STATEMENT OF PAUL THOMAS PREISZ 11 JUNE 2024

PROCEEDING DETAILS	
Matter:	Special Commission of Inquiry into Healthcare Funding
WITNESS DETAILS	
Name	Paul Thomas Preisz
Address	390 Victoria Street, Darlinghurst
Occupation	Chief Medical Officer

STATEMENT

On 11 June 2024, I Paul Thomas Preisz, state:

1 This Statement made by me accurately sets out the evidence that I would be prepared, if necessary, to give to the Special Commission of Inquiry into Healthcare Funding (**Special Commission**) as a witness. The Statement is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I will be liable to prosecution if I have wilfully stated in it anything that I know to be false, or do not believe to be true.

My background

2 I hold a Bachelor's degree in Medicine and I am a fellow of the Australian College of Emergency Medicine. Annexed and marked **PP-1** is my curriculum vitae.

3 I am the Chief Medical Officer of St Vincent's Hospital Sydney Limited (**SVHS**). I have been in this role since 1 April 2024.

4 I have worked in Emergency Medicine in various roles throughout my career, including:

a. staff specialist at SVHS between 1990 and 2001;

b. senior staff specialist at Sydney Hospital since 2001;

c. Deputy Director of Emergency Medicine at SVHS between 1995 and 2019; and

d. Director of Emergency Medicine at SVHS between 2019 and 30 March 2024.

5 I continue to work one clinical day per fortnight as a senior staff specialist in the Emergency Department at St Vincent’s Hospital.

6 I have held positions within the College of Emergency Medicine including senior examiner and chair of the Fellowship Examination Committee.

7 In my role as Director of Emergency Medicine at SVHS I was responsible for:

a. overseeing existing and implementing new, clinical policies, procedures and processes used in the Emergency Department (**ED**);

b. managing the ED's medical budget;

c. innovation and development of new practices and models of care, as addressed at paragraphs 15 to 28;

d. managing approximately 80 doctors, including 23 permanent staff specialists; and

e. supervising the ED's ongoing education and research programs at both undergraduate and postgraduate level.

8 As the current Chief Medical Officer of SVHS, I am responsible for Research, Pathology, Diagnostics and Medical portfolios. This includes overseeing the medical workforce, particularly the senior doctors, being Visiting Medical Officers and Staff Specialists. I liaise closely and directly with the Chief Executive Officer and Chief Operating Officer of SVHS, along with medical councils and advisory bodies, and interact with the Ministry of Health as required.

9 As I have only been in the role of Chief Medical Officer at SVHS for 10 weeks, this Statement focuses on my observations and knowledge of the ED at SVHS in my previous role as Director of Emergency Medicine.

SVHS' acute ED services

10 The SVHS ED is a tertiary level inner city adult emergency department that currently sees between 50,000 and 60,000 adult patients (being people over 16 years of age) per year.

11 The ED accepts and treats all adult medical emergencies, including all subspecialities of medicine and surgery. It is an accredited trauma centre. It also provides an acute mental health service dealing with all mental health emergencies including involuntary admissions.

12 Due to its inner-city location, a high number of vulnerable patients present to the ED for treatment every year. This cohort has complex co-morbidities, for example:

a. the ED receives a high number of alcohol and drug related presentations compared to other emergency departments;

b. acute mental health disorders, including drug-induced psychosis, also have a higher presentation rate than other EDs; and

c. there is a high proportion of Aboriginal and Torres Strait Islanders presenting to the ED. This is a vulnerable group of patients with a high incidence of complex and chronic conditions, poor overall health outcomes and socioeconomic disparity.

13 To accommodate the treatment and assessment of these patients, the ED has been designed to include a precinct which incorporates:

a. a dedicated, purpose-built safe assessment space to assess mental health patients and patients affected by drugs and alcohol, with specialised nursing and a full-time psychiatrist to provide holistic support; and

b. two short stay inpatient units to admit patients as appropriate – namely the Psychiatric Emergency Care Centre (PECC) and Psychiatry Alcohol Non-prescription Drug Assessment (PANDA) units. I describe PANDA in detail below. PECC is an inpatient unit providing person-centred care to individuals who present to the ED during a mental health crisis, operated by a multi-disciplinary team under the care of an admitting psychiatrist.

14 This precinct is an example of the specific programs and units that have been created as part of the ED which change or adapt the models of care for vulnerable patients to address the complexities they present. I describe this in more detail in the examples in paragraphs 15 to 28 below.

Psychiatry Alcohol Non-prescription Drug Assessment and Management (PANDA)

15 PANDA is a multidisciplinary, holistic model of care established in a short stay in-patient unit as part of the ED precinct described above. PANDA was developed over a period of 15 years and funding was sought for 10 years before it opened in November 2019. Building works were funded through a combination of a grant from the NSW Government and philanthropic donations.

16 PANDA combines clinicians from medical specialties including clinical pharmacology and toxicology, emergency medicine, drug and alcohol, psychiatry, and allied health. It admits and treats patients which no other unit or individual specialty within the hospital is equipped to look after, including involuntary admissions.

17 PANDA is ongoingly funded on an activity basis. There is no reliance on benefactors, grants or other sources of funding to operate the model. The model has significant benefits which I describe below.

18 Prior to PANDA opening, these patients, as in most emergency departments, initially occupied a bed in the ED and received immediate emergency care but no other ongoing active treatment for underlying complex comorbidities.

19 This patient cohort typically remained in the ED for extended periods of time because they were difficult to refer to inpatient units. These patients were also susceptible to self-discharge and high rates of readmission, creating a burden on the ED system and resulting in poor health outcomes for these patients.

20 The PANDA model is recognised as the first service of this kind in Australia. The model has been successful in relieving the burden on the ED by having a dedicated unit for these patients to be admitted to, reducing the occupancy of ED beds, and significantly improving health outcomes. I have observed the model to be effective in moving patients out of the ED and onto the ward of the short stay unit, where they receive appropriately adapted care.

21 The model has been replicated in other states and services. By way of example, I am aware from reports in the media that the NSW Government intends to create similar specialised units in the state's busiest EDs such as Prince of Wales and Nepean Hospital with the aim of reducing the pressure on ED services and improving patient care in line with the existing PANDA unit model.

Flexi clinic

22 In around 2021, SVHS had around 2,600 presentations of Aboriginal and Torres Strait Islander patients to the ED per year, which is around 5.2% of all ED patients. I have published the following article on this topic: Preisz P, Preisz A, Daley S, Jazayeri F "*Dalarinji; A Flexible clinic belonging to and for Aboriginal people in an Australian emergency department*" Emergency Medicine Australasia 26 July 2021. -

23 One of the metrics used to assess the effectiveness of an emergency department is the concept of "Incomplete Treatment" which captures a combination of the number of incidences of when a patient "did not wait for treatment" or "left against medical advice". For Aboriginal and Torres Strait Islander patients in 2019 this was 19.5% of ED presentations, more than double the NSW state average of 8.6% at that time. This indicated that the traditional ED model of care and ED processes were not suited to catering to the needs of Aboriginal and/or Torres Strait Islander patients. This is also addressed in the article I refer to in paragraph 22.

24 Under the 'flexi clinic' model, all Aboriginal and Torres Strait Islander patients presenting to the ED triaged as category 3, 4 or 5 (using the Australian Triage Category scale) are referred directly to and rapidly seen by a designated team. This aims to reduce "incomplete treatment" rate for Aboriginal patients in the ED.

25 The model involves the following elements:

a. a team comprised of a rostered Emergency Department senior clinician and an Aboriginal Health Care Worker (**AHW**). Once a patient is identified as Aboriginal or Torres Strait Islander, the process is activated for this senior clinician (either a staff specialist or a Senior Registrar after hours) to see the patient on arrival;

b. the place in which the patient is seen is flexible. It can be anywhere the patient is comfortable and deemed ‘culturally safe’ and medically appropriate for that patient’s clinical needs;

c. the patient may leave and return to the ED at any point and when they return they are not required to wait in line again. If they choose to leave during consultation, a “Dalarinji” card is provided, with a summary of the current plan. On return, this card is presented at triage and management will continue the treatment from the point at which it was interrupted;

d. for follow-up treatment, there is no requirement for an appointment time or for the patient to attend a fixed outpatient clinic and a number of options are explored. Follow-up also occurs by telephone 48 hours after they are seen in the ED;

e. streamlined processes have been put in place for any radiology and pharmacy services required for the patient; and

f. there has been accelerated cultural awareness training and ethics training for all ED staff.

26 The Flexi clinic approach has significantly improved the quality and equity of access to medical care for Aboriginal patients in the ED. This model of care reduced incomplete treatments to the same level as non-Aboriginal patients. There has been no impact on the waiting times and treatment outcomes for non-Aboriginal patients.

27 There was a cost to establish this model in the form of personnel costs incurred through removing staff from frontline duties whilst they participated in the design and set up the model, and then backfilling these positions. This equated to about

one day a week for several months in the design and setup phase. Once the model was established and implemented, it did not require any additional funding over and above the traditional model of care. The model requires the employment of an Aboriginal Health Worker, which not all health services may have embedded, as part of the ED, and training of staff to participate in the model.

28 To address the growing need for increased capacity of this service and to ensure it continues to improve health outcomes for this vulnerable population, the overall ED model must be reviewed from a staffing perspective (e.g., reviewing FTE models and teams) and scaled (e.g., from 3 teams to 4) in order to meet new peak demands. This increase in capacity requires additional staff, including trained AHWs, front line physiotherapists and nurse practitioners and in turn additional funding for that staff.

Impact of funding on models of care

29 Funding for the ED, like other emergency departments across NSW, is episodic and activity based. It assumes patients come in to the ED, are treated and then discharged or admitted to another service as a one-off episode and funding is based on that activity.

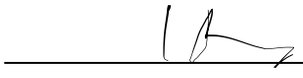
30 The activity based funding does not sufficiently account for patients who have been admitted through ED, and are treated in ED for prolonged periods while awaiting a ward bed (known as 'boarding). These patients require the same level of care as they would on the ward. However in circumstances where they are not moved to a ward but instead have their entire stay and treatment in ED and are then discharged from ED, the admission activity will be "reversed" and the activity and therefore funding reverts to an ED episode as opposed to an inpatient admission. This does not properly reflect the services that have been provided.

31 The measure of success of alternate models of care is challenging as metrics such as NWAU, readmission rates or times to be seen are not fully descriptive of the services being provided. This is particularly so when prior to these models of care the vulnerable cohort of patients did not receive health services other than immediate emergency care.

32 For all models of care to be most effective they must not be operating over capacity. I have specifically observed this with the Flexiclinic model, which is most effective and efficient when the ED overall sees less than 150 patients per day. Increasing activity and workload issues within a service has a disproportionate

negative impact on Aboriginal patients by increasing the incomplete treatment rate more than for non-Aboriginal patients.

33 Further, as described in paragraphs 15, 27 and 28 above, when new models of care have been designed and implemented, it has been necessary to seek additional funding, for things such as capital works or for initial model development, which relies on either the Ministry or (sometimes significant) philanthropic support.

Signature of witness  P PREISZ