New South Wales

Special Commission of Inquiry into Healthcare Funding

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Name: General Medicine Service, Children's Hospital Westmead

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20 November 2023

Mr Richard Beasley SC
Commissioner
The Special Commissions of Inquiry into Healthcare Funding

Dear Mr Beasley SC

General Medicine – The Children's Hospital at Westmead (CHW), The Sydney Children's Hospitals Network

Re: CHW Hospitals MSC submission for The Special Commissions of Inquiry into Healthcare Funding

Thank you for the opportunity to submit directly to the Special Commission of Inquiry into Healthcare Funding. Our CHW Medical Staff Council sought and received extension for submissions until 28th November. This summary was submitted to the Medical Staff Council by the 31 October and Chair Dr Angus Alexander advised that this submission will be provided as an appendix to the CHW Medical Staff Council Submission. On behalf of CHW General Medicine and as Acting and Department Head of General Medicine at CHW and Senior Staff Specialists in General Paediatrics, we wish to draw your attention to the significant challenges, staffing and resource limitations due to budgetary constraints which impact on the capacity of our service to continuously provide high quality excellent patient and family centered care.

Background

The General Medicine Service provides cares for children 0 to 18 years with a wide range of general paediatric conditions in both the inpatient and ambulatory setting. Our General Medical Team provides both a local service to the rising population of Western Sydney and the surrounding catchment areas AND a tertiary quaternary service for children and young people who present to the Children's Hospital at Westmead (CHW).

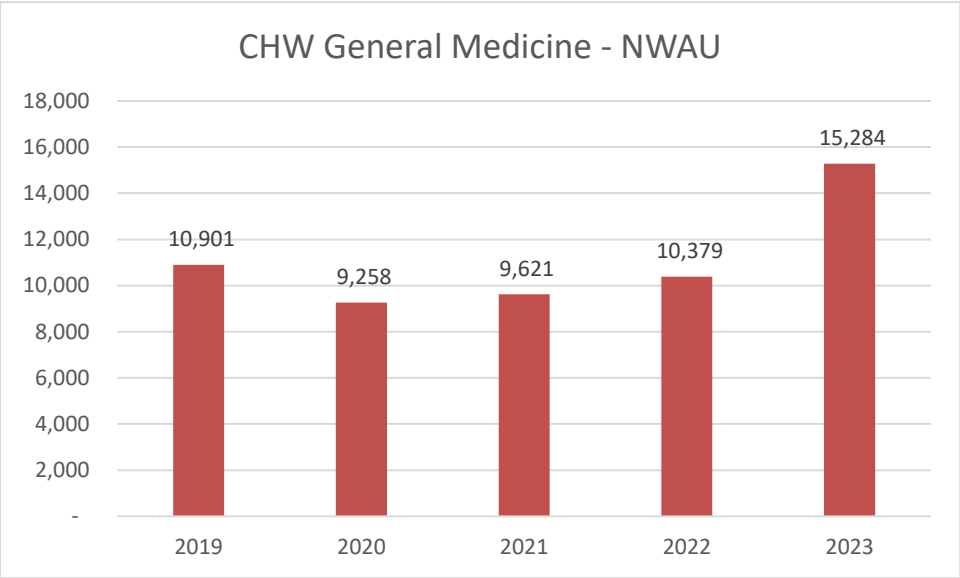
The General Medical Team broadly provides 2 inpatient models of care; Short Stay which is a high turnover 48-hour length of stay model and a Long-stay model which includes children whose inpatient care exceeds 48-72hours, those who present with undifferentiated conditions requiring further investigation and management and *Chronic and Complex care* where General Medicine clinicians provide and, co-ordinate the care of patients with complex medical needs.

Factors resulting in increasing workload

The workload of the General Medical Team has been impacted over the last 10 years with the team required to manage an increasing volume of patients many of whom have complex care needs. Factors that have impacted this clinical landscape include:

1. Paediatric population growth in Western Sydney (see appendix) which has not been matched by appropriate health resourcing with a focus on infrastructure but inadequate funding for staff to operationalise services (e.g. delay in opening Blacktown Hospital Paediatric services)
2. Parents choosing to bring their children to a Tertiary centre where care is perceived to be superior with many having lost trust in their local service.
3. Unpredictable, unseasonal, and high presentation numbers of children with viral respiratory infections requiring admission post COVID pandemic.
4. Medical research and advancement in technology and care resulting in higher survival rates beginning in the neonatal period and extending to transition to adult care at aged 18 years. Frequently funding for new treatments, for example Nusinersen for Spinal Muscular Atrophy, fail to incorporate funding for the lifelong General Paediatric care that comes with increased survival.
5. Multicultural and socially diverse patient population with high social care needs.
6. Chronic and complex care needs resulting in greater dependency on tertiary level medical care and care co-ordination.
7. Requirement to train and support parents to manage their children's complex care needs at home for example the use of complicated appliances such as CPAP machines, and pumps for feeding and their associated consumable resources.

Preliminary data (see below table) of our recent activity demonstrates a significant increase in NWAUs in the last year compared to pre-pandemic 2019, and a general increase in activity.



Our team has continued to work in this agile environment, pivoting in recent years expanding our service delivery to include ambulatory, telehealth consultation and advice, and virtual care models without dedicated and specific funding to match the need and resources. There is a lack of trained administrative officers to support these models of care and no recognition of sufficient time, infrastructure, and equipment required to continue to provide such care as business as usual. With the advancement of virtual care and the empowerment of the patient consumer – healthcare providers are doing more work and fitting in more care encounters (not well captured in ABF due to lack of resources/appropriate support in this area) to meet the expectations of the patient in the community.

Resource requirements for the safe maintenance of current models of care

Short Stay model of Care

The short stay model of care has experienced rapid expansion commencing at an initial 16 beds in 2020 to 32 beds with overflow of up to 10 to 15 patients within the Emergency Department daily.

Current workload and staffing issues:

1. Baseline staffing for this Short Stay model of care both in terms of senior and junior staff has not increased with the expansion in bed numbers.
2. Additional funding is provided as a 'winter strategy' but over the last 3 years, the demand has been year-round rather than seasonal resulting in shortfalls in staffing and worker stress.
3. To provide safe JMO staffing level particularly at night, the team was required to re-align our junior medical staff to work in the unit. As a result, a junior doctor in the early stages of training now covers clinical care of up to 50 often complex patients in the main block with limited registrar support.
4. There has been an exponential rise of patients admitted under General Medicine post-pandemic despite ED avoidance strategies. This has resulted in higher burden on the

JMOs with up to 25 to 35 admissions per day requiring processing and high turnover creating paperwork associated with discharge and GP liaison.

5. An increasingly busy emergency department has pushed clinical tasks such as undertaking a thorough history and examination and performing diagnostic procedures including phlebotomy and lumbar puncture to the General Medical team to conduct on the ward.
6. Shortfalls in pathology staffing resulting in there being no routine phlebotomy service to the short stay unit thus requiring JMOs to do this work.
7. VMO workforce with limited hours and no dedicated staff specialist FTE to this area resulting in inadequate JMO teaching provision, a requirement for accreditation.
8. JMO stress caused by the above resulting in increased sick calls, JMO resignations, complaints to the RACP and the Gen Med term going from being one of the most popular to the least desirable rotations.

Redress required:

1. Increased JMO workforce to match clinical workload ensuring worker and patient safety.
2. Staff Specialist presence in the unit to co-ordinate and provide daily teaching and clinical support to both JMO and Nursing staff. This would ensure that the General Medical term meets RACP accreditation requirements and would increase JMO and Nursing worker job satisfaction.
3. Provision of permanent funding for adequate VMO hours to match increased activity and allow 2 consultants to round each day year-round. This reduces ward round times, allows JMOs time to undertake tasks arising from the round thus reducing the risk of un-rostered overtime and associated burnout.
4. Permanent funding of the Gen Med Fellow in the Short Stay Unit. Currently funding is dependent on soft money via the foundation despite this position being essential to the day to day running of the unit.

Chronic and Complex model of Care

The role of General Medicine in the co-ordination of the care of patients with chronic and complex care needs is vital and valued by all teams within the organisation.

Current workload and staffing issues:

1. Activity in this area has increased without concomitant increases in funding.
2. The team currently have 2 Chronic and Complex Care CNCs who have capacity to co-ordinate the care of 50 patients each. This is inadequate and as a result, there is inequitable access to this vital support with many vulnerable families left struggling to manage and co-ordinate their own child's care through what is becoming an increasingly complex health system.
3. VMO workforce with restricted hours that does not allow for them to round as long or as often as required for the patient load or attend vital multi-disciplinary meeting required to provide co-ordinated patient care.
4. Staff specialist FTE is only 5.2FTE across the 4 teams with most staff specialist being Part-time. After hours attendance (weekend rounds) for a 1FTE equivalent staff specialist is 1 in 3 which exceeds the ASMOF definition of reasonable which is 1 in 5.

5. High burden of administrative tasks (rapid rounds, complex care huddles, committee participation, research collaboration and policy and procedure maintenance), outpatient work (18 outpatient clinics per week) and teaching (medical student and JMO including provision of hospital wide RACP exam preparation) falls on the Staff Specialists in General Medicine who already carry a high clinical load.
6. The team have taken on unfunded models of care such as providing a pre-admission work up and co-admitting complex patients having lower limb orthopaedic surgery to prevent medical complications and safety net their medical management during their admission.

Redress required:

1. Doubling of the Chronic and Complex care CNC workforce to meet the increasing demand.
2. Doubling of the Staff Specialist workforce to allow time for important non-clinical work, ensure safe clinical workload, allow ability to maintain work-life balance and prevent clinician burnout.
3. Quarantining of Staff Specialist time for non-clinical work including, monitoring safety, progressing future planning, participation in research collaboration (clinical and quality improvement) aimed at improving clinical care and supervision and teaching of JMOs. This is currently afforded to other clinical teams but not those working in General Medicine.

Ambulatory and Outpatient model of care

General Medicine currently supports 18 outpatient clinics per week. This includes several specialty clinics including an orthopaedic pre-admission work up service, dysphagia service and Multi-Disciplinary Feeding clinic. There is a high burden of children referred for management of neurodevelopmental behavioural conditions. Patients with chronic and complex care needs are seen in the outpatient setting and require multi-disciplinary input and longer appointment times. There is increasing demand to take on patients who do not reside within the CHW local area.

Current workload and staffing issues:

1. Lack of resources and staff specialist FTE to support the high load of patients with neurodevelopmental behavioural concerns. These patients require additional work outside of the 'actual clinic time'. This includes clinic correspondence to referrers and clinicians, schools and therapists, liaison with NDIS, Centrelink, Department of communities and Justice, and other agencies.
2. Specialty clinics are increasingly managing their waitlists by insisting on paediatric referral as a triage criteria and this adds to the burden for general outpatient clinics.
3. There is no outpatient allied health, social work, or psychology support for children in our outpatient clinics and likewise a lack of appropriately funded and resourced allied and mental health support for inpatient care resulting in less comprehensive and suboptimal care provision.
4. Metropolitan Sydney paediatric units are increasingly limiting the conditions seen in their outpatient clinics to control their waitlist issues. Many have refused to see

patients who have been admitted elsewhere and refuse to take on the care of patients with chronic and complex conditions residing in their local area.

5. Unfunded speciality services taken on by General Medicine as it is seen as the right thing to do to improve patient care and safety has increased pressure on other service provision as clinicians take these on as additional work. Examples include the Multi-Disciplinary Feeding Clinic and the Orthopaedic pre-admission work up clinic.
6. General medical team is increasingly imposed upon to 'upskill' as the solution for other specialty teams within CHW to reduce their wait times or workload. This is not appropriate and contrary to NSW Health's desire to providing value-based care and commitment to the right care in the right place at the right time for all children and young people. It also contradicts the many findings and recommendations of the Henry Review.
7. There is a general lack of access to affordable care in the community (General Practitioners, Private paediatricians and specialists) along with long waitlists for other specialties such as developmental behavioural paediatrics and allergy clinics.
8. Limited clinic space does not allow for JMO staff to work independently under the supervision of Senior medical staff in the outpatient setting. Outpatient clinic work is a requirement of JMO training at all levels and failure to provide this risks accreditation and compromises the training experience.
9. As a result of the above, wait times for General Medicine which were previously a reasonable 6 weeks have increased to greater than 6 months.
10. Increasing demands from patients and requirements from government to provide telehealth consultations which are conducted at times outside of usual scheduled clinic times.
11. Inadequate and low skilled administrative staffing to support the outpatient clinic activity.

Redress required:

1. Doubling of staff specialist FTE to safely maintain current workload and support existing unfunded activity.
2. Provision of more outpatient clinic rooms to allow JMO participation in this clinical setting thus allowing the department to meet RACP training requirements essential for accreditation.
3. Progression of a multi-disciplinary model of care with allied health support in the outpatient setting for all clinics particularly those where patients with complex needs are seen.
4. Sufficient funding for CHW General Medicine to meet the growth and demands of patients within our CHW local area.
5. Sufficient funding of subspecialty teams and Metropolitan Sydney Paediatric units to prevent shifting of work to an already overloaded General Medical service.
6. Provision of higher-level administrative staff to support outpatient clinic co-ordination and post-clinic administrative workload.

Conclusion

In summary, General Medicine has the highest activity of any department with increasing workload year on year. We are facing significant challenges with increasing demand without matching resources and funding. Recent application for enhancement to future proof the

department and meet the demands of both clinical, teaching and training and administrative work has been unsuccessful and not considered a priority of the organisation. The overall wellbeing and morale of the senior and junior workforce is suffering with resignations and early retirement from senior staff and recruitment has been challenging. We have a proven track record in producing high-quality well-trained clinicians in their final years of training, yet we are less attractive than many other paediatric units for advanced trainee and provisional fellow jobs due to the onerous workload and chronic lack of resourcing and staffing. There are risks to RACP training accreditation for JMOs due to the onerous workload and service nature of the General Medicine rotation and lack of resources and staffing to truly support dedicated education and teaching time, and the mental health and wellbeing of all doctors (both junior and senior staff).

There is no clear plan as to how General Medicine at Children's Hospital at Westmead will continue to provide the high standard of care patients deserve and that the SCHN Vision and Mission and NSW Health would demand.

Yours Sincerely,

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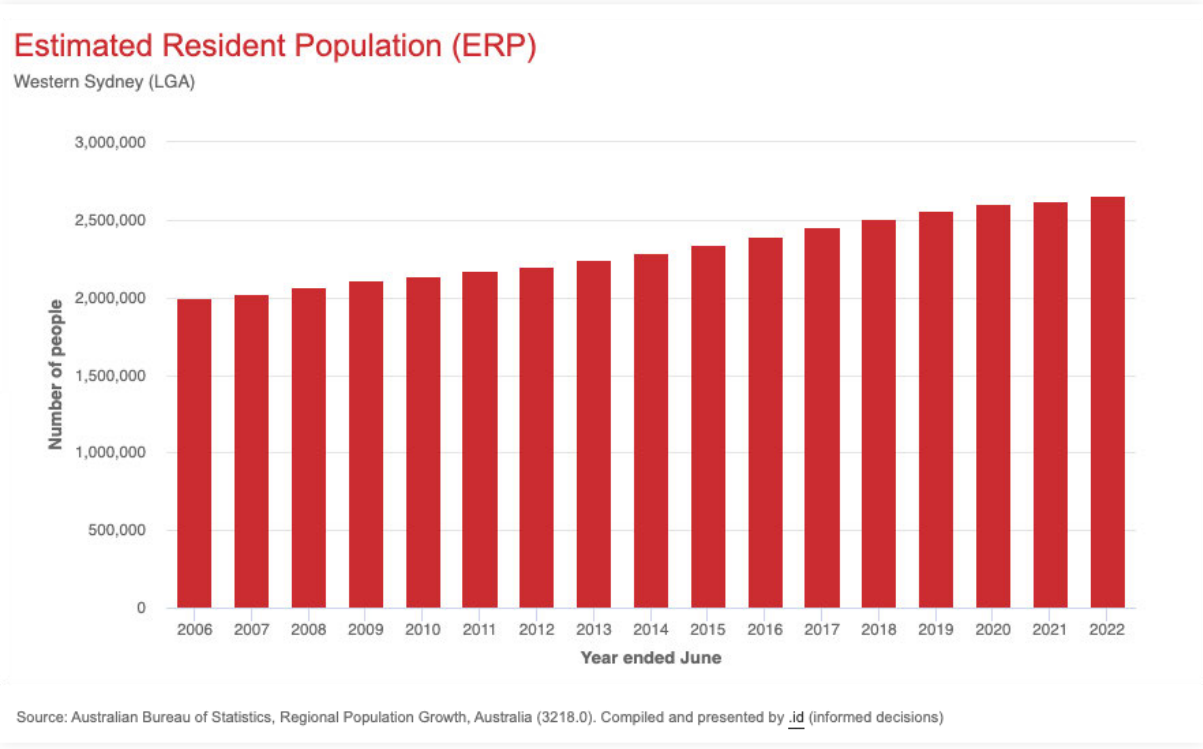
Appendix:

Population Growth in Western Sydney LGA alone:



Source:
https://profile.id.com.au/cws/population-estimate#:~:text=The%20population%20estimate%20for%20Western,in%20Greater%20Sydney%20was%200.78%25.