Witness Statement

Name: Associate Professor John Preddy

Occupation: Clinical Director of Paediatrics, Wagga Wagga Base Hospital

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

A. My role

3. I am the Clinical Director of the Murrumbidgee Local Health District Paediatric Department, an Associate Professor in Paediatrics at the University of New South Wales Wagga Wagga Rural Medical School, and a VMO Paediatrician at Calvary Riverina Hospital and the Riverina Medical and Dental Aboriginal Corporation.
4. I am also the Co-Chair of the Agency for Clinical Innovation's Paediatric Network and a member of several State-wise committees including CYPFESC (Child Young person and Families Executive Steering Committee NSW MOH) Health system review, regional health care implementation committee and several working parties examining health care delivery systems.

B. The need for delineating roles in the delivery of acute paediatric care

5. Dedicated children's hospitals, paediatric departments in non-children's hospitals and primary care play a crucial role in providing acute health care to children. However, in my view, it is important that the scope of their respective roles is clearly delineated, optimised and coordinated in a way that takes advantage of their different strengths if we want to ensure we are delivering the best health outcomes for sick children in the most efficient way.
6. Children's hospitals are important because they are the only hospitals where highly specialised quaternary care can be provided to children. Providing quaternary care is complex and resource-

intensive (including in terms of both equipment and staffing), which means it is also very expensive to deliver. Generally, it is not feasible to provide this level of care outside of dedicated children's hospitals.

7. On the other hand, the reality is that approximately 70% of paediatric admissions occur outside children's hospitals, and a larger proportion of paediatric outpatient care. The advantage that paediatric departments outside of dedicated children's hospitals have is that they are often closer to home for children than the small number of dedicated children's hospitals (which are in metropolitan locations), and they can often provide secondary and tertiary care in a more cost-effective way because:- bed occupancy at most level 4 paediatric units is relatively low therefore they have capacity, level 4 units can offer hospital in the home and acute review facilities that are impractical to offer from Children's hospitals from a geographic perspective.
8. Furthermore, local follow up from the paediatrician overseeing care at a level 4 paediatric unit is efficient for health services and consumers who have less time away from work and school. In my experience, the closer a child's care can be delivered to their home, the better for mental and physical health outcomes. Care close to home allows for a family and person-centred approach to care; both parents and often grandparents can attend hospital and clinic visits - the whole family can be involved with in-patient care of a sick child, families can rest at home, and other children have their care needs met. For example, children who require regular recurrent treatment, such as infusions, usually do not need to continuously return to the children's hospital to receive treatment because such treatments can be safely delivered closer to their home. Utilising virtual care to remotely involve sub-specialists can complement admission to a regional or outer metropolitan level 4 paediatric unit.
9. For these reasons, in my experience, the system works best when children who need acute care can receive it first in their local area, either through their local hospital or through a local

primary care provider where appropriate; can be transferred without delay to a dedicated children's hospital if quaternary care is needed; but then can be transferred back to their local hospital without delay once they no longer need that level of specialised care that is not available locally.

10. In general, emergency departments are very hostile and scary places for young children, particularly those with less urgent medical problems (lower triage priority) and who often wait for many hours. Expediting care via a rapid access facility, on-site, and staffed with experienced GPs (or career medical officers) with paediatric specialist support when needed, is efficient and provides a far better experience for families. Emergency departments are better utilised for urgent complex patients.

C. Barriers in the current system

11. In practice, I experience several barriers to the system working in this way.
12. First, frequently, there are inadequate beds available in children's hospitals for children to get the quaternary care they need in a timely way. At least on some occasions, this appears to be because beds in those hospitals are being taken up by the provision of secondary and tertiary care to children, which could be provided elsewhere.
13. Second, children's hospitals often do not transfer children back to their local hospital paediatric department once the need for quaternary care has ended. This is the case even when there are beds available in the local hospital. For example, on average throughout the year, the paediatric ward occupancy levels at many regional level 4 hospitals are between 50 and 60%. Utilising these beds more efficiently to provide care will free up capacity at Children's hospitals.
14. Third, there seems to be a lack of consistent referral pathways for general practitioners to refer children for specialist treatment, this has led to GPs increasingly bypassing referrals to general paediatricians (who may be based in the child's local area) and instead referring children to sub-

specialised paediatricians (often in children's hospitals). Ultimately, this leads to more children receiving care in a sub-specialised setting than may be warranted, often further from home. Referral pathways from GPs to local general paediatricians and from local general paediatricians to quaternary care at a children's hospital when needed - may assist in ensuring that the capacity of high complexity, subspecialised paediatrics is accessible to those that require it.

15. Fourth, at the moment, patient transfers generally happen because of relationships between particular clinicians in paediatric departments and clinicians in children's hospitals. With the exception of NETS, there is no centralised nor coordinated system for managing transfers of children requiring quaternary or other specialised care in New South Wales.

D. Ways of addressing these barriers

16. In my view, these barriers could largely be addressed within the current system, with the following changes.

17. First, the scope of care provided by children's hospitals should be focused on quaternary care with increased collaborative care - a) between Children's hospitals and level 4 paediatric units, and b) between general paediatrician and sub-specialty paediatricians. As the starting point, children should be transferred back to their local paediatric department once the need for quaternary care has ended and if appropriate care is available locally.

18. Second, it is important that general paediatricians work to their scope of practice, so that they only refer a child to a children's hospital where care needs truly exceed their capacity to deliver services. I think to some degree the responsibility for this falls to local leadership and management paediatrics. For example, I regard it as part of my role as the Clinical Director of the Murrumbidgee Local Health District Paediatric Department, where I am responsible for the paediatric department at Wagga Wagga and Griffith Base Hospitals (level 4 units), to ensure that my team of clinicians and I are working to the top of our scope of practice.

19. Third, there should be a referral pathway from general practitioners to general paediatricians, in their local area and where necessary further referral and collaborative care between general paediatricians and sub-specialised paediatricians.
20. Fourth, the steps set out above would be facilitated if there were a system-wide coordinated approach to facilitate patient transfers for the provision of complex paediatric care in New South Wales.
21. This could be in the form of a centralised bed management and allocation system which provides visibility of the beds available in both local paediatric departments and children's hospitals and facilitates communication between paediatric departments and children's hospitals to coordinate patient transfers.
22. The sort of system I envisage is similar to the one that already exists for neo-natal care. If a patient requires a sub-specialty opinion a discussion should occur between the general paediatric service and appropriate sub-specialists. A collaborative care plan should be drawn up including appropriate use of children's hospital beds. There should be agreed outcomes and referral back to the level 4 unit ASAP. Such a system should be complemented by the efficient use of virtual care. A centralised database could be developed with real time referral information and pathways for complex paediatric care, rather than relying on personal relationships to achieve patient transfers. If there was a dedicated password protected bed management system the site could also host clinical practice guidelines and other up to date material relevant to paediatric care in NSW.
23. Finally, consideration should be given to building capacity for level 4 paediatric wards to deliver hospital in the home care (HITH). Hospital in the home, utilising face to face and virtual care for low acuity patients (traditionally managed in hospital) is efficient and appreciated by families

who prefer to be at home if possible. HITH improves capacity and can form part of a suite of services that ensure seamless and patient centred care on a State-wide level.

24. A consistent and well connected service model will ensure 'right care, right time right place' and 'care as close to home as possible' providing world class care with as little imposition on children and their families as possible. Efficient use of level 4 facilities will also ease congestion in Children's hospitals, which may then in turn reduce the need for further infrastructure expenditure in the expansion of Children's hospitals.

Name: John Preddy

Date: 30/5/2024.

Signature: