Aeromedical Services WA Inquiry – Formal Hearing Transcription
Inquirer: Dr Marcus Kennedy
Organisation: Clinical Strategy and Planning Division, Department of Health WA – Dr R Lawrence
Date: 10 February 2022, Time: 1610 – 1632

KENNEDY, DR: Good afternoon. I'd like to thank you first up for your interest in the inquiry and for your appearance at today's hearing.

I understand everybody's busy at the moment, so I appreciate it. The purpose of the hearing obviously is to assist me in gathering evidence for the inquiry into Aeromedical Services in Western Australia. I'll start by introducing myself, my name's Marcus Kennedy. I've been appointed by the Chief Health Officer to undertake the inquiry. And beside me is Jonathan Clayson who's the Inquiry's Project Director.

I need you just to be aware that the use of mobile phones or other recording devices is not permitted in this room and if you could just make sure that your phones on silent or switched off, that would be appreciated. Again, I need to advise you that this hearing is a formal procedure convened under part 15 of the Public Health Act 2016 and that although you are not being asked to give your evidence under oath or affirmation it's important that you understand that you must answer all questions and that there are penalties under the Act for knowingly providing a response or information that's false or misleading.

This is a public hearing and the transcript of your evidence will be made for the public record. If you wish to make a confidential statement during the today's proceedings, you should request that that part of your evidence be taken in private and we will be able to accommodate. I understand that you've been provided with the inquiry's terms of reference, the inquiry's current State considerations paper, a focus list of relevant considerations and information on giving evidence before the inquiry. Before we begin do you have any questions in regard to the process of the hearing?

LAWRENCE, DR: No, thank you.

KENNEDY, DR: For the transcript could I ask you to state your name and the capacity in which you are here today?

LAWRENCE, DR: I'm Robyn Lawrence and I'm the Assistant Director General Clinical Strategy and Planning.

KENNEDY, DR: Thank you. So I'd like to now invite you to address the focus considerations list and any other matters that you would like to and we have around half an hour for that, so I'm comfortable for you to speak for 15 or 20 minutes or less, if you need to.

LAWRENCE, DR: Yes.

KENNEDY, DR: If it's like it's more than that I may interrupt because I might have specific questions.

LAWRENCE, DR: Sure.

KENNEDY, DR: I'll try not to interrupt as we go along, however, try as I do I seem to be getting worse at that as the day goes on and that's becoming more conversational. However, we'll see, I'll try and let you say what you need to say and then clarify what I need clarified later.

LAWRENCE, DR: Thank you.

KENNEDY, DR: Thank you.

LAWRENCE, DR: I think what I've got to say will be relatively short, so that - - -

KENNEDY, DR: Okay.

LAWRENCE, DR: - - - conversation will probably be easier for both of us. I came into this role in August last year in 2021.

Prior to that my I guess linkage to the aeromedical transport would be through being a chief executive, and I know you've had the chief executives, so I won't go into any of those issues. Plus, being part of the health executive table where I hear of some of the concerns, particularly from the WA Country Health Service.
Over the years I've been engaged in demand management strategies and how we manage demand across the system, so I have got experience in that and how we would like to see that run better into the future. And that, of course, goes beyond just the aeromedical retrievals but the full emergency system as we see it and that integration from pick up through to admission or assessment in the hospital setting.

In my role as the incident controller with COVID we started to look at how we manage this again, which isn't new, it's a longstanding problem, and how we would manage that through the COVID setting. So, I guess we can see where those - some of those gaps are and some of the complexities around that and how you manage particularly high volumes and periods of peak demand, which is obviously where it usually falls down. If there's no demand, it's not too much of an issue. And also, an understanding of how all those pieces fit together in the system.

In my current role I now will have responsibility for the consideration of the State or we're calling the SHOC, the State Health Operation Centre. It may not be called that in due course. And there has been early work done for that over the last couple of years, which did essentially get put on hold when COVID struck because it's such a big project to prosecute, and there are some really key components to that, including the aeromedical transport service and the contracts that exist around that and its processes as well as the St John Ambulance contract and 000 and how those things can be integrated.

I think it's fair to say that the key factors that would be required to make a SHOC and the key outcomes that people want are not universally accepted even around our own executive table. Everybody's got a slightly different view of what it should do and that is one of the challenges in trying to nail that down and say what exactly can it do? Is it a safety and quality tool? Is it a monitoring tool? Is it a coordination tool? What are the higher order of those priorities that we want to prosecute and how do you best make them happen and not losing sight that at the end of it it's about the patient and getting the patient the treatment they require in the shortest possible time in the safest possible way?

They can't be everything to everybody and I think there also needs to be a recognition that it's very difficult to create a SHOC that is just health focused because there are other issues at play. As an example, police would very much like that we were in their coordination centre and if we have a SHOC we would probably prefer they were linked to our coordination centre. So, working how you do those two things and meet those objectives is also important as we move forward.

I've got no doubt we could coordinate emergency responses better across the system and have better visibility of them and hopefully that would deliver better outcomes but there's a lot of work to be done to be able to implement that in a robust way. I think that's probably a good starting point.

KENNEDY, DR: So what kind of time frame do you anticipate around the SHOC?

LAWRENCE, DR: I think - - -

KENNEDY, DR: It depends how long the pandemic is, right?

LAWRENCE, DR: Correct, yes. So, we have stood up the patient flow coordination centre and a home monitoring service for COVID and we always saw that as a bit of a tester of how you could start to do some of these things on a longer term. We've only ever stood up the patient flow coordination centre at times of significant disaster. So, at the Bali Bombing was one example where these things would get stood up. But predominantly it's been when we've been moving hospitals where we've stood it up. So, we haven't got a lot of experience in actually making it work. There are many obstacles in making it work at the minute and we' have to work through those, the least of which is a location to be able to have a big enough centre to be able to do it, so we have a very small location at the minute.

If you got knuckled under and go to it you couldn't do it in less than a year. It's just it's too big a logistic exercise and aligning contracts and if you've got to align transition of existing services that's a very long process by the time you traverse all the bureaucracy that goes with that as well as setting up the system to make it work. I think if we could get agreement in kind to revise the project and get an agreement within six months about what it was you wanted that would be a good starting point.

KENNEDY, DR: What do you see as the sticking points in terms of that design work? What is that is wanted? From an aeromedical systems perspective - - -

LAWRENCE, DR: Look, I think - - -

KENNEDY, DR: - - - is there things that are sticking points or - - -

LAWRENCE, DR: I can't speak for RFDS but I think all of the providers and even from the documentation I read the services they provide are excellent, there's no doubt about that, and none of us really want to change what we do or give over control of anything. So how you navigate that I think is the first point. There's systems that would need to be aligned, so that we could all have visibility. Now, none of that's insurmountable with today's technology, so that shouldn't be a sticking point. But who's going to have ultimate governance of that and the direction and what sort of skill set you need to do that, it's not simply put - I think you've got to have clinical governance in that centre, if you're making decisions around dispatch and who's going to get priority to what locations, so there's clinical resources that need to be put in place.

You've got to have an agreement about how that will work and who's going to govern. I know there's the issue around outreach and how far you govern into that space and how much care is provided and who takes over the care at what point. And we can see that actively playing out currently with the COVID care model about those handovers. Is it when you make the phone call? Who takes responsibility?

KENNEDY, DR: Yes.

LAWRENCE, DR: So working through that from my perspective I think I would tackle it and lead it as a way to say, look, I think there's a basic set of things you need to achieve, coordination and clinical safety improvement. There's a broader suite of things you could do in due course around safety and quality and monitoring of the broader system and the challenge is what is the priority in that.

So aeromedical is just really one small component, we need to bring the whole lot together. And then there's a whole lot of desires that our health services have around what you could and couldn't manage and where those - who's responsible for which components.

So, does the coordination centre delve into the hospitals as well as into the aeromedical transport and the other emergency transport? So, you'd definitely have to nut those out first and define very clearly. So, I think the definition is the clear point you've got the external providers and how you navigate them into a system, whether you have to actually bring them. And I guess my personal view is it's very hard if you're trying to do it and maintain the structures we've got.

So, if you've got independent governance of the Royal Flying Doctor Service and the helicopter sitting over there and then St John Ambulance, which actually most of them can't transport where our helicopter can because it can drop on the hospital obviously. But most of them are integrated and they're all doing their own thing governed by their own board with their own strategic plan. It's very challenging because whether we like it or not the objectives aren't aligned.

KENNEDY, DR: I think that's very nicely said. The issue of extending the work of the SHOC into health service space the classic example of that from an aeromedical perspective obviously is destination determination. Now, we've had some quite passionate discussions about that today from some of the health services. How do you approach that from your perspective and from the SHOC perspective? I mean it's something that's not decided I would take - - -

LAWRENCE, DR: Yes.

KENNEDY, DR: - - - take it at the moment.

LAWRENCE, DR: I'm a centralist, there's no doubt about, I'm probably a chief or an ex-chief executive who very much more is aligned to the centre having certainly a more coordination oversight and better relationships than necessarily some of my colleagues. Having said that though health services do need to be responsible for patient flow and movement of patients in their own health services. To enable that to occur what has to happen is they have to have - the centre i.e. the SHOC would have to have very good real time information about what actually is going on in the hospital, so the decisions that you make aren't bad ones.

And I don't know whether this has come through already but each of the health services uses their patient administration system slightly differently even though the definitions and the way they're meant to are the same. So as an example some hospitals will show the patient still in the bed when the patient goes to theatre, others will show that bed empty because the patient is showing in the theatre system, which means if you allocate a patient against it you've got a

problem. So alignment of some of those things becomes really critical, making sure that they actually do update the beds that are open and closed more than once a day whereas currently they're just open and they stay open whether they've got staff in them or not. So, there's a lot of those practical things.

New technology systems would make that much, much easier. The PAS (*Patient Administration System*) is good for what it does but it's not necessarily ideal for this. And we do have other capacity and access tools which facilitate that. But if we want them to be able to manage their end and the centre to integrate, getting those things right so that you're not having to make a lot of phone calls and having lots of points of conflict is really critical. And I think having respected senior people who build those relationships with the patient flow teams in the hospitals, so that there is an understanding in that they know when to talk to each other, daily check-ins. There's ways to get around it but they all need to be built because it's just not a model we're used to.

And that does leave - I'm sure if they haven't already they will tell you, you know, it leaves sometimes people phoning around because they phone one site and they say we're full and they phone the next site and they say they're full. Sites might not actually be full because they might have beds on hold because of the trauma service or the something else service and nobody knows that they're expecting a road transport from here into the bed that looks like it's empty. So, all of that to make it run properly you've got to have visibility of that entire system and there's bits of those pieces that you actually can't see on all of our systems.

KENNEDY, DR: Yes. So, one of the challenges that appears to be fairly obvious in the system is that there is no particular strategic planning or thinking around Aeromedical Services that's being well documented up until now. It probably feels like a Dorothy Dixer but I'm going to ask you whether you support that in general terms. Not just Aeromedical Services but, you know, in a sense there's the whole patient transport concept that I struggled with in terms of finding, you know, what is the whole system approach to this.

LAWRENCE, DR: Yes, and, look, that's an absolutely fair comment. I think one of the reasons it is it's very challenging to - - -

KENNEDY, DR: Yes.

LAWRENCE, DR: - - - build that with the constraints you've got, if you don't have control over some of it to build the strategy and not know whether the government's supportive can be a lot of work to run into brick walls and we have done that on several occasions with different things. But it is definitely on the agenda.

The patient transport strategy and that can be as broad or as narrow as the director general would like it. And for my sins that probably sits in my portfolio for once the pandemic's calmed down.

KENNEDY, DR: Okay. And that could be segmented, you know, Aeromedical Service could be one component of that.

LAWRENCE, DR: Absolutely, yes.

KENNEDY, DR: Given that it articulates with just about every other form of transport as well.

LAWRENCE, DR: Yes. And I think, you know, if you go back historically when the rotary services came onboard how they ended up with DFES I mean I was peripherally involved at the time and there was a massive argument about where they should have been, which health lost.

KENNEDY, DR: I could ask you to expand on that but it probably - - -

LAWRENCE, DR: No, well, it's so long ago the details are fuzzy.

KENNEDY, DR: - - - it probably doesn't matter.

LAWRENCE, DR: Yes, I think, you know, it's one of those government made a decision about - - -

KENNEDY, DR: Yes.

LAWRENCE, DR: - - - where it was going to put it and it for its own reasons, which might be completely correct, I don't know, but it seems very incongruous, which has already been picked up in the documents.

KENNEDY, DR: Yes.

LAWRENCE, DR: That you have a helicopter sitting with DFES, which is mostly used for aeromedical. And I think the other thing that's been picked up is whilst we've got helicopters they don't have full capability, so - and I wasn't really aware of that until I had to try and get a patient off a vessel who was ventilated with COVID and we couldn't do it. And, you know, we were in the position where we weren't allowed to bring the vessel in, but the patient was intubated and ventilated on the vessel having had a cardiac arrest and no way to lift them off.

KENNEDY, DR: So the solution that's proposed by a number of people that we've consulted with is in terms of the current State work around the coordination is some form of process or system, a thing, which does the coordination of Aeromedical Services, and which brings together in some structure or way collaboratively the players or the people that are involved in the assessment, the support, the outreach, and then the transport logistics and clinical care during transport, and destination planning. Is that something that's consistent with your thinking and the treating kind of view around SHOC?

LAWRENCE, DR: Yes.

KENNEDY, DR: Is it something that's kind of within that thinking or is it something that could set aside and become part of that thinking at a future time or how do you - - -

LAWRENCE, DR: Certainly, within that thinking.

KENNEDY, DR: Yes.

LAWRENCE, DR: If we were going to do a SHOC I would envisage all of those things coming together.

KENNEDY, DR: Yes.

LAWRENCE, DR: It's how you do it. It's not to say you couldn't do it with the structures exactly as they are now. So today when we open our patient flow coordination centre, we have a St John Ambulance officer who's got all of their technology - - -

KENNEDY, DR: Yes.

LAWRENCE, DR: - - - in front of them sitting in the service and that's how we are coordinating. We don't really have control over it but if they have a 000 call they kind of do their own thing, so we don't have full control. So, you could do it with what we've got without making massive changes, it's just slightly more complex. And then you get into the resourcing and how is it being resourced and all of those sorts of things, which inevitably come up.

KENNEDY, DR: So, the concept and the strategic goals of those systems is essentially the same and how you blended them would be a matter of design rather than deciding whether you wanted to do it.

LAWRENCE, DR: Correct, it would be design and I guess, you know, government decisions around some of those key things but you certainly could make it work with the model we've got now with enough resourcing to bring them together to sit people together to make it function.

KENNEDY, DR: Okay, thank you. I don't think that I have any other specific questions for you. Is there anything else that you wanted to raise in terms of the considerations that have been put to you or other matters?

LAWRENCE, DR: No, I don't think so.

KENNEDY, DR: Okay. I think a centralist is probably going to have few arguments with most of what's here. Would that be fair to say?

LAWRENCE, DR: Yes, I just have them with my friends instead.

KENNEDY, DR: Yes. Well, I think it is very much a feature of aeromedical systems is that they're - you know, the pattern of their structures in every jurisdiction is - you know, there is a central focus - - -

LAWRENCE, DR: Yes.

KENNEDY, DR: - - - for them. Whether there's more than one in that jurisdiction is a different question, you can have more than one sort of coordination point, but it all has to come together at some point because there is a whole system to manage and - - -

LAWRENCE, DR: I did notice in the documentation the issue about coordination with Northern Territory.

KENNEDY, DR: Yes.

LAWRENCE, DR: I think that's adding a dimension we haven't considered before, particularly if you're trying to control it centrally and how you're going to do that working relationship with them. So that would be interesting to explore but it could be done as part of the same process with an agreement with NT.

KENNEDY, DR: Yes.

LAWRENCE, DR: I would imagine but - - -

KENNEDY, DR: It's largely about forgetting about borders and then coming up with those arrangements for just who pays for what. But there are other - lots of other jurisdictional examples there. In southern New South Wales essentially - - -

LAWRENCE, DR: Yes.

KENNEDY, DR: - - - is part of Victoria.

LAWRENCE, DR: Yes.

KENNEDY, DR: Northern New South Wales is part of Queensland to a degree.

LAWRENCE, DR: And I think the routine means people do go backwards and forwards across there.

KENNEDY, DR: Yes.

LAWRENCE, DR: So, it's not an issue. And we do know a lot of our indigenous communities on the border actually receive their care from NT.

KENNEDY, DR: Yes, yes.

LAWRENCE, DR: I guess if you've got a coordination system you just need an entry point to be able to link in for that.

KENNEDY, DR: Well, and from an aeromedical efficiency perspective, you know, the flight distance from up there to down here is a lot different from - - -

LAWRENCE, DR: Across.

KENNEDY, DR: - - - going across the - - -

LAWRENCE, DR: Yes.

KENNEDY, DR: - - - that area. So, there's, you know, potentially real savings to be made in that area as well. Okay.

LAWRENCE, DR: All right, thank you.

KENNEDY, DR: Well, look, I don't have anything further, so we will call the hearing to an end.
A transcript of this hearing will be sent to you, so that you can correct any minor factual errors, if there are any, before it's placed on the public record. You will need to return the transcript to us within 10 works days of the date of the covering letter or email otherwise we will just assume that it's correct.

While you cannot amend your evidence, if you would like to explain particular points further, present further information, you can provide that in addition to your submission to the inquiry when you return the transcript, if you wish. But otherwise thank you very much for your time today, I realise it's been an impost in your day, but it's been very valuable for us to hear your perspective, so thank you for coming.

LAWRENCE, DR: Thank you very much.