Network. Whilst this view is more likely to be expressed at SCH, it has also been supported by observations from CHW.

- The importance of organisational culture in facilitating or hindering the change process may have been underestimated and not adequately addressed through the change management process. Although a widely regarded leadership development program was established, it has not been enough to align and leverage cultures. It is felt that the engagement of the clinical staff in the change strategy has been limited. Many feel disrespected and ignored and that the strengths of both sites have not been recognised or celebrated in the creation of the new SCHN.
- There is a view that the change program underpinning the creation of the SCHN was not resourced adequately. The Executive did not have enough resources or time for both the change management program and for the operational management of two hospitals. This was compounded by creating the single executive structure to manage two large teaching hospitals and a number of other service responsibilities. This has resulted in change management being reactive rather than proactive. Many people see the cardiac issue as an example of the consequence of a failure to plan and manage change with engagement of clinicians and clear decision-making. The outcome is now interpreted as a takeover by some at SCH and a failure to use evidence as clear criteria in decision-making by some at the CHW.
- There has been insufficient support for clinician engagement in the change program. Merging services has meant more work for clinicians. Standardising is difficult enough on one site and there is very little support to keep projects moving when the clinicians have competing priorities for their time.
- There is no clear branding strategy to support the change to a Network. In addition to the SCHN brand, the two hospitals retain their individual branding identities and even their intranets. There are now three intranets. This is inconsistent with trying to create an integrated organisation. Although there is a branding policy, people do not comply with it. There are significant costs associated with this approach to branding.
- There are major obstacles to working across the sites such as lack of car parking for staff who need to travel between sites, no travel support such as buses, travel times and traffic conditions reduce productivity of key leaders, unreliable technology for meetings and extra phone dependency. Many of these extra costs are incurred by SCHN staff.

3. The organisational structure does not support the operational requirements of two hospitals with different service arrangements with precincts and some 40 kilometres apart. It does not support or facilitate cultural change and has impeded effective decision-making and service delivery in both the hospitals and the State-wide services.

- The strongest consistency in views is that the lack of site presence and local decision making is the root cause of many other problems. These include delays in decision making, lack of effective consultation and evidence in decision making at the highest level of SCHN. There is a sense of staff and campus disempowerment, limited access for middle managers to executive leaders for help with problem solving, a sense of inequity and competition between both campuses, lack of communication, lack of effective relationship and contractual management with relevant precincts, and lack of executive corporate support on campuses. There is a sense that the Executive are doing the best they can but their roles are too broad and their time and resources too limited. There is a view that the Executive and Board are now disconnected from the reality of service provision on the ground on a daily basis. This has paradoxically resulted in more bureaucratic processes and a lack of responsiveness for simple things.

- The issues caused by the organisational structure are compounded by distance, with the round trip to and from each site being about three hours. This is very inefficient and results in insufficient support on each site.
- There is a view that roles within the structure are not clearly defined and too broadly focused. Some issues around which there was consistency of view include;
    - There is insufficient time and project support allocated to Clinical Program Directors
    - Most decisions appear to go through the Director Clinical Operations (DCO) which creates a bottle neck for decision making.
    - The workload for the DCO role is too high and the result is that there is a disconnect between the staff on the ground at both sites and the Executive.
    - Nursing leadership has been weakened through the management structure. They have no direct line authority within the clinical structure of either hospital. The Directors of Nursing (DONs) and cross site service leaders are sometimes at odds since there is no direct line of management responsibility between the DONs with Nurse Unit Managers. The site based DONs have no operational management of their respective hospitals and the role of the Network DON is unclear to the nursing staff.
    - Allied health have little time allocated to their executive role and is left out of strategic planning. A review of their governance structure has been undertaken and waiting executive feedback.
    - Education is a multi-disciplinary function and there is a view that it should not be managed by the Network DON. Education has suffered because the job of the Network DON is too broad.
    - The organisational structure and focus does not support the State-wide services of NETS, Children's Court Clinic, Bear Cottage, NSW Poisons Information Service, or the NSW Pregnancy and Newborn Services Network.

4. The decision making process is confusing and opaque to the people on the ground.

- There is a common view that decision making is not transparent. It is consistently reported by non-executive staff that proposals or requests seem to get lost in the decision making process with little follow through or communication about the status of requests or "briefs." There is little local delegation for decisions required to take faster action around operational issues at each site. This results in inefficiency and lack of trust between middle management and Executive.
- Both the SCH and the CHW staff believe that decisions regarding new money or service development are made in favour of the other hospital. There is a very strong perception of inequity on both the SCH and the CHW campus. There appear to be lower levels of funding compared to interstate counterparts of the SCHN and this may be compounding the sense of inequity.
- There is a view that decisions that have been made and communicated have not been implemented with little communication about why. This is not conducive to open trusting relationships between the clinical staff and the Executive and Board.
- It is a common perception that there is a reluctance by the Chief Executive, Board and Executive to make the hard decisions that sometimes need to be made to move forward. This includes personnel decisions. It is perceived that there is a tendency to try to satisfy everyone which ends up satisfying no one.

5. There are different cultures in each hospital and the differences are now compounded by a lack of trust between the hospitals.

- People from both hospitals say that there has been a degree of competition between the two institutions for 40 years which continues today. The issues outlined above have compounded these differences and there is now a level of distrust between clinicians across the SCH and CHW which will be difficult to overcome. People from both sites have identified the need to acknowledge and leverage the cultural differences and to improve alignment when considering and designing governance arrangements. Leadership and advocacy for children would be stronger if the cultures were more aligned around key areas / issues for collaborations, thereby enhancing the potential for a strong unified voice for children.
- A number of submissions highlighted concerns regarding unchecked intimidating or "bullying" behaviour of quite senior medical, nursing and administration managers which is inconsistent with the values of the organisation. There is a view that this kind of behaviour is not addressed.

6. The lack of regular, honest and timely internal two-way communications between the clinicians on the ground, the clinical leaders, the Executive and Board has compounded all the issues identified above.

7. There is a common view that the interests of children and families requiring the service of NETS, The Children's Court Clinic, Bear Cottage, NSW Pregnancy and Newborn Services Network and the Poisons Centre are not served well by the governance of SCHN being largely peripheral to their main focus.

- Most people who participated perceive increased levels of bureaucracy and delays in important operational decisions.

8. There is a view that participation of consumers should be strengthened and their ideas acknowledged and actioned.

- The merger of the two hospitals committees has decreased the time and attention of the members at each hospital.
- There is a need for more deliberate attention from the Board and Executive and middle managers to consumer input and suggestions and a formal process to provide feedback on any action taken as a result of consumer input. The Board and Executive could ensure that a process of culture change takes place in the organisation to increase the capability of the staff to engage consumers in decision making and to increase the capability of the consumers to participate.

9. Funding for paediatric care may not accommodate and acknowledge the difference between paediatric care and adult care.

- There is a view that, in the absence of higher funding for paediatrics, other LHDs may withdraw from some services with resultant less complex non tertiary cases presenting at SCHN. This is not the most cost effective use of resources of the SCHN. Conversely return transfers from SCHN to LHDs may be more difficult in the absence of well developed secondary paediatric services.
- There is a requirement to understand the SLA's for LHD's in relation to Paediatric care and to align incentives with a broader state-wide networked approach to care.

APPENDICES

Appendix 1 – SCHN Governance Review Terms of Reference

EXPERT PANEL – REVIEW OF GOVERNANCE FOR THE SYDNEY CHILDREN'S HOSPITALS NETWORK

The Ministry of Health, in conjunction with the Sydney Children's Hospital Network (SCHN) Board is proposing to convene an Expert Review Panel to review the current governance model for the SCHN, including the Children's Hospital at Westmead (CHW) and Sydney Children's Hospital at Randwick (SCH).

Background: The SCHN was created as a statutory corporation in 2010 as part of the Government response to the Special Commission of Inquiry into Acute Health Care in NSW, through bringing together the two major Sydney metropolitan children's hospitals to establish a single, statewide service, to support the improvement of the health and wellbeing of children in NSW.

Objectives: While the SCHN has achieved some significant developments in providing health care for the children of NSW and in child health research and education, the operating environment has changed considerably since it was established, creating both challenges and opportunities.
These changes include:

- significant health capital investment on both the Randwick and Westmead campuses;
- significant university commitment to research and education at both Westmead and Randwick;
- designation of the Randwick and Westmead sites as part of advanced health research translation centres;
- investment commitment by NSW Health to development of paediatric services in Campbelltown;
- the designation by the Greater Sydney Commission of health and education precincts and the three city approach to metropolitan Sydney.

Advice sought: The advice of the Panel is sought to identify the most effective governance of SCHN to maximise the benefit of these developments and build on future benefits going ahead, including advancing local service accessibility and excellence as well as improving the integration of paediatric services across levels of care and across the State.

The advice should consider changes to urban and regional population, the growth planning framework for greater Sydney and the infrastructure and service investment already made by NSW Health and various universities in south east and western Sydney and the needs of regional NSW in relation to tertiary and quaternary level services. The Panel, in making recommendations should also consider the following key drivers:

- the maintenance of the high level of paediatric services offered at the Randwick and Westmead campuses;
- benefits that can be obtained through the increased synergies across the geographic sites, leveraging on the investments in the Health Education Precinct;
- changing demographics and the future health needs of children and adolescents particularly those with chronic and complex conditions;
- enhancement of broader NSW state-wide paediatric planning and service networking.

The Panel is asked to provide their advice to the Health Secretary by 30 April 2019.

NSW GOVERNMENT

Appendix 2 – Proposed Clinical Consultative Group Process

REVIEW OF GOVERNANCE FOR THE
SYDNEY CHILDREN'S HOSPITALS NETWORK

Proposed Clinical Consultative Group Process
Purpose

The Ministry of Health, in conjunction with the Sydney Children's Hospital Network (SCHN) Board has commissioned an Expert Review Panel to review the current governance model for the SCHN, including the Children's Hospital at Westmead (CHW) and Sydney Children's Hospital at Randwick (SCH)

- The advice of the Panel is sought to identify the most effective governance of SCHN to maximise the benefit of these developments and build on future benefits going ahead, including local service accessibility and excellence as well as improving the integration of paediatric services across levels of care and across the State.
- The advice should consider changes to urban and regional population, the growth planning framework for greater Sydney and the infrastructure and service investment already made by NSW Health and various universities in south east and western Sydney and the needs of regional NSW in relation to tertiary and quaternary level services.

Governance

The Review Panel will report to the Secretary of Health. The Review Panel will consist or Dr Kathy Alexander (Chair), Dr Peter Steer and Ms Sue Peter.

The Review Panel will be assisted by a Process Clinical Consultative Group which will meet 3 times throughout the review process to fulfil the following terms of reference;

Meeting 1

Be briefed on the proposed program of activities to achieve the purpose of the review,

Provide feedback on the proposed process to ensure an appropriate diversity of relevant views are heard

Meeting 2

Be briefed on progress of the Expert Review Panel and advise on any gaps identified in consultation process to that date

Meeting 3

As per (ii) at the conclusion of the intended interview period

The Process Clinical Consultative Group will have the following membership;

Medical perspective across clinical services

NSW GOVERNMENT

Nursing perspective across clinical services

Allied Health perspective across clinical services

Teaching/research from across the research and academic domain

Process

Draft a list of interviewees

Meeting 1 with the Process Clinical Consultative Group to seek advice on list of interviewees

Undertake majority of interviews

Review Panel to consider any potential gaps still not adequately considered through the interviews or submissions to date.

Conduct Meeting 2 with the Process Clinical Consultative Group to discuss gaps and to seek advice on a broader consultation process around these gaps.

Complete interviews and consider submissions.

Analyse data

Draft final report with recommendations and consider any unresolved gaps in information.

Conduct meeting 3 with the Process Clinical Consultative Group to consider strategies to close off any unresolved gaps in information.

Final report to the Ministry.

Appendix 3 - Resulting framework for participation as advised by the Process Clinical Consultative Group and Panel

SCHN GOVERNANCE REVIEW - INVITATIONS ISSUED					
	PCCG identified Service Stakeholder Group	**No of Reps**	**Date**	**Location**	
1	**Process Clinical Consultative Group**	12	Fri, 22 March	Randwick	
2	**Diagnostics incl:** ▪ Infection Control ▪ Imaging ▪ Pathology ▪ Nuclear Medicine	 7 8 5 3	Fri, 12 April	Westmead	
3	**Allied Health**	23	Fri, 12 April	Westmead	
4	**Acute Care incl:** ▪ Emergency ▪ Transplantation ▪ Anaesthesia ▪ ICU ▪ Surgery ▪ NETS ▪ Neonatology ▪ Renal	 5 5 6 10 11 6 5 1	Wed, 17 April	Westmead	
	▪ David Winlaw	1	Thurs, 18 April	Teleconference	

	▪ Philip Roberts ▪ Mike Jones	1 1	Thurs, 18 April Thurs, 18 April	Teleconference Teleconference	
5	**Research** ▪ Adam Jaffe	19 1	Fri, 12 April Thurs, 18 April	Westmead Teleconference	
6	**Single Cross Campus Services incl**: ▪ Rheumatology ▪ Palliative Care ▪ Bear Cottage ▪ Cardiology ▪ Ambulatory Care / GPS / Trapeze	 2 5 1 5 15	Wed, 17 April	Westmead	
7	**Dual Services, site based not jointly managed incl:** ▪ Oncology ▪ Child Development Unit ▪ Child Protection ▪ Community Child Health ▪ Orthopaedics ▪ Nephrology ▪ General Paediatrics ▪ Respiratory ▪ Additional staff	 7 3 3 4 6 5 7 4 5	Wed, 26 April	Randwick	
8	**Nursing and Education**	16	Wed, 17 April	Westmead	
9	**Junior Medical Staff** Sydney Children's Hospitals Network	10	Thurs, 23 May	Randwick Westmead	3 x Apology
	Review Panel identified Service Stakeholder Group	**No of Reps**	**Date**	**Location**	
10	**Board** ▪ Individuals	3	Fri, 22 March	Randwick	

	▪ Individuals	3	Fri, 5 April	Randwick	
	▪ Individual incl Audit & Risk Committee Chair	2	Fri, 26 April	Randwick	
	▪ Chair/Acting Chair	2	Fri, 26 April	Randwick	
	▪ Group	7	Fri, 5 April	Randwick	2 x Apology
11	**Executive**				
	▪ Individuals	5	Fri, 22 March	Randwick	
	▪ Chief Executive	1	Wed, 17 April	Westmead	
	▪ Acting Chief Executive	1	Wed, 24 April	Teleconference	
	▪ Group	7	Tues, 2 April	Teleconference	
12	**Non Clinical Staff**	14	Wed, 17 April	Westmead	
13	**Medical Staff Council, Executive**	11	Tues, 2 April	Teleconference	
14	**Medical Staff Council CHW**	60*	Thurs, 11 April	Westmead	
15	**Medical Staff Council SCH**	60*	Tues, 16 April	Randwick	
16	**Clinical Council**	34	Fri, 5 April	Randwick	
17	**Clinical Program Directors**	21	Fri, 12 April	Westmead	
18	**Family and Consumer Council**				
	▪ Network Manager - Patient and Family Engagement	1	Fri, 5 April	Randwick	
	▪ Patient Friend	2			
	▪ Network Manager - Patient and Family Engagement	1	Wed, 17 April	Westmead	
	▪ Patient Representative	1			
19	**Sydney Children's Hospitals Foundation**				
	▪ Board Chair	1			
	▪ Chief Executive	1	Fri, 12 April	Westmead	
	▪ Deputy Chair	1			Apology
	▪ Board Member	1			Apology
20	**Paediatrio / CRMI /CCIA**				
	▪ Chair of Paediatrio	1	Fri, 22 March	Randwick	Apology

	▪ Director of Children's Medical Research Institute	1	Fri, 5 April	Randwick	
21	**Redevelopment** ▪ Clinical Services Planner	1	Fri, 26 April	Randwick	
22	**LHDs - Chief Executives** ▪ South East Sydney ▪ Western Sydney	1 1	Wed, 17 April	Westmead	
	▪ John Hunter Children's Hospital	1	Fri, 12 April	Westmead	
	▪ South West Sydney	1	Fri, 26 April	Randwick	
	▪ Illawarra	1	Fri, 12 April	Westmead	
	▪ Murrumbidgee	1	Fri, 26 April	Randwick	
23	**LHDs - Children's Healthcare Network Leads/Head of Paediatrics /Paediatric Clinical Leads** ▪ NSW Chief Paediatrician ▪ Illawarra paediatric medical clinical leads ▪ South West Sydney paediatric medical clinical leads ▪ Murrumbidgee paediatric medical clinical leads ▪ Sydney LHD paediatric medical clinical leads ▪ HNE paediatric medical clinical leads ▪ Medical Lead Children's Healthcare Networks - Southern	1 1 1 1 1 1 1	Fri, 26 April	Randwick	
24	▪ Nursing Lead Children's Healthcare Networks - Southern ▪ Medical Lead Children's Healthcare Networks - Western ▪ Nursing Lead Children's Healthcare Networks - Western ▪ Medical Lead Children's Healthcare Networks - Northern ▪ Nursing Lead Children's Healthcare Networks – Northern	1 1 1 1 1			
25	**Ministry of Health** Deputy Secretaries				

	▪ Strategy & resources Division	1			
	▪ System Purchasing & Performance	1	Fri, 5 April	MoH	
	▪ Population & Public Health	1			
	▪ People Culture & Government Division	1			Apology
	Secretary	1	Fri, 26 April	Woollahra	
26	**Universities**				
	University of Sydney				
	▪ Head of School of Public Health	1	Fri, 26 April	Randwick	
	University of NSW				
	▪ A/Dean of Medicine & Snr Vice Dean-Clinical Affairs on behalf of Vice-Chancellor	1	Fri, 26 April	Randwick	
	TOTAL	**496**			

- Note that the figures marked * represent attendees to the Medial Staff Council meetings

Appendix 4 - List of Submitters

Title	Frist Name	Surname		Title	First Name	Surname
Dr	Susan	Adams		Dr	Alison	Loughran-Fowlds
Dr	Stephen	Alexander		Ms	Cathy	Lovell
Dr	Ian	Andrews		A/Prof	David	Lowinger
Ms	Kathryn	Asher		Ms	Verity	Luckey
Dr	Matthias	Axt		Dr	Jeanette	Marchant
Dr	Nadia	Badawi		Dr	Amanda	Marsden
Ms	Trish	Bennett		Ms	Diane	Martin
Dr	Andfrew	Berry		Ms	Alana	Maycock
Dr	Kaustuv	Bhattacharya		Dr	Damien	McKay
Ms	Margaret	Bresnahan		Dr	Alicia	Montgomery
Dr	Gillian	Brooks		Dr	David	Mowat
Dr	Kathryn	Browning Carmo		Ms	Melissa	Mroz
Dr	Michael	Brydon		Dr	Tim	Muling
A/Prof	Annie	Bye		Ms	Glenda	Mullen
Ms	Lindsay	Byrne		Ms	Dianne	Muniz
Dr	Neil	Caplin		Dr	Kristen	Neville
Dr	Jeffrey	Chaitow		Dr	Andrew	Numa
A/Prof	Daniel	Challis		Dr	Matthew	O'Meara
Ms	Jane	Cichero		Dr	Simon	Pagetty
Ms	Maria	Coelho		Ms	Ciara	Paramore
Prof	Ralph	Cohen		Ms	Melissa	Parkin
Prof	Richard	Cohn		Ms	Lyn	Peek
A/Prof	John	Collins		Ms	Natalie	Pidcock
Dr	Matthew	Crawford		Mr	Anne	Preisz
Ms	Marilyn	Cruickshank		Dr	Kristina	Prelog
Dr	Bruce	Currie		Dr	Hari	Ravindranathan

Mr	Kim	Da Silva		Ms	Catherine	Reilly
Dr	Luciano	Dalla-Pozza		Dr	Philip	Roberts
Mr	Josh	Emanuel		Dr	Susan	Russell
Dr	Philip	Emder		Dr	Hugo	Sampaio
Ms	Christine	Fan		Ms	Anne	Senner
Prof	Glen	Farrow		Ms	Elizabeth	Shepherd
Mr	Kevin	Fernandez		A/Prof.	Gary	Sholler
Dr	Marino	Festa		Dr	Puneet	Singh
Ms	Daniela	Feuerlicht		Dr	Davinder	Singh-Grewal
Ms	Rebecca	Fisher		Ms	Vicky	Smith
Ms	Sue	Foley		Dr	Michael	Solomon
Mr	Paul	Gallagher		Dr	Marlene	Soma
Mr	Robyn	Galway		Ms	Kylie	Stark
Mr	Alan	Gardo		Ms	Wendy	Stephen
Ms	Kirsty-Leah	Goymour		Dr	Michael	Stormon
Ms	Christie	Graham		Dr	Kevin	Swil
Ms	Michelle	Grail		Dr	Arthur	Teng
Ms	Debra	Grech		Dr	Ganesh	Thambipillay
Dr	Donald	Hannah		A/Prof	Gordon	Thomas
Dr	Henley	Harrison		Dr	Susan	Towns
Ms	Charlotte	Helly		Dr	Susan	Trethewie
Ms	Dianne	Hill		Dr	Charles	Verge
Dr	Bee	Hong Lo		Ms	Nadia	Vigna
Dr	Paul	Hotton		Ms	Sandra	Wales
Ms	Michelle	Hughes		Dr	Jan	Walker
Dr	David	Isaacs		Ms	Lyn	Ward
Dr	Ian	Jacobson		Dr	Mary-Clare	Waugh
Prof	Adam	Jaffe		Dr	Andrew	Weatherall
Dr	Ramanie	Jayaweera		Dr	Chris	Webber
Dr	Mike	Jones		Mr	Meg	Wemyss
A/Prof	Alyson	Kakakios		Ms	Sally	Whalen
Dr	Hala	Katf		Ms	Sue	Wicks
Ms	Tina	Kendrick		Dr	Richard	Widmer
Dr	Sean	Kennedy		Dr	Gary	Williams
Prof	Alison	Kesson		Prof	David	Winlaw
Dr	Henry	Kilham		Ms	Ingrid	Wolfsberger
Ms	Clare	Klimes		Dr	Melanie	Wong
Dr	Maria	Kyriagis		Ms	Sarah	Wood
Dr	Catherine	Langusch		A/Prof	Sue	Woolfenden
Dr	John	Lawson		Dr	David	Ziegler
Ms	Robyn	Lea		A/Prof	Karen	Zwi
Dr	David	Lester-Smith		Dr	Richard	Webster
Prof	Raghu	Lingam				