Aeromedical Services WA Inquiry – Formal Hearing Transcription
Inquirer: Dr Marcus Kennedy
Organisation: Royal Flying Doctor Service Western Operations – Ms R Tomkinson, Dr K Hennelly, Mr D Whitham, Mr A Green
Date: 11 February 2022, Time: 1315 – 1500

KENNEDY, DR: Welcome and good afternoon.

WHITHAM, MR: Thank you.

GREEN, MR: Good afternoon.

KENNEDY, DR: Thank you for your interest in the Inquiry and for your appearance at today's hearing. The purpose of the hearing is to assist me in gathering evidence for the Inquiry into Aeromedical Services in Western Australia. And I'll begin by introducing myself, my name's Marcus Kennedy and I've been appointed by the Chief Health Officer to undertake the inquiry. Beside me is Jonathan Clayson, the Inquiry Project Director.

I would like you to be aware that the use of mobile phones and other recording devices is not permitted in this room and ask you to please make sure that your phone is on silent or switched off. This hearing is a formal procedure convened under part 15 of the Public Health Act 2016 WA. While you are not being asked to give evidence under oath or affirmation it is 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 is false or misleading.

This is a public hearing and a transcript of your evidence will be made for the public record. If you wish to make a confidential statement during today's proceedings, you should request that that part of your evidence be taken in private. You have been previously 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 to the inquiry. So, before we begin do you have any questions about today's hearing or its process?

WHITHAM, MR: No.

GREEN, MR: No.

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

TOMKINSON, MS: Rebecca Tomkinson, Chief Executive Officer Royal Flying Doctor Service Western Operations.

KENNEDY, DR: Thank you.

WHITHAM, MR: Damien Whitham, General Manager Operations RFDS Western Operations.

KENNEDY, DR: Thank you.

GREEN, MR: Anthony Green, General Manager of Aviation for the Royal Flying Doctor Service Western Operations.

HENNELLY, DR: Kieran Hennelly, General Manager Clinical Royal Flying Doctor Service Western Operations.

KENNEDY, DR: Thank you. You will now be invited to address the focus considerations list that's been provided to you and for this we'd ask that you speak to these matters for up to 60 minutes give or take, I'm happy to take that a bit either way. I will try and remain silent during

that period and listen to your presentations. However, there may be areas of clarification that are needed, and I may interrupt. Otherwise at the end of that time I will have some questions for you, and we may then move onto other matters, if you want to consider other things.

So, I don't have a preconceived idea in terms of the way that you present the material that you wish to present, I'm comfortable for you to address the hearing in whichever way you feel most appropriate.

TOMKINSON, MS: Thank you, Inquirer.

KENNEDY, DR: If you wish to take your mask off while you're speaking, if you need to, to speak clearly and/or feel comfortable, at the distances we've got it's okay.

TOMKINSON, MS: Thank you.

KENNEDY, DR: You chaps are a bit close together, so as much as you have faith in each other I think I'd be a bit careful.

TOMKINSON, MS: Astute of you.

KENNEDY, DR: That's what I'm paid for.

TOMKINSON, MS: Thank you.

KENNEDY, DR: Go ahead.

TOMKINSON, MS: If I can, Inquirer, I'd like to start by opening a few opening remarks. Western Australia is vast, remote and sparsely populated State. It presents, as you rightly suggest, an extreme aeromedical scenario in most locations. Ensuring that every West Australian has reliable access to equitable healthcare and emergency lifesaving treatment is a fundamental principle that underpins our health system. This is an enduring challenge for our State.

The RFDS was founded on a principle of addressing the tyranny of distance. That continues to form the basis of our commitment to everyone living, travelling and working in WA. For more than 93 years ago our founder John Flynn identified the opportunity to use aircraft to support regional and remote communities to access essential health service, an innovative and disruptive idea at the time.

He procured an aircraft and set about partnering with existing services to bring essential healthcare to more Australians. We have been innovating our service, moving from that single aircraft to a fleet of world class aeromedical assets and a highly specialised workforce.

The State Government and the people of Western Australia have every reason to have confidence in the safety and quality of our aeromedical service. However, we are not the only aviation company, health service or Aeromedical Service in Western Australia's aeromedical landscape.

The State government, health system and our community have the right to be assured that every provider is operating a safe effective and well-integrated service that represents value for money. And we know the State has the responsibility to deliver a strong sustainable

transport system for patients. To that end we thank the Inquirer for his work to date and appreciate the opportunity to offer our prepared comments on the focus considerations that you prescribe for this hearing.

A significant percentage of your considerations, including many of the ones you've identified for discussion today, such as four, 14, 15, 17, 26 and 113 speak to the need for a holistic strategy, policy, standards, governance and assurance of the State's patient transport system and the Aeromedical Services in it. We broadly agree with these considerations.

The State has no mandatory patient transport strategy or policy state-wide patient transport clinical services policy, governance framework or legislation. And no system wide data set, data definitions or data repository relating to patient transport. The Department of Health did publish Ambulance Services Western Australia a Framework for state-wide ambulance service operations in December of 2021.

The Department states that the Framework is intended to provide guidance on the conceptual infrastructure of ambulance services in WA, which it defines to include aeromedical services, and of the expectations of Government and the Department as the System Manager. The Framework includes eight domains that broadly align with the Sustainable Health Review's enduring strategies. The content of the Framework is not contentious, and we welcome it as a part of a broader suite of governance documents, but it is just that, a framework with the detail still to be developed.

The RFDS was not consulted on the document and it has not been published as part of a binding policy framework. In 2019 the Department of Health undertook consultation, including with the RFDS, on a state-wide ambulance services policy, which also defined aeromedical services as an ambulance service. This policy was going to incorporate mandatory standards with respect to operational principles for ambulance services, capability specifications and response requirements. This policy was not finished, the Framework was produced instead.

We agree that the Department of Health as System Manager should provide leadership and assurance of the entire patient transport system. We would expect the Department to have a comprehensive state-wide patient transport strategy along with a suite of specific policies and standards relating to the delivery of services that are applicable to all providers at all stages of a patient's journey. We would also expect it to publish these documents as part of a binding policy framework as afforded through the Health Services Act.

It has been on the record for many years that the State needs to develop these foundational documents. In 2015 WA Health established a patient transport strategy project. The project was chaired by the Deputy Director General. The project board consisted of the Chief Executives of each Health Service along with the Chief Medical Officer and executives in Procurement, Resourcing and Innovation, and Health System Reform.

The project included all road based and aeromedical services, including PATS, NETS and ERHS, ad hoc engagements and non-contracted services. One output of the project was the publication of the WA Health Patient Transport Strategy 2015 to 2018.

The strategy identified what an effective patient transport system would look like and established a three-year program of actions along the themes of governance, standards, information, finance, provision and procurement and indeed partnership. The State entered into contracts with St John's Ambulance and the RFDS soon after knowing that these contracts

were not contemporary and that it had work to do to understand the service requirements and development fit for purpose policies, standards and funding models.

These contracts are still in place today and have remained largely unchanged. The current contract between the State and RFDS has been extended twice since then. We expect WACHS will need another contract extension as the discussion on the scope specifications or key performance indicators for the new contract are still ongoing. The lack of System Manager assurance is not a reflection on the quality of the service by the RFDS but on the quality of the contract, which it, as you point out, is not explicit about standards, and has outdated KPIs.

We note that many considerations, including 49, 133, 134, 160, 162, 164, 182, 183 and 184, speak to some aspect of the aeromedical system or our aeromedical service to which you make no adverse findings but suggest the State should cite, audit or specify something for verification and assurance. You suggest that WA Health lacks the systems to assure the safety and quality of aeromedical providers whilst acknowledging that non-provider respondents consider the risk management systems and clinical guidelines of providers to be comprehensive and well governed and a delivery of clinical services by providers to be sound and safe.

The RFDS has sought to independently quality assure the standard of its service and has demonstrated this through the achievement of national quality safety health service standards. We remain ready, as we have been advocating for, to establish a more contemporary contract that focuses on outcomes and reflects the standards we demand of our service and its governance and any further requirements identified by WA Health.

In consideration 25 and 108 you suggest that there's a slight disconnect between providers and purchasers regarding service expectations. This is a little disappointing but not unexpected. It is also reflected in your suggestion in consideration 34 that the RFDS has a privileged position. We provide a critical and complex 24-hour seven day a week health service in partnership with a whole of health system. That is, as you suggest, needing to look at some aspects of the services provided but still needs to articulate the standards, indicators, governance or reporting requirements and systems that it would like and/or complete co-design process to refine or develop these aspects of the service or the contract.

We are privileged in the context that we have the opportunity to serve over 10,000 West Australians each year often on the very worst day of their life and often in areas where the State itself struggles to deliver health services. We see every day the value and trust that Western Australians place in our service, which delivers more than $10 million a year in donations to benefit the sector. The RFDS does not take for granted the community's trust in our service, our incredible staff, and our many strong partnerships across public, private and industry organisations.

At present the RFDS conducts the vast majority of the State's aeromedical transfers and does so without exclusivity. In the presence of clear system leadership - in the absence of clear system leadership - or a contract fit for purpose, specifications and metrics, it is our deep expertise, robust policy settings, governance, well developed strategy and commitment to working in partnership across the health system that ensures that everyone in Western Australia has access to safe, consistent and quality aeromedical services.

The services provided by the RFDS are world class and subject to strong corporate, aviation and clinical governance. We are company limited by guarantee governed by an independent

board of directors. The board is chaired by Sam Walsh AO and the board members are executives and clinicians who are experts in their field and have contemporary and relevant governance experience. We are charity regulated by the Australian Charities and Not-For-Profit Commission ensuring we maintain our constitution's purpose and obligations to the community that we serve. We are a hospital accredited to the National Safety and Quality Health Service Standards through the Australian Commission of Safety and Quality in Healthcare.

While the standards are not specifically designed for an aeromedical service they are, as you point out, very applicable and a key mechanism used by the Department of Health as the System Manager to ensure the standards of all State hospitals. We are an airline designated as a Category A operator by the Civil Aviation Safety Authority in the National Surveillance Selection Process, the same category as Qantas and Virgin. We hold the relevant Air Operator's Certification and are subject to ongoing and continuous surveillance from CASA

People in regional and remote WA have every reason to trust our service. As with all services there is room for improvement. There always will be and we will be the first to continue looking for that improvement and making those changes. But we are assured that we provide high quality aeromedical services.

We, however, cannot offer the same assurance for all other service providers, which is why we agree common mandated standards are so important and should be included in all contracts and potentially legislated. Our contractual relationship with WA Country Health is a commercial one where under the standard terms and conditions specified by the Office of Government Procurement within the Department of Finance with overview from the State Solicitor's Office. We appreciate that the contract is not fit for purpose, but its weaknesses are not related to our charity status.

The contract was established in accordance with the Delivering Community Services in Partnership Policy because the State is purchasing a community service, not because they're purchasing the service from a community benefit sector organisation.

On that point, and with respect to consideration 7, I would caution against any suggestion that efficiency and professionalism are not achievable within benevolent or community organisations. On the contrary, the community and for-benefit purpose sector often demonstrates greater agility, strategic strength, and value for money and have the courage to go where commercial interests see no profit. Australia's entire health system and aged care system is very well served by organisations operating in the community benefit sector and key medical transfer providers such as RFDS, St John's Ambulance and CareFlight demonstrate this.

Any suggestion that contracting a for profit entity is synonymous with the delivery of stronger commercial or patient outcomes we don't feel has any basis. A relevant recent experience of this is the report from the Royal Commission into Aged Care Quality and Safety, which concluded that Not-For-Profit aged care facilities outperformed full profit facilities across the board."

The key difference for the State in contracting the RFDS with its charity status has been the significant subsidisation of the service, thanks to the generous financial support provided by West Australians, which has equated to more than $110 million over the last 10 years alone, the assurance that any profit is reinvested in mission driven services and delivery, and the

significant contribution and commitment of our communities that fundraise, work and develop ideas and options for us over more than 90 years.

We look forward to establishing a more contemporary contract and for every provider in our aeromedical transfer sector to operate in accordance with the same high clinical and aviation standards.

We agree with the interjurisdictional experts that long-term contracts are essential, as you suggest, in consideration 40. Comprehensive aeromedical services such as those provided by the RFDS require significant and ongoing investment in infrastructure, assets, workforce, training and innovation. 10-year contracts provide certainty and allow for longer term strategic service planning. This promotes investment in assets and people, reduces the cost of capital, supports the establishment of favourable terms for supply of goods and services, and in the case of the RFDS provides greater assurance to potential benevolent partners increasing value to the State.

We would also highlight the importance of communicating future procurement strategies well in advance. We appreciate that WA Country Health first advised us in 2020 that it intends to enter into a long-term agreement at the conclusion of this contract and it has reiterated that commitment again recently. Long lead times for aeromedical services contracts ensure that providers and stakeholders can manage any change effectively and with minimal impact and risk. We look forward to this new contract.

Many of your considerations speak to a lack of coordination across the entire patient journey. This is one area where the system has come together to introduce positive change. In their journey to definitive care regional and remote patients, particularly those being transferred between health facilities, often move between five teams with different governance, locations, standards, and clinical mix. They also sometimes require escorts and the negotiation of admission into a metro hospital.

We recognise the important of system integration and coordination. We have supported the establishment of the Acute Patient Transfer Coordination Centre. The ATPC has been established to coordinate the transfer of WACHS patients. It streamlines and centralises referrals for the transfer of a key cohort of WACHS patients. This involves clinical assessment and the coordination of state-wide bed management and transport connections.

We have worked alongside WACHS and St John's to establish this service and have co-located a transfer liaison officer who is a senior RFDS representative in the service to support state-wide integration. We look forward to learning from the outcomes of this and continuing to refine and build the model to improve coordination and patient outcomes.

While the RFDS has worked in partnership with all stakeholders to negotiate patient coordination for many years we do have limited authority and have often relied on trust, existing relationships, and mutual respect to achieve an outcome. We expect that the ATCP being part of WACHS will enhance the efficiency of patient coordination ensuring that the RFDS coordination centre can focus on the clinical coordination of aeromedical transfers and the management of our aeromedical network as it does today.

We believe, as has been already spoken to, that a federated integrated coordinated system would best serve the WA community. We know that improving patient flow improves patient outcomes. We also support recommendation 12 of the Sustainable Health Review and each

of the priorities aligned to it. Should the State choose to further centralise coordination we would welcome the opportunity to co-design and co-locate in a federated coordinated model with St John's, WA Country Health, WA Health, and any other relevant partners to optimise the flow of patients throughout the State.

With respect to network management we believe that the decisions relating to aircraft and crew tasking should sit within the contractor's aeromedical provider. The RFDS operations centre runs 24 hours seven days a week, it is the beating heart of our entire service and it's critical to the best use of the available resources. The centre manages the coordination and logistical integration of our people and our assets giving consideration to the availability of aircraft and clinicians both immediately and in the context of maintenance schedules, regulations and industrial agreements, network demand and projected demand, weather and road conditions, and air field accessibility.

The RFDS operation centre has valuable intellectual property and deeply embedded skill sets. This area of our business delivers significant efficiencies for the State and for our patients. We are absolutely committed to improving the transparency and coordination of patient flow.

There are several references in the focus consideration to provide a competition and ring-fenced agreements influencing patient outcomes. We feel any suggestion that the construct of the market influences our tasking decisions or care of our patients not to be correct. As you point out, at the coalface the aeromedical culture is one that focuses on patient care with all parties striving to provide the best and most appropriate care for patients being transported. We all operate within an imperfect system at times, but we do so with a commitment to partnership and putting the patient first every time.

St John's has a team member in the RFDS coordination centre to create as seamless an experience as possible for patients and the health system. When we call on third party providers from our panel to fly when we aren't able to, we pay them their commercial rate and receive the standard contract funding. We do not pass the full cost of this onto the State. We work collaboratively at both an executive and operational level. The best interests of the patient are central to all tasking decisions. Indeed, there are many examples in my own experience where tasking decisions have been made in the knowledge that there would be significant financial cost to the RFDS.
I know there will be examples of times where we could have done better as a service and as a health system. However, decisions about tasking or patient care are not based on commercial outcomes.

We would also note that while mandated standards, contemporary contracts, meaningful metrics, and system level coordination are essential. Our own clinicians need to maintain responsibility for clinical care of our patients. It is appropriate that clinical risk and responsibility for patients in our care sits with us. We have demonstrated our competency with clinical accreditation to the NSQHS and note this would be an ongoing requirement of our clinical accreditation as a service as it should be for all aeromedical service providers.

It is also the benchmark of good governance that clinical responsibilities remain within the organisation where the clinical decision-making sits close to the ultimate care of the patient and the supervisory roles that guide and support operational staff. Any treating clinician needs to make decisions regarding the care of their patient.

We agree that the three-tier system of transfer prioritisation in the current contract would benefit from being refined. We have had discussions to this effect with WA Country Health and NETS. We continue to operate in accordance with the transfer prioritisation categories set out in the current contract but would welcome the opportunity to align the future contract with any other prioritisation categories such as the clinical prioritisation used throughout WA Country Health.

Where there's a disagreement about clinical prioritisation there is an established process for escalation. A more refined model and a more collaborative coordination mechanism will increasingly improve this.

We broadly agree with considerations 18, 19, 20 and 59, that there may be some benefit to the State negotiating more comprehensive agreements for intrastate patient management, particularly in the Kimberley, Ngaanyatjarra Lands and the Great Southern. It is not necessarily the case that the health services in the Northern Territory or South Australia are always culturally more appropriate for our Aboriginal patients living close to the border though in many cases they may well be. Importantly, these decisions must be made in consultation with our patients and approval of these communities and their representatives and not on their behalf.

We appreciate the complexity that the State faces in negotiating intrastate healthcare agreements. And recent issues with cross-border transfers, COVID-19 provisions, and capacity issues in the Northern Territory hospitals have illustrated sometimes the challenges of this model.

RFDS has been transferring patients into WACHS funded beds in Royal Darwin Hospital for many years and we occasionally make requests to service providers in adjoining states to receive WA patients. If an increase in intrastate transfers was required, we would be willing and able to deliver this service.

With respect to consideration 95 there is no denying that state-wide challenges of meeting the clinical and general support needs of acute and subacute mental health patients, particularly in the regions. Few patients are more vulnerable than those who have a mental health diagnosis and are managed under the provisions of the Mental Health Act. While transfers with a principal diagnosis of mental and behavioural disorders account for only four per cent of our services they are complex, particularly given the need for the involvement of the police in the end to end transport, the ongoing bed shortages in the metropolitan area, and the varying capability in regional and remote areas to care for people with acute behaviours.

We know that the impact of these services challenges can be troubling for patients, their loved ones, clinicians, and other patients at small regional health facilities. We recognise that any long-distance aeromedical transfer of a patient under the provisions of the Mental Health Act represents a failure of the services targeted at mental health. The need for long distance travel can be a catalyst for further physical, social, psychological, cultural risk for our patients. Transport is often the least bad option and RFDS has extensive experience in mitigating the most challenging aspects of that experience.

The reality is that a lack of mental health capability and resources in the region often leads to us being tasked to respond when a patient has reached a very severe or acute level of mental distress. We do the best for patients within the capability of our service but there are much broader issues at play within the mental health system impacting on the delivery of these services across the State. RFDS reports regularly to the Office of the Chief Psychiatrist about

such transfers and has been proactive in measuring outcomes and conducting multiagency reviews of these cases to identify areas for improvement. We very much welcome your advice on how the aeromedical service and the patient transport system can better support the journey of mental health patients and there is no question that additional resources would expand the services available.

With respect to NETS we recognise the importance and time critical nature of the work performed by WA NETS for unwell newborn patients in regional areas. As one of our key partners we are committed to our ongoing work with NETS WA to ensure we are supporting the best possible neonatal service across a strong joined up network in Western Australia.

RFDS provides aeromedical services for NETS WA in the form of an aviation platform and supplies a flight nurse with currency in NETS care. We have worked particularly closely with the NETS management team over the last two years to identify and embed improvements in relation to training, reporting, escalation and governance. We conduct regular clinical meetings with NETS to review cases and discuss their responsiveness of our service.

While our commitment to NETS WA has never faltered, we have focused on enhancing our service to our very important partner. We are aware of conversations about a dedication aviation platform to optimise service delivery in this highly subspecialised and often time critical space.

We see system wide coordination will improve visibility of options and support the case for dedicated resources and further investment.

A contract with a more considered prioritisation framework is important. The enhancement of the telehealth services in regions will support decision makers around the prioritisation and treatment. This would by its very nature improve the timeliness of aircraft availability and we would welcome the opportunity to support this bespoke service. In the absence of a dedicated service any increase in aeromedical Services capacity will positively impact the NETS service.

We are confident that a two-clinician model is usually the most appropriate mix to meet the clinical needs of patients receiving aeromedical care on all asset types. Almost all RFDS flights have two clinicians. Most are a flight nurse and a doctor crew. We support considerations 142 and 151. We agree that the State should establish and mandate a minimal clinical standard for crewing across a patient's transport journey, including during aeromedical transfer. It has always been important to WA Health and in a well-established principle of - and is a well-established principle of - aeromedical retrieval that a patient should travel up a gradient of care. Should WA Health contemplate changes in the scope of practice expected of aeromedical crew in some circumstances relating to, perhaps, distance diagnosis or priority we would welcome the opportunity to contribute to that conversation and service model.

We are proactively considering novel workforce models that may better meet the clinical needs of our patients, including the use of registrar, paramedics, and nurse practitioners. Given that crews in WA service particularly lengthy flights, with the average one-way flight being 500 kilometres, we would expect that a one doctor, one nurse configuration will continue to be the most appropriate crew for comparatively more flights than experienced in other jurisdictions. This crew configuration also often provides greater flexibility to divert mid-flight to higher priority taskings, which can be lifesaving in a State the size of WA.

We agree with consideration 146 regarding the need for a specialised workforce with appropriate levels of training and an optimal scope of clinical practice. We believe that the nature of the service in WA's geography will continue to demand a mix of clinical care specialists and rural generalists, particularly in regional areas. The RFDS has been proactive in acquiring and maintaining this clinical workforce and has a well-developed framework to ensure we prevent skills fade and facilitate skills development through our inhouse clinical education program.

We support consideration 53. We are about to commence accreditation to deliver the Diploma in Pre-hospital and Retrieval Medicine known as a DIPPHARM. We expect that to become the industry standard and have aligned our training and education with that syllabus.

We are committed to benchmarking our service and support consideration 169. We are collaborating in the development of the National Register for Aeromedical and Retrieval Practice. We support the principle of cross-credentialing that you highlight in your consideration 157 and have entered into an MOU with WA Country Health regarding cross-credentialing to support regional health service delivery at times of peak demand.

If a centralised cross-credentialing process was established, we would support it and we would help to ensure the specialist clinicians who occasionally join our service have optimised by it. But we would expect that all providers would retain the right to specify requirements for their services that can occasionally go above the minimum standards required.

We strongly support opportunities to work in partnership with providers to enhance experiences for regional clinicians and we are committed to working in partnership with WA Country Health to undertake and translate research and innovation.

With respect to funding, the State does not pay the full cost of aeromedical interhospital patient transfers for the service that it contracts from the Royal Flying Doctor Service WA. The Commonwealth pays a proportion of standby, which was subject to significant intergovernmental negotiation between 2016 and 2018, and the service is subsidised by up to 10 per cent by donations, philanthropy and bequests with corporate philanthropic partnerships funding the vast majority of capital costs for our jets and the helicopters. As a community benefit organisation, the RFDS is able to facilitate significant additional investment into our State's aeromedical health service, which shouldn't be underestimated.

We agree in part with consideration 43, which suggests that the contract should include funding for capital investment. A contract that contemporises service expansion and assets replacement would certainly be reflective of a more mature purchasing framework and we look forward to developing an investment profile in partnership with WA Country Health. However, we would hope that the opportunity for a service provider to access funds for capital investment from benevolent partnerships or other mechanisms would not be restricted to maximise the value of the service to the community.

Throughout the last seven years the funding model in the contract has proven itself unsuitable in meeting the needs of either the RFDS or the State. Fluctuations in service demand result in disproportionate swings in revenue and the indexation of the contract price, which is done by the Consumer Price Index, does not reflect the key inputs of our service, which more accurately align with the cost profiles of aviation and health service industries.

A funding model that better reflects the cost of delivering an efficient and effective service and transparently acknowledges the financial support that the RFDS brings to the capability and sustainability of the service would be an important step in moving to a contemporary contract.

In the absence of a contract that responds sustainably to demand fluctuations and includes provisions for capital, the RFDS has proactively invested in the inputs required to meet the changing demand profile of our State with the support of WA Country Health and the Department of Health. This has included investing in a 20 per cent uplift in frontline staff as well as a jet service, our high acuity road transport unit, and the planned new helicopter service. We have proactively worked with WA Country Health, WA Health, and our partners to offer these expanded services to the health system.

The integration of the Rio Tinto Life Flight jets has been absolutely fundamental to our ability to keep meeting the growth in demand. Since their commissioning the jets have flown 5.3 million kilometres, spent almost 10,000 hours in the air, and transported nearly 7,000 patients, more than 45 per cent of whom were Aboriginal. They have transformed our network capability and we expect that the Fortescue Heli-Med service will have a similar impact.

However, decisions on long term funding models and the total funding envelope should be grounded in network configuration that is driven by an understanding of service model requirements. We broadly agree with the systematic structure system outlined in your considerations. We certainly agree with the cascade of strategy to planning and standards to funding and contracting. We agree that the current network configuration could be optimised, that there is unmet need and that additional assets in the system would be of significant benefit. And note your views in considerations 76, 77, 78, 80 and 97 on the sustainability of rotary wing assets in many regional areas, your suggestion that all hospitals should have a co-located helipad, and the idea that different regional retrieval hubs with various assets may be appropriate.

While we have a genuine commitment to optimising the locations of bases and the broader configuration of the network, and we note that there have been comments raised in relation to the appropriateness of additional bases in the Midwest, Southwest and Great Southern, we don't have a firm opinion on the specific circumstances or the considerations. We believe, as you suggest, that decisions about configuration of the network need to be derived from a strategy that is integrated with the State’s clinical services planning framework aligned with key drivers, like workforce, future regional demographics, the service expectations of the community, and the funding available to meet those needs.

Historically the State Government has not paid the full price of the services it receives and over the last five years the RFDS has generally self-funded and cross-subsidised the introduction of new and expanded services to meet demand as we understand it to be. We operate an efficient and high-quality service within the context of the funding contract and the information we have available to us. We welcome the opportunity to work in partnership with WA Country Health, WA Health, and key stakeholders to identify a patient transfer clinical service framework and network configuration that best meets the future needs of our community within the funding available. We know that clear service requirements and a sustainable funding model will improve the timeliness of aeromedical services to and health outcomes for regional and remote West Australians. We stand ready, as we always have, to serve the people across Western Australia and the entire health system whenever required and welcome the opportunity to further expand the State’s aeromedical capability.

Today we deliver the best possible service we can with the resources available to us through the contract we have with the State. Capacity in our aeromedical service is driven by the availability of assets, pilots, engineers, clinicians, and coordinators.

As you know, we have 17 PC-12s, three soon to be four Pilatus PC-24 jet aircraft, and two EC-145 helicopters, and two road based high acuity retrieval units. The scale of this asset base and our regional infrastructure is a strength. This is the largest aeromedical fleet in the State's history.

The Pilatus PC-12 is an absolute workhorse, there is on other aircraft in that class capable of short take-off and landing and all surface landing with the reliability for high altitude flight pressurisation and an impeccable historical safety record. The Pratt & Whitney PT-6 engine that powers our PC-12s is the most reliable, efficient and readily available turbo prop engine of its class.

Our Rio Tinto Life Flight jets are equally respected. With the RFDS identifying the jet capability would better serve communities in the North and the Great southern areas of our State, we set about procuring a suitable aircraft and securing a commercial partner to cover the capital costs. Then in partnership with Pilatus we developed the aeromedical fit out of the PC-24 here in Western Australia and also note the significant investment by the State into the aeromedical PC-24 and Commonwealth into the same asset.

Our long-term partnership with Pilatus is deeply valued. As a preferred provider we have a Pilatus engineer co-located at our Jandakot base to streamline diagnostics and the shipment of parts, a real asset in Western Australia where our planes are subject to severe and extreme weather events and unique airfields. The PC-24 aeromedical fit out is now available from Pilatus as a global turnkey solution for anyone wanting to convert a PC-24 into an air ambulance.

Our EC-145 helicopter is the global go-to for aeromedical rotary aircraft. It is a safe, robust twin engine fully instrumented and night vision capable helicopter that has just been procured also by WA Health *(corrected to WA Police on review of transcript).* If we require winching or mass patient moving that would be undertaken by the ERSH service in Western Australia and not by the aeromedical assets available to the RFDS.

We note that consideration 72 relates to concerns about the integration of the EC-145s and the suitability of that platform. We have confidence in the platform and have worked in partnership with the health system and key transport partners to establish a service model that will see the assets available for WA Country Health patients soon.

Fleet standardisation is a normal and valid strategy used by commercial airlines and government air forces to minimise risk and to reduce costs. Every asset type within our fleet has an identical specialised aeromedical interior. Every one of our aeromedical Pilatus PC-12s is the same on the inside as our EC-145s and Pilatus PC-24s are.

Across all assets we carry the same equipment and have worked closely with our clinicians to ensure that any necessary variations do not compromise their ability to operate intuitively across every platform. We know this reduces clinical risk and it also reduces costs and waste. This simple principle applies to our aviation fleet. Multiple asset types require multiple hangars, tools, engineers, parts and pilots. The policies and manuals to assure them, the trainers to check them to line, and the contracts and relationship to service them.

Managing multiple asset classes increases safety risk and regardless of whether the assets are within one service provider or across multiple providers it can become a more complex Aeromedical Service.

In the last 10 years there have been three notable global groundings of aircraft. Only the Boeing 737 Max was found to be a systematic aircraft issue. The likelihood of that happening with the PC-12 given the vast number of them globally and the many years they have been in service is incredibly low risk. And the safety risk of a single airline running multiple models is a much greater risk than identified by the single type of the PC-12.

Should a global grounding of the PC-12 aircraft fleet ever occur we are confident that WA airlines, the RFDS Federation entities, and our global aviation partners would support us to ensure business continuity.

In the absence of legislated or mandated standards we maintain an internally assured panel of alternate aviation and Aeromedical Service providers who we contract when demand is exceptionally high, or we have had an issue impacting our availability. This is the most efficient and value for money model for creating surge capacity and business continuity in our understanding of the appropriate models.

We appreciate that surge capability is important but agree with WA Country Health that the provider environment needs to be commensurate to the scale of the aeromedical service demand in the State, which is limited and operates in areas of market failure.

Any investment in service capability will attract the greatest return, if it is invested in the primary service provider, rather than a range of individually governed arrangements. The asset base, pilot check training, and maintenance of clinical competency are necessary and high cost overheads that should be minimalised across the aeromedical transfer system.

With respect to your considerations regarding the management of the Commonwealth and State arrangements for primary and interhospital patient transfer, we agree that it’s a historical anomaly that in Western Australia the aeromedical asset determines the governance and funding stream for an aeromedical retrieval. We don't have a position on whether the State should advocate for the Commonwealth to transfer funding and accountability for the delivery of the primary aeromedical retrieval service, as you suggest in consideration 818. Sorry, 187 and 190.

We do firmly agree that any separation of service providers for these contracts would be financially unviable. I should say we do firmly feel that the separation of service providers for these contracts would be financially unviable as a significant proportion of the State’s aeromedical system operates in areas of market failure and requires the scale delivered by both.

We don't agree that having separate contracts for primary and interhospital Aeromedical Services is problematic. We appreciate that it could benefit from the contracts being clearer in the deliverables and if competition with the particular KPIs was to emerge that that would need to be addressed. There are no standards or performance measures in the Commonwealth contract or the State contract currently that create conflict with the provisions of the service. All patients receive treatment in accordance with their clinical prioritisation

regardless of their location and the circumstances of their origin and that should remain the focus.

To that end we don't agree with the suggestion in consideration 40 that the State should only enter into a contract with a provider who provides no other services. As you point out in consideration 75, there is little precedent for fragmentation of rotary wing aeromedical services into primary and IHPT. We consider the same argument to be valid in relation to fixed wing services and suggest that the separation of these services in Western Australia would not be as efficient and riskier from a clinical and aviation perspective.

We are a State large in geographical area, small in population, and operating in large areas of market failure. The scale of our service is a significant quality and safety outcome both clinically and in aviation. We welcome the opportunity to demonstrate our commitment to providing world class independently accredited aviation and clinical care for Western Australians living, working and travelling in some of the most remote areas of the world. These current-state considerations show the challenging contractual context and governance environment in which the RFDS continues to operate.

We welcome the findings that WA Health should be providing system leadership and sustainable resourcing for the entire patient transport system. Long term contract clarity and clear mutual service expectations are the most fundamental pieces to improving end to end patient care for aeromedical services and other patient transport. In managing the daily - in managing our experience of increasing demand we have not waited for this clarity. Our own strategy and efforts have led to innovation, service expansion, and ever improving standards. But we all know that the community deserves even more aeromedical capability and the assurance that every provider is safe.

At every stage we look to collaborate and align with the WA Health system, and WA Country Health in particular, and we welcome the opportunity to make system wide improvements in partnership with the State. We look forward to the development of a 10-year agreement with the State that can form the basis of our long-term partnership as they embark on the considerable strategic, policy, governance, and funding pieces required to inform the next contract.

Finally, the report notes the strong culture and commitment of our people and I would like to reflect on that. Maintaining a strong workplace culture focused on safety and patient care is something the RFDS is fully committed to and actively invests in. We put the safety of our patients, our assets and our people first and our proven ability to do as an organisation is our strength.

It is an enduring privilege of my role the opportunity to lead a team of people with an unwavering commitment to safety and patient care. Be they engineers, pilots, nurses, doctors, back office or ops, I know that every decision they make is in the best interests of the patient with the information and the resources we have available. Our team are more than a credit to our organisation, they are our organisation, and I am as proud as ever to represent them today and the service we provide in partnership with WA Country Health and the WA Health system.

Thank you for the opportunity to respond to the focus considerations.

KENNEDY, DR: Thank you very much. Thank you for a very well-considered and comprehensive response.

Is there anything further at this stage that other members of your team would like to add in terms of general discussion around the considerations?

WHITHAM, MR: Not at this stage.

GREEN, MR: Not at this point, no.

HENNELLY, DR: No, thank you.

KENNEDY, DR: Okay. Perhaps if I can just reflect you back to the considerations again. Are there - firstly, it's important to understand the difference between considerations and recommendations. The considerations have come to be in a - in some respects monstrous document, which reflects the passion, diversity and volume of input and interest in terms of the aeromedical system development and the Inquiry's work. And so, it's probably better for you not to think of them as my recommendations or to refer to them as my recommendations because none of them are recommendations at this point, they're observations, considerations and many of them are not mine.

So what they have done though I think is to bring a conversation to this, which has been important in terms of getting common issues to the table, and for people to be able to consider those in different ways and we have had much discussion so far. If we can just look back at them are there aspects of that document or aspects of the considerations that are listed that you fundamentally disagree with? Are there considerations in there that you would say pretty much outright "We don't agree with that"?

TOMKINSON, MS: Thank you.

That's a big question. I think, as I've outlined, there are some aspects that are fundamental to Western Australia such as the scale of the State that we feel are very significant to the service that we provide today. And the opportunity to continue to build on the fundamentals of the service that we provide is an important place on which to start. So, we very much agree that there is absolutely room for improvement across the system and that indeed the contracting environment that you refer to is a very sound reflection of the challenges that we experience in the contracting environment. And that it would definitely benefit from the provision of greater structure, governance, policy underlying our frameworks. However, we feel that that should be built from the foundations that we've already established.

KENNEDY, DR: I guess again then to broaden the question to the rest of your team, if that's okay. Are there any other aspects of the considerations that other parts of the organisation have major discomfort with?

HENNELLY, DR: I'm not sure that I'm keen to get drawn into too many specifics in a forum like this. But certainly our - some statements that have given me pause.

I've taken them in the spirit in which they are intended which, as you say, is the beginning of a conversation rather than the end. They reflect different points of view and I think that's probably what's important for me to take away. As I've said when I've spoken with you previously, my feeling would be that this would be the beginning of - this would be an opportunity to create an evidentiary data set to actually have data driven strategic decision

making. And so, there are individual examples I could take issue with but I don't think now is the time or the place for that.

KENNEDY, DR: Okay. You do raise a point though, which I found remarkable, during the consultation phase and that is the varying opinions expressed. And I take them as opinions, much of it, you know, not all of its absolutely fact. Very little of what I heard was backed up by data. But opinions and perceptions are important, they are what people hold and that's what they believe. And it is an interesting situation that there are quite different views about aspects of the service or the system of your service. Do you see anything in terms of improvement opportunities or perhaps things that have been raised during this, which may point towards a resolution of that dissonance? A bringing together of those kind of perceptions, so that there is only one page or maybe one and a half pages that people are on and not all over the place.

TOMKINSON, MS: I think to your earlier comment, that certainly the considerations have generated broader conversations and the opportunity for people to think more deeply about how we can continue to put and improve patient care. And those conversations will absolutely benefit patient outcomes. I think the work that we've all come together to do is a concrete evidence base of the coordination requirement. And I think most certainly, as you've observed, the opportunity to do that end to end patient transfer, and in a coordinated federated environment would be a key strength to addressing a number of the particular challenges that people have spoken to of their various forms. That overall that collaboration is absolutely key. Coordination, visibility, transparency absolutely key to building on a future-state aeromedical service and certainly one that I feel that we are all already progressing towards. We might have slightly different understandings at times of some of those particular pieces and where there are still aspects of the specifics that do need to be worked through. And I feel very strongly that it needs to build on the strength that we all already bring to that table and that co-design, co-creation process will most benefit West Australian patients.

And it's easy for a West Australian to say that we're unique and special but it's not that - we actually are, there are some very significant geographical challenges and population based challenges that the provision of healthcare services, particularly the tertiary hospital environment, do present for our jurisdiction that are different in other areas. And I think that we have developed well established processes to help us address that. And that you have provided an opportunity for us to understand more about that and to engage in a more collaborative conversation about how to leverage those strengths and I welcome that opportunity.

KENNEDY, DR: I won't pursue special and different. Do you mean that Western Australia is smaller than Canada?

TOMKINSON, MS: I mean that the - - -

KENNEDY, DR: Do you get what I'm saying?

TOMKINSON, MS: I do, I do. I do.

KENNEDY, DR: So, everyone is special and different.

TOMKINSON, MS: Yes.

KENNEDY, DR: So, I agree, I think one of the resounding themes that's come through here, through the consultation work up until now has been around the coordination space and how that could and should look. And that the - you know, I guess to provide an overview of it the clear impression at the moment is that what's missing from that is not the willingness of each of the organisations to be in one space and to join into a collaboration that's around improving those processes but what's missing from it at the moment is what is the governance process that sits around that and what is the arbitration point within that.

And that even the best system, which runs on consensus 99 per cent of the time will need, as every aircraft system does, as every aeromedical system does, there needs to be decision points, so in the best federated model will require at times arbitration. And so, do you have any thoughts about how that over mantle could work, what its roles might be, how it could sit in the system? Is there any vision that you've applied to that to this point or is this still a work in progress?

TOMKINSON, MS: I think that we absolutely will benefit from a federated 'coming together' of the respective coordinating bodies. And I absolutely agree that, despite the very best of every system, there is the requirement to have robust arbitration processes, so that you don't ever actually need to use them. And I think that they can be co-designed in consultation with all parties.

I think the key here, that has been discussed previously, is the relationships and the true partnering of how the entities come together. And I think if that arbitration model is developed in consultation across all, then it will ensure the commitment from all to that particular process. And I think that there are existing models globally around complex challenges that we would be able to adopt and utilise. And certainly, the opportunity for the inquiry to have a look at those and make some recommendations would be welcomed.

KENNEDY, DR: I think also at the other space where that arbitration or decision point is important is the limits of your system. So where your system or where the aeromedical system interfaces with a handoff point or a collection point I think one of the things that's quite clearly missing is the - you know, the ultimate decision making capability at that point, which is, you know, what is best for the patient given the system situation at any particular time in terms of particularly destination planning, which can be a real issue.

A number of the parties who have presented either here or through the consultation process have talked about their perceptions of deficiencies in the prioritisation of cases and in the sharing of knowledge and decision making and status around prioritisation
And, you know, as much as they point out the fact that the - a coordinator or decision maker around priority allocation may not be fully aware of the patient's needs and the health service's situation et cetera et cetera they similarly cannot be aware of the needs of - or the situation of the aeromedical system in terms of resource availability, competing demand et cetera.

However, what that's resulted in I think is that there is clearly a difference in any understanding of prioritisation and a discomfort with the way that that is managed in some cases. I'm not saying it's all of the cases but there - it's a recurring theme. How do you see that as, you know, in terms of a challenge? Is that something that could be looked at in the shorter term? Is that something that you've understood for some time but been unable to influence? Is it something that has been overly tied up in the contract structure that's made it impossible to change or - I'm just struggling with it because I hear it and when I see the issues that haven't

been resolved my next question is, well, why haven't we resolved that, we all know it's an issue, we've known it's been an issue for a while.

TOMKINSON, MS: I think there's contributing factors from a number of those items that you've suggested. I mean obviously the contract does require a certain level of compliance, however, even contracts can be, you know, adjusted. I think the challenge is in coming to a fit for purpose prioritisation across the different systems, so it's not just an aeromedical piece but from the referring clinician to the road transport component as well. I do think that we are more progressed than ever, despite how it might feel, on the understanding that prioritisation is part of the key.

And certainly, the ATPC has been working on that prioritisation integration. And I think we are right at that stage now where that is the next key platform to be addressed. I think that there is absolute appreciation from all of our respective clinicians that we need to address the definition of prioritisation. We talked about the need and the establishment of a contemporary contract environment. It would certainly be addressed in that new stage. I do take your point you shouldn't wait for that, these things as it - when they are as important as that need to have that ongoing and need to be addressed immediately.

However, this is a complex piece for our State. I think the piece that sometimes is missing in the conversation is the overall network that we are managing across the assets and the clinicians and the availability of resources for us as an aeromedical provider. I know every organisation is going to say if we had more resources, we would have a different outcome. There is a truth to having more resources that are required to enhance the overall availability. However, coordination will also assist in the availability of the current network. And certainly, the prioritisation piece is one that our clinicians have already been having conversations and progression towards. Perhaps Kieran?

HENNELLY, DR: Yes, I mean there's no philosophical objection to a change in prioritisation within RFDS. There's a contractual - I was going to answer yes when you listed all of those potential reasons why there may be obstacles. There are contractual entanglements but some of it's just bandwidth. We've had several proximate threats to our operational kind of model in recent months and years that we've had to deal with one by one. We will absolutely get to that and I think it will make a difference.

WHITHAM, MR: (Indistinct 2.23.53) just add a few things as well. So just continuing with what Rebecca was talking about we have a priority system from priority 1 through to 3 where within the health system in particular APTC 1 through 5. Obviously, there's been ongoing collaboration and communication with WACHS (indistinct 2.24.09) to align those. And as Rebecca has mentioned in her statement, we are open to that and it's something (indistinct 2.24.1). Obviously the APTC has shone a light on a somewhat disconnect between the hospital environment and the RFDS. It's important to know that we operate in an aeromedical environment as well and our specialist retrieval team who prioritise within the scope of our current contract do so based on information they have at hand at that point in time.

Obviously the APTC will prioritise 1 through to 5 and it's important to note that in the period that the APTC has been operational from 14 January that's been fairly closely aligned between the priorities that have passed down from that APTC to the RFDS. So, in the absence of ongoing negotiation and variation and because of the delays or extension to contract we haven't been able to have those things in place prior to the implementation. That's something

we're very open to and it has been discussed through various clinical and operational forums that have been ongoing for the last 12 to 24 months.

KENNEDY, DR: Perhaps the loudest voice in this space has been from NETS and Neonatal Services, which I'm sure you would appreciate. And I think their challenges, or their concerns don't relate only to prioritisation although they do cite specific cases where there's been reprioritisation of cases, which they have prioritised at a higher level and have been rescheduled unilaterally. However, beyond the prioritisation question they also raise issues of compatibility of platforms and equipment and availability of resource to the extent that they indicate that up to 50 per cent of their aeromedical cases are subject to some form of delay.

I'm not sure whether that's an overestimate and I haven't seen anything in your KPIs that would obviously mark that, however, they do talk to that issue. So, whatever the reality might be in that space there's a clear mismatch between service expectation and service delivery and that remains unresolved. Did you wish to talk to that in some way to explain perhaps your perceptions of that situation and what may be that the solutions that could be necessary in a future system that could avoid that?

TOMKINSON, MS: I think a future system is a dedicated resource for the NETS capability and the subacute specialty that it is. And the only challenge to that - - -

KENNEDY, DR: Subacute.

TOMKINSON, MS: - - - speciality that it's so complex for its particular needs.

KENNEDY, DR: Can you clarify what you mean by "Subacute"?

TOMKINSON, MS: Perhaps I used the wrong definition, Inquirer, but I'm just trying to say that it has a very bespoke set of needs - - -

KENNEDY, DR: Okay.

TOMKINSON, MS: - - - for both the clinical - - -

KENNEDY, DR: I would say hyperacute.

TOMKINSON, MS: There we go. Very bespoke set of needs that (indistinct 2.27.31) to be able to. And often that's standby component. So, I think the biggest challenge for our service, as I spoke to, is the overall management of the entire retrieval demands that are occurring at any one time with the asset availability.

KENNEDY, DR: Yes.

TOMKINSON, MS: Obviously we would more than welcome an opportunity to provide a standby service for NETS and ensure that we were able to facilitate that, and I think that's something that they have spoken to. It hasn't previously been the opportunity to fund that and I think that we have demonstrated together both organisations some substantive service improvement over the last two years. Not to suggest that there's not further work to be able to be done in that space.

And I think the acquisition of particular speciality tools and equipment also very important for us to have early conversations around the design specifications as to how we will be able to utilise them in the asset base that we already have or what we can do together to ensure that there's an interoperability between those asset bases. A dedicated NETS service would address this on a standby basis. Of course, that requires the subsequent funding to sit alongside it. In the meantime we are actively engaged and continue to work very closely and collaboratively to address those challenges around timing, yes. I'm going to throw to Dr Kieran Hennelly, if that's okay.

KENNEDY, DR: Yes.

HENNELLY, DR: Yes, so I mean Jonathan *(Clinical Director, NETSWA)* and I been having a few conversations around this in the last 12 months or so. And if you break down our figures at least, and we haven't done a full reconciliation between their figures and our figures, in terms of total workload and cancellations, which we're using as a proxy for unserviced demand. The Southwest is one area and the Top End is the other area. The quantum is much greater in the Southwest and most of those go by road.

When you get into the nuance, as you would know better than I, there is no one single platform that anyone can provide to NETS that can service all of their demands, if they go for a true state-wide service. I know there's been some discussion in the top end about NETS NT reaching across. My understanding is their capability is different, so again, it gets very nuanced.

I think they could use a rotary platform. I think they could use a fixed wing platform that could get into dirt strips and I think they could use a jet, so it starts to get pretty expensive, which is where the - you know, it's very easy then to start spiralling off into what the future service might look like. But, you know, I think we're beginning to understand the nuance, I don't think we've got to the solution yet.

KENNEDY, DR: Yes, I mean I would suggest that as attractive as dedicated platforms are to clinician subgroups and everybody wants one let's face it. You know, an (indistinct 2.30.55) a NETS one, a PETS one, an everything one. I think the answer is where you head in terms of the issues of compatibility, the issues of design, procurement et cetera are really a much better solution.

If you're going to have flexibility in platform capability, so you've already got jets, planes and kind of helicopters, which wouldn't actually suit that purpose. But, you know, I think if the range of equipment that they or other clinicians need to use is going to be accommodated through good planning et cetera. That's the answer. It does beg a question though why is that not there now? I'm coming back to you. This is a longstanding problem where there is a known issue of equipment compatibility. Why isn't there a system to fix that?

And I propose that may be - that is again this mantle of governance that needs to sit around the system and ensure that that collaborative space, which is not just about mission management but it's about system management. So, yes, there's a component of it, which is about the coordination centre but there's all the - there's also a component of that which is about system coordination, system shape, system strategy. And if that were present, then perhaps there would be less of a gap in this space.

TOMKINSON, MS: Certainly, we agree with that premise and we talk to the alignment of a state-wide patient transport strategy, which would address a number of those - - -

KENNEDY, DR: Yes, (indistinct 2.32.37), yes.

TOMKINSON, MS: - - - particulars. And that what we are experiencing in the absence of that that we're all doing the very best we can with the very best of intentions and working to try to resolve some of those pieces.

We concur that an investment - overall investment strategy that sits alongside that state-wide patient transport policy would ensure that our service delivery, our network configuration, our asset bases aligns to all of those respective expectations and more importantly will bring those conversations to the table. So, I think what also needs to happen with the System Manager is this is the expectation of those particular cohorts and then an agreement as to whether or not those are able to be addressed or will be prioritised or - - -

KENNEDY, DR: Yes.

TOMKINSON, MS: And then everyone is clear that it's not us making a unilateral decision, it's an agreed position of state-wide patient transport as to how we are going to address and work through those categorisations and prioritisation needs.

GREEN, MR: If, sorry, if I may just add from an aeronautical sense, Inquirer. You mentioned the lack of system about equipment compatibility, so just for clarity that system does exist. The neonate cot systems that are equipped into our aircraft for those NETS transfers do require engineering orders to actually be equipped into the aircraft. So, we do work closely and have historically worked closely with NETS. And I'll ask Kieran to add to this from a clinical sense in a moment. But from the equipage sense we do have approved configurations of equipment that fit into our platform types in multiple configurations. So, by that I mean single neonates or multiples. We have that equipment, we know what it is, and NETS know what incubcribs they need to provide in order to bolt into whichever platform we are going to be using at the time for that retrieval.

So that system is there but to the CEO's point there is always room for improvement. There is always room for review in the scope of assets, how many of those do you have, where are they located. So, but just to be clear the system because of the aviation regulations are there for the equipage into the assets - - -

KENNEDY, DR: Yes.

GREEN, MR: - - - that we have at the RFDS.

KENNEDY, DR: Yes, but their accessibility or availability from time to time might be an issue or - - -

WHITHAM, MR: Inquirer, if I may, so we've (indistinct 2.35.17) of location or where they're coming from (indistinct 2.35.21) from all around the State to tertiary hospitals. Obviously, the current environment's fairly well known that patient numbers have increased, the (indistinct 2.35.31) increased. (Indistinct 2.35.32) services outside the RFDS in terms of the RFDS primary retrievals IHPT retrievals, patients from all around the State has generally increased.

It's been exemplified by the fact that the borders are somewhat closed and the populations artificially increased by 20 per cent, people travelling around the State.

It does add a huge - well, if I can say this, it adds a huge burden on the State's network and we're no different. So obviously for us NETS does fall firmly into that, so we would like nothing more than a contracting agreement with NETS, something that (indistinct 2.36.06) provide the services as required when they want it, how they want it. Patients are taken on - with what's known at the current time with the current network. Everyone is triaged according to clinical priority.

As Anthony has said, we have worked collaboratively with NETS for some years now. I've seen various reiterations of their NETS cots. We started with them on a PC-12 from humble beginnings all the way through to two or three versions of the cot, all of which are generally funded internally. So, we can support NETS and also fund it through NETS to actually develop these systems. As you'd be aware everything that aviation and medical is extremely expensive and we do everything we can to get these systems in place. We have dedicated stretchers, which come at an astronomical price tag to actually have these stretchers sit on. We have the engineer always put in place.

We've done the same thing with the PC-24 and we're continuing to work with them to ensure that we can provide that service in a timeline. But like anything we do operate a networked approach and there is a high demand on all of the network at this point in time, so there ultimately may be delays but we do everything we can to get to people and the children and the kids as quickly as we can.

GREEN, MR: And for clarity as well there is NETS equipment based within our RFDS for immediate use. But as you alluded to, there are a significant number of variations, medical requirement variations, that may require an asset swap. And it is very difficult to have every possible configuration available and at all times. But we would welcome that conversation.

WHITHAM, MR: We also have the equipment throughout our bases as well to provide a timely response.

KENNEDY, DR: Thank you. One of the challenges that the Inquiry is confronting is to look at service gaps, areas where service expansion could be recommended due to current limitations et cetera. And where there was a conversation previously in terms of the data and understanding the data across the system I would reinforce your wish, and I think I actually did write that consideration, that the lack of very clear system level data has made that work quite challenging to try and count things once and count them correctly and understand.

But so and we've reflected some of that in the documents that you've seen and there's additional work that is going on behind the scenes but it's far from scientifically robust I would guess and some of it will come down to estimations and approximations. From your perspective as a provider do you have specific feelings or recommendations or would like to highlight areas of service, service gap or deficiency that the inquiry should make sure that it's aware of or accept? Either fixed wing or rotary or other?

TOMKINSON, MS: So, Inquirer, if I can you're looking to the specifics of the asset class or the overall system design.

KENNEDY, DR: Asset class, asset distribution, base location, you know, the population and workload in specific places. Any area where you feel having read what you've read, we may not have been aware of gaps.

TOMKINSON, MS: So, for us the opportunity to look at our own network operating model is something that we have initiated to look at that very question. So, we're asking that internally of our teams and our people.

KENNEDY, DR: So, the design of your network?

TOMKINSON, MS: Yes.

KENNEDY, DR: Yes.

TOMKINSON, MS: Yes, and of our operating model. I do feel without it looking like a - that is underpinned by a state-wide patient transport strategy and that first we understand what we believe are the requirements and then we can design the network accordingly. There is a historical component to the established network that has a logicality to it that does I believe serve it relatively well. You will have seen in the last five years that we've moved our services from Derby, for instance, to Broome to establish a new base and clinical asset investment to recognise that the majority health system is based in the hospital now, it's in Broome.

KENNEDY, DR: Yes.

TOMKINSON, MS: And we have undertaken pieces like that. However, a full clinical framework for the State matching alongside where the State is placing its health assets would again optimise where we place our receptive bases and clinical assets.

For us the obvious piece has been the introduction of the rotary asset for business continuity and it's specific applicability to the 250 K radius as it sits outside of our Jandakot base, which drops the helicopter around the Wheatbelt and into the Southwest for interhospital transfer. There is a logicality to that occurring from our Kalgoorlie base.

There's also discussion obviously in the system around what might be required in the Midwest out of Geraldton. We don't have an active base at Geraldton, however, that doesn't mean that there can't be a service provider from that. I echo the Chief Executive of WA Country Health's comments about a need to establish a state-wide rotary asset strategy and I think that that would address - so we agree that there should be an expanded platform for the use of a rotary asset but we should first write that strategy to understand where those assets should be placed.

The key piece to us, which we have undertaken, is the investment in additional frontline team members. So, we have worked to increase our availability of our frontline staff, flight doctors, flight nurses - - -

KENNEDY, DR: Sure.

TOMKINSON, MS: - - - pilots and engineers. And certainly, model and demographically those demand curves we appreciate the last two years has been quite a fundamentally different world and we've had to all respond to that quickly. But that is a key that we are

looking at by addressing our operating model and we will co-create and have those conversations with particularly WA Country Health but the broader healthcare system.

KENNEDY, DR: So that's done in collaboration with WACHS and in consideration of the clinical services' models for the various locations.

TOMKINSON, MS: Yes. So clearly that would also be required in any new contract that was established.

KENNEDY, DR: Yes.

TOMKINSON, MS: So, when talking with WA Country Health about how it sees the needs for its aeromedical service, then obviously we would be designing the network configuration, the staffing configuration alongside that to deliver on those requirements, prioritisations, KPIs et cetera. And again, as you - these aren't small pieces of work and they take time to establish that holistic overarching strategy that we in the absence of are working to look to see how we can optimise the current configuration.

KENNEDY, DR: So, what is roughly the time frame of that modelling?

TOMKINSON, MS: So, we are just looking now at in the engagement of consultants to work with us on an operating model. We will reach with WA Country Health to work through that process and then agree a time frame for ourselves as to - you know, there's some immediate pieces we need to do - - -

KENNEDY, DR: Yes.

TOMKINSON, MS: - - - just to meet - - -

KENNEDY, DR: Okay, all right. At this stage it's a plan about a plan.

TOMKINSON, MS: Mm HM.

KENNEDY, DR: You did mention the rotary wing implementation and I guess it's inevitable that we talk about that. There has been a lot of discussion about it and a number of things written in the considerations, which you may agree with or disagree with, and I may agree with and disagree with some of them. I guess the question that I would have in relation to that to the implementation given that it would be normal practice for a not for profit provider to invest heavily in infrastructure only when there were recognised business application which had longevity and potentially a return on investment. And I think that's a reasonably premise, that you would probably agree with.

The thing that I'm not clear about given the degree of differing opinion about the platforms and location and type and all the rest of it is, to understand what led RFDS to believe that the purchase of the two aircraft would be followed by the State incorporating those aircraft into the system given that they are by design not related to primary response. But what was the step between there that I'm unable to kind of follow? Why would you buy aircraft if - or what happened that allowed you to buy aircraft believing that they would be incorporate in the system?

TOMKINSON, MS: So, there were discussions at the time with WA Country Health and the WA Health system as WA Country Health spoke to the other day. I think it really is catalyst by a global pandemic occurring and the need for us to look at what we were providing as a service and we identified and had needed to look at business continuity, particularly around service expansion, but also additional platforms to like road to use in times of surge capacity. And the rotary asset was identified as particular to the 250 K radius into the wheat belt and utilisation for COVID.

We worked quickly to identify and understand what assets were available. There was an opportunity to purchase at a good competitive price point. We had discussions that this was our intent. We agreed in principle. Our board made a decision to look at an innovation and understood through its design of its ten-year strategy planning process, which was undertaken 12 months before, that this was an asset class that would be required in the future. So we agreed in principle to bring the assets onboard. We also agreed that it would be a trial and we agreed that that trial would inform any future use.

KENNEDY, DR: When was that decision made?

TOMKINSON, MS: So, we acquired the helicopters - - -

KENNEDY, DR: No, sorry, when was the decision made?

TOMKINSON, MS: So, the specific acquisition of the helicopters was at the end of 2020.

KENNEDY, DR: So, the decision about there will be a purchase was made at the end of 2020?

TOMKINSON, MS: Yes.

KENNEDY, DR: Okay.

TOMKINSON, MS: But it was done in consultation with WA Country Health with WA Health. I have had conversations with DFES's Commissioner Klemm. We have all agreed WA Country Health and WA Health to an in-principle application of this asset class understanding that the trial would inform any future application. We do not see that that necessarily means that there is a future service. It does mean that as a community benefit organisation we have invested in this innovation with the understanding that it will best meet the needs of our patients, which is the way in which our board has undertaken to make decisions.

KENNEDY, DR: So, did you consult - you consulted with DFES prior to making a decision about the purchase of the rotary wing platform?

TOMKINSON, MS: Not about the particular asset class or about the operating model.

KENNEDY, DR: Okay.

TOMKINSON, MS: But that we were looking to undertake this move, yes.

KENNEDY, DR: So, they would have been aware prior to you making a decision that you were going to purchase a rotary wing platform.

TOMKINSON, MS: I don't think they were aware before our purchase, but they were aware that we have the asset class.

KENNEDY, DR: Okay. So I mean as the primary response provider and a State organised - State backed organisation of expertise in the space with an established service can you see that there may have been merit in a discussion with them in regard to extension of the rotary wing capability in Western Australia?

TOMKINSON, MS: I think there's always - - -

KENNEDY, DR: Particularly in the Perth environment.

TOMKINSON, MS: I think there is always merit in those discussions absolutely.

KENNEDY, DR: Is there a reason that that didn't occur then?

TOMKINSON, MS: Not a specific one. There was a lot happening throughout that particular 12-month period as we were all planning for a set of circumstances that very graciously did not unfold, very fortunately for Western Australia. However, there has been quite an extraordinary undertaking in health service delivery over the last few months.

KENNEDY, DR: So, if (indistinct 2.50.20) the reason that that consultation and a more systematic approach to that planning process didn't occur was related to the pandemic.

TOMKINSON, MS: I don't think it would be accurate of me to provide any specific reason but I can say that we were very focused on our business continuity, our surge capacity, and our ability to delivery for West Australians at a time of a global pandemic and that in making those decisions we had the presence of West Australians at the front of mind. It's also focused on interhospital transfer, which is possibly the component of that aspect, through which I don't disagree, it's always very important to have many different opinions and opportunities to have a community interest but it isn't seen - - -

KENNEDY, DR: Yes.

TOMKINSON, MS: - - - as a primary emergency response asset (indistinct 2.51.11).

KENNEDY, DR: With respect I don't believe that RFDS Western Ops is a naive organisation or does not have visibility of other aeromedical systems in Australia where there is fundamentally integration of rotary wing platforms across primary and secondary response. Is there a reason that you wouldn't have considered involvement in a model along those lines or pursuing discussions that may have precipitated further development of rotary wing capability to serve the interhospital transport component of your work?

TOMKINSON, MS: I think, as I say, there was an enormous amount occurring and the need to look to ensure that the service was able to deliver. So, if the specifics of your question is would we benefit from engaging with further consultation there's no question of that.

KENNEDY, DR: So, in retrospect and if we were to 'greenfields' all of this would system design and consultation in a collaborative federated kind of a way be a better way forward?

TOMKINSON, MS: I think in all aeromedical services absolutely.

KENNEDY, DR: Okay.

TOMKINSON, MS: Underpinned by a state-wide patient transport strategy.

KENNEDY, DR: Yes, I think that would help a lot. Are there any other matters that you feel that the Inquiry should be aware of or should be a focus for the work that we do? I think there's - I mean there are - I guess maybe I should go back for a moment of commentary here, that the thing that is outstanding about the Western Australian aeromedical system is that it's outstanding. There is an excellent service there. And I think one of the things that you need to be very careful of in doing Inquiries and making recommendations is that you don't upset the things that don't need to be upset, that you don't create change for its own sake. Change should only happen because you're aiming at improvement.

And I think we have got broad agreement through the process over the last few months of some of the really big issues that could help a lot in the next phase of what aeromedical practice might look it in Western Australia. One of the areas which I think is going to be quite important is the way that relationships are managed, and I think that you raised this earlier on.

And I think that it's, you know, understanding the way different parts of the system work together, how they stand next to each other. How contracts and evolving systems and models of service delivery in the aeromedical space work and look may be different to the way those systems worked and the way organisations see themselves and work compared to 10 years ago, 20 years ago, 30 years ago.

And I think it's a challenge for all organisations whether they are large organisations with a rich benevolent history like RFDS or newish organisations like the EHRS and DFES to be nimble in their approach to the environment and to the cultural context in which they're working requires a willingness to change over time. And I think that is a big challenge. That wasn't a question. I guess to finish off are there any further issues or matters that you would like us to look at further or - - -

TOMKINSON, MS: I think that I would just like to share that the opportunity to deliver for the State and certainly in adjusting the service delivery model, the understanding of the specifics that would be needed in that is an important part of how we can deliver on that innovation and change. I'm sure that you will have ascertained from the various conversations that there certainly isn't an understanding that there's an opportunity for continuous improvement and that there is an opportunity for co-creation and co-design. And that certainly there are some fundamental documented strategic pieces that need to be in play to help inform those decisions and those processes.

And in the absence of those with the best of intent we've all been looking to deliver for the patients of Western Australia. And I think that's an important base on which we all continue to build aeromedical services in WA. But there certainly isn't any resistance in the understanding that indeed all healthcare environments are very dynamic and the next decade will deliver enormous change in healthcare. Most of it to the great benefit of patients, which is a wonderful outcome, but it will require all of us to be able to co-design and co-create what that change looks like.

We would also talk to the importance of culturally sensitive service delivery and how significant our services are for Aboriginal and First Nations people in Western Australia and that the

design of those services needs to be in collaboration and alongside Aboriginal Medical Services.

KENNEDY, DR: I would agree. I think you've highlighted the - probably the largest challenges, which are the policy and strategic environment and the need for further development in that space and I completely agree with that because it creates the playing field, so that would certainly be a focus of where we go to from here. Okay, thank you. We'll wrap up at this point. I do need to just remind you of a few things. The transcript of the hearing will be sent to you, so that you can correct any minor factual errors.

Perhaps you should send us your dissertation, which would be greatly appreciated. However, the transcript will be sent to you. If you need - you will need to return the transcript to us within 10 days of the date of the covering letter or email otherwise, we'll deem it to be correct. And although obviously you will not be able to amend your evidence, if you would like to explain particular point that are in the transcript in more detail or present further information, that's perfectly okay. And you can provide this as an addition to your submission to the inquiry when you return the transcript, so that we will incorporate all of that into the ongoing work and thinking of the Inquiry.

So once again, thank you very much for your evidence and for your attendance and for your very professional presentation. And I think clear, clear messaging about the focus and commitment of your organisation to the service that it provides and to the people of Western Australia, which I don't underestimate in any sense. And I guess just to conclude, the issues the Inquiry reviews this kind of change process always begs with a degree of fear that there will be unnecessary change or change for its own sake.

And I would hope that through the process that we've had in terms of the amount of listening we've been able to do to arrange messages that we get to a point where we are able to add value to your system by suggesting rational improvements that build, you know, greater performance, better performance, clinical quality and safety, efficiency and security for those involved in the system as well, so that's the goal. So, thank you very much for coming and no doubt we will speak again at some point. Thank you.

HENNELLY, DR: Thank you.