Aeromedical Services WA Inquiry – Formal Hearing Transcription
Inquirer: Dr Marcus Kennedy
Organisation: St John Ambulance Western Australia – Ms ML Fyfe, Mr A Smithson, Dr C Gayle, Mr J Cuthbertson
Date: 14 February 2022, Time: 0800 – 0948

KENNEDY, DR: Good morning.

FYFE, MS: Morning.

KENNEDY, DR: Morning.

CHRISTIE, DR: Morning.

CUTHBERTSON, MR: Morning.

KENNEDY, DR: Happy Valentine's Day.

CUTHBERTSON, MR: Did you bring flowers?

KENNEDY, DR: No cards, either? Isn't that where it came from?

Business. Thank you very much for your interest in the Inquiry and for your appearance at today's hearing.

The purpose of the hearing today is to assist me in gathering evidence for the Inquiry into Aeromedical Services in Western Australia. I'll begin by introducing myself. My name's Marcus Kennedy, and I have been appointed by the Chief Health Officer, to undertake the Inquiry. Beside me is Mr Jonathan Clayson, the Inquiry's Project Director. We'd ask you to be aware that the use of mobile phones and other recording devices, in this room, is not permitted, and could you please make sure that your phone is on silent or switched off.

The hearing is a formal procedure convened under part 15 of the Public Health Act 2016 WA, and while you are not being asked to give your evidence under oath or affirmation, it's important that you understand that you must answer all questions and that there are penalties under the Act for knowingly providing a response or information that's false or misleading. This is a public hearing and 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've previously been provided with the Inquiry's terms of reference, the Inquiry's current state consideration paper, a focused 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 the process?

FYFE, MS: No.

KENNEDY, DR: Thank you.

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

FYFE, MS: Michelle Louise Fyfe, Chief Executive Officer, St John Ambulance Western Australia.

CUTHBERTSON, MR: Sorry, Joseph Cuthbertson, Head of Specialist Operations, St John Ambulance.

SMITHSON, MR: Antony Smithson, Chief Operating Officer, St John Ambulance.

CHRISTIE, DR: Dr Gayle Christie, Deputy Medical Director at St John Ambulance.

KENNEDY, DR: Thank you.

You'll now be invited to address the focused consideration list and other material in the consideration paper, that you may wish to, that has been provided to you, and you may speak to these matters for up to 60 minutes or so, although, we are being flexible in that space. After your address, I'll ask you specific questions and in the remaining time available, we may address anything else that you wish to. I will try to allow you to present the first part of this without interruption, if at all possible, however, if there are areas which I'm unclear of and need explanation of, I will ask you for explanation.

We have found that if you wish to remove your mask whilst providing your evidence, that's entirely reasonable, both from the point of view of being able to see, if you have these, and for clarity of speech. But for the rest of the session, other people will keep their masks on. Thank you, and over to you.

FYFE, MS: Thank you, and thank you for the opportunity to appear before the Inquiry this morning.

As a not-for-profit organisation, St John has been an integral part of pre-hospital patient care in Western Australia for over a hundred years. Our purpose is to serve humanity and build resilient communities through the relief of sickness, distress, suffering and danger and we see this Inquiry as an opportunity to demonstrate the value we deliver to the State, the Department of Health, and importantly, the patients and the communities we serve.

We are patient-centred, delivering a suite of services, including first aid training, community and patient transport, community defibrillators and a first responder network, event health services, urgent care and primary health, all of which is designed to wrap around our community in an integrated manner to support the delivery of emergency ambulance services, thereby optimising their effectiveness and benefit to the patients and the health system.

So, our highly skilled workforce is the backbone of this integrated model, where career and volunteer personnel work side by side to provide first-class pre-hospital patient care. It includes volunteers, paramedics, community paramedics, clinical support paramedics based on-road and in our State Operations Centre, and our critical care paramedics on board the RAC Rescue Helicopter.

Our critical care paramedics are a group of highly experienced paramedics who undergo significant additional and ongoing competency-based training and education. It is grounded in evidence-based best practice in order to deliver an extended knowledge and skill set in delivery of pre-hospital critical care.

Their strong and established working relationships with our community - our country paramedic and volunteer crews help facilitate the seamless transition of care within and across all platforms of our 000-response capability. At this time, St John WA are contracted under a service level agreement with the Department of Fire and Emergency Services for the provision

of tasking clinical staffing, clinical governance, clinical risk management, clinical equipment supply and asset management, to the WA Emergency Response Helicopter Service.

The Emergency Response Helicopter Service conducts primary emergency aeromedical retrievals, secondary aeromedical inter-hospital patient transport, search and rescue and other approved tasks. The helicopters operate as a network, providing redundancy cover for each other and are crewed and equipped to provide a suite of advanced pre-hospital critical care interventions, including asset insertion of our highly specialised critical care paramedics to complex, time-critical incidents or inaccessible patients.

The strategic partnership between St John WA and the State Government has delivered a quality emergency aeromedical service for the West Australian community since the commencement of the service in 2002. In preparing for today's hearing, St John have reviewed the focus consideration documents and would like to address it in four main themes: corporate governance, clinical governance, coordination and capability.

If I turn, first, to corporate governance, in respect to the focus considerations 3, 4, 5, 11, 14, 15, 16, 17, 18, 26, 59, 82, 92 and 130, throughout the course of these hearings, we have heard about the absence of a policy and planning framework with respect to both current services and to describe the application and expansion of future aeromedical services. It is clear that an absence of whole of system planning for aeromedical and transport requirements, and how they inform and link to the health system planning, results in a variety of contract models and performance indicators that reside in different business areas specific to those requirements.

An informed strategy and service delivery plan would guide contract deliverables supporting achievement of a state aeromedical capability. St John WA advocate for such a framework, and we advocate that such a framework should clearly define roles, governance, capability usage across operational domains to ensure efficiency of resource utilisation, and to mitigate duplication of effort across agencies. It should clearly link to broader health planning and enable coordination at a system level, from roadside to tertiary bed management.

St John would actively support the development of a State-wide aeromedical strategy, inclusive of policy, such a planning framework and roadmap, to inform and guide the aeromedical industry. Creation of such a strategy should be undertaken in consideration and in partnership with organisations responsible for ambulance, aeromedical and health services. These organisations are essential to appropriately inform the design of such a framework and optimise service needs and outcomes. The strategy should guide service providers in understanding the State's needs with clarity of future purpose and direction.

As the provider of emergency ambulance services in Western Australia, St John would suggest that without a unified approach in the development of such a strategy, there is a risk of duplication of effort in adequate consideration of care pathways and definitive care available and an uncoordinated investment strategy.

In respect to focus considerations 9, 10, 14, 28, 32, 33, 38, 40, 43, 60, 187 and 190, currently, within Western Australia, governance of aeromedical services, both primary response and secondary inter-hospital patient transport, is housed within contractual arrangements divided across multiple government departments. The absence of a whole system approach to planning for aeromedical and transport requirements has resulted in the current situation,

leading to different performance indicators with a lack of patient outcome and clinical governance measures.

An informed service delivery plan would guide contract deliverables in service areas, supporting achievement of a State aeromedical capability strategy. An example of the misaligned contractual process are the current contractual arrangements for St John WA and the WA Health with regards to the 000 State Operations Centre. Under current arrangements, St John must tender separately for aeromedical and on-road primary emergency response services provided by the State Operations Centre. It is our strongly held view that tasking of assets in response to an emergency should be housed in the one location, and the contracts should not be dependent upon the mode of transport, and that that location is our 000 State Operations Centre.

With reference to the focus consideration points 9,10, 11 and 61, St John agree, and we would offer this additional consideration: as a member of the Council of Ambulance Authorities, St John are actively involved in the Council's aeromedical working group, who are currently working to draw together and share information innovations and learnings across its members. As with our membership of the CAA, we see the establishment of a national body as a forum where evidence-based research and best practice can be shared between industry colleagues from both State and commercial entities.

If I may just grab a glass of water?

I'll turn to clinical governance. In respect to focus considerations 3, 13, 28, 113, 130, 157, 169, 170 and 188, the absence of a holistic, system-wide aeromedical clinical governance framework results in a clouded view of outcomes across the current aeromedical system and - as it is conducted and reported in silos. This lack of policy and planning frameworks limits the opportunity to guide clinical governance framework planning for industry engagement, partnership and innovation, to enhance service level design and capability. St John advocates that the development of a clinical services plan for State-wide aeromedical services would be of benefit to and a component of our State health services' strategy and planning.

The development of a clinical governance framework for aeromedical systems should provide assurance of patient safety and outcomes across the whole patient journey, from point of call, to definitive care and repatriation. In the absence of such a plan, clinical governance of our rotary wing care is consistent with our organisational clinical governance system, reporting to the Department of Health and the Patient Safety Surveillance Unit.

Our contract structure requires audit of all rotary cases. This is overseen by the St John Deputy Medical Director, Dr Christie, and forms part of our ongoing peer review process, as well as identifying cases for escalation to our Medical Policy Committee. The Medical Policy Committee is an independent medical forum of clinical leads from across the State health system. Identified clinical incidents are reported to the Department of Health, as per our ambulance contract requirements. Rotary wing tasking is reported monthly to the contract, and quarterly rotary wing tasking review is undertaken with representatives from the Department of Fire and Emergency Services, the WA Country Health Service, the Royal Flying Doctors Service, and Metropolitan Health Services. A review of the tasking process is undertaken annually by the same representative group.

I'll turn to coordination. In respect to focus considerations 5, 6, 17, 18, 20, 59, 62, 71, 84, 85, 86, 88 and 90, as the State provider of emergency 000 ambulance response, St John is

uniquely positioned to provide an integrated coordinated model of notification of incident, allocation of resources local, on-road and aeromedical, and facilitation of patient transport to tertiary care. The current tasking for the Emergency Rescue Helicopter Service is contracted to and undertaken by St John Ambulance as part of our 000 service. Dedicated clinical staffing within the State Operations Centre are focused on timely and accurate despatch of helicopters for community emergency response. As previously mentioned, aeromedical despatch activity is reviewed and reported weekly, and a quality review of the rescue helicopter tasking is undertaken by the ERHS Operation and Tasking Review Committee.

At times, we respond to requests for search and rescue and inter-hospital patient transport. Our system does not have visibility of State-wide demand or the capability to receive as it relates to inter-hospital patient transport. There is an opportunity for the system manager to provide this system-wide situational awareness. Our system, by a virtue of our service design, is focused on the provision of ambulance care. The collective benefit of tasking all 000 services, including rotary wing assets, through this platform, ensures a uniform approach to patient care needs in emergency community response. St John acknowledges that while there is good communication during the tasking and mobilisation of the patient, the WA aeromedical operating environment would benefit from a system coordination capability which provides the effective oversight and control of bed allocation and management at a whole of system level.

While the WA Country Health Service Acute Patient Transport Coordination Project is an important first step in this regard, it is our view that compartmentalising it within one service provider is a missed opportunity for holistic system design and coordination that considers the overall demand needs and capacity availability in live-time across all services. As a provider of 000 ambulance services for the State, we would welcome the opportunity to feed into a broader overarching coordination structure across the whole of the system. I can say that such collaborative coordination systems are already in existence, including our current presence at the WA Police Coordination Centre.

Now, whilst operating in a different sphere of operations, it is an excellent example of coordination and collaboration, which enables us to collectively address events in live-time and coordinate joint resources in a very effective manner.

I'll turn to capability assessment. In respect to focus considerations 15, 20, 59, 62, 63, 64, 65, 73, 74, 75, 82, 93, 95, 142, 143, 146 and 151, further to our earlier theme around the need for system governance, we believe the development of an aeromedical capability needs assessment should be undertaken to inform system design and planning, in conjunction with the State Ambulance Service. We strongly support continued investment in rotary assets to support community emergency response in parallel to this, given the contemporary demand and the underinvestment in this space.

St John, in partnership with the Department of Fire and Emergency Services, presently have emergency medical hubs in Jandakot and Bunbury. We support, the introduction of further emergency rotary assets to support the 000 ambulance service and agree that the State is currently underserved in relation to aeromedical capability, no doubt, in part, due to a lack of system planning, to understand the contemporary needs of communities and guide future capability requirements and investment.

With reference to focus consideration 143, we agree, support and advocate for dual clinical staffing for aeromedical patient care. Under the current Emergency Rescue Helicopter

Service contract, under that operational model, St John are required to provide one clinical staff member per shift, and that is a critical care paramedic. St John recognised that this is not reflective of contemporary staffing models for rotary services and has and will continue to advocate for a dual clinician model in future contracts and to maintain a level of clinical quality and safety for current and future care.

As previously stated, development of a State-wide aeromedical strategy and policy framework would enable the consistent application of standards of practice to guide contract provision across service delivery types. We recognise and support the need for subspecialty clinician requirements of specific patient groups, such as NETS, in aeromedical care, and agree that a demand analysis should inform clinical staffing need. We strongly advocate that community emergency ambulance response - air or road, is best served by dedicated and experienced pre-hospital clinicians familiar with the challenges inherent in working in these often-austere environments, and who already form part of our 000 service delivery model.

Our critical care paramedics, who, after undergoing a robust and competitive recruitment process, undergo extensive further training via a comprehensive evidence-based and continuing education program, coupled with a robust competency framework. This enables them to deliver a high level of care via a suite of targeted, life-saving pre-hospital critical care diagnostics and interventions, which have been demonstrated to improve outcomes in some of our most severely injured and unwell patients.

St John WA has been working alongside the community for over a hundred years, resulting in a strong level of trust within the community. We are consistently rated as one of Australia's top ambulance services based upon response times and the lowest cost to government, but by no means are we perfect, and we continue to strive for continuous improvement in our service. From this Inquiry, we hope to gain some clarity, insight and guidance around the delivery of aeromedical services so we can better serve our patients and our community.

And we look forward to continuing our work in the provision of emergency ambulance services, both on-road and aeromedical, to the community of Western Australia.

Thank you.

KENNEDY, DR: Thank you very much.

I guess I'll start by apologising for the large number of considerations, but that's why they're numbered as well. They are considerations, and they're not conclusions, they're not recommendations, they are a range of variably developed thoughts that have come through the consultation process, and it's been very important to have each of the stakeholders engage with those and to provide perspectives on them, as you have, both comprehensively and eloquently, today.

FYFE, MS: Thank you.

KENNEDY, DR: Thank you.

Is there any input or statements that other members of your team would like to make prior to moving onto any questions or further discussion?

FYFE, MS: It would appear not.

KENNEDY, DR: You have got all that sorted out over coffee before? There appears to be varying relationships in this system, between government, Health and the operational agencies - if we call them that. What do you see as the strengths and weaknesses of your relationship with Health and do you have comment on any of the other arrangements in - that are in intersection with the work that you do - and by that, I would mean, obviously, DFES, ERHS and WACHS Command Centre, WACHS government - no, WACHS, Health, government?

FYFE, MS: I think we work very hard to maintain strong relationships across that whole sector. If I turn, first, to our relationship with the system manager - so the Department of Health, we work very closely with them, I have a close working relationship with the Director-General and the Assistant Director-General - Deputy Director General and Assistant Director General of Procurement. We work very closely to integrate emergency ambulance services across the system.

Now, whilst that's a contractual relationship, it extends further to working with the hospital services providers - so each of the HSPs, both at the senior administrative levels, but also at the frontline, at emergency departments. There's a very close working relationship there. And in fact, we have placed hospital liaison managers in each of the major tertiary hospitals across the city to build on that relationship. And I think the strength of that relationship is the communication, which is honest and open. We don't always agree, which is, I think, the sign of a healthy relationship, that we don't always agree, but we always work towards a solution.

The weakness in that current relationship is around short-term contracts, in that, in an organisation who contracts to the government, short-term contracts - and when I say, "Short-term", I mean of two or three years, make it very, very difficult to invest and have capital investment into a larger - into large infrastructure projects.

Now, we're obviously working with the State on that, and we certainly hope that our next contract will be of a longer period and we're currently in negotiations with regards to that.

KENNEDY, DR: Towards 10-year contracts, or - - -

FYFE, MS: Well, I would like 10 years - if I can convince the Department of Health of 10 years, I would like that, but certainly, a minimum of five. I think, in order to invest in infrastructure and invest - and it's a large infrastructure across a very, very large network, we certainly do need some certainty.

Our relationship with the hospital service providers - so both the Metropolitan service providers and the WA Country Health Service, is strong. Again, we don't always agree, and - but we work to deliver a service within the system. And if I was to be critical, I would say that, at times, that system doesn't work well within itself - so it's fragmented, and we suffer because of that fragmentation.

KENNEDY, DR: Why is it fragmented?

FYFE, MS: And - I think it's probably the way it's structured, and I - and this is a very personal opinion, I come from a command and control background, I come from a background where there's a hierarchy and there's one person in charge, and - - -

KENNEDY, DR: Do you mean Queensland, or - - -

CUTHBERTSON, MR: Here, here.

FYFE, MS: We'll go with other emergency services' hierarchy, and I suppose what you have here is leadership decentralised, and I understand the reason for it, but at times, that makes it difficult when it comes to decision-making and overall leadership, ownership and governance.

KENNEDY, DR: So, you're referring to the methodology or the model of devolved governance - - -

FYFE, MS: Yes.

KENNEDY, DR: - - - basically, which health systems variably like and then change their minds about and - - -

FYFE, MS: Yes, and - - -

KENNEDY, DR: - - - varies from state to state, obviously?

FYFE, MS: And our state's about to go through a governance review of just that. And I understand that it does work, but at times, it means that there is fragmentation.

KENNEDY, DR: Yes, because within the child organisations, there is significant autonomy, which leads to the differences and policy frameworks and strategies and competition - - -

FYFE, MS: Yes.

KENNEDY, DR: - - - and that can obviously affect your interaction with them individually and as a system.

FYFE, MS: Absolutely. And dependent upon who we're interacting with, at times, there are, you know, differing opinions and - - -

KENNEDY, DR: Would - - -

FYFE, MS: - - - decisions.

KENNEDY, DR: - - - you agree with the premise that devolved governance systems - or devolved systems of managing critical State emergency infrastructure, you know, have challenges attached to them?

FYFE, MS: Absolutely, yes.

KENNEDY, DR: So I mean, my perception of the aeromedical system here is that it's kind of devolved, which is another word for the fragmentation that you've described in various bodies looking after bits of it, that in a way, that's possibly the result of a general approach, which is, you know, around devolving governance. So rather than it ever having been put in one place, it's sitting in multiple places and then interacts with everybody at the HSP level, which again, causes exactly the same issues that you were talking about.

FYFE, MS: Which I think is - and I absolutely agree with that, which is the premise behind our submission - or as I've said earlier, about overall system governance that actually sits with the system manager, and has input from not only the HSPs, but also the other agencies that work towards that. It just seems to me to be the best way to actually have a whole of system view - - -

KENNEDY, DR: So - - -

FYFE, MS: - - - because at this point in time, we don't.

KENNEDY, DR: - - - how does that work at a structural level when you look at the existing arrangements in WA where Health doesn't specifically provide services, but generally, contracts them? What - how - what do you see as the structure - if you had aeromedical services as being a thing that interacts with ambulance and WACHS and hospitals and everyone, how is that managed?

FYFE, MS: So, I think there's a good example occurring right now, actually, and it's part of the COVID response, which is the Patient Flow Coordination Centre, and you have the WACHS APTC. I think there's a perfect opportunity to bring the two together. And across the whole - and it's not actually about the response, it's about the coordination. And I'm - the example I will use - and I'll fall back to my previous life, is if you look at policing and the way that they manage this, they have two centres. One is the Operations Centre, which is essentially, the same as our State Operations Centre, which takes the calls, understands the demand and despatches the response. And that's very dynamic and it works in live time.

Separately, you have a Coordination Centre, which has a view across all of the services across the whole of the State, and can see, for example, if something - and it's a policing example, but you know, something occurs in Bunbury - say, there's a terrorist incident in Bunbury, the despatch and response doesn't stop over here, but a Coordination Centre says, "Well, we need to move some resources around to be able to attend to that". They're not dictating what the response is, they are merely moving resources to it.

And whilst it's not quite as easy to translate that to Health, I think there is a way of having that Patient Flow Coordination Centre expanded across the whole of the system, where you have tasking and operations doing what they're doing, but feeding that information into the Patient Flow Command Centre, understanding what bed stock is across the system, understanding if I'm going to transport a patient from Kalgoorlie - or say, we're going to transport a patient from Bunbury and they're going to the State Trauma Centre, understanding that - the availability there, and someone's going to be there to meet us.

Or if it's an inter-hospital patient transport, if we're transporting to Port Hedland to Perth - so RFDS land at Jandakot, our ambulance picks them up and transports them to Fiona Stanley, understanding there's actually a bed there for them, and that there is a flow through. Because what happens now, is we actually arrive at Fiona Stanley, we go via the Emergency Department, there is no bed, my ambulance is ramped until there is a bed, thereby depleting my capability out on the frontline. So that movement across - and understanding the whole flow, I think is - I don't think it's as difficult to establish as it may seem, and in fact, I think the actually bones of it are there right now.

KENNEDY, DR: They are.

FYFE, MS: And I'm not sure if any of my colleagues - no?

CUTHBERTSON, MR: No, all good, because you're on point, boss.

FYFE, MS: Thank you.

KENNEDY, DR: So I absolutely agree, I think, you know, the - in some respects, quite often, the timeframes and urgency of the police and ambulance 000 response is different to a large chunk of the aeromedical response and in-hospital flow, however, the principles are exactly the same in terms of the process steps could be labelled the same, it's just the timeframes are sometimes different. However, there's the - you know, the rotary component of that, which is exactly the same - - -

FYFE, MS: Yes.

KENNEDY, DR: - - - in all regards.

You talk about the potential for a, you know, coordination point - you know, let's call it the office of coordination, how does that office relate to the Health Department? So you work under contracts, so the contract says you shall deliver these services for this price and so forth - price for the minute, but the Department can monitor that the services are provided and you have a process of assurance that makes that happen.

In terms of RFDS, the Health Department, through WACHS, has a contract with them - which is meant to do the same, that coordination place in the middle is not an organisation as such at the moment - - -

FYFE, MS: No.

KENNEDY, DR: - - - it's a cluster of collaborations - coalition, if they're willing - something like that, but people are there almost out of goodwill to - because they've seen the same issues that you've described, in terms of the need for coordination. And it has, through those collaborations, linkages back to your area, to RFDS, to WACHS, but as far as I can see at the moment, it doesn't have a specific link to Health via the Patient Flow area - that's not connected at the moment, but say it were, there's not an organisation there to contract and to manage - - -

FYFE, MS: No.

KENNEDY, DR: - - - so how do you solve that?

FYFE, MS: I suppose - I'm trying to think of the best way to articulate it. Firstly - - -

KENNEDY, DR: This is one of the most strategic conversations we've had in the hearings, by the way.

FYFE, MS: Thank you.

KENNEDY, DR: So you've raised it in a way that is very strategic, and it's obviously from the way that you work.

FYFE, MS: So - and I'll try and keep it strategic.

KENNEDY, DR: Keep going.

FYFE, MS: I see - the Department of Health is the system manager, so as the system manager, there needs to be, in there, an ability to manage the system.

KENNEDY, DR: And responsibility, even?

FYFE, MS: Yes. So - and I think there is an example - there are examples, as you see right now, and it is based upon our COVID response, but we have the State Health Incident Command Centre, which is a perfect example of exactly what we're talking about.

KENNEDY, DR: Yes.

FYFE, MS: So whilst that's been stood up under the Emergency Management Act for Incident Command, it actually gives a very - it is quite - it is a good case study for how you would have a coordination centre or office of coordination to manage exactly that. What it requires though - I think it requires input from all concerned, so - and not just the government entities. So, for example, you would input from the HSPs, RFDS, St John, and whomever else to guide what is happening across the system.

But also, to pre-empt issues across the system, because if you're looking at the data as it's coming through, you can pre-empt what's going to happen. So, for example - and we do this now, with our - with the Metropolitan HSPs - and in fact, with WACHS as well, we provide them with our ambulance live - live ambulance data. So we can say that, between the hours of - you know, today, between 10 and 11 am, we received 45 calls or - for that hour, then, the hospitals know that within half an hour to 45 minutes, those 45 ambulances are coming to somewhere near you, so they can prepare for that influx.

Now, I think that's a relatively low-level example, but with that data, and being able to analyse that data, you can look across the system to see how it's faring. And while - and that will benefit us, not only from an ambulance and aeromedical perspective, but I think it actually benefits the whole of the system and more to the point, it benefits the patient. But the system - the structure is already there, and it's been working for two years as an Incident Command Centre.

And I'll probably defer to Joe, who is going to look at me - because Joe is our Incident Command for our COVID response, as one of his other duties, and has spent a good deal of time with the SHICC and how that would translate.

CUTHBERTSON, MR: Thanks boss, thank you, sir.

So, in terms of the point around how does it manage at a system level, I think there's elements of Health that require management across all service providers to enable best outcomes. I understand, at a devolved level of governance, the ownership at a patient level and the targets that they set for the patients that they catch within their areas, however, there are elements of health service design that encompass the entire State, and I fear that if that's devolved, it becomes fragmented.

And I think that what we see in the current environment, the fragmentation of that does not result in a clear data picture to inform a whole of State need.

KENNEDY, DR: So I think I'm going to get into trouble for exceeding the terms of reference somewhat, because I'm going from aeromedical to save the world, but really, what's being described is SHOC, is the - which I don't like the concept of a centre. I keep coming back to - to me, SHOC is a service - a centre's just a place where it happens, but that concept - that central coordination concept is important to aeromedical services. So, you really cannot have a proper State-wide aeromedical service, unless you have a coordination centre that resembles this thing that we've been talking about. So, I think we're furiously on the same page.

I would like to move to, perhaps a few more specific, possibly less globally strategic things. I can't remember what you said about number 13 - so I'm being slightly facetious there, number 13 talks about EHRS and its position - and others talk to this as well - in terms of housing within DFES, which a number of respondents to various components of our consultation raised as a kind of incongruity, and something which nobody said would be, you know, a green fields option, if they were setting up a, you know, a health-focused rotary service. Does St John's have a view on the best location of the - I guess, the contract and relationships and governance of that service?

FYFE, MS: Yes, we do. Our view is that it is, primarily, an emergency ambulance response and as such, it should sit with the State's emergency ambulance provider. As it is, the State's emergency ambulance provider - which is, at this time, is us, tasks and mans the helicopter and has clinical governance over the helicopter. It would appear logical to me, and our organisation, that it sits with our organisation. But if you want to take that to a different - if we talk - that's very personal for St John, but I would say, it should sit with Health.

KENNEDY, DR: Fundamentally?

FYFE, MS: Yes, fundamentally, it is a Health service, so it should sit with Health.

KENNEDY, DR: The current model of rotary services in WA is, I would agree, a primarily 000 emergency, pre-hospital response, but that really talks, fundamentally, to the unmet need in terms of rotary services in WA, which includes a very large proportion of work, which could be around inter-hospital transfer.

When you consider that additional balance, does the housing it within ambulance remain, if we're saying that maybe, you know, the unmet at the moment, in terms of rotary secondary transfers in the South West is probably in the order of a third to 30 to 40 per cent of the current workload, so the thousand cases done now, it's probably another three to four hundred. So, it's a really mixed service.

FYFE, MS: It is a mixed service, but obviously, our focus has always been in that pre-hospital environment.

KENNEDY, DR: Yes.

FYFE, MS: And I'd suggest, across the State, there's, you know, an unmet need there, in that pre-hospital environment as well. And whilst there is an inter-hospital patient transport component of that - and there is, in our on-road ambulance as well, for us, the focus really is

on that pre-hospital environment and those severely ill people who can be - whose health outcomes can be significantly changed.

I think there is - and I think there does need to be an evaluation of that inter-hospital patient transport piece, about where aeromedical is the right mode of transport versus road, and - I'm not a clinician, but I do understand that, at times, aeromedical transport is actually detrimental to the patient and - you know, the same as long road transfers are certainly.

So I think there needs to be a close evaluation of that, but if I go back to my submission, the questions that we're grappling with now are questions we grapple with, because there has been no planning and no overarching strategy, and I think you know, form follows function, so if we go back to what the strategy is and then, out of that, comes the form of it.

KENNEDY, DR: Would you agree that if you were sending an emergency helicopter service up, whose focus - I mean, the inter-hospital component of rotary wing services in virtually all settings - apart from some geographical variability, in virtually all setting, there is a high component of time criticality or special needs that can be met by the clinical (indistinct) 8.50.06 helicopter.

There's nobody, really, that I'm aware of, who uses helicopters for inter-hospital transfer just because they can - in other words, to replace road, when road is otherwise feasible.

So the point that you make, in terms of establishing the need - so that capacity requirements and the capability requirements, I would say, in most systems, it - that the capability requirement is heavily - there's a heavy overlap between primary response and time critical inter-hospital transfer, in terms of the skill sets required - heavy overlap's not absolute. And there are small pockets of systems where rotary platforms are doing only inter-hospital work - and there's only one of those in Australia at the moment, in Brisbane, everywhere else - every rotary platform is pretty much shared between primary and second transfer.

FYFE, MS: So perhaps if I put it like this? So, if you were to consider - so as an emergency ambulance service, our current contract is for emergency pre-hospital response, but it is also for high acuity inter-hospital patient transport. So, if we were to say that's what our current overall State contract is - and the aeromedical piece is - - -

KENNEDY, DR: It's just a different platform doing that work.

FYFE, MS: - - - it's just the mode of transport. So high acuity inter-hospital transport does fall within our current contract, it's just that the aeromedical contract sits with DFES and doesn't come under that overarching ambulance contract.

KENNEDY, DR: Yes.

FYFE, MS: And I'm just going to defer to my Chief Operating Officer to make sure that I've got that right.

CUTHBERTSON, MR: Yes - no, that's correct.

FYFE, MS: Thank you.

So that's another way of looking at it. So that time-critical high acuity very unwell patient, from an inter-hospital patient transport perspective, we do that now, we just do it on-road, the helicopter is simply not a platform.

KENNEDY, DR: Would you see any challenges as a contractor as opposed to a State ambulance system? As a contractor managing contracts for rotary wing or other aeromedical services, are there challenges attached to that?

FYFE, MS: Well, I think there's challenges for everyone. I don't think - well, managing any part of a business, brings with it, challenges. We've been delivering services for the State government for a century, and we are the only organisation that has ever delivered an ambulance service in this State, so we are well-versed in delivering an ambulance service. And we are highly integrated with the Department of Health. I think - I personally don't see any challenges with us then delivering a different platform on behalf of the State, but if there are challenges, there's nothing there that can't be worked out. And I'm just looking over at my team - everyone agrees?

CUTHBERTSON, MR: Yes.

KENNEDY, DR: Are there synergies in doing that?

FYFE, MS: Absolutely, and I think if I go back to my previous statement about - we run the ambulance service across the whole of the State, and aeromedical is another mode of transport for an ambulance service across the State.

Can I just add there - sorry, one of the points about our relationship, directly with the Department of Health, is there is strong contractual governance, because it has been such a long-standing relationship and arrangement, and there's strong understanding about our organisation. I think that contractual governance, our regular meetings, the oversight, our reporting regime, that whole relationship - because it is so strong - like I said, we don't always get along, but it is a strong relationship, I think that makes the delivery of other services, as part of that contract, more seamless.

KENNEDY, DR: Okay. Although you are involved in the work of inter-hospital transfer, is it reasonable to say that the primary responsibility for inter-hospital transfer work outside the metro area sits with RFDS?

FYFE, MS: From an aeromedical perspective, yes.

KENNEDY, DR: Yes. And that a significant component of the aeromedical transfer work in the more densely populated areas of the South West would sit with RFDS, as in, hospitals that are within the 100 - you know, 100 to 250, 300 kilometre zone out of Perth, sits within the RFDS inter-hospital transport penumbra?

CUTHBERTSON, MR: Ma'am?

FYFE, MS: Yes, of course, because I don't know that I necessarily agree.

CUTHBERTSON, MR: Are you referring to retrieval to tertiary facilities?

KENNEDY, DR: No, I'm - - -

CUTHBERTSON, MR: No?

KENNEDY, DR: - - - referring - - -

CUTHBERTSON, MR: So within - - -

KENNEDY, DR: - - - to - - -

CUTHBERTSON, MR: - - - the region itself?

KENNEDY, DR: - - - all inter-hospital transfers, not just tertiary level retrieval.

CUTHBERTSON, MR: The St John Ambulance conducts many road retrievals between small hospitals in the South West on a daily basis.

FYFE, MS: And if I may - particularly, because we're talking that hundred to 200 kilometres, in fact, the majority of those are undertaken by St John Ambulance.

The majority of them are done on road. And I'm happy to defer to my Chief Operating Officer there, so - because I'm - - -

KENNEDY, DR: In the zone beyond that, then, if we move into the normal operating space of the - of fixed wing aircraft and stuff, we're talking 175 kilometres out would be - from a patient perspective, this kind of zone where you would consider inter-hospital transfer using rotary - using a fixed wing platform (indistinct) 8.57.36?

FYFE, MS: Antony?

SMITHSON, MR: Yes, I was going to say - - -

KENNEDY, DR: That's like, the normal thing, where they're operating.

SMITHSON, MR: Yes, I was going to say, a lot of that depends, as well, on the availability of those assets at the time.

KENNEDY, DR: Yes, and for a lot of those people, road transfer would be plan B.

SMITHSON, MR: Yes, but plan B is quite often - - -

KENNEDY, DR: Yes, so - - -

SMITHSON, MR: - - - the option - - -

KENNEDY, DR: - - - availability - - -

SMITHSON, MR: - - - that is taken.

KENNEDY, DR: - - - resource, weather, et cetera?

SMITHSON, MR: Yes, all of those factors.

KENNEDY, DR: However, you know, the core work of RFDS is in providing those - that is their core business, really, it's providing those transfers as well as the more remote ones.

So they provide an aeromedical service, what would stop the system from moving in the direction of transition of the helicopter service to RFDS to be managed there for Health, given that it might perform 30, 40 per cent of its work in the inter-hospital space?

FYFE, MS: I would suggest - - -

KENNEDY, DR: It's just another contractor administering another contract and the governance of it - coordination of it could happen at a system level.

FYFE, MS: And I would suggest what the community would lose would be that pre-hospital emergency response capability from the helicopter as it's tasked from 000. And there is an - - -

KENNEDY, DR: Sorry, can I just interrupt? Maybe you didn't answer the - - -

FYFE, MS: No - - -

KENNEDY, DR: - - - question?

FYFE, MS: - - - maybe not?

KENNEDY, DR: If you took the current ERHS capability sitting within DFES, and moved it to be managed within Health - - -

FYFE, MS: Yes.

KENNEDY, DR: - - - by a health contractor - not St John's, but RFDS, just another health contractor who's in the aeromedical business and got itself two helicopters already, what kind of - what would stop that from working in the same way as the system works now?

FYFE, MS: I'll defer, first, to Joe, and then, to Dr Christie.

CUTHBERTSON, MR: I guess, in terms of fragmentation, the lack of integration into the 000 network for community emergency response may be a bearing - - -

KENNEDY, DR: It would be no more fragmented than it is now.

CUTHBERTSON, MR: Most possibly not, but in terms of solution building for the future, I - my personal view would be to create less fragmentation than the status quo.

KENNEDY, DR: I think there would be less fragmentation than the status quo, because you would be moving from DFES to a health organisation that already has, you know, skin in the game, in terms of rotary platforms. It's not something that's been proposed in any of the considerations, but in a way, it's an allogenous - different, but similar to moving it within Health to another contractor.

I agree with your argument that your linkage through 000 to that system is more fundamental and more significant. But the other can't be discounted either, because there's also some rationale in it.

FYFE, MS: Perhaps, Gayle - - -

CHRISTIE, DR: I think, just from my point of view, I've - I worked with RFDS for seven years prior to coming to St John Ambulance, and I don't think, from a clinical perspective, they're in a position to be managing the pre-hospital load that the helicopter has from their staffing model. They have very little experience working in the pre-hospital field. Their specialty is inter-hospital transfers, and they staffed to do so with a nurse and a physician of varying levels, from GPs, registrars up to (indistinct) 9.01.45 and anaesthetists.

I think if you look at the workload of our current two helicopters, about 80 per cent is primary work and paramedics are the most experienced to be able to be working in that space, and therefore, should fall under the ambulance service from that directive.

I think RFDS have enough on their workload with inter-hospital transfers, which are increasing exponentially, and I think keeping that separation between pre-hospital and inter-hospital, whilst there is a connection between the two, is vital to keep the - both systems running effectively.

KENNEDY, DR: Yes, I understand what you're saying, but I'm a little bit lost in terms of understanding why something which can work really well - as it is now, the EHRS, within a non-health environment, if you were to take that model and move it into Health, you're arguing that it wouldn't work? I don't - that - I don't follow that?

If you took the current model, its relationships with 000, the only thing that you're doing is shifting the contract point and perhaps, some of the clinical governance, into a more health environment. You can't fundamentally make an argument that simply doing that would degrade the service. It would only degrade if the model were then altered within the new arrangement, which by contract, you could avoid.

So that's - so there is an argument for - if you're coming into Health for the helicopter to - helicopter service to come into ambulance or to RFDS or to some Health structure - other Health structure, WACHS, the office of coordination, an office of aeromedical services, some point, that it - - -

FYFE, MS: I think there are many different wands you could use.

KENNEDY, DR: Yes.

FYFE, MS: I think, fundamentally, though, we would say that we agree that this is a Health asset that should be managed within the Health sphere. Actually how that works, I think probably needs further - you could - you can do lots more work with regards to that to make sure that, from a planning and a framework perspective, the needs of the communities and the patients are met by however it is managed. But fundamentally, we would agree that it should be part of Health.

KENNEDY, DR: So, one of the current criticisms of that service is that the tasking for inter-hospital transfers doesn't work very well - it doesn't work as well as it should work, that it's

very heavily focused on pre-hospital work. And there is clearly - I mean, a - you know, I've looked at data from WACHS and DFES and from RFDS and none of its right, and a lot of it overlaps and is duplicative. But even when you take a really conservative look at that, there is unmet need, for sure.

So why is that not working at the moment, because the system, as far as I can gather, is that RFDS makes a call on the need for inter-hospital rotary transfer, and that, then, is communicated through your service and quite often, doesn't happen, or it doesn't happen as often as it should? Is it not being asked for as often as it should be, or is it being rejected, or does it fall down somewhere? I don't understand this component, so - - -

FYFE, MS: Perhaps if I turn to - - -

KENNEDY, DR: Sure.

FYFE, MS: - - - Joe?

CUTHBERTSON, MR: Thanks for the question. I think what you've articulated there, not only in terms of the data sets of demand, is across the whole system. I think, without an accurate picture of what all service demand is and what capability exists to meet that demand, not only at the front end, but also at the receiving end, limits us to make best decisions in an operational environment.

In terms of a very focused look on a task by task basis, the nature of the fragmentation that exists at the moment, means that some of these decisions are made at a relationships level, not only in terms of the referring at the start of the patient's journey, if it's an inter-hospital patient transport, but also in terms of the tasking of an asset, does that always work well? No, it does not, because it's not purposely system led, it's managed by collaborative efforts.

KENNEDY, DR: I appreciate your perspective on that, but it doesn't help me understand, really, why it's not working or at what level it's not working and how - has anybody turned their mind to it - to this point, to say that's a known issue there - - -

CUTHBERTSON, MR: Sorry?

KENNEDY, DR: - - - and how do we deal with it?

CUTHBERTSON, MR: Absolutely. We've had challenges in tasking of inter-hospital patient transport for a number of years, and we've purposely tried to address that through collaboration at the quarterly tasking meetings, and at annual tasking review, by bringing all of the key partners in together to try and describe a methodology of conducting an assessment of that patient need at that time. That's reflected in the current tasking criteria, which was a joint effort across all of those partners to address that. It means that, on a case by case basis, for inter-hospital patient transport, that a medical to medical discussion is undertaken between the service providers, and to have an agreed view on how that patients moved.

I think, in the setting of - does it work or does it not work, the agreement is that the patient needs to be moved, so the default from that conversation is not that the patient does not move, but an agreement on how and when to move the patient based on the current availability of assets and the current demand.

KENNEDY, DR: So, the lack of an appropriately qualified and informed coordination point - - -

CUTHBERTSON, MR: With authority.

KENNEDY, DR: - - - with authority, is the answer to what you've just talked about. So that ad hoc relationship based, "Best as you can", kind of attempts to move a patient who may benefit from rotary inter-hospital transfer doesn't have a central point, which can standardise, authorise and be responsible for some of that decision-making - - -

CUTHBERTSON, MR: From end - - -

KENNEDY, DR: - - - and - - -

CUTHBERTSON, MR: - - - to end.

KENNEDY, DR: - - - then, and therefore, advocate with the tasking agencies, whose focus is clearly pre-hospital, by mandate.

Because essentially, there is a risk of diverting, you know, in all systems, where you've got rotary doing both inter-hospital and primary there is always the risk of diverting rotary platforms into the pre-hospital setting, when there's a perception of greater need in primary setting, which is usually a combination of cultural position and organisational mindset and resource limitation. It's a combination of all of those three, but that's not a balanced combination in any systems.

CUTHBERTSON, MR: That's - I would agree. And I - if I may, I'd also suggest that when that authority - if that authority was to exist, that it includes the patient's destination, such that - like, we tend to focus, quite often, at what's happening at the front end, because that's our business, but having a patient waiting in ED for eight hours - - -

KENNEDY, DR: So, the best model - - -

CUTHBERTSON, MR: - - - because - - -

KENNEDY, DR: - - - to resolve that, we're agreeing, I think, is a point at which coordination occurs, where the patient's demand, in terms of clinical need, is understood, the destination is understood and determined, and that each of the resource providers in that space - whether it's aeromedical or road or other clinical care providers - whatever it might be, are all in a command centre type collaborative decision-making process, where the best option's looked at first, and then, all the other alternatives - and I mean alternatives from the patient point of view and the system point of view, are all able to be considered.

It sounds like heaven, doesn't it?

FYFE, MS: And I think, as you've just described it, is perfect, as far as we're concerned, but it's also about that problem-solving, because there is no one size fits all. And the - in this environment, whether it be in the emergency environment or the inter-hospital patient transport environment, there is no one size fits all, and there's no, like, tick the box and that's how that one works. There needs to be that ability to do that problem-solving piece of work. Some transport, some emergency response are relatively simple, and when I say, "Simple", it's - I don't know mean in that it's easy, but it is a quick decision, "This is how we'll do it".

But there are a large range of patients out there, both in the pre-hospital and the hospital environment, that require problem-solving and decision-making. And I think that - the best way to solve the problem and the best decision is made when you have input from everyone to that coordination point.

KENNEDY, DR: Okay. As a hypothetical - so as a potential and maybe aspirational manager of a rotary service within the State, do you have a view on the RFDS acquisition of the two helicopters that have recently been purchased - and which are now to take part in a trial to see, presumably, whether they are an appropriate solution to a perceived need, do you have a view on this matter?

FYFE, MS: RFDS and St John work very closely together, obviously, and we work very closely out there on the frontline, and our organisations are - whilst competitive at times, we are close partners. I think the decision to acquire helicopters was a commercial decision made by RFDS. My view as to the reasons behind that are that I don't have a view, so to speak, and I wasn't involved in the decision.

However, now that that acquisition has taken place, we are most certainly working with RFDS and how our two services integrate at the frontline, and - because patients still need to get to the helicopter, so how do we work with our volunteers and our career paramedics out there to facilitate that in the safest way possible.

As to the benefits of it, I think it'd have to reserve my opinion until I see how it works, but it's very clearly inter-hospital patient, we've had - theirs is the inter-hospital patient transport, our participation, obviously, in aeromedical, is heavily focused on pre-hospital.

KENNEDY, DR: Yes, as you talked about before, you have a role in inter-hospital - - -

FYFE, MS: Yes.

KENNEDY, DR: - - - transfer, and if you were looking after the helicopters, you'd have some - a further role. Were you consulted prior to the decision to purchase those helicopters?

FYFE, MS: I was informed of the purchase.

KENNEDY, DR: After the purchase was finalised?

FYFE, MS: Yes.

KENNEDY, DR: You said that it was a commercial decision, would you consider it - this is an opinion, would you consider it usual practice for a not-for-profit health organisation to purchase multi-million dollar assets if it didn't have a linkage between that asset and subsequent income generation?

FYFE, MS: I think that'd have to be a decision for that organisation, and that organisation's board, as to the cost benefit analysis of such a large purchase.

KENNEDY, DR: So if there were no contract to suggest that there was an income stream to be derived from that very large multi-million-dollar investment, it would be very difficult, in my mind, to see a cost benefit - - -

FYFE, MS: And - - -

KENNEDY, DR: - - - unless, of course, you perhaps redeployed those helicopters subsequently - not helicopters, assets, subsequently into another, I mean - tourist industry, or something.

FYFE, MS: And to be fair to RFDS, I'm not privy to any of the preparatory documents, so it probably would be unfair to pass comment - and not privy to any of the financials either.

KENNEDY, DR: Okay. You talked, in your presentation, about the need for an aeromedical capability needs assessment in partnership with ambulance, can you tell me what you mean by that?

FYFE, MS: So how I would describe that is the pre-hospital emergency helicopter response that we deliver to the South West - which is the most populous part of regional Western Australia, is delivered only in the South West. I think there needs to be an assessment of the need across the entirety of the State, and particularly, as it stretches out into the Mid-West Gascoyne and out into the Goldfields, where you have increasingly large populations. We have an increasing - I'll say, need, but there is increasing circumstances where an aeromedical platform could be of benefit to our patients and certainly, those seriously unwell patients.

And I do know that, certainly, in the North West, there's a number of - whether they be local government areas or other organisations up there, that they too agree that there is opportunity for that aeromedical platform and - in that pre-hospital environment. And I think it's very easy to draw conclusions from that, but the point that I would make is I think there needs to be a proper assessment, and once again, that assessment of, what's the greatest benefit to the patient, how are we going to deliver the best service to our patients and to our community, with the best patient outcome.

And then, of course, out of that, falls, how do you finance that, what is the cost of that, and how do you fund that, and then, how do you deliver that. And I think that's the assessment that I would suggest is required. Lots of people have lots of opinions, and - - -

KENNEDY, DR: And everyone wants a helicopter?

FYFE, MS: - - - everyone wants a helicopter, but - and I think lots of people have lots of opinions, so the best possible step would be to do that proper, deep dive and assessment of the need and then, what is the capability to service that need.

KENNEDY, DR: Yes. I think you can forecast that as being one of the recommendations of the Inquiry, and it's clearly one of the strategic steps that's necessary in terms of moving to, not just a new model, but you know, a model that fits the demands of the State.

FYFE, MS: And if - sorry, if I may - - -

KENNEDY, DR: Yes, go ahead.

FYFE, MS: - - - as part of that, there's a large focus on regional Western Australia.

KENNEDY, DR: Yes.

FYFE, MS: However, we have got an expanding urban area that may well benefit from an aeromedical platform as well, particularly, given - certainly, back in the old days, as it was described to me, an aeromedical capability in an urban area wasn't required, because everyone lived within 15 minutes of a tertiary hospital. That's not the case now.

And in fact, we travel vast distances and - we travel vast distances, say, from the Peel Region to Royal Perth Hospital, where is the State Trauma Centre, and we bypass a number of hospitals to get the person - to get our patient to the best possible care. I think that capability assessment or needs assessment should take into consideration, not just regional Western Australia, but also suburban - and urban Perth, to see whether there is a need, and whether that need can be addressed.

KENNEDY, DR: Yes, I would agree. In fact, that was my next question, so - - -

FYFE, MS: I'm sorry.

KENNEDY, DR: Thank you.

So if a - I don't know, the new tender's, you know, being negotiated now for helicopters and this - you know, a move, in terms of fleet to a different type of helicopter, which is, you know, more contemporary, more versatile, faster, bigger, better - also pretty nimble, in terms of, you know, metropolitan work, so not out of the question at all, if you were able to secure, you know, benevolent funding, perhaps, from a mining magnate or someone that - or perhaps, the government, and they said, "You can have another one of those", has St John's got a view - has St John's done any mapping or thinking about where such a machine could live - - -

FYFE, MS: And I'm - - -

KENNEDY, DR: - - - for best benefit, or are you going to refer me back to the capability needs assessment that we just talked about?

FYFE, MS: I think there is a capability needs assessment, but I'm sure we have formed an opinion, and I'm going to defer to the experts.

CUTHBERTSON, MR: We've discovered that, particularly with urban sprawl, that there would be benefit to having a light utility helicopter to be able to support frontline care. It's probably within our bandwidth to be able to achieve that at the moment, but I think, both yourself and Michelle are on the money, in that in an environment that's under-resourced aero medically, that an appropriate first step is to get a better picture of the overall need, and plan towards that.

KENNEDY, DR: Are you suggesting another Perth-based helicopter?

CUTHBERTSON, MR: I'm suggesting that we should better identify what the contemporary need is and - - -

KENNEDY, DR: Okay.

CUTHBERTSON, MR: - - - understand future - - -

KENNEDY, DR: All right.

CUTHBERTSON, MR: - - - planning to move towards - - -

KENNEDY, DR: No, that's - - -

CUTHBERTSON, MR: - - - that.

KENNEDY, DR: - - - fair enough, if you haven't got the mapping or haven't done the demand work, then there's no point in guessing about it, but I think just from the simple work that has been provided to me, in terms of data that you have provided and WACHS has provided about inter-hospital transfers and that I've got in terms of mapping and that ERHS work, there's only, probably, three sensible potential locations, which would include Perth, Bunbury and Kalgoorlie would be the other one, which is an interesting one.

FYFE, MS: And I think there's certainly been - I will agree with you, Perth, Bunbury, Kalgoorlie, and I think there's also been a push for Geraldton, out there in the Mid-West Gascoyne, which is a fast growing region, and whether there is a need there that needs to be addressed.

KENNEDY, DR: Yes, it's all got to be - I mean, it, obviously, would need to be mapped out and lots of things considered, but, you know, Geraldton is well within the range of, you know, A139s from Perth or Kalgoorlie, so it's about rapidity of response and what's needed beyond. Anyway - but they're big questions. I just want to go back to a couple of specific things that are of a fairly clinical kind of bent - so I might head in your direction, but I'll direct them here, we talked about a - the system of audit of all aeromedical cases in the ERHS, which you are obviously responsible for at a governance - clinical governance level, what's meant by that?

FYFE, MS: So, I will defer - - -

KENNEDY, DR: I thought you might.

FYFE, MS: - - - to Dr Christie, as the clinical lead for - - -

KENNEDY, DR: So - - -

FYFE, MS: - - - (indistinct) 9.25.44.

KENNEDY, DR: - - - can you describe the audit process for these cases - or your audit process within ERHS?

CHRISTIE, DR: Yes, sure. So that's currently changing at the moment. So what used to happen was there was a clinical support paramedic, who had this as their portfolio, you worked in (indistinct) 9.26.02, they have a series of criteria for which cases would require audits, anyone that had an RSI, anyone with blood products, anyone who was a winch job - there was a whole list of criteria, they would pull those cases. Every fortnight, they would be presented a peer review meeting, and there would be representatives from clinical governance, myself or a representative, the clinical support paramedics and the CCPs themselves.

We would discuss the case. If anything came up at that point - so if there'd been a patient deterioration or an adverse event, that can then be escalated both through our own clinical governance system in St John's, and also, through the medical policy committee, which - as Michelle said earlier, has representatives from across specialities in medicine and it would be discussed at that level.

That process has now changed a little bit in that we have two new critical care paramedic interns. It's now their portfolio. And we're moving to audit all cases, not just ones who meet parameters. Obviously, the parameters are changing as we bring in new skills, for example, blood gas analysis, whereas before, we looked at (indistinct) 9.27.16 CO2 levels, now we're going to look at a blood gas analysis of CO2. But the plan is, essentially, every case will be pulled up and audited, because we are doing it fortnightly - that's manageable, and it's a good way to peer review and then escalate if there was any issues with the cases.

KENNEDY, DR: So how do you thematically review those cases?

CHRISTIE, DR: How do we - sorry?

KENNEDY, DR: Thematically - - -

CHRISTIE, DR: Thematically?

KENNEDY, DR: - - - review those cases - so they're reviewed in a - every case is reviewed from whoa to go.

CHRISTIE, DR: Yes, so we're changing that process too, in that from - I've been working at St John's for 18 months now, and developing and advancing our critical care paramedic cohort, we're now going to be splitting them - so we will still review every case, but every quarter, we're going to be doing specific airway reviews, so anyone that has an advanced airway intervention, we will specifically look at those with our airway registry and all kind of criteria related to pre-hospital RSI and the benchmarks for that.

We're also going to be specifically looking at our pre-hospital haemorrhage control, so any patient who has blood products, haemostatic measures or any kind of coagulation factors, they will be audited - targeted audited every - quarterly as well. So, on top of the review of every single case, we will be targeting those two groups, because they're the two biggest killers within trauma and the vast majority of patients are trauma patients, so we will be targeting them specifically.

KENNEDY, DR: Okay. Have you ever considered a kind of broader approach to audit?

I understand, from a case review perspective and how you would essentially look at cases in this way and look for variance around normal practice or so on, I mean, have you considered looking at audit from the perspective of themed, structured - and you have, obviously, with the airway and haemostasis approach, but by looking at other guidelines or pathways within your practice, analysing those in specific detail - like, it may be, for instance, temperature control, or - you know, as opposed to looking at every case?

CHRISTIE, DR: I think those are things that we are definitely looking towards. As I say, there's been a lot of things that I've tried to advance in the last 18 months, and this is obviously an area we're just moving into now to hone down on our audit.

KENNEDY, DR: Okay. It is a different and slightly more complex - and as a developing service, I can understand the challenges around it, but sometimes, it can also take you to a richer place, in terms of process understanding. I wanted to explore your views on the use of medical practitioners in rotary wing setting also and understanding the organisation's view on that. Horses for courses is my thinking, in general terms, but there are different jurisdictional views on this and unfortunately, far too many of the views around the interdisciplinary space, based on craft group passion, rather than capability needs assessment.

FYFE, MS: And I think, as you'll note from my opening address, we are a strong advocate for a dual clinician model, and we'll continue to advocate for that. I think the makeup of that dual clinician model - I understand there's a range of different views, as you rightly put, we - I don't know that we necessarily have a specific position as an organisation, but we certainly take advice and we want that evidence-based position for what is the best care for our patients, also, given our demographics, and our geography and our ability to attract whatever clinician that is.

But I will defer to my clinical lead as the expert in this area?

CHRISTIE, DR: And so - just briefly, my background is about 16 years in pre-hospital medicine. In the UK, you can dual train, you're dual accredited in pre-hospital and emergency medicine, which is the training pathway I took, and I've worked in five different pre-hospital and retrieval services both in the UK and here, which have utilised all platforms and all kind of crew combinations.

And I think I can echo what Michelle says, is whatever model is used, it must be evidence-based, and it must meet our patient demographic and need.

KENNEDY, DR: Do you think the evidence-based is good enough for you to really make that statement?

CHRISTIE, DR: I think when you look at - - -

KENNEDY, DR: And lack of evidence is not a basis for anything.

CHRISTIE, DR: Yes, I think, when you look at the evidence right now, there isn't good, strong evidence - - -

KENNEDY, DR: No.

CHRISTIE, DR: - - - to support physicians' pre-hospital, but then, when you look at the studies - - -

KENNEDY, DR: Or not?

CHRISTIE, DR: Yes, when you look at the studies, they're of variable quality, and it's difficult to make any strong inferences from them.

KENNEDY, DR: I mean, I've been hunting for a trial for the last 25 years, and I've got it, show it to me, because - - -

CHRISTIE, DR: I'm still - - -

KENNEDY, DR: - - - there is - - -

CHRISTIE, DR: - - - looking.

KENNEDY, DR: - - - not one piece of work that definitively or even powerfully says that one model is better than the other.

CHRISTIE, DR: Yes, and I think we just need to work on, as I say, our demographic, and what the patient requires, and - - -

KENNEDY, DR: So - - -

CHRISTIE, DR: - - - the skill set required.

KENNEDY, DR: - - - in the absence of evidence, you come back to, how do you build a system that is - that embraces the needs of the patient, the availability of the workforce, but not just the availability of the workforce, because before you had critical care paramedics, you didn't have critical care paramedics, so you didn't have that workforce, you developed. So the development of the workforce is also about making a strategic decision about what the system needs in the longer term and working towards it, not just saying, "We can't get doctors to do that", or, "We haven't got critical care paramedics to do that, so therefore, we won't do it".

So, I think it's a really complicated area.

FYFE, MS: And I think - and I completely agree with you, and if I go back to my opening statement, where we talk about what you need, actually, is a strategy, and in that strategic development - strategic development draws on information from all areas, draws on expertise, where it's available, evidence, where it's available - if the evidence isn't available, it goes and looks for the evidence, and it looks at facts and data, and out of that, you form your current position and then, where you want to get to - - -

KENNEDY, DR: Yes.

FYFE, MS: - - - and what steps you need to take. And at this point in time, that does not exist for the aeromedical - - -

KENNEDY, DR: No.

FYFE, MS: - - - services in this State. And I think, out of that, comes, then - and so use your strategy, and then, obviously, it filters down to, "Well, here's our plan for delivering on that strategy". And part of that plan is about resource availability and capability and how you go about either employing it, bringing it in, or as you say, if it doesn't exist, how do you go about creating it?

And I think there may well be a great opportunity to create a pathway for that, particularly given the wilds of our State and - - -

KENNEDY, DR: I think absolutely, I mean, if it's not the (indistinct) 9.35.13 interdisciplinary practice, I don't know what is, and you know, you just continue that conversation into what

should paramedics be doing in WA, what should nurses be doing in WA, yet how do you make that whole interdisciplinary space work better and more richly, and wouldn't a coordination centre be a place to drive a lot of that from and demonstrate, you know, interdisciplinary practice, you know, in a great way. Okay. Let me just have one more look at my book of sticky questions and see if there's something else that I need to - is it fair to say that your - that St John's is not terribly involved in the transport of NETS cases, that that's self-managed through their vehicles and RFDS?

FYFE, MS: That would be - - -

KENNEDY, DR: So, you're not - - -

FYFE, MS: - - - correct.

KENNEDY, DR: - - - often involved in that space, or you are?

FYFE, MS: If I - - -

SMITHSON, MR: Yes - - -

FYFE, MS: Antony?

SMITHSON, MR: - - - within the Perth Metropolitan area, we provide the crews for the NETS vehicles.

KENNEDY, DR: The crew?

SMITHSON, MR: Yes, so we do have a contract with them.

KENNEDY, DR: And you obviously provided the badging for their vehicles as well?

SMITHSON, MR: Yes, we supply the vehicle, essentially.

KENNEDY, DR: And they bought it?

SMITHSON, MR: Yes, we - based on our demand, based on our advice, and - - -

KENNEDY, DR: They paid for it?

SMITHSON, MR: Yes.

KENNEDY, DR: You coloured it in?

SMITHSON, MR: Yes, why wouldn't we?

KENNEDY, DR: Well, if you could, why wouldn't you? Yes. It's called collaboration, I think, that's why you would.

Did you have anything that you wanted to comment about in terms of the aeromedical involvement in disaster management, emergency management, in as much as it would interface with your area, or is that covered - may be covered by other things?

FYFE, MS: So perhaps, I'll give a personal perspective, though? Coming - I spent 34 years as a police officer, and as Assistant Commissioner with Western Australia Police before I took over as the Chief Executive Officer for St John, and I have to say that I was - I'm trying to think of the right - I'll go with, "Disappointed", when I took over, about the lack of interagency exercise - or whatever, when it came to - whether it be terrorist event or you know, disaster management - those sorts of things.

KENNEDY, DR: Pandemic exercises, perhaps?

FYFE, MS: And we're getting much better at those. I think - and that has changed, and there is greater collaboration between other emergency services, from our organisation overall, and I think there is - given the capability of the Emergency Rescue Helicopter, I think there is an opportunity to work closer with WA Police when it comes to that emergency response, given that they, too, have their helicopter platforms and their fixed wing platform. I think there is great opportunity for further collaboration. And because we are one of those organisations that's kind of got a dual personality, we are a health service provider, but we are also an emergency service, so whilst there needs to be that collaboration with Health and the other health service providers, there also needs to be that emergency service collaboration as well.

KENNEDY, DR: Well, yes, and particularly, in that - you know, the helicopter rescue - - -

FYFE, MS: Yes.

KENNEDY, DR: - - - SAR kind of component of its work, which is a very small minority and may rarely be called on but is - that is a consideration.

FYFE, MS: And I think I can say, that from that search and rescue piece, that we do have a good relationship with WA Police as the hazard management authority for search and rescue. We do have a good relationship with them. And in fact, the fact that we have paramedics that sit in the Police Operations Centre, and have a good interaction with our State Operations Centre, actually means that that collaboration and planning an emergency response works even better, because there is a relationship there. And none of these things ever happen between 9 and 5, when everyone's at work, they're always out of hours, and difficult times, difficult locations, so having that 24/7 interagency, inter-organisation collaboration piece works very, very well.

KENNEDY, DR: It's interesting, in the Health helicopter space, where most services bolt on 1 per cent of capability - which is around SAR and rescue, whereas there's also independent - other helicopter services that, fundamentally, do - like, 99 per cent SAR and rescue, do you reckon, maybe, there'd be an opportunity to put the 1 per cent in there?

In a way, to me, the concept of having Health helicopters, which are all geared to do search and rescue as well, both from a point of view of equipping, training, upskilling, maintenance of skill - all the rest of it, to build all of that into a machine that gets used for that 1 per cent of its life, just seems odd?

FYFE, MS: And I can certainly see that perspective, but I think there's also another perspective about insertion of the critical resource for the patient, and at times, that's about getting one of our CCPs - - -

KENNEDY, DR: Yes.

FYFE, MS: - - - to people in inaccessible locations and then, being able to extract that patient.

KENNEDY, DR: Yes.

FYFE, MS: And I think that needs to be taken into consideration - - -

KENNEDY, DR: Yes.

FYFE, MS: - - - when thinking about what is the setup of the aircraft.

KENNEDY, DR: Yes.

FYFE, MS: And particularly, in some of our very difficult locations, our CCPs do some pretty amazing work out of the back of that helicopter.

KENNEDY, DR: Yes. There are - I mean, part of it, perhaps, is volume related.

You know, there are lots of models where paramedics are inserted into strange environments - you've probably looked after some of them in the past, so - yes, inserting a paramedic into that workspace is not a new concept, but building that capability in a health asset times three, just seems - you know, times two, seems - you know, I'm - I'll leave it there. It's not absolutely my area of expertise, but I think it is something that needs to be looked at, particularly as things like the health rotary fleet grows over time, you know, do you really want every helicopter in the State, that carries patients, to be able to, you know, to (indistinct) 9.43.31 stuff?

FYFE, MS: And I think that's where that needs assessment and capability - - -

KENNEDY, DR: (Indistinct) 9.43.39.

FYFE, MS: - - - the whole - but there again, I think that - you know, look at the facts, look at the data, and then, make the plan out of that.

I also think that there's - one of the other considerations is that very, very grubby subject of finance and money and what's able to be funded, and I think, at times, there is a bringing together of two different capabilities, because it's more cost efficient and effective to do it together than it is to do it - two separately. But once again, all of that needs to be taken into consideration and out of that, come the plan.

KENNEDY, DR: Well, that's right, because when you start off with that model and you lock into it and you grow it, it suddenly becomes non-cost effective - - -

FYFE, MS: Exactly, but - - -

KENNEDY, DR: - - - and it becomes excessively expensive.

FYFE, MS: And I think there's - - -

KENNEDY, DR: So stopping and re-looking - - -

FYFE, MS: I think there's an opportunity to have - you can have an aeromedical capability that has a range of capabilities - - -

KENNEDY, DR: Yes.

FYFE, MS: - - - and it doesn't necessarily all have that winching capability. For example, if we were to suggest a helicopter response for Metropolitan Perth, it would be that very nimble - very quick, very nimble insertion, but you wouldn't necessarily have the FLIR (?) or night-vision or winching capability or any of those sorts of things, it would be that very nimble - - -

KENNEDY, DR: Yes.

FYFE, MS: - - - service.

KENNEDY, DR: See, I suspect, if you raise that discussion with a helicopter expert, they would probably say to you, what you gain - what you believe you save by doing, you know, a lean metro helicopter, probably costs you more in system development, because you're now running a fleet of two different types of helicopters. So, you're going to have two of everything, backup, maintenance, training, skills retention - all of the rest, and so the argument would be a really difficult one to make actually. So - - -

FYFE, MS: And - - -

KENNEDY, DR: Yes.

FYFE, MS: - - - I think - and it may well be the case, but I think the - and what - the point I would make is that the discussion has to be had.

KENNEDY, DR: Yes, I think the planning around that has to happen. I think, one of the things about aeromedical systems is that flexibility in the system is really important. And by that, I mean, you know, a platform is just a platform, and it needs to do lots of jobs, whether it's doing a NETS job, an ECMO job, a side of the road job or an inter-hospital job, the same platform, really, in most systems, should be able to do all of those things, whether it's got wings on top or wings at the side. You know that concept of flexibility in platform and crewing, that you can move in and move out of, is actually the hallmark of a really high functioning aeromedical system. It's not, you know, we've got the best of this component of it, it's being able to do all of those things, and I think that's a challenge.

Any final comments or issues that you want to raise, or messages that you'd like to leave for me to - - -

FYFE, MS: I might just - - -

KENNEDY, DR: - - - conclude?

FYFE, MS: - - - defer to my colleagues to see if there's anything either of any of them would like to speak to - and no one's leaping at the chance. I think we just want to thank you for the opportunity to participate and to be with you this morning. Obviously, we offer our services, should you require them. If you require any further information, please, just let us know, and we'll be happy to provide it. And I think, if I was to reiterate it for, probably, the hundredth time

this morning, I would say that, yes, system governance and system management is the piece that I think really requires some focus.

KENNEDY, DR: All right.

FYFE, MS: But we thank you for the - - -

KENNEDY, DR: I would - - -

FYFE, MS: - - - opportunity.

KENNEDY, DR: Thank you. I would strongly agree with you there.

So it falls to me to thank you for your attendance at the meeting today - at this hearing today, and also, I thank you for your generous cooperation and provision of responses, data and input up until now, and for hosting our visit the other day. It's been very, very helpful, from the point of view of the Inquiry, which - you know, which is more than just aeroplanes, when it comes to aeromedical, that's obviously important, this interface with so many parts of the health system.

I think, when you finished your initial presentation at 30 minutes, that I was going to get a very long coffee break this morning, but I'm very happy that we've had, what I consider, a very strategic and probing and constructive discussion of a range of issues, so thank you very much for that. A transcript of the hearing will be sent to you, so that you can correct any minor factual errors before it's placed on the public record. You will need to return that transcript to us within 10 working days of the date of the covering letter or email, otherwise, from a process perspective, it will be deemed to be correct.

While you can't amend your evidence, if you would like to explain particular points in any more detail or present further information, you can provide this as an addition to your submission to the Inquiry when you return the transcript. So once again, thank you very much for your input, thank you for your attendance, and for the input of the whole team, and I look forward to releasing some recommendations and a report over the coming months.

FYFE, MS: Thank you.

KENNEDY, DR: Thank you