Special Commission of Inquiry into Healthcare Funding

Statement of Dr Susie Piper

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Occupation:	District Medical Lead for Paediatrics Southern, NSW Local Health District

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

2. This statement is provided in response to the letters dated 28 June and 31 July 2024 issued to the Crown Solicitor's Office, and addresses the topics set out in the 28 June 2024 letter relevant to my role.

A. INTRODUCTION

3. I am a general paediatrician, the Head of Paediatrics at South East Regional Hospital (**SERH**) in Bega, and the District Paediatric Medical Lead at Southern NSW Local Health District (**SNSWLHD**, **the District**). I have worked at SERH full-time since March 2023. I have been the SNSWLHD District Medical Lead for Paediatrics since 2021. Prior to moving to Bega in 2023 I was living and working in Wollongong, where I held a similar district paediatric medical leadership role.

4. A copy of my curriculum vitae is exhibited (**MOH.0010.0458.0001**).

B. SNSWLHD PAEDIATRIC SERVICES

(i) Overview

5. SNSWLHD has Level 4 Paediatric Services with a children's ward and paediatric medical and nursing staff at Goulburn and SERH. The new Eurobodalla Regional Hospital will have a children's ward and will become a third paediatric hub for the District when it opens.

6. Maternity services are also provided at Queanbeyan, Cooma and Moruya Hospitals but there is no paediatric inpatient unit or on-site paediatric presence in those units. The

coastal paediatricians based at SERH currently provide remote support and outreach clinics to Cooma and Moruya Hospitals and in Eden and Narooma.

7. Children requiring tertiary care are usually transferred to the Sydney Children's Hospital Network, but there are some transfers and referrals to Canberra, where some paediatric subspecialty services and paediatric surgery are available.

8. SNSWLHD is part of the tiered perinatal network with Canberra, so most SNSWLHD neonates and pregnant women requiring a higher level of care are transferred to Canberra which has a Level 6 Neonatal Intensive Care Unit (NICU).

9. Graduate medical students from the Australian National University (ANU) medical school rotate through paediatrics in Goulburn Base Hospital and at SERH.

(i) Goulburn Base Hospital

10. Goulburn Base Hospital has a 6 bed children's ward. There are two full time paediatric staff specialists who cover the on-call roster on weekdays. The paediatric on-call roster relies on locum cover every weekend. There are approximately 300 births per year, and approximately 5000 paediatric Emergency Department (**ED**) presentations per year.

11. General Paediatric Outpatient clinics are provided at Goulburn Hospital with outreach clinics to Crookwell.

12. The Goulburn Paediatric unit is accredited with the Royal Australasian College of Physicians (**RACP**) for paediatric training and a registrar rotates from The Sydney Children's Hospital Network every 6 months.

13. The on-call load is heavy as there is no on-site paediatric junior medical officer (**JMO**) outside of business hours which means calls to the on-call paediatrician are frequent and often require urgent on-site attendance.

(ii) South East Regional Hospital

14. SERH has a 6 bed children's ward. There are 4.8 full-time equivalent (**FTE**) paediatric staff specialists covering the on-call roster 7 days / week (0.2 FTE is vacant). The on-call roster has been fully covered with no locum use since the positions were recruited (March 2023).

15. In the 2023-2024 financial year there were 229 births and 4,619 paediatric ED presentations at SERH. There were 209 births at Moruya and 140 births at Cooma.

16. The paediatricians provide virtual support to Moruya and Batemans Bay EDs. There were 4,874 paediatric ED presentations to Moruya and Batemans Bay during the 2023-2024 financial year. Children from Eurobodalla requiring inpatient admission are transferred to SERH, which is approximately 2 hours to the south. These children will be able to be managed locally in Eurobodalla once the new hospital opens. Children from Cooma ED (2,494 paediatric ED presentations in 2023-2024) are usually transferred to Canberra if they need admission, but the Coastal Network paediatricians provide phone support as needed and children are occasionally transferred from Cooma to SERH.

17. Outpatient clinics are provided at SERH, and outreach clinics are provided to Cooma, Eden, Moruya and Narooma. The SERH Paediatric unit is accredited for paediatric training with the RACP. There is a Specialist Training Program (**STP**) funding for an advanced trainee position. A Post Graduate Year (**PGY**) 2 resident medical officer (RMO) is rostered to the paediatric team during business hours. The paediatric rotation is popular as it provides valuable paediatric experience for junior doctors in their second post-graduate year. There is no on-site paediatric JMO outside of business hours which means calls to the on-call paediatrician are frequent and often require urgent on-site attendance.

18. A large portion of the paediatricians' workload is outpatient clinics where continuity of care is important and much easier to achieve with permanent staff rather than locums. The clinics have a heavy administrative workload and are supported by 3.0 FTE administration staff.

19. There is enormous demand for outpatient services with a long waiting list. The Coastal Network paediatric clinics provide the only outpatient paediatric service between Nowra, the Victorian border and Canberra. The closest private paediatric clinics are in Canberra or Nowra and many families do not have the capacity or means to travel to access other services. There are still over 400 children on the clinic waiting list (down from over 900 at the beginning of 2024).

C. SERH PAEDIATRIC WORKFORCE

20. The hospital was totally reliant on locum paediatrician cover when it first opened in 2016 and remained heavily reliant on locum paediatricians until the 5 permanent staff

specialist paediatric positions were created and recruited. The positions have been filled and there has been no locum use since March 2023. Being able to recruit to a team of paediatricians rather than to a position as the only specialist is likely to have contributed to the success with recruitment. Successful recruitment was largely through known contacts.

21. The 5 paediatrician model has been successful as it is attractive to join a supportive team environment with a sustainable on-call requirement of not more often than 1 in 4 (taking into account leave). There would be a risk of burnout and fatigue if on-call was more frequent as the on-call workload is heavy. The paediatrician takes calls from GPs, and multiple EDs (SERH, Moruya, Batemans Bay, and occasionally Cooma and Bombala). The phone rings frequently and there is no on-site paediatric JMO outside of business hours, so the paediatricians frequently have to attend in person. The model facilitates the delivery of outpatient clinics by the paediatricians who are not on-call.

22. The team has remained stable, and since the full implementation of this model, the outpatient waiting list has been reduced by almost 50%. An essential part of implementing the model was ensuring there was sufficient outpatient clinic infrastructure and administration support to allow for the expansion in clinic services.

D. PAEDIATRIC CARDIOLOGY OUTREACH CLINIC RUN BY THE SYDNEY CHILDREN'S HOSPITAL NETWORK

23. The Sydney Children's Hospital Network (**SCHN**) commenced a quarterly paediatric cardiology outreach clinic at SERH in 2024. SCHN approached SNSWLHD to collaborate and commence the clinic. The cardiologist brings their own equipment, SCHN do the booking and scheduling, and SNSWLHD provides the rooms and 'meet and greet' administrative support. SNSWLHD provides accommodation for the cardiologist.

24. To date, two clinics have been held in March and July 2024, and each clinic has seen approximately 20 patients.

25. In addition to the provision of services to patients close to their home, the clinic provides valuable education opportunities for SNSWLHD. For example, at the last outreach clinic, the visiting cardiologist participated in a local General Practitioner (**GP**) evening education seminar with the local adult cardiologist.

26. Long term sustainability of this model will rely on continuing goodwill from SCHN in providing the cardiologist and supporting their travel. Rural families would be assisted by having a similar subspecialty paediatric outreach model for other disciplines (for example, paediatric neurology, endocrinology, gastroenterology, rehabilitation). SCHN would require additional resources to provide these services.

E. DJING.GII GUDJAAGALALI KIDS CLINIC

27. The Djing.gii Gudjaagalali Kids Clinic in Eden is an example of a successful partnership between the Department of Education and health providers.

28. The clinic operates in the Wellbeing hub at Eden Marine High School. It is led by Dr Corin Miller, a rural GP with paediatric special interest. It aims to bring targeted, culturally appropriate, collaborative multidisciplinary paediatric outpatient care into the school environment at no cost to the children and families. The clinic is located at Eden Marine High School but accepts referrals from the surrounding primary schools. The SERH paediatric outreach clinics to Eden are held in the Djing.gii Gudjaagalali clinic.

29. The model is being evaluated currently and there would be scope to roll out the model at rural sites across NSW. This would require robust partnership between state and federal health and education services and a sustainable funding model would need to be developed.

F. CHALLENGES AND OPPORTUNITIES

30. In addition to what is already set out above, key challenges and opportunities centre on:

    a. Workforce: Recruiting and retaining nursing, medical and allied health (speech pathology, physiotherapy, occupational therapy, psychology) staff with strong paediatric skill sets. We need to ensure therapists have a broad skill set that includes paediatrics as there is unlikely to be sufficient activity to justify stand-alone paediatric positions. (The relatively small paediatric caseload is at risk of being overshadowed by the high health care needs of the ageing population).

    b. GP workforce sustainability: There is an overall decline in numbers of GPs in the region to provide primary care to SNSWLHD paediatric patients. Many GP practices have closed books at present. We need to invest in the future GP workforce. There is potential to develop rural generalist roles for GPs with special interest and skills in paediatrics who can participate in paediatric on-call rosters. Investment in this type

of role will assist with GP workforce development and would help to grow a paediatric skilled GP workforce who share acute care and hospital on-call responsibilities while also working in primary care and providing GP services to the community.

c. There is capacity at SERH to provide training for rural GPs who want to develop a paediatric skill set, however a funding model is needed to allow this, particularly for GPs who have already completed their GP specialist training but are seeking additional advanced skills training.

d. In terms of development of the rural generalist medical workforce at the JMO level, there is an opportunity is for us to create attractive, high-quality rural training opportunities from the early post-graduate years onwards, including opportunities to experience general practice (to 'grow our own'). This should include providing opportunities to experience general practice in the early post-graduate years while employed within the hospital system. The single employer model for GP training is a step towards this, but it would be helpful for pre-vocational trainees (who may not have decided whether they want to pursue general practice or other training) to also have an opportunity to experience general practice. SERH is piloting a rural critical care year which includes some general practice experience for PGY3 doctors in 2025 with the aim of recruiting a cohort of junior doctors who will then be able to go on to train as rural generalists / rural GPs.

e. Rural generalist medical workforce investment at the senior medical officer level is also needed, so that we have permanently employed doctors working across primary care and in our hospitals and less reliance on locums to cover our rosters. We need reliable, accessible primary care services and good quality ED and acute hospital services with permanent staff. The hospital should not 'compete' with primary care for medical staff. Ideally, we will have rural generalist doctors who work both primary care and in the hospital. Rural generalist doctors should be able to be employed as Staff Specialists and not just as Visiting Medical Officers.

f. The new Eurobodalla Regional Hospital will have a new paediatric service and will require a new paediatric skilled workforce. Eurobodalla is two hours north of Bega, so a sustainable paediatric on-call roster will require another 5 paediatricians, unless alternative models such as shared rosters with GPs with special interest / skills in paediatrics can be developed. The role delineation of the hospital and service impacts on this planning, as a Level 4 service is required to have a specialist paediatrician on-call.

g. There is potential for virtual services, particularly for outpatient clinics, but acutely unwell children and babies usually require hands on assessment and management by a clinician with paediatric and/or neonatal skills. The tyranny of distance means that one paediatrician can provide virtual support for a larger area but cannot provide 'hands on' assistance for an acute emergency at more than one site, so separate sites need separate on-call rosters for this.

h. Current legislative requirements in respect of psychostimulant prescribing mean that patients require regular paediatric outpatient clinic review, and this limits clinic capacity to see new patients. Until recently, GPs were not permitted to prescribe psychostimulant therapies, placing significant demand on paediatrician consultations. Recent changes in the regulations to allow more shared care / co-prescribing will be helpful, however GP workloads are already heavy and many may not be willing to take on a co-prescribing role. We have not yet seen any significant impact on outpatient clinic numbers.

i. Activity based funding does not work well for rural centres where geography requires a service to be available at multiple sites (for example, maternity services need to be available at 5 sites across SNSWLHD because of the distances and travel involved). There will be a fixed cost to provide the service regardless of whether they birth 5 babies / day or 1 baby / day. There needs to be acceptance that activity may be low and that it will be expensive (or 'inefficient') to provide the service. The same applies to children's wards which often operate with fluctuating occupancy.

Susie Piper

7/8/2024
Date

Witness (name and signature):
Renai Heffernan

7/8/24
Date