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Special Commission of Inquiry into Healthcare Funding

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Name: Department of Paediatric Anaesthesia, Children's Hospital Westmead

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Dr Andrew Weatherall and Dr Ramanie Jayaweera
Senior Specialist Paediatric Anaesthetists and Co-Heads of Department
Dept of Anaesthesia,
The Children's Hospital at Westmead,
Hawkesbury Rd,
Westmead, NSW, 2145.

Mr Richard Beasley SC
Commissioner,
Special Commission of Inquiry into Healthcare Funding
Level 5, 121 Macquarie St,
Sydney, NSW, 2000.

20th November, 2023.

Re: Impact on Patients Requiring Critical Paediatric Services of NSW Health Funding Approaches

Dear Commissioner,
We write as Senior Specialist Paediatric Anaesthetists and Co-Heads of the Department of Anaesthesia at The Children's Hospital at Westmead (CHW) to assist the Special Commission into Healthcare Funding.

We write under the umbrella of the Medical Staff Council as part of the bigger picture described by our colleagues across CHW. The submissions come from a range of departments sharing their specific challenges with familiar themes but their own flavour. We fully support our colleagues and offer our own supporting evidence with the goal of supporting the work of the Special Commission.

Our task is to write on behalf of our paediatric anaesthetics team because we feel compelled to speak for children and young people across the state who deserve access to the best healthcare in the world.

The lack of adequate health funding to look after paediatric patients makes it impossible to deliver on that vision.

This is our daily reality. It is a situation created by a few core problems:

- The approach to funding paediatric health services guarantees inadequate resources to deliver the level of care accepted as standard in other states.
- A lack of support for a sustainable workforce with the capacity and capability to deliver complex paediatric care.
- Short-term funding strategies that remove the ability to build better health systems prevent us from delivering new initiatives that are better for patients, while spending more taxpayer money to deliver less care.

The impact on families is obvious in stories of patients waiting 500 days for surgery on the airway (coverage in The Australian, February 25, 2023; see *Appendix 1*) or over 700 days for surgery to manage a curved spine while potentially dealing with pain and facing preventable disability (coverage in The Sydney Morning Herald, April 7, 2023; see *Appendix 2*). Delayed access to care in

paediatrics can be a devastating failure as often these operations are required at a critical point in growth and development. Missing an important window to deliver care changes futures.

This makes the work of the Special Commission vitally important.

Starting on a path to better healthcare for children starts with a few simple steps:

- Properly review and update the model for providing funding to look after children and young people.
- Invest to enhance the overall workforce while modernising the Award for specialists in New South Wales – this is critical to solving a recruitment and retention crisis that threatens health services not available anywhere else in this state.
- Deliver longer-term commitments to health spending - this will empower passionate healthcare workers to pursue better care for children and save the NSW taxpayer money.

These simple steps are the start of a journey. The framework for a better future is available now. This makes it possible to chart a course towards nation-leading paediatric healthcare over the next 3 years and then get on with the work of walking on that path.

Section 1: The Failure to Fund What We Do

The anaesthetists at CHW provide care for over 14,000 patients each year. That care is not just about operations. Paediatric anaesthetists are involved in provision of the Acute Pain Service, clinics and preoperative assessment, multidisciplinary planning for complex admissions, medical imaging and diagnostics, procedural sedation, unique diagnostic programs for families across the entire east coast of Australia, care coordination for some of our most vulnerable children with challenging behaviours and clinical care in emergencies across the wards, emergency department and intensive care units.

Our focus includes patients who weigh a few hundred grams and were not quite ready to be born to young people aged 16 and beyond.

It includes patients presenting for necessary surgery that changes their lives and patients requiring emergency surgery to save their life. Some of those patients will have extremely complex health conditions that is a critical part of understanding how to look after them.

The children calling on this hospital require unique care. That is true when they need services only available at CHW such as paediatric heart surgery, liver transplantation and the Severe Burns Injury Service. It is true when they are being looked after as part of the busiest programs in the state for neonatal surgery, neurosurgery or cancer care.

The realities of this highly specialised care are reflected in the costs required to deliver that care.

However, the application of the Activity-Based Funding model in New South Wales does not recognise the health needs of children. It discriminates against young people specifically in ways described below.

This may seem counterintuitive for a system originally designed to establish a fair, transparent, equitable and predictable approach to hospital funding that is informed by the cost of care delivery.

However, the Final Report of the Review of Governance for the Sydney Children's Hospitals Network (referred to as the Alexander Review in this document) delivered in June 2019 noted that funding for the Sydney Children's Hospitals Network was **14% below its nearest interstate counterpart** as per Children's Hospitals Australasia data. The panel recommended work to review the adequacy of the existing funding model to meet the needs of paediatric care.

This work has not happened. Underfunding of paediatric healthcare in NSW is an embedded part of the system.

Why is Activity-Based Funding Failing Kids?

Activity-based funding is not meeting the needs of children for a variety of reasons.

Internationally recognised best practice in tertiary and quaternary paediatric hospital care incorporates more than just highly complex care in the moment. It is dependent on cooperation of multidisciplinary teams, specialised equipment and environments for the paediatric setting and extended hospitals stays to support recovery and meet the patient's development needs. As noted in the Alexander report the nature of the specialist care, the increased requirements to support whole families and the need for much more extensive diagnostic explorations plus intensive periprocedural care to ease patient stress all come with costs above and beyond the average cost of caring for an adult.

This means far more resources are required to care for children and young people than for adult centres considered as equivalent under the ABF approach.

The reality of tertiary and quaternary paediatric care also means that incentives built into the ABF approach to focus on a more rapid turnover of patients clashes directly with the needs of our complex patients. ABF applies an average cost heavily influenced by straightforward care to the most vulnerable children in the state with the greatest need for support.

The arrangements in NSW appear to corrode the funding devoted to paediatric hospital care even further. Commonwealth funding to support patient care is significantly influenced by the annual National Efficient Price for public hospital services that is set by the Independent Health and Aged Care Pricing Authority (IHACPA).

However, NSW Health then diverts funding derived from the National Efficient Price to centralised services such as eHealth, HealthShare for procurements and the Ministry itself. The budgetary growth in these areas is substantial even while clinical services struggle for funds. This growth in the budget of the centralised services is reflected in the NSW Health Annual Reports.

Funding that is already inadequate for the needs of children is being diverted away from the hospital.

Finally, these problems are exacerbated by a lack of growth funding for the hospital, disclosed in detail to clinicians by the SCHN Executive to help explain resource constraints. Discretionary growth funding has been frozen for the last 3 years.

This freeze coincides with an increase in activity year-upon-year. As we emerge from a pandemic with a surge in presentations to the hospital from children with breathing problems and a waiting list extending to thousands of patients who had care delayed, the growth funding picture has not changed since the last decade.

The Key Points

- Current funding approaches do not reflect the complexity of paediatric healthcare.
- The gap between the funding calculation and reality has been highlighted for years.
- A recommended review of funding models has not happened.
- Frozen growth funding is making the problem worse.

⇒ *This means there is an opportunity to review paediatric healthcare funding and boost support in the right areas to deliver better outcomes more efficiently.*

Section 2: A Case Study of Threats to a Sustainable Workforce

The ability of our department to meet the clinical workload essential to children from across NSW has been severely compromised by an inability to maintain a specialist workforce. Without specialist anaesthetists with the right training and experience to provide the care required at CHW there are real threats to the delivery of critical state-level services such as liver transplantation and cardiac surgery.

This recruitment and retention crisis has threatened the department for a number of years and is a direct result of:

- An Award for Staff Specialists in NSW that is completely out of step with the requirements of modern healthcare and inferior to every other state in Australia.
- A lack of funding to provide the scale of workforce needed to deliver enough work.

Our department started flagging concerns of a looming staffing crisis as early as 2016. Every warning we offered of a looming rapid turnover of new staff at a time of multiple retirements of experienced anaesthetists then came to pass. Reviewing the turnover of newly appointed specialists between December 2018 and July 2021 reveals that of the total number of staff appointed, departures or reductions in hours by those new specialists at the hospital effectively meant a **turnover rate of 42%** within a 19-month period as they left to other paediatric centres or reduced their time at CHW. There were further departures of experienced clinicians on top of this.

Identifying Contributors to the Recruitment and Retention Crisis

There are a number of factors working together to produce this instability. Over the last decade the nature of the work required by paediatric anaesthetists has become more complex with higher acuity patients requiring more advanced care. There are numerous contributors to this but in simple terms it is a direct result of looking after patients with more health needs having more involved surgery.

This means that the hours for specialists continue to extend further into the evening. Emergency cases are more frequently required at all hours of the day and night. 'On call' has become 'always

on site on the frontline' both because more procedures are required and because the challenging nature of the work means specialists are required to support junior doctors more frequently.

The increasing difficulty of our clinical work is not up for dispute. In proceedings at the Industrial Relations Commission initiated by the Australian Salaried Medical Officers Federation on behalf of our department and our intensive care colleagues (Dispute Number 2022/00009840) the Commissioner noted this in a statement available to the public.

He noted the 'uncontested evidence that over the last 10 years there has been an increase in the complexity, acuity and number of patients being treated in the Departments' and that he 'cannot readily accept the Health Secretary's submissions … that the "average hours worked by these specialists over the roster period in evidence are not excessive"…'

This evidence included diaries showing specialist anaesthetists working for up to 24 hours continuously to look after children. It included 'on call' days that really meant being at the hospital for 20 hours. The evidence described evenings that become nights with multiple operating theatres working into the early hours of the morning to look after the sickest children in the state. This is the work that could not be denied.

In the context of this increasingly complex and onerous work, conditions for Staff Specialists have got worse. The ability to undertake the research, education and quality improvement work to guarantee higher quality care that delivers more for less has been progressively eroded. Undervaluing that work leaves highly trained specialists feeling equally undervalued and discourages them from staying committed to the public hospital system.

More challenging work conditions are accompanied by reduced availability of equipment and resources to actually provide care. The office spaces to undertake clinical support activities are not available. Leave is difficult to access in an understaffed department. Every element of the work experience has become more challenging.

The arrangements under which Staff Specialist are determined by an Award first drafted in 1966 with no significant revisions since 2006. This Award has been a disincentive for highly skilled anaesthetists to commit to tertiary paediatric work.

The Award has driven an exodus to locations interstate, the private sector or at the very least a decrease in the portion of time spent at our paediatric hospital. Specialists spending less time at the children's hospital are not available to support the most challenging areas of care such as paediatric cardiac anaesthesia and transplant anaesthesia. It is these state- and national-level services that are most vulnerable to disruption.

The Interstate Comparison
Every other state has recognised the changing nature of medicine through Awards or Agreements that reflect the actual work done. The industrial instruments themselves are framed in a manner that shows that they value the specialists who deliver care. It is an approach that encourages deep engagement in the system. Those states have stabilised the workforce by making their industrial arrangements appealing and just. This allows a focus on delivering healthcare rather than the respective Ministries initiating inefficient short-term responses described later in this submission.

All other states in Australia:

- Deliver base remuneration for specialists up to 50% higher than the total remuneration offered to attract and retain clinicians in NSW.
- Recognise out of hours work, whether it is overtime or as part of on-call, recall and digital recall arrangements, with direct pay for the time worked.
- Recognise explicitly the value of clinical support activities (research, governance, education and support of new technology and information technology systems) in driving positive change in healthcare delivery and delivering more efficient healthcare in the long-term.
- Feature specific clauses that show a commitment to the health of senior medical practitioners, such as specified breaks to manage fatigue (reflected in Queensland's Certified Agreement No. 6, 2022, Clause 5.4).
- Make strategies to support Training, Education and Study more available to clinicians.

While the Commissioner noted that there is 'considerable support in the evidence for changes to the Award', the response from NSW Health remains disappointing.

As part of the proceedings we have seen a proposed variation from the Ministry directed at addressing the problems raised in the dispute. The work shared, if adopted, would guarantee a collapse in the Staff Specialist workforce across the state.

For our department the result has been a significant shift to Visiting Medical Officer arrangements. Although this has created some stability for now, other states have solved similar situations with more cost-effective options using Staff Specialist arrangements. By maintaining this model they also guarantee the systems improvement that ultimately contains healthcare costs.

The Numbers Problem

The issue of recruitment and retention is compounded by a simple numbers problem – there are not enough paediatric anaesthetists to look after the number of children and young people who require healthcare at CHW.

A crystallization of the numbers issue has already been publicly reported in The Sydney Morning Herald on February 27, 2023 regarding operating theatres being used as storerooms (see *Appendix 3*). This reporting included documentation that in November 2022 Specialist staffing amounted to the equivalent of 26.4 FTE. This was less than the total potential FTE at the time of 29.9. More importantly it was **more than 25% below** the agreed requirements to staff the existing CHW operating theatres of 35.4 FTE.

Our Department was still in that position despite continuous efforts to improve staffing levels since 2016.

With underlying funding that does not recognise the actual complexity of paediatric healthcare and a total freeze on discretionary growth funding it has been impossible to keep pace with the growing demand for our services.

This staffing issue was covered in detail in the IRC processes referred to above. NSW Health was directly involved in those hearings. The failure to recognise and respond to the escalating needs of the children and young people of NSW by supporting a boost in staffing and efforts to improve recruitment and retention led directly to the **explosion in the waitlist for necessary surgery at**

CHW while new operating theatres sat empty. 2308 in June 2022 became 2500 in September 2022 and 2656 in January 2023. That is a 15% increase in 6 months.

There has subsequently been progress to approach the 35.4 FTE staffing required for the main operating precinct at CHW. There is still no funding to increase staffing to open the new operating theatres on a day-in, day-out basis.

We have been waiting more than half a decade for support to make this happen. At present these new operating theatres continue to sit empty multiple days of each week.

Healthcare is delivered by people. Empty buildings offer nothing to the people of NSW.

Just as importantly working in a constantly overstretched system drives valuable people away. It discourages brilliant anaesthetists of the future from considering work in this rewarding but challenging field.

This leads to more long days, more frequent and onerous on-call and pressures to abandon the research, education and clinical governance initiatives that drive better outcomes.

Failing to Support the Workforce Means Failing on Everything
The effects of a failure to support a sustainable specialist workforce ripple out to impact the whole of the state. An adequately staffed paediatric anaesthesia service at CHW is critical to:

- Maintaining the training pipeline that delivers the anaesthesia workforce needed across the state of NSW.
- Enhancing the ability of CHW to adequately support practitioners across the state in their critical role in providing paediatric healthcare.
- Engaging clinicians to save the system money.

The Training Pipeline
A key component of the training pathway for specialist anaesthetists is a volume of practice and development of core expertise in looking after children. Gaining this expertise is critical in a system where anaesthetists across the state are often called upon to be part of the care of critically ill children when they first present to hospital, noting that over 90% of paediatric ED presentations happen outside the Sydney Children's Hospitals Network (from 'Review of health services for children, young people and families in the NSW Health system, December 2019, page 28).

The consolidated exposure to paediatric perioperative medicine available at The Children's Hospital at Westmead means that every year the largest volume of paediatric anaesthetic experience occurs within the walls of this hospital.

As this is a critical component of completion of specialist training and the caseload in other centres is limited, obtaining an adequate volume of paediatric practice has become a critical choke point in the system. This was specifically noted by the President of the Australian and New Zealand College of Anaesthetists in a letter to the then Minister for Health, Hon Brad Hazzard, and the then Minister for Rural Health, Hon Bronwyn Taylor, MLC dated 6 September, 2022 (see *Appendix 4*). This letter has been the subject of public reporting.

In this communication, a critical workforce vulnerability was one of many cited significant concerns: 'There are currently too few paediatric anaesthetists in the New South Wales health

system, which is limiting our ability to train new specialists, and leading to the chronic under-utilisation of operating theatres at a time of high demand following the COVID-19 pandemic.'

There are future specialists who have been delayed in entering the NSW system because of a lack of adequate paediatric experience. Limiting staffing of a core training facility by ignoring a recruitment and retention crisis has a flow on effect to provision of important perioperative services everywhere. Understaffing built facilities directly limits the capacity to help train more specialists.

The whole system suffers. More importantly patients suffer while they wait for surgery.

Supporting Rural and Regional Practitioners
While there are critical services only delivered at the major paediatric centres, most paediatric healthcare happens outside the walls of the major paediatric centres, as noted above. This makes it critically important that specialists dedicating their professional life to other centres, particularly rural and regional areas, have opportunities to develop expertise and then maintain ongoing clinical exposure.

Our department already attempts to support rural and regional health practitioners through education opportunities and by facilitating clinical placements to maintain their clinical exposure. This includes rural anaesthetists and GP anaesthetists, along with other specialties. This support is critical to delivering a core goal of the health system – to facilitate provision of care as close to home as possible wherever possible.

In August 2022, a working group from within our Department provided a submission for consideration by the Critical Response Action Group after a request facilitated by the Agency for Clinical Innovation. We were asked to suggest ways to enhance support for anaesthetists working in rural and regional areas to be considered as part of a response to the 'Inquest into the death of Emiliana Obusan (Date of Findings 19 November, 2021)'.

While any such submission is provided as an option to consider and may therefore not be adopted, it does highlight opportunities that could be considered. The suggestions went beyond establishing education partnerships or an ongoing role for short-term clinical attachments. The submission also suggested introducing an option for a supported 6-month clinical fellowship to enhance paediatric skills. Workforce suggestions such as practitioner exchange programs could also be facilitated by the Department if staffing were adequate.

Opportunities such as these, which ultimately aid a core health system goal of delivery of care closer to home at lower cost, still require support for our workforce to deliver these potential benefits. For as long as solutions are off the table we will continue to pass up an opportunity to deliver a better and more efficient healthcare system.

It costs the state money when we do not support patients and clinicians in rural settings.

Engaging Clinicians to Save the System Money
A key benefit of the Staff Specialist model is the work on clinical support activities that delivers better healthcare that is more efficient over the longer term. This work is sometimes referred to as 'non-clinical time' but this false labelling significantly undervalues a vital part of an innovative and adaptive system.

Clinical support activities include work that is critical to the system such as education, research, clinical governance, innovation and delivery of new care paradigms. Good clinical work delivered on behalf of patients does not occur without these vital endeavours.

Doing them well requires people with expertise to have the time devoted to this core activity. Not undertaking clinical support activities leaves us not just standing still but going backwards. It is a surefire way to condemn the system to a future of paying more while delivering less.

In the context of working on a values case to support the Staff Specialist workforce model for our Department, we undertook preliminary work to try and demonstrate the financial value of clinical support activities. The value of this endeavour is under recognised in NSW Health because no meaningful effort is made to account for the benefits that arise from this work, or the costs that mount when systems improvement is not delivered.

The work, which looked at a 3-year period leading up to the July 2021, incorporated a description of what was delivered and the benefits to patients and the system. It also attempted to capture financial gains when taking into account savings in the system generated both by the initiatives undertaken and the avoidance of external consultants to develop similar programs.

At the time of that review, the specialists had worked on introduction of the electronic anaesthesia record, equipment and procurement deals, introduction of big data systems to underpin the clinical environment, a new paediatric Early Recovery After Surgery (ERAS) pathway for scoliosis, new care paradigms for children with challenging behaviours needing hospital intervention (described later in this submission) and development of proactive multidisciplinary teams to plan perioperative care. The combined savings in the prior 3 years amounted to $2.2 million. The projection for subsequent savings if all the identified programs were delivered amounted to an additional $4.8 million over the next 2 years.

Those programs have not been able to advance in full.

The Key Points

- An outdated Award and a lack of support to make sure staffing matches clinical needs created a recruitment and retention crisis in the Department.
- This workforce crisis has had direct impacts on patients and families.
- The failure to support an adequate workforce means operating theatres are still empty.
- These problems do not just impact CHW, they decrease care across the state and cost the system money in ways not properly recorded by NSW Health.

⇒ *A clear-eyed focus on workforce solutions will enhance delivery of services and ultimately contain costs over the longer term.*

Section 3: The False Economy of Short-Term Fixes

Our Department has a close-up perspective on the wasteful impact of short-term fixes on the delivery of healthcare.

It is made very real when money is granted for short-term bursts of 'surgical catch-up' rather than sustained funding that can be used to build an efficient service working every single day for the families of NSW.

It is revealed when the hospital contracts their own work to private hospitals. This comes with rules that stipulate that the money comes with a use-by date and a prohibition from using it to support work in the public hospital even if that could deliver more with the money.

We can see a failure to understand long-term benefits that result from ensuring we have the information technology resources or procurement processes that are suitable for local purposes rather than being compromised by centralised decisions that do not meet our local needs.

It is apparent every time we put forward a model of care that will be better for patients and a more effective use of public funds, only to find there is no appetite to provide the funding to launch it on its way.

A specialist paediatric service cannot be turned on and off quickly. The most sustainable way to make sure we are ready to deliver care is to provide certainty that we can build with the right expertise, then focus brilliant clinicians on finding the absolute best way to get things done with available resources.

The New Building Example

As discussed earlier in this submission, the long-term staffing issues created by a recruitment and retention crisis delayed use of the new operating theatres incorporated into the hospital building known as Block K. Staffing for a separated location involves additional challenges because additional on-site specialist staffing is required to provide local site coordination and to ensure there is adequate support in emergency situations. The result is that to run 2 operating theatres, as an example, the staffing needs are more than simply adding 2 theatres.

This created an unfortunate situation for the hospital Executive. NSW Health had indicated recurrent funding for 'Block K services' would only follow if there was evidence that operations had happened there by the end of financial year 2022-2023. However, there was not actually the staff to operate both the existing CHW theatres and the new theatres. The only solution was to have days where more theatres closed in the existing CHW building than were made operational in the new building.

The inability to secure from NSW Health the actual amount required to make Block K operational in a staged, step-by-step fashion and the conditions attached to what funding was available meant **the hospital had to decrease its efforts to address the surgical waitlist to secure funding for the next year.**

This reality is borne out in the Healthcare Quarterly reports from the Bureau of Health Information:

	Oct-Dec 2022	Jan-Mar 2023	Apr-Jun 2023
Surgeries performed	1284	1327	1357
Elective surgery performed on time	80.3 %	73.7 %	73.6 %
Waitlist	2656	2555	2578

Relatively static numbers of surgeries performed despite the best efforts of the hospital to stretch while the waitlist and on-time performance remains flat.

This unstable approach to funding clearly fails the children of New South Wales. New buildings need to come with a plan to provide the staff to make them work.

A strategy to deliver tertiary and quaternary services by identifying the right people and bringing them onboard takes time. An assurance that funding will step up over a period of time is essential to recruitment.

We cannot build a robust clinical service with time to focus on delivering better healthcare more efficiently if no one knows what the state of play will be in 6-months time.

When 'Catch Up' Funds Mean You Fall Behind

The problem of 'surgical catch up' funds is just a different version of a similar problem. There is an acknowledged serious issue with waitlists. This is on top of the growing needs for surgical services in a hospital that also serves a local community which happens to have the fastest growing population of young people in the country.

In a setting of a definite and ongoing need for increased services, the short-term allocation of catch up funds with 'use it or lose it' rules is deeply inefficient. It inhibits efforts to make the best possible plans for use of those public funds to provide care to the community.

To make the most of catch-up funds you would need to be sure there is a ready pool of specialist paediatric anaesthetists just waiting for the call. There is not.

Highly trained specialists do not remain idle for long. They find work elsewhere and then they are not available when the catch up funds arise. This 'catch up' money cannot be spent on delivery of clinical care for patients and eventually disappears from the frontline while children still wait for the surgery they need to change their future.

Stable, recurrent funding that secures a permanent workforce with the equipment and resources they need is essential to providing timely care for children and families.

Outsourcing At Inflated Rates

A third stream of wasteful healthcare spending is to outsource the care of patients initially presenting to the public system to private hospitals. This 'Collaborative Care' model distorts delivery of services and costs the taxpayer more to deliver less:

- Funding allocated under a 'Collaborative Care' approach in initial stages of the pandemic catch-up response could only be spent on private hospital services with no capacity to divert the funds to get the work done in the original public hospital, even where that would have been more efficient.
- Paediatric hospitals were further disadvantaged during that catch-up phase. The Ministry would not provide any funds unless the public hospital guaranteed private hospitals a certain volume of work. Those guarantees were part of contracts arranged by the Ministry. However, the Ministry had made no efforts to set contracts for paediatric care and the children's hospitals had to start from scratch creating a significant delay in funding.
- Public hospitals must undertake additional administrative work to facilitate contracts and list coordination in these external facilities.
- The public dollar is used to cover the costs of every practitioner involved at the private hospital, paying rates higher than they would be paid in the public system, along with the costs charged by the facility. The result is surgical work being done at a cost many times more than if it had been facilitated in the public hospital.
- With limited appetite from private hospitals to undertake paediatric work, the patients cared for under this model are the patients who need CHW the least. The most vulnerable patients with the most pressing urgency are left behind while core capacity remains unfunded.

'Collaborative care' is a choice to spend taxpayer money on private hospitals rather than invest in public facilities. The result is the worst possible outcome - minimal impact on waitlists, public hospitals starved of investment, increased overall costs for healthcare and the patients with the greatest need still not receiving care.

Ignoring Long-Term Successes with Short-Sighted Plans

While short-term fixes and fluctuating funds fail the public, better long-term solutions attract no funds. As a Department we have put forward models of care that require initial investment to provide the staff needed to help them fly. These are models that offer better healthcare experiences for patients, families and the staff who look after them while also offering huge benefits to the health budget.

They sit unfunded while failing short-term strategies continue to attract lump sums of cash.

A Case Study of a Flagship Service

The Department of Anaesthesia CHW has run a 'Special Kids Peri-Operative Program' for children with autism and behavioural difficulties since 2017. This is a program that revolutionises the effort taken to coordinate the care of children who find the very experience of attending hospital for basic care distressing and harmful. It involves careful review prior to attendance, personalised plans to manage anxiety that start before leaving home, coordination of multiple clinical teams to undertake interventions under a single anaesthetic that would normally require multiple admissions and expedited discharge plans. It is built on the work of clinicians directly including families and carers as part of the team making brilliant plans.

This highly successful program received recognition with a NSW Health Award in 2021.

It is at risk of collapse without a coordinator to make it a sustainable model.

This is despite the original analysis showing that across the first 69 admissions the team managed to consolidate 213 individual procedures. Preventing 144 hospital admissions in children who find attending the hospital a mammoth challenge is deeply meaningful.

Just one of the case studies originally analysed saved the health budget $72857 and the program overall generated additional opportunities for revenue for the hospital to the value of $472,176 across the initial analysis period.

However the NSW Health budget has no room for this program and we will be endeavouring to stabilise the service by employing the coordinator so desperately needed using funds from the Sydney Children's Hospitals Foundation.

Meanwhile the children of Queensland will have access to a similar program commencing at Queensland Children's Hospital. The difference is that the service is funded.

This case study is not isolated. The Department has also developed a highly regarded initiative to create a multidisciplinary team to proactively coordinate the care of children with complex medical conditions who will predictably need surgery. The goal is to stop the practice of waiting until these children are referred for surgery to review patients. Instead constant monitoring of patients and ongoing focussed care by physicians and allied health practitioners will make sure they are as strong for surgery as they can be. Through a combination of reduced stay in hospital and a reduction in complications, conservative projected savings are $1,300,000 in year 1 and $2,400,000 in year 2. The real world savings would obviously be captured and refined with commencement of the actual program but the issues are clear.

This innovation is also entirely dependent on funding from the Sydney Children's Hospitals Foundation if it is to start delivering benefits to patients.

The health care system is ignoring investments that pay off in the future many times over. There is no real ability to measure impacts of new initiatives over time.

It is no small thing to note that these programs include a core aim of reducing the number of days that children and families spend in hospital. Peer-reviewed evidence published by the hospital indicates that the cost to a family averages $589 for every day in hospital[1]. These two programs will save families hundreds of thousands of dollars per year.

Funding more efficient healthcare programs delivers for the whole of the community.

The Failures of Centralising Core Activities

As a marked contrast to the funding famine afflicting front line services, some areas of NSW Health have no difficulties expanding their budget. Examination of the NSW Health Annual Reports over

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[1] Mumford V et al. Measuring the financial and productivity burden of paediatric hospitalisation on the wider family network. J Pediatr Child Health. 2018;54:987-96.

the last few years reveals that since the 2019/2021 financial year, eHealth has seen an average growth in their budget of 20%.

The results of this consolidation of the health budget are not so evident at the bedside. We have an electronic health record with no substantial capacity to extract data that would be useful for systems improvement. We have an imminent plan to roll out ERIC as a computer platform specifically for intensive care. This system suits intensive care but it does not speak the same language as the rest of the patient's electronic record.

A centralised system delivering separated electronic records within the same hospital is a guarantee of reduced patient safety.

At the same time the cost of centralisation appears to be fewer information technology resources locally. Our department makes regular requests of a hard-working IT group to upgrade and improve systems for the benefit of patients. The number of unanswered queries peaked at 28 before we finally retreated, wondering how to fix problems in the absence of resources for local IT support.

It is a similar story when it comes to procurement. The budget in HealthShare as recorded in the NSW Health reports has averaged 13% since financial year 2019-2020 with growth rates up to 38%.

This does not translate into critical patient equipment being available. Over 3 years ago the Department provided an early warning that the machines used to deliver anaesthetics and provide breathing support throughout operations were approaching their effective use by date.

It took more than 2 years to finally purchase the machines using donated funds. Lag times on delivery mean they are not in the operating theatres yet. The delays in replacing the machines appears to be because there is no meaningful budget for vital equipment. A budget for centralised services in procurement equalling a 13% annualised growth rate since the 2019-2020 financial year leaves those of us on the ground with no money to replace items as critical as the machine that keeps a child alive while also providing an anaesthetic or the instrument needed to place a breathing tube.

We continue to scramble to find ways to solve IT challenges inside the department.

Centralised services with growing budgets from activity-based funding income diverted away from the frontline are failing patients and worsening conditions for staff.

There needs to be some capacity to manage critical areas such as IT and equipment purchasing at a local level.

Frontline services with effectively zero growth in funding are not the issue at the heart of unsustainable health budgets.

The Key Points

- World-leading healthcare requires certainty and planning.
- Sporadic funding models and short-term fixes deliver less care at inflated costs.
- The lack of funding to support initiatives that will pay for themselves leaves patients and clinicians worse off.
- Centralised services are compromising local solutions to deliver better patient outcomes.

⇒ *Committing to recurrent funding would permit more strategic use of funding to deliver better health outcomes to maximise benefits for patients in ways that pay off over the longer term.*

Section 4: A Chance for Solutions

The purpose of this submission is not just to point at problems. Patients and families expect more of us and we demand more of ourselves.

There are undoubted challenges but our goal is to give patients and families access to healthcare that equals anything they could hope for anywhere on the planet. This also means we are clearly focussed on delivering that healthcare as efficiently as possible. Greater efficiency means we can provide that world-leading healthcare to more children and young people across this state.

Simple steps can make a difference that starts today, delivers tomorrow and keeps building a better system. Some of these steps will benefit the entirety of the state's health landscape. A world-leading health system can be delivered without the health budget swallowing 50% of the state budget in the future.

Step 1: Review the application of Activity-Based Funding to reflect complexity of care

As outlined above, Activity-Based Funding as it is applied in NSW discriminates against children. Young people in NSW are being placed at a distinct disadvantage compared to children in other states. There is an urgent need to review the funding model for paediatric healthcare to remove this ongoing deficit.

This should involve:

- Reviewing the current funding approaches where they apply to paediatric healthcare. This includes adapting the approach that captures paediatric patients in the standard setpoint of the State Efficient Price.
- Acknowledging the well-identified reality that paediatric patients require specific solutions for matters including in procurement, equipment, the built environment and IT packages.
- Ensuring less funding is diverted from paediatric patients to centralised services such as eHealth and Healthshare to enhance resources per patient and also facilitate more local initiatives in procurement and IT services.
- Interstate comparisons to provide a reference point but not a limit to what should be delivered.

Step 2: Focus on workforce

Addressing the inadequacies of the Staff Specialist Award are a critical part of restoring balance to the specialist workforce in NSW. Making Staff Specialist roles desirable offers stability and the vital additional benefit of avoiding the extreme costs of turnover of the senior workforce.

It is feasible to deliver a Staff Specialist Award that delivers conditions comparable to other states and is more efficient than the present VMO approach to which the senior workforce is skewed. The Staff Specialist model is also more supportive of engaging the senior medical workforce to undertake the clinical support activities that enhance the healthcare system.

A better Staff Specialist model can deliver a pathway to more sustainable growth in the medical workforce. It is essential to increase the absolute number of clinicians available to undertake work.

To deliver step 2, the following are required:

- Update the Staff Specialist Award in ways that have already been delivered in other states. This includes making the overall conditions more competitive with other states, recognising overtime and on-call/recall patterns of work with direct pay for work done, enshrining the value of clinical support activities and incorporating a focus on wellbeing, and training and development opportunities for specialists.
- This adaptation of the Award will deliver a more stable workforce that delivers ongoing health budget efficiencies over the medium- to long-term.
- Modernising the Award is not solely about supporting specialist paediatric services. Changes such as these are highly relevant to maintaining a vibrant workforce that will serve vulnerable areas including rural and regional centres.
- The Award can also be restructured in a way that allows health organisations to focus on more efficient capture of clinical activity to optimise funding delivered via the Commonwealth government.

Key to taking this step is an understanding that **NSW Health is already spending more money for less benefit.**

Step 3: Develop better measurements

NSW Health can do better at measuring the impact of models of care and new initiatives on overall health outcomes and the impact of changes on the health budget.

At present an initiative such as the program for children with challenging behaviours struggles to get funding. The opportunity cost of such a program not being expanded is not captured. Once initiated, there is limited support for comprehensively tracking clinical outcomes in real time. There is minimal ability to monitor the trajectory of impact on the health budget, including a comparison to what would have been business as usual if there was no change.

Without proper measurement it is difficult to make good choices to support initiatives that will make a difference to patients while being favourable for overall resource utilisation.

A similar issue applies to appreciating the value of clinical support activity. Clinical governance and quality assurance lead to better models of care. Research turns the questions of today into solutions that are better for patients. Education ensures continuous advances of knowledge and optimal functioning of highly trained clinical teams.

This clinical support activity is valuable to the health system on its own terms and should remain a remain a core part of the delivery of healthcare as an inherent good. Clinical support activity is particularly vital to creating a system that is ready, driven by engaged clinicians, to deliver healthcare innovation.

To deliver step 3 it is essential to:

- Work with clinicians to develop systems to more efficiently capture and report on clinical outcomes that are attributable to new models of care.
- Work with clinicians to develop systems to continually track the financial impact of decisions taken compared to business as usual, along with the opportunity cost of decisions not taken.
- Support clinical teams with those with finance expertise to develop ways to acknowledge the value to the health budget of clinical support activity.

Step 4: Prioritise recurrent funding

Stable recurrent funding allows health services to make strategic plans that deliver more efficient healthcare. Surges of intermittent funding add costs as hospitals scramble with the administrative load of stepping programs up and down rapidly. Short-term funding that comes with conditions as to how it is deployed by healthcare facilities also prevents them from making decisions that deliver services in the most efficient way possible.

It is stable recurrent funding that ensures optimal planning. It is predictable recurrent funding that can ensure that new buildings serve the community instead of sitting empty. The reality for the Sydney Children's Hospitals Network is that we have two major hospital developments that will require the sort of workforce that takes years to build properly. We have no ability to start that work because there is no plan for that recurrent funding available.

The buildings are intended to be operational in 2025. We are currently on a similar path that has seen operating theatres used as storerooms. More buildings sitting empty because there is not the recurrent funding to support the people who make healthcare happen.

To deliver step 4 it is essential to:

- Focus on recurrent funding that meets actual projected service needs.
- Minimise the practice of short-term surge funding and offer this funding to the health organisation in a stepwise fashion commensurate with their requirements.
- Deliver this recurrent funding alongside the measurement methods developed as part of step 3 so that the impact of new initiatives can clearly be recorded and a comparison to the trajectory of 'business as usual' is also appreciated.

Conclusion

The Special Commission is a tremendous opportunity to fully understand the health landscape and make positive steps with simple solutions. We can deliver more for children, young people and their families. We can support the healthcare workers who deliver exceptional care on a daily basis to make sure they feel valued and remain deeply engaged in the NSW public sector.

The alternate is to continue on the path NSW Health have already set.

That is the path that has left children and young people waiting hundreds of days for essential surgery and critical services vulnerable to collapse.

That means a distorted approach to Activity-Based Funding that is diverting funds away from patients and critical workers to centralised services that are underdelivering.

That means maintaining archaic Awards that encourage an exodus of specialists from the public system. It means an unbalanced distribution of senior specialists with gaps across the state papered over by fly-in, fly-out locums being paid more than permanent workers.

It means empty new buildings, inefficient short-term catch-up funding and outsourcing of public hospital work with less delivered at more cost.

It means ongoing failures to make the most of new opportunities and to understand the opportunity costs when we do not support innovation, all because we do not measure the right outcomes.

It is a short-sighted focus on tomorrow that is driving a NSW Health approach that embeds excess spending into the future of this state.

The Ministry is already spending the money. The solutions being offered to deliver more for the community are simple.

We deeply appreciate the opportunity to assist the Special Commission. If there is an opportunity for a follow-up discussion we would welcome the chance to offer more. Please contact Dr Andrew Weatherall (Andrew.weatherall@health.nsw.gov.au) and Dr Ramanie Jayaweera (ramanie.jayaweera@health.nsw.gov.au) if there are any avenues to continue this work.

Dr Andrew Weatherall
Senior Paediatric Anaesthetist
Co-Head of Department of Anaesthesia
The Children's Hospital at Westmead.

Dr Ramanie Jayaweera
Senior Paediatric Anaesthetist
Co-Head of Department of Anaesthesia
The Children's Hospital at Westmead.

Appendix 1 - Reporting on CHW 25 February 2023

THE AUSTRALIAN

Hospital services 'at risk of collapse'

Kelsey Boivin with son Madoc, 4, at their home in Sydney. Madoc was on a waiting list for a total of 500 days. Picture: John Feder

By NATASHA ROBINSON

Aa

Senior medics at one of the nation's most specialised children's hospitals have warned critical services including cardiac and transplant surgery are "at risk of collapse" with paediatric intensive care and anaesthetic services hit by chronic staff shortages.

The doctors have revealed the crisis inside the Children's Hospital at Westmead in Sydney in court papers that document the extraordinary increase in demand on the resources of the public hospital in the past decade as children undergo increasingly complex surgery and are admitted with greater degrees of severe disability and comorbidities.

The explosion in workload now sees about 40 per cent of clinical care performed by doctors after-hours, with surgery regularly stretching into the night and 30 per cent of cardiac surgical patients admitted to the paediatric intensive care unit after 6pm, with this surgery frequently performed on weekends.

The NSW health ministry stands accused by the doctors' union of risking child deaths by refusing to properly pay overstretched staff overtime or reasonable salaries, leading to a staffing retention and recruitment crisis. The intensivists and anaesthetists working at CHW are paid up to $200,000 less than the salary packages of their counterparts in Victoria and Queensland. Staff specialists in NSW are paid a salary that does not change regardless of hours worked. They do not get paid extra for after-hours or weekend on-call work, but rather are paid an "all in one salary" supplemented by a "staff specialist" allowance of 17.4 per cent.

"With the current workforce experiencing an incredibly high reduction in full-time-equivalent staff and resignations, the inability to recruit appropriately trained consultants and an inability to train or retain future consultants, the end result is a substantial increase in the serious life threatening issues of death to babies," Damien Lee, an industrial officer for the Australian Salaried Medical Officers Federation told the NSW Industrial Relations Commission. "Serious life threatening issues of death to babies, children and young people across Australia could be mitigated with appropriate staffing."

Mr Lee's comments reflected evidence by CHW head of intensive care Andrea Christoff, who warned in a statement tendered to the Industrial Relations Commissionthat "the (paediatric intensive care unit) is at risk of collapse if we are unable to stabilise staffing in critical care ... we will not be able to adequately staff statewide services like paediatric cardiac surgery without a sustainable roster pattern for staff specialists."

One doctor told the IRC she at times had worked 90 hours a week. Intensivists and anaesthetists are periodically on-call over the weekend but in reality they need to be present at the hospital and are involved in continual clinical care. Doctors are often on-call attending patients continuously for 48 hours over the weekend and get little rest from the weekend

roster stint that stretches from 7am on Friday until well into Monday morning.

The IRC was told doctors have at times fallen asleep in their cars driving home from the hospital.

Despite the evidence, the NSW health ministry argued before the IRC that staff working hours were not excessive and the doctors' union was seeking to engineer a situation in which doctors' walked off the job at 6pm every day and were effectively placing the lives of children at risk. The union was "seeking to achieve a result that ... would destabilise two essential departments of the CHW," the ministry's submission to the IRC says. "That result would have life-threatening consequences for some of the sickest children in NSW."

This argument was rejected strongly by ASMOF and all of the specialists who noted their recorded work showed they were in the hospital at all hours looking after children. ASMOF took the position that it was only asking to have those hours that the specialists must work on behalf of sick children recognised.

The paediatric intensive care unit is currently operating with a senior medical officer workforce of 9.5 full-time-equivalent staff, although hospital executives contend this is because some staff are on unexpected leave and the number of FTE staff on the roster is higher, in the order of 13. The hospital's own advice has indicated a workforce of 16 FTE senior specialist is required for a sustainable roster.

The anaesthetics unit is similarly understaffed, with a current shortfall of about 10 positions. They calculate there was a 42 per cent turnover rate of specialists in 2021, with staff reducing their hours or leaving for interstate. The Sydney Children's Hospital Network (SCHN) says it has recently recruited six anaesthetists who will commence at Westmead from between this month and August.

Doctors were forced to lodge an official incident report in 2021 when a trainee was left to contend with the anaesthetic requirements of a critical ill child in the emergency department who had been involved in a serious accident, and no staff specialist was available to help because of understaffing.

"The trainee needed assistance to manage that child from the anaesthetic point of view," one doctor's affidavit says. "There was no senior consultant who could go because we were all stretched so far because there were very serious cases going on upstairs, and we had a lack of staff. On this occasion the patient was not put at additional risk but the senior staff present were sufficiently concerned about the potential risks to patient safety to file an incident report. The potential risks to the patient were very serious. It could have been a risk to life."

Doctors have revealed that elective surgery was frequently being cancelled at the hospital because of the resourcing crisis, including cardiac surgery.

Kelsey Boivin's four-year-old son Madoc, who has a rare genetic disorder called Beckwith-Wiedemann syndrome, had airway surgery cancelled twice last year and was on the waiting list in total for 500 days. Ms Boivin said the second time Madoc's surgery was cancelled, the consultant's frustration was obvious. "She came out and she sort of shook her head through the glass and I burst into tears," Ms Boivin said. "I was devastated.

"She said, 'It's crazy. We've got a cardiac patient who has been cancelled today for the fifth or sixth time.' She was visibly angry. They do not have the staff to man the beds."

The hospital network said urgent surgery was always prioritised. "Any child requiring urgent surgery receives this without delay and the majority of all elective surgeries continue to be performed on time," a spokesman for the SCHN said. "All patients on the elective surgery list are managed according to clinical urgency, which is determined by their own treating doctor."

CHW has a 22-bed paediatric intensive care unit to care for some of the sickest children in the state. All beds are currently open and operational according to the hospital executive.

The elective surgery waiting list at CHW has blown out to almost 2500 and numbers on the waiting list jumped 32 per cent between July 2021 and June 2022. In third quarter of 2022, one in four children waited longer than clinically recommended.

The SCHN said it was working to put forward an amended award with provision to pay paediatric anaesthetists and intensivists shift penalties, however shift penalties in NSW exclude the hours of midnight to 7am. The network is currently paying these staff a 10 per cent onerous hours allowance. The IRC commissioner commented in a statement published by the court that treating the doctors like shift workers was not appropriate and did not resolve the issue.

"SCHN has offered a range of options to the paediatric anaesthetists and intensivists at The Children's Hospital at Westmead to address their concerns within legal frameworks and NSW government public sector wages policy, including recruiting for additional staff," the SCHN said. "The executive continues meeting regularly with the two clinical teams."

Appendix 2 - Reporting on CHW 7 April 2023

Twelve-year-old Ebony needs spinal surgery. She's spent two years waiting for it

Kate Aubusson
April 7, 2023 – 5.00am

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Ebony Williams has languished on a waiting list for spinal surgery for 706 days and counting, with no end to her pain in sight.

The 12-year-old from Goulburn is among more than 200 patients at the Children's Hospital at Westmead who have been left waiting for essential orthopaedic surgeries beyond the clinically recommended maximum times, many enduring painful and debilitating conditions for more than a year.

Ebony Williams with her mother Bobby at their home in Goulburn. DION GEORGOPOULOS

Orthopaedic surgeons warn the delays are putting children at serious risk of irreversible damage to their limbs or spines, and come as the hospital faces a worsening staffing and funding crisis.

Elective surgery waiting lists at CHW blew out to 2656 children at the end of 2022 – including almost 600 waiting for orthopaedic surgery, the Bureau of Health Information data shows.

Ebony, who has cerebral palsy, needs a spinal fusion to correct severe scoliosis – an S-shaped curve of her spine that compresses internal organs.

Elective surgery waiting lists at CHW blew out to 2656 children at the end of 2022 – including almost 600 waiting for orthopaedic surgery, the Bureau of Health Information data shows.

Ebony, who has cerebral palsy, needs a spinal fusion to correct severe scoliosis – an S-shaped curve of her spine that compresses internal organs.

A record 779 children had been waiting longer than clinically recommended for their surgeries across all specialties – far exceeding the 29 children waiting too long for surgery at the end of 2020 and almost double the 407 children at the end of 2021.

The maximum wait time for a spinal fusion should be 365 days. Ebony is approaching the two-year mark.

"We still don't know how much longer she'll have to wait," mother Bobby Hall said of her wheelchair-bound daughter.

RELATED ARTICLE

Exclusive Children's Health

Sydney doctors can perform heart transplants on kids. Why must patients go to Melbourne?

"In the meantime, Ebony is the one who has to suffer with the pain of scoliosis.

"I can only imagine the pain for her having to sit for prolonged periods with scoliosis. It takes a toll on me too, having to watch her go through that pain and not be able to do anything."

Premier Chris Minns and Health Minister Ryan Park announced last week they would convene a surgical taskforce to tackle the state's elective surgery waiting lists – including the 17,000 patients across NSW whose waiting times breached clinically recommended timeframes at the end of 2022.

The state government will also begin drafting the terms of reference for a royal commission into NSW health services within weeks.

The announcement followed revelations by *The Sydney Morning Herald* in February that four operating theatres at CHW were being used to store medical supplies while thousands of children waited for essential surgeries due to a staffing recruitment and retention crisis in the anaesthetics and intensive care departments exacerbated by long hours of high-intensity work, fatigue and burnout.

It has been almost a year since 50 senior staff specialist intensive care doctors and anaesthetists signed a letter to then-health minister Brad Hazzard in May 2022 warning that a staffing recruitment and retention crisis was putting the care of the state's most vulnerable children at risk.

Dr Robert Molnar, orthopaedic surgeon and chair of the NSW branch of the Australian Orthopaedic Association, said the situation had reached crisis point.

“A lot of these kids who need spinal deformity surgery are complex cases,” Molnar said.

“I can’t imagine being the poor parent whose kid is put on a wait list with no end in sight.”

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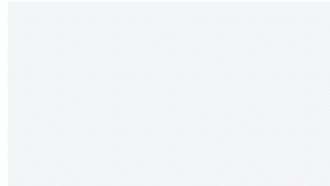

Exclusive Hospitals in crisis

Are these operating theatres the most expensive cupboards in Sydney?

Almost one in three children classified as “semi-urgent” elective surgery cases waited longer than the 90-day maximum for their surgeries in October to December 2022, including children with conditions including painful bone deformities that can prevent them from attending school.

For Category C “non-urgent” cases, more than one in four children waited longer than the maximum 365 days, including children who need spinal fusion to correct scoliosis.

Molnar said the backlog was partly due to the moratorium on some elective surgeries during the pandemic, but the wait times were particularly dire at CHW due to chronic under-resourcing, staffing shortages and limited access to operating theatres.

“There has been no real investment in the orthopaedic services at this hospital for the last 20 years,” Molnar said.

“There has been no real investment in the orthopaedic services at this hospital for the last 20 years,” Molnar said.

He said the magnitude of the crisis would not be solved by NSW Health’s plan to fund extra temporary operating theatre sessions.

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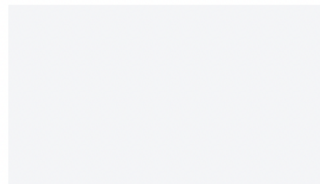

Hospitals in crisis

Critically ill overwhelm NSW emergency departments in record numbers

He urged the new health minister, Park, to include orthopaedic surgeons on his surgical taskforce.

“On behalf of the children awaiting essential orthopaedic surgery, the NSW AOA calls on the government to enact an expedited solution,” Molnar said.

Park said he would determine the terms of reference and taskforce members over Easter, adding the priority would be patients waiting longer than clinically recommended for their surgeries.

“I need to get that number as close to zero as possible,” Park said.

A spokeswoman for the Sydney Children’s Hospital Network, which oversees CHW, said all children needing urgent planned surgeries or emergency procedures would receive them without delay.

“Any parents who feel their child’s condition has deteriorated while waiting for their procedure are encouraged to contact their treating doctor for a clinical review and they can be placed in a higher urgency category if required,” she said.

The taskforce is expected to report back to the state government within three months.

The Morning Edition newsletter is our guide to the day’s most important and interesting stories, analysis and insights. Sign up here.

Appendix 3 - Reporting on CHW 27 February 2023

Are these operating theatres the most expensive cupboards in Sydney?

Four new operating theatres are being used to store medical supplies and equipment amid a staffing crisis at The Children's Hospital at Westmead.

Kate Aubusson
FEBRUARY 27, 2023

Four new operating theatres are being used to store boxes of medical supplies and equipment while thousands of children wait for essential surgeries amid a worsening staffing crisis at The Children's Hospital at Westmead.

The hospital promised the paediatric operating theatres in the $460 million Central Acute Services Building (also known as Block K) would be open by February to help clear the backlog of elective surgeries as the number of children waiting longer than clinically recommended has grown exponentially since the building was first opened almost two years ago.

Operating theatres at The Children's Hospital at Westmead are being used to store medical supplies rather than being used for surgeries.

But an impasse between the hospital's executive and its specialist anaesthetists who run the operating lists means the state-of-the-art theatres, which cost hundreds of thousands of dollars to construct and fit out, lie dormant.

Operating theatres usually cost on average $2500 per hour to run, including equipment, utilities and salaries.

Photos obtained by the *Herald* show the theatres are filled with trolleys stacked with boxes and cables, medical-imaging equipment and multiple operating tables yet to be used.

One photo shows an operating theatre set up for an information session. In the photo, rows of chairs have been arranged before a screen displaying the text: "Human Factors of OT Staff ... Westmead ... February 2023".

The Children's Hospital at Westmead had 2500 children on its elective surgery waiting lists at the end of September 2022. Hospital staff say that number has increased over the past several months.

When Block K was opened in March 2021, 56 children had been waiting longer than clinically recommended for their surgeries in both Westmead and Randwick children's hospitals.

On November 11, a spokesperson for the Sydney Children's Hospital Network released a public statement saying the operating theatres "are expected to open in early 2023".

But just 10 days earlier, co-heads of the anaesthetics department had told hospital management that this timeline was impossible.

An internal letter from the heads of the anaesthetics department dated November 2, 2022, describes two meetings with the hospital's executive on October 11 and November 1 in which the specialists said operating theatres could not be opened by February without compromising already overstretched services for some of the state's sickest children.

The letter says the hospital's anaesthetists could not keep up with the demand for current services due to "our ongoing staffing crisis".

“We are concerned that SCHN appears to be suggesting Block K must expand services despite clear advice that we cannot facilitate that with our present staffing situation,” the letter reads.

Health Minister Brad Hazzard referred the *Herald*’s questions to the Sydney Children’s Hospital Network.

A spokesperson for SCHN said the network continued to work towards opening the new operating theatres, that recruitment was ongoing and any child requiring urgent surgery received it without delay. The majority of elective surgeries continue to be performed on time using existing theatres.

“SCHN has offered a range of options to the existing anaesthetists at [The Children’s Hospital at Westmead] to address their concerns. This includes working hard to find ways to increase remuneration for the anaesthetists within legal frameworks and the NSW government public sector wages cap.”

The specialists have been pushing for an increase in remuneration, a “recruitment and retention allowance” of 40 per cent on their base pay (lower than the 50 per cent allowance in some other states), and better conditions to recruit and retain staff.

The senior staff specialists, directly employed by public hospitals across the state, are subject to NSW’s public sector wage cap, and the NSW Industrial Relations Commission determined in December 2022 that the employment award that covers them does not account for the 24/7 nature of their work.

A comparison of remuneration for specialists between Australian states shows paediatric anaesthetists in Melbourne can earn close to $600,000 and their counterparts in NSW earn about $360,000.

The SCHN spokesperson said six newly recruited anaesthetists would start work at the hospital between February and August.

Appendix 4

ANZCA
FPM

President and CEO
Australian and New Zealand
College of Anaesthetists

6 September 2022

The Hon Brad Hazzard, MP
NSW Health Minister

The Hon Bronwyn Taylor, MLC
NSW Minister for Regional Health
NSW Minister for Mental Health

Dear Minister Hazzard and Minister Taylor

Safety and quality concerns at the Children's Hospital at Westmead

The Australian and New Zealand College of Anaesthetists (ANZCA) is committed to setting the highest standards of clinical practice in the fields of anaesthesia, perioperative medicine, and pain medicine. As one of the largest medical colleges in Australia, ANZCA is responsible for the postgraduate training programs of anaesthetists and specialist pain medicine physicians, in addition to promoting best practice and ongoing continuous improvement that contributes to a high-quality health system.

ANZCA has been made aware of a range of concerns that impact on the safety and quality of paediatric anaesthesia and perioperative medicine at the Children's Hospital at Westmead ("Westmead"), and the wellbeing of specialists responsible for such care.

There are currently too few paediatric anaesthetists in the New South Wales health system, which is limiting our ability to train new specialists, and leading to the chronic under-utilisation of operating theatres at a time of high demand following the COVID-19 pandemic.

As part of our role in training doctors to become anaesthetists, one of our core responsibilities is to accredit hospitals to ensure our trainees are effectively and safely trained by consultants in supervisory roles. To this end, we have made ANZCA's Training Accreditation Committee aware of some of the concerns at Westmead, outlined in detail in this letter.

ANZCA understands and appreciates that this matter has been given the attention of the NSW Health Secretary, Susan Pearce, and the college has written a letter to her outlining our concerns (attached).

However, since the letter to Ms Pearce, it is our understanding that matters have deteriorated, further affecting the ability of paediatric and perioperative anaesthetists to perform their duties to the state's youngest patients.

ANZCA House
630 St Kilda Road, Melbourne VIC 3004
+61 3 9510 6299
www.anzca.edu.au

The issues at Westmead represent a significant concern for our fellows and trainees, not least as it pertains to their ability to perform the highest standards set by ANZCA, but also as it affects their psychological and physical well-being as practitioners. The fact that Westmead is the only tertiary hospital in NSW capable of performing key paediatric surgical procedures only compounds this concern.

The issues raised with the letter to the Health Secretary remain pertinent:

1. High quality paediatric anaesthesia and perioperative medicine is critically dependent on specialists with the right expertise to deliver this unique subspecialty care.

2. The most complex paediatric cases require a tertiary paediatric setting (such as at Westmead). Key subspecialities (for example relating to children's liver transplants, cardiac surgery, complex orthopaedics, etc.) will suffer unless these specialist shortfalls are addressed. Staff specialists drive systems improvement through research, education and ongoing work in clinical governance and the development of new healthcare initiatives which may not occur in arrangements where service delivery is prioritised.

3. The nature of the complex paediatric cases seen at a specialised tertiary unit such as Westmead means that more junior registrars require supervision at all times, placing an additional burden on consultants.

4. The resultant understaffing and work conditions are placing these specialists under undue stress, causing high levels of fatigue or burnout. This, in turn, may represent a risk to patients and negatively impacts on the quality of education for trainees.

5. The limited number and high workload of existing specialists at Westmead is undermining their ability to provide critical support to regional and rural medical centres through rotations, shared education meetings and face-to-face outreach education.

As noted, since the letter to the Health Secretary, ANZCA understands that these matters are either unresolved and/or worsening.

Further to this, there are compounding factors, which relate to the ability of Westmead to provide necessary care to the entire state, including emergency procedures in rural and remote communities:

1. Our fellows are concerned about the increased potential for significant delays in medical provision for children in rural communities who are given perioperative and non-emergency review.

2. Relatedly, given the growing backlog at Westmead, critical and emergency procedures and interventions in rural areas are more likely to be improperly assessed and treated.

3. Further, operating theatres are being chronically under-utilised, even when – or especially when – at full demand.

4. Westmead is the main – or only – hospital responsible for performing the following surgeries affecting children across NSW in:

    a. Interventional cariology,
    b. Paediatric cardiac surgery,

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c. Paediatric burns surgery,
d. Paediatric oncological diagnosis and surgery,
e. Complex paediatric orthopaedic surgery,
f. Paediatric plastics and reconstructive surgery,
g. Paediatric neurosurgery,

If unaddressed, this worsening situation may well cause a systemic breakdown of perioperative paediatric care in New South Wales.

It is our hope that, with your intervention and guidance, this matter can be resolved as a matter of urgency. Needless to say, this matter not only affects the well-being of our specialist pracitioners, but also the lives and wellbeing of children in NSW.

If you would like to discuss this letter, please contact us through our advocacy manager George Rennie at grennie@anzca.edu.au or +61 400 859 587.

Yours sincerely,

Dr Chris Cokis
ANZCA President

Mr Nigel Fidgeon
Chief Executive Officer ANZCA