Witness Statement

Name: Dr Angus Alexander

Occupation: Chair of Staff Medical Council of The Children's Hospital at Westmead

1. This statement sets out the evidence that I would be prepared to give as a witness to the Special Commission of Inquiry into Healthcare Funding.
2. The contents of this statement are true and correct.

A. My Role

3. I am a paediatric general surgeon with an interest in paediatric urology. I have worked for the Sydney Children's Hospital Network ('**SCHN**'), primarily at The Children's Hospital at Westmead ('**CHW**'), since August 2013. I have also done calls and operated on call at Sydney Children's Hospital Randwick ('**SCH**'). I operate and run a clinic at Hornsby Ku-ring-gai Hospital.
4. I am the Chair of the CHW Medical Staff Council ('**MSC**'), a position I have held since 2021.

B. Challenges with the Sydney Children's Hospital Network

5. These are two main hospitals in the SCHN – CHW and SCH. In my experience, the CHW and SCH compete for inadequate funding to support two tertiary/quaternary children's hospitals. Both hospitals advocate strongly for their status and funding. Much of this has played out in the media. Politics, rather than sound medical decisions, have played an outsized role in the allocation of resources, funding and specialist services.
6. In my view, the structure of SCHN itself is not the issue. It is the lack of a clear overarching plan for paediatric care in New South Wales ('**NSW**') and the role of the Network Hospitals within the bigger picture, that has allowed hospitals to compete with each other to maintain or achieve their status and funding. In my view, there should be a clear vision for paediatric care in NSW that is well articulated to all levels of the health workforce. This vision will inform a clear plan and structure that includes appropriate distribution of resources, funding and education.

7. The SCHN has released a five-year plan for the network, but that does not help to resolve these issues. I am also aware of the view held by clinicians within the SCHN that there was a lack of adequate consultation with clinicians in developing this plan. There has been a long period of mutual mistrust between clinicians and NSW Health. This predates the present executive but there have been missteps (largely around poor communication) that continue to agitate the interactions between the workforce and the executive. To my observations, the executive is often caught in the middle, able to see the problems on the ground but powerless to effect meaningful change because of a completely inadequate budget. In order to overcome this, I consider that there needs to be better funding, more collaboration and much better communication.
8. I believe that creating a five-year NSW Paediatric care plan would help engage clinicians to work together to develop strategies to tackle the current challenges facing the delivery of paediatric services. The plan should consider:
    a. What does the overarching service delivery plan across NSW and the SCHN encompass;
    b. This will inform what specialist services will be provided at each of the two sites of CHW and SCH;
    c. What other services need to come on-line and where should they be sited;
    d. What level of service should they provide;
    e. What is the role of nurse practitioners;
    f. Do we have enough capacity in the community to keep sick children in their local community and out of the main teaching hospitals – unless they need to be there;
    g. What training needs to occur to provide the workforce for this state-wide care;
    h. How are we going to attract and retain staff to NSW and Sydney in particular, given the as costs of living in Sydney and housing costs in particular; and

i. The expectations and opportunities for clinicians to provide and develop paediatric care in the local community.

9. The plan should include paediatric care that will be provided by local communities and hospitals. How those hospitals will be supported by the Network in a 'hub and spoke model' are essential for sustainability of the spoke sites.
10. This could include appointing consultants in a site-agnostic appointment that sees clinicians responsible for patient care across NSW, caring for patients in a seamless model of primary, secondary and tertiary care.
11. Within such a model, the 'spoke' facilities would not necessarily need to be part of the SCHN, however there should be an overarching governance structure with oversight of paediatric services across NSW. Funding for paediatric services in the 'spokes' could, and in my view should, rest with the LHDs, but it needs to be protected and used exclusively for paediatric services. That way LHDs would be invested in delivering paediatric care as part of a coordinated, comprehensive umbrella of paediatric care across the State.
12. I do not think the incentives are currently in place to support the effective management of paediatric patients across NSW. Some effort is made to sift out where various patients should be managed, but there is a lack of support for and from the peripheral hospitals for this to be successful.
13. To my observation, the inadvertent centralisation of paediatric emergency care is a major problem. It overburdens the teaching hospital and has deskilled many state facilities. This creates a huge burden of referrals that could actually be managed locally in a coordinated system. Clinical services are also developed on an ad hoc basis without clear planning or coordination, which risks deploying resources and funding in a sub-optimal way.
14. Education of and support for general practitioners (**GPs**) and Paediatricians to decrease the number of children sent to the emergency department ('**ED'**) should also be included in the plan. Currently, there are some paediatric guidelines to help GPs know when to refer

patients to ED, but these are not very effective. It takes time to set up a website to disseminate guidelines and other types of information, and without a clear plan there is no urgency nor is the role out structured or comprehensive.

C. Funding of Paediatric Services

15. CHW services the fast-growing population of Western Sydney, catering to a community that has generally lower socio-economic status and often more complex needs.
16. There is a serious lack of community paediatricians who can manage patients with behavioural issues or chronic conditions, requiring long-term care.
17. I consider that the Activity Based Funding (**ABF**) model does not accurately capture the nuances of providing services for paediatric patients. Paediatric care is highly nuanced; investigations and procedures in children require significantly more resources than in adults. Just a few examples that illustrates the problem include young children require a general anaesthetic to be kept still during an MRI. Children frequently require conscious sedation, play therapy, and additional nursing and medical staff to perform investigations that would need a single clinician in an adult setting. Ward space, accommodation, meals and bathroom facilities cannot just cater for single adult patients but need to be considerate of a parent sleeping at the patient's bedside, different meals according to the age of a child, bathrooms catering to children and adults.
18. The funding arrangements for CHW's neonatal intensive care unit (**NICU**) are another example of a flawed funding based on the National Weighted Activity Unit (**NWAU**) system. The NWAU allocated for neonatal care does not consider the concentration of extremely sick patients, many of whom have complex congenital abnormalities and require multiple complex investigations and operations.
19. Clinicians at other hospitals frequently contact the specialists at CHW and SCH for advice. This is appropriate to draw on our expertise and can help to expand knowledge at other

hospitals. However, this extra work is not recognised in the ABF model. There is no activity captured in relation to second opinions of x-rays by radiologists.

20. I am aware of occurrences where, due to the present funding models, activity undertaken in hospitals and departments doing most of the care are not remunerated for this activity. Some or all of the activity undertaken by CHW clinicians is routinely not captured in this way.

Signature: AG Alexander

Name: **Dr Angus Alexander**

Date: **7 June 2024**