Aeromedical Services WA Inquiry – Formal Hearing Transcription
Inquirer: Dr Marcus Kennedy
Organisation: WACHS Command Centre – Ms K Bosich, Dr J Yeung
Date: 11 February 2022, Time: 0910 – 1010

KENNEDY, DR Good morning. I'd like to thank you for your interest in the inquiry and for your appearance at today's hearing and for making the time. The purpose of the hearing is to assist me in gathering evidence to the inquiry into Aeromedical Services in Western Australia. 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 Mr Jonathan Clayson who's the Inquiry's Project Director.

We'd ask you to please be aware that the use of mobile phones and other recording devices is not permitted in this room and if you could please make sure that your phone is either on silent or switched off we'd appreciate that. The hearing is a formal procedure convened under part 15 of the Public Health Act 2016 and although you will not asked to give your 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.

There is - this is a public hearing and a transcript of your evidence will be made for the public record. So 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 considerations paper, a list of focussed relevant considerations and information on giving evidence to the Inquiry. So before we begin, do you have any questions about today's hearing and processes.

For the transcript could I ask that each of you state your name and the capacity in which you are here today.

BOSICH, MS: Kylie Bosich, the Director of the WA Country Health Service Command Centre.

YEUNG, DR: Justin Yeung, medical director WACHS Command Centre and League for Occupation, Transfer Coordination and Strength.

KENNEDY, DR You're now going to be invited to address the focus considerations list that's been provided to you and other matters in that paper.

You may speak to these matters for approximately 30 minutes, if you tend to be running over that a little bit but I'm happy for - to be flexible there. After your address I'll have some specific questions and in the remaining time available you can address any other matters that are relevant to the Inquiry. I will try to allow you to speak through your initial presentation and - but may interrupt if there are areas which I don't understand or require further explanation for the Inquiry. You are welcome to take off your mask if you need to, to speak clearly and when you are speaking. Go ahead.

BOSICH, MS: Well, thank you for the opportunity to present today. Justin and I come here representing the WA Country Health Service Command Centre which has been a service that's been operating since 2012 supporting country clinicians with access to emergency specialists 24 hours a day, seven days a week. We are one phone call that allows nurses and doctors in country to get access to specialists when they need it for their patients.

Having that command centre and access to specialists has led us to come to delivering and creating the acute patient transfer coordination service and I think, you know, in WACHS, having a good solid transport and coordination service is really important because we have so much reliance on transport to get our patients from country into the care that they receive.

It's been a long term goal and really what we've been aiming to achieve is similar with all our services, is that one stop shop and acknowledging that there's no wrong doors when people come through and it is into a centralised system and in particular from an APTC point of view, having RFDS and St Johns in the room, having transport providers come to us, having those calls come through, we can actually start to build oversight about what's going on and the demands and everything that's going on across the system.

Even though we have a one stop shop and there's no wrong doors, what we do see is a future need for a clear delegated decision-maker around what those patient transports are. We know that from a command centre point of view and having APTC built into the command centre we've got the ability and the technology to put eyes on patients to make clear clinical decisions, be able to determine a good clinical urgency, have availability and eyes on available assets and we're able to continue to provide assistance in that bed to bed care that needs to happen during those things - those times.

We know that within the service that there's things that would be helpful for us to get to this place of being able to care and one of them is about, you know, a good mandate and a policy and a strategic framework that allows us to be able to deliver the care we want. We've built data and we own the data and we build the information from that command centre services and we have the delegated responsibility to provide those cares into the hospitals. We're still building that for APTC, so you know, we know that those enablers have got - has worked previously and we're now moving that into the world of APTC.

I think Justin - it's been a long-term goal of ours because we have seen so many incidences over time around where coordination could have been done better and the patients could have been cared for better and I think it's been a long journey of getting to this place.

And Justin knew what I was going to say, we talked about the CPTU and the journey that we went on that we knew that we need to get to.

YEUNG, DR: Thanks, Kylie.

So, for me it's been a really interesting journey to get to this point. So my role in the health system has changed over the last 20 years where I've been 10 - spent 10 years at Royal Perth Hospital in the ED there as a receiving emergency physician and then going country in 2010 and part of my role in 2011/12 was actually to bring together a project to look at clinically coordinated patient transfers for Country Health.

So that was an 18-month program that was driven by a number of events and inquiries, not least of which was the Joyce Inquiry into ambulance but also it was a - considered to be an extreme risk on the State trauma unit's registry not having a single point of - a single desk, if you like, or single door for clinic (indistinct 9.17.15) patient transfer. So that was an 18-month program and we did put together a framework for the State about recommendations to - for a clinical coordination unit and part of that due diligence was doing the jurisdictional reviews across the East Coast.

Now, that was, if you like, the first iteration and it didn't get up in the end but what was happening contemporaneously was the emergency telehealth service which is one of the clinical streams of the command centre and if you like, it's almost like there's now leverage, I guess, with clinical experience and the technology and the expertise that has been built up in the interim 10 years to actually give us a platform to actually relook or give us the opportunity to relook at a coordination function and I guess from the other aspect, from my point of view

is that in the 10, 12 years that I have been in country, I've been on the other side of the equation is actually trying to refer my patients into metro and between hospitals.

And so a lot of those key points that Kylie raised which is single point of contact, reducing the opportunity costs for the referring clinician down to as little as possible, trying to make the referral process, all those conversations to get your patient moving sort of being a series of conversations that may take up to, in some circumstances, up to an hour and reduce and actually compacting that into a parallel conversation and doing three-way conversations and what have you.

I think that the evolution, I guess, of what we did 12 years ago to now is really built on the back of the telehealth service that's been crated and as Kylie mentioned, the command centre has a number of clinical streams now which includes the emergency telehealth service which does 27,000 consultations in the last year. We have a 24-hour inpatient telehealth service, we have a 24-hour mental health telehealth service. We've just started a midwifery and obstetrics and soon to start palliative care.

So, the levers are all there to actually have an integrated end to end service for our referring clinicians by way of the acute patient transfer coordination or APTC. That project started in October last year, I think. 2020 actually and we've gone through various stages or phases, if you like. There was a co-location collaboration with our colleagues in St John Ambulance and RFDS and there's a period of learning and project development which has culminated, if you like in a phase 2 trial which is a live ops trial four weeks ago over weekends.

And because of the COVID scenario playing out in Western Australia we've been asked to really fast-track that and we're starting as of today actually, we'll have a seven day a week service, 12 hours a day to provide that one stop shop for our referrals and coordinated care.

BOSICH, MS: It hasn't been without its challenges.

YEUNG, DR: No.

BOSICH, MS: And - but it's certainly a positive start, I think, you know, has been a long-term history of trying to get this to this stage in this State particularly when we look to other jurisdictions who are well mature and well-established and we look to them on a regular basis about how we've designed and delivering this kind of service.

KENNEDY, DR Okay. Is that the end of your presentation at this stage?

YEUNG, DR: I think so.

KENNEDY, DR Okay. So perhaps if I can then refocus you to the considerations paper and to start perhaps by asking you are there any particular issues or specific issues that have been raised in that paper and it is a - you know, it's a primitive and unfiltered paper to a degree intended for the purpose of conversation and discussion. Are there aspects of that which you have strong opinions about perhaps that you disagree with first or things that you wish to state strong agreement with.

BOSICH, MS: Probably starting with policy and system, I think we talked a little bit yesterday about policy and system and around the strategic framework so absolutely I'd see from a point of view around the multiple platforms, multiple players that the lack of a plan, a strategic plan for transport providers that builds in and acknowledges them as a part of a health service has

led - and it continues to not give anyone the opportunity to see what the long-term plan is and to plan too, you know, expend, to invest so having a clear understanding of the plan that we're all aligned to would actually go a long way to the bettering of the collaboration and to building, you know, a Western Australian future.

So I think having a strong strategic plan and strategic framework and then a policy underneath it helps support where we're trying to get to, you know, I really think that it's one of the levers that needs to happen for any change in future. The other part to that is around how, you know, and we talked about it yesterday, about the shop concept but there is a need to have good government structures. There is a need to have someone who is accountable and responsible in the delivery of that strategy for the delivery of the services, to the delivery of the plan.

And I suppose even from an operational capability we've started the APTC which, you know, was not in operation when the Inquiry started, when we first started but, yes, I think from us a central oversight having that centralised coordination service and oversight was strongly agreed with.

KENNEDY, DR Okay. Can you explain to me, for the Inquiry the - your vision of a fully mature APTC what it would be delivering, in what style and how?

YEUNG, DR: So, the vision statement, if you like, is - would be tab A, a one-stop-shop for our referring clinicians. Now, that might be referring clinicians from a Country Health site through to another Country Health site. It might be through to - WACHS through to metro and similarly from metro back to country so a repatriation piece. I see that we have a clinical prioritisation or transfer prioritisation that is very transparent, and it addresses the clinical needs of the patient as well as addressing the site capability of our many WACHS sites and many of our WACHS sites don't have doctors. Many of our WACHS sites don't have pathology.

So to include that in our clinical prioritisation system, similarly the - again, with what's happening playing out with COVID in Western Australia is that the level of expertise of the clinician, the bedside may well change, it may well become less robust than it is now so having that is also part of our prioritisation system but actually to have a sister prioritisation system that is applicable to the transport side of things as well as the clinical side of things and actually being a one system - one prioritisation system across the whole patient journey. We would like to see and we're working towards having a specialist clinician, a specialist - medical specialist being the medical coordinator for the system.

Now, whether that be a emergency physician, intensive care physician, an anaesthetist but having that critical thinking being at the forefront of the assessment of that patient which I think at the moment is a little - it doesn't have that feel and the other side of that is that it would be supported by a nurse - nurses and potentially paramedics as being part of that clinical side of the operation and all of these people being co-located in one room. We see that the logistics side of things will be co-located as well so the road and fixed wing, rotary wing, logistics officers also being co-located. We see as - also as part of that patient flow being embedded and we're starting that journey as well.

The patient flow is - it was mentioned at yesterday's hearings as being quite siloed across the HSPs, the health service providers, and I guess, also from a Country Health point of view, probably not as developed as in metro. We see also, again with COVID playing out, we have a central role with the COVID care at home population and if you like, being that central repository of experience and oversight for all the working - moving pieces in Country Health.

We see that we'll be operationally adjoined to, if not co-located with a WACHS operational hub.

So one of the visions for WACHS is to actually have a 24-hour duty manager who knows at any time in the system what the capacity is, what the activity is, what the pinch points are and having that situational awareness attached to our unit as well. Lastly, I'd like to see that there is, I guess, an authority piece that goes with that and obviously that has a significant amount of accountability and responsibility with that role but I think that with a number of the clinical incidents that we have that have led to this point that the lack of that one authority figure in our structure would be the medical coordinator to make a decision one way or the other, just make a decision and stick with it and have the authority to stick with it I think is a missing link in the system at the moment. So, I would see that role being really important.

We heard yesterday or I heard yesterday that you know, there is variable authority with the HSPs and I think each health service provider have their own policy and their own structures and I think that's going to be a challenge for us to actually how that might work and certainly we've seen that from a COVID point of view as well and that's playing out in a different sphere.

Ideally in the end, we want to have - to leverage also off our clinical streams so I see our APTC leveraging off our telehealth streams and I can't help but think that there'll be amazing advantages in the system of actually having that coordinator, that clinical expertise, that critical thinker being able to put eyes on a patient and make a rapid and contemporaneous decision based on an immediacy that way which I don't think has been available in this State before. That's my vision.

BOSICH, MS: I was going to add a couple of other things, I couldn't - there is a long-term vision, I suppose, and it does take a major reform or major change, cultural change from a health services point of view so - and for us around having a shared workforce I think there's real value and we've seen from the Queensland example where having clinicians who work in the coordination service who can also have an empathy and understanding of what it's like to be on a transport arrangement and what that looks like so better decisions are being made because you've got that shared workforce.

I think we've got a very small workforce in WA, professional workforce in WA so we really do need to enable the RFDS, the St Johns, those others to be able to all teach and learn from each other so that we can share that workforce and previous experience because I think there's a wealth of experience around doing that and that's just not from medicine, that's from nursing as well and from Allied Health and paramedics. There is a greater need for a workforce that is there's a shared one. Having a system, software solution, IT system, something that's actually centralised that's visible, that actually uses, you know, intelligence.

We have intelligence in IT now around assisted decision-making that can start to ensure that decisions are predictable and understandable and transparent and build intelligence around what the service is and I think we haven't had that, we've always relied on individual providers and individual organisations to have data and try and somehow make sense of that data in different ways. So, having a clear defined definitions of the system and having a software solution, there starts to measure end to end journey.

So I think that certainly the workforce and an IT system and more - and one of the things I did a presentation yesterday to WACHS clinicians about the start of APTC service and one of the greatest challenges and we've heard it's is about access to good clinical specialty consultant level and understanding at a consultant level in a metro hospital about the requirements of

those patients and no bed locks, no ping ponging around different kinds of areas. So having access is not about the bed, it's actually about clinical, you know, yes, this patient needs to come and this patient needs to receive this level of care and accepting that that's actually required. It's challenging that we don't have equitable access at times to beds given that, you know, we're some distance away. So, I think, yes, some authority around, you know, the ability to gain access for our patients.

KENNEDY, DR Do you see the scope of the service being a movement of all patients, you know, of varying levels of acuity and so on? Because I mean, to be frank, there's a lot of organic movement through health systems that occurs, almost without thought. Do you need to manage every one of those movements? Is that part of the system?

YEUNG, DR: Yes, so good point, and we're working through that at the moment. I think, if we had active involvement with every single patient transfer, I think we'd slow things down. So, part of what Kylie was talking about with the software solution is actually having some - and we're going to explore, is actually having some machine learning available in the system, and decision-support tools.

I think the challenge is going to be is there is a small handful of those milk run patients who could deal - could have benefited from having expert eyes and critical thinking over them, so I think it's the balance of what - and not slowing down stuff that works versus actually having oversight. I think the key comment here is oversight.

KENNEDY, DR: Mm hm.

YEUNG, DR: We want to have oversight of all those patient movements, actively involved with the ones that have either time critical or have certain triggers, but letting everything else go through, but having some sort of flag to say, "Well, hang on a minute, that road transfer, or that air transfer, from A to B, that doesn't sound quite right". And we've actually had examples through the APTC in the last four weekends where that's been picked up by our people in the room saying, "Look, you might want to put some eyes on this patient because it doesn't seem quite right".

Yes, I won't go through the details, but there have been cases where we have looked at those cases and, I guess, gently navigated to actually intervening as opposed, "We have no authority at the moment", but gently navigate to a solution where that is the right thing for that patient.

KENNEDY, DR: But from an aeromedical perspective, if there were a system for aeromedical coordination, which was centralised, if there was shared vision of - I mean, the aeromedical component is really just the transport platform component of everything else you've spoken about. That would resolve any issue of, you know - well, it wouldn't resolve it, but it would minimise the likelihood of, you know, inappropriate transfers like that, because you would have involvement and oversight in terms of your service. From a road perspective, you know, understanding the population, that's unlikely to be as - well, it may be a big issue. Perhaps, can you speak to that?

YEUNG, DR: So, I think that the - so it is a big issue. So, the roadside thing is a big issue, and it's been, for me, a bit of an eye opener actually seeing the inner workings of how country ambulance works. And there's no doubt that individuals are all trying to do the best that they can, but as a system, it doesn't quite meet the needs of the patient. And I think that's the advantage of having all our intelligence in one room.

So I think the answer to the first bit of your question is that there is advantages of perhaps seeing all platforms, so rotary, given that that sits with DFES and Ambulance, at the moment, and fixed wing, as well as road ambulance, I think having - seeing all those moving parts actually does allow a certain amount of operational intelligence and actually high-level decision making. And we saw that play out on the weekend, actually, the bushfires.

We had a number of our facilities evacuated, and we also had a number of our facilities in harm's way. And there was really good intelligence showing that a dozen ambulances were being cohorted to this site for response capability, but there was a crash here, and there were burns here, and where those moving pieces are. So, I think that interface point's really important, and I think road is a big part of it for us, but it's certainly not the only part.

KENNEDY, DR: Okay. You mentioned, your description, the concept of patient-flow management. And as I learnt yesterday, this is a fairly contentious area, a degree of passion attached to it. And there's different ways of looking at it, some people are excessively simplistic about it, and some people create more complexity than there needs to be or believe that there's more complexity than there needs to be in it.

But there's, clearly, a difference in perception between perhaps people who are in your situation, who are every day, moving patients, and have a view on the need for them to get somewhere, versus the people who are receiving in terms of how they need to prioritise their extraordinary workloads and complex environments, and lack of resources, because everyone's got a lack of resources.

Do you have any views on how this is resolved? Because at the moment, there seems to be a gap in that space, and patient flow is part of, the resolution of that, I understand. But from an aeromedical point of view, this is not something that you can really afford to have in your system, which creates uncertainty, or delay in tasking, or potential for rerouting, or calling off flights and stuff like that. The system needs to be managed pretty efficiently. Do you have views about how the current variability of opinion and views could be resolved?

YEUNG, DR: Do you want to go first?

BOSICH, MS: Yeah, look, it is a complex - - -

KENNEDY, DR: You can say, "No".

BOSICH, MS: No.

KENNEDY, DR: But it would be helpful if you had some ideas.

BOSICH, MS: It is a really complex system, and having had the challenges of having- you can see your patient who needs, clearly, an intervention that's not available at your site, and needs an intervention - - -

KENNEDY, DR: Yes.

BOSICH, MS: - - - at a particular time.

KENNEDY, DR: Yes.

BOSICH, MS: And the complexity of trying to line up - - -

KENNEDY, DR: Yes.

BOSICH, MS: - - - a plane, a bed, an escort, all of those things, it's very challenging to say that just because there's a bed not there, when you've landed all those other really more challenging areas, that a patient should not be transferred, because there's no bed.

KENNEDY, DR: The contra view is, clearly, that you don't see the 100 people that in their queue already.

BOSICH, MS: Correct. But they also don't see the 100 ambulances that have come in their door that unexpected as well. So, I think - - -

KENNEDY, DR: So, your argument is that their workload inflows are fundamentally unpredictable?

BOSICH, MS: Unpredictable.

KENNEDY, DR: And this is actually a manageable, small component of the inflow.

BOSICH, MS: Correct. I think what has been challenging, and I sympathise lots with Metro, is around we may have asked and booked a bed, or booked a patient inflow, but the system is a verbal, telephone call, kind-of-approach where our patient might have been diverted, or may not transfer, the actual time of arrival's never known, it's never clearly transparent, so managing and inflow, when it's not very transparent, is a real challenge and that's part of the system and solution, is having very good visibility of actual time so you're not held to a bed being open, and you're not held to that ETA you know exactly, so you can start to manage, a bit better, the known flows.

KENNEDY, DR: I think that is the fundamentally, rational approach to this scenario is that whatever the queuing may be, whatever the congestion may be, there is a space where there is no control over what else comes in, what else hits your system, if you're a health service provider, whether it's ambulance arriving, whether it's ambulance arriving when there should be bypass, because the next patient's just so sick they can't go anywhere else, or whether it's someone who walks in with a bellyache, that turns out to be a triple 000.

BOSICH, MS: Yes.

KENNEDY, DR: Yes. There is not fundamental way of turning that tap off, and so as long as that approach is not used for 50 per cent of your transfers, and it's the rare event where there's a real need to do something that makes a difference to the patient's outcome, you know, I have - you know, I'm quite clear on that.

BOSICH, MS: Okay. And just to add to that, I think having much clearer clinical understanding, with a much clearer - - -

KENNEDY, DR: Yes.

BOSICH, MS: - - - time to definitive care, to the clinical priority, or urgency replay, to patients, is around, you know, "What is this case", and "What is the time to definitive care", or "What's the tolerable time to the bed site". So, what asset or support's required by that patient, at that bed site.

So being very clear around that time frame and being able to share that with our metro counterparts, or those receiving our patient, gives a much better view. And one of the most simplistic things that happened when we started this APTC journey was being very articulate about what the patient needed. So, this patient's being transferred for imaging, or in-patient surgical care, or surgical consult. So often, it's about, you know, this is the provisional diagnosis, or this is what we're seeing, but actually defining what you're transferring for, and making that very clear upfront, was something that I learnt was not articulated as well as it could.

YEUNG, DR: Just a couple of comments from my point of view. I mean, there is a reason I went to work in Country, and hospital overcrowding might have been one of the Metro, but you know, as a Metro consultant, I had no idea what was out there. All I knew was another patient was coming in. And I think the benefit of having situational awareness and I guess, some experience from a patient flow point of view, not, you know - the capacity of the system, notwithstanding having some understanding that if you're coming from, you know, from a Corrigin or a Kellerberrin, or whatever, there's one bed.

And the assertion that you're sending them because you've got no capacity is actually true, but there's one bed and there's one nurse. And I don't think that realisation is actually - I don't think that that awareness is going to be there in Metro, and you know, if you're a resident or a registrar, or even a newly-minted consultant who's never, you know, stepped out of 6010, you're not going to know that. So, I think that's one of the benefits of what we're proposing here.

I think it's a learning process for all of us because even the regional centres, some of the big regional centres, have no idea about the little places in their region. So, I think it's a learning journey for everyone.

KENNEDY, DR: So that probably moves on to the, you know, concept of the overarching governance and perhaps not authoritative, but you know, arbitrating capability, that capacity within your system.

What do you see the shape of that as being? Or what do you see the options or opportunities in that space, in terms of how that could look, how that could work, if there were, you know, further development of the APTC? If there were, you know, changes that may occur in the aeromedical systems space? Is that separate, or different, to what may go on in terms of the need for aeromedical services governance? Is it all incorporated? Or how do you see that as working?

YEUNG, DR: Yes. I think it's going to be a challenge.

I'm hoping what we have put together is a mix of experienced clinicians who actually - no, I think it's about relationships to start with. I mean, it's a journey, so the relationships and the clinical, I guess, kudos, of people that we've put together I think will be part of that initial start to that governance process. I think the - I mean, an example would be, there was a really bad crash in one of our regional sites, where we wanted to do an end-to-end patient review.

And because that was across pre-hospital road, pre-hospital rotary, when in a hospital, then in a hospital, so in hospital, then into hospital, fixed wing, there was no real governance mechanism to host that, and also trauma from a receiving point of view. So we did that under the APDC auspices, and some of the comments was - I mean, there were great, the feedback

was really, really good and the system, as a whole, worked really, really well, but it was the first opportunity for three or four different organisations to get together and have an end-to-end review.

So that was really through relationships. I think where it will transition eventually will be through more formalised governance structures and frameworks, that will encourage, initially, but potentially, eventually become a mandated part of the system, that that will have to be that way. I think we've used the phrase, maybe yesterday, but we've used the phrase, in the initial catchups, around "no wrong doors approach", and we don't want to be punitive at all to anybody, either the clinical or a review process, by using those sort of mandated pathways, we want to do it, encourage it, be collaborative, but I think, eventually, it needs to have a framework where it's very clear who and how that system works.

BOSICH, MS: I think there's a part around the coordination, the actual oversight coordination, there does need to be someone - decision maker, some form of decision making, a named decision maker that's very clear, and this is from an end-to-end to coordination for a patient. So you know, for being able to bed, or say, "No" to a patient actually transferring, there has to be some clinical oversight with somebody that's in charge, who can make those decisions, and holds and understands that there is a decision.

That person also needs to have those relationships that can actually be able to talk through those decision making.

KENNEDY, DR: So, if I'm clear, what you're suggesting is that if you have your nirvana located, integrated, collaborative, coordination place - - -

BOSICH, MS: Yes.

KENNEDY, DR: - - - where all aspects of outreach and communication and coordination tasking, platform allocation, destination finding, et cetera, all live within there, which is all important to aeromedical systems, but then there is then a something that sits on top of that, that has the authority in an operational sense to deal with those scenarios.

BOSICH, MS: Yes.

KENNEDY, DR: Bearing in mind, obviously, that you've got multiple organisations sitting within that space.

We're not talking about something that owns all of those organisations - - -

YEUNG, DR: Yes.

KENNEDY, DR: - - - we're together - - -

BOSICH, MS: Operational.

KENNEDY, DR: - - - an operational, management, decision-making point, if there is a need for those decisions.

BOSICH, MS: But I think there's also a need for an overarching over the operational, and we go back to how do you, you know - because to get to that place, you still need the contracts, you still need that - - -

KENNEDY, DR: So where does that place get - if it's got that operational leadership and control point, where does that its strategy, overarching governance, et cetera, from? Where does that fit into the system?

BOSICH, MS: For my view, it is the system manager, it is the State, it's the State that says, "This is where your strategy is, this is what that" - - -

KENNEDY, DR: The State?

BOSICH, MS: Yes, like, a department system manager.

KENNEDY, DR: A department.

BOSICH, MS: System manger, Department of Health. It is a health responsibility, it is the Department of Health, they lead strategy development, they lead policy development, they set the tone. And I think the Country Ambulance Strategy, well, certainly what we highlighted there, is a need for legislation, or there's a need for policy that actually says, that, "This is what we're going to do, and this is what is agreed". We've started with an ambulance framework that also includes aeromedical services, that starts to outline what is expected, and what the community can expect from a service. But there is a need for that statement to help drive and enable future changes.

KENNEDY, DR: So, the State has a view around devolved governance, which, you know, in an aeromedical setting, you know, may have some implications.

Do you - because in a sense, there's an oddness about an aeromedical system articulating with the highest level of Health, but do you have a sense for how that could look different in the future? Or how that could work?

BOSICH, MS: For me, you know, we work in the area of influence we can, and from a WACHS perspective, and from a WACHS country patient, who are one of the highest users and who have the greatest need. I feel like we've been able to start to develop that within WACHS to say, "This is what our country patients need, that's why we've got a country-aimed strategy".

Happy towards a patient transport strategy for WACHS, it's about how that gets built in and what sort of framework is that done in - you know, how we can also leverage influence from a policy statement. But yes, from a WACHS perspective, we can work in within that level of influence and start to work on those.

And I think, you know, with the contract, you know, having RFDS contract within WACHS, being able to modify that and build what the requirements are, over time, and moving the Country Ambulance contract over to WACHS, we could start to define service level agreements, we can start to define what's required from the workforce. We could start to define about data sharing and get that agreement to be able to move forward.

KENNEDY, DR: Mm hm.

YEUNG, DR: I think the tricky thing is that - I think the tricky thing from that point of view is, if it's delegated to WACHS as the HSP to do that, and have an operational authority piece, I think the tricky thing is how that translates to the other HSPs and Metro. So it's all very well and good, I think, to have an authority structure which, you know, can make decisions from

within the HSP, but as soon as it steps outside of that, and we have to move our patients to Metro, and they're saying "No", that's the tricky bit.

And I'm not sure what the overarching construction would be unless it's a state-wide policy piece that says, "That role, within that organisation, has the authority and you just have to live with it".

BOSICH, MS: There is that.

KENNEDY, DR: So essentially, what you're saying is that if you follow the approach of devolved governance practice, then the further you devolve the management of complex kind of interagency matters like this, you start to fall into the realm of unexpected consequences, which I believe is a Western Australian saying.

YEUNG, DR: Sounds like it. I think there's challenges.

KENNEDY, DR: But I guess there are additional challenges - - -

YEUNG, DR: Yes.

KENNEDY, DR: - - - which you will strike, the further you bring that system, the aeromedical system, down into our service level.

Okay. Do you have a view with respect to the suggested realignment of EHRS, which is, essentially, an ambulance service, from my view, to sit within Health and not within DFES, as a non-government department, as would be the case for most aeromedical, rotary-wing services around the country?

BOSICH, MS: I think from - we explained a little bit yesterday, around that it does need to have better clinical governance, and it does need to transition to Health to be able to get support of around clinical expertise and governance and all those things, but I do take Geoff's point.

Yesterday was very good around aviation and aeromedical, and that's something that Health doesn't actually have at the time his point, doesn't say we can't build that or obtain it. But I think having it separate outside of Health, and having even the tasking of that outside of then the coordination centre, makes it challenging to be able to use the assets that you need, for the patients you've got, and have good decision making on how that asset is used too.

KENNEDY, DR: Okay. Do you have a view on the commissioning of the two additional, RFDS rotary-wing platforms, in terms of how that may affect, you know, the aeromedical system and the work that you're engaged with and so on?

BOSICH, MS: I think, you know, through the Inquiry paperwork, it seems that, you know, WA is under-resourced in rotary-wing assets and capability. I see that we're doing a lot of work with RFDS and working really hard together around making sure the commissioning of that service is built in and structured with St John's with the ERHS, and very clearly starts to deliver benefits to patients that a rotary wing can, which is that door-to-door kind of transport in a time critical manner.

So, I think it's, you know - there is a need and it's how we build that in to make sure that we've got good capability. We have previously been challenged in getting the ERHS to do inter

hospital patient transfers, so having that additional capability for all those time-critical, time-urgent kind of patients would, I think, add benefit to the patients of WA.

YEUNG, DR: I think the overview of the capability and the patients that they're going to retrieve need to be much more aligned and the tasking of that, and the requesting of that. And the subsequent tasking needs to be aligned, and at the moment, it's not.

KENNEDY, DR: Yes.

BOSICH, MS: The APTC will be tasked, or will be authorising the use of that helicopter, so we are starting to build in to that ability that that patient is identifiable, that it is a patient that would benefit from a rotary-wing transfer.

KENNEDY, DR: Okay. So I mean, like you said, there, I understand that the initiation of a case in that setting is something that could occur in multiple ways, in that a case may come to you directly through contact, or through telehealth, or a case may come directly to RFDS as interhospital transfer request that's based with them. I would assume, therefore, then there' going to be a central point at which those requests come.

BOSICH, MS: Mm hm.

KENNEDY, DR: Just, yes, from my understanding of that component of the tasking and assessment of the case, is there an initial assessment of the case at the RFDS level, if the request goes there first? And then a second assessment of the case when it comes to the command centre? Or how does that work.

YEUNG, DR: So I think it goes back to my comment around, at the moment, we're in transition, and we're taking a no wrong doors approach, I think that will - so basically, if it goes through the RFDS pathway, then they'll deal with that.

If it comes through APTC pathway, we would deal with that. We will then need to have that interaction, but I think, as we become more experienced, and as the system becomes more mature, we will transition towards having only one portal of entry. But because we're doing this as a trial and we're bringing on regions, I think that one of our regions will be onboard this weekend - - -

BOSICH, MS: Yes.

YEUNG, DR: - - - and we've got limited hours, we've got - it is a - there is a body of work from our end to actually inform our referring clinicians that this service is up and going. We are in a phase trial, even though we've been told to go from toddling to running in a much more shorter time frame, but I think that that will transition to a single portal of entry, at some stage in the near future.

BOSICH, MS: What we've already seen through APTC is that if a clinician wants to do a - because the scope of this, the RFDS helicopter, is only IHPTs, so what we've already seen in APTC, is somebody, a clinician, has gone to St John's directly, or RFDS directly, we've got visibility of that in APTC. That conversation happens between the TLO and the medical coordinator, without we actually, in a timely fashion, go, "Oh, this is what's going, what do we think? Do we need to reach in to the clinician at the bedside? How do we discuss this case? How do we authorise and approve"? So, with all co-located, having an intelligence at that time, it will build, and only get better, when we get to 24/7.

KENNEDY, DR: Do you see that there may be risks attached to having multiple inflow points?

BOSICH, MS: Yes.

YEUNG, DR: There is no doubt there will be potential risks, and we - that's why we're taking this no wrong doors approach at this stage, is to - because there's a lot of this - we had a case on the weekend where there was muscle memory, so basically, "I'm in a stressful situation, I will go down the path I know". And the key here is to have a streamline of conversations between our operations centres and the respective operations centres, that's the Saint, and RFDS, we're working along those lines now. We have got direct contact, it's actually making them streamlined and reducing the time, but there is potential risk.

KENNEDY, DR: Mm hm.

BOSICH, MS: But I think there's - it is a change management, you know, from a clinician at the bedside, who is muscle memory, you don't want them to be ringing RFDS and being told to hang up and ring somebody else. So, I think this is what we're trying to avoid. It's around as we change, and as we transition into a 24/7, it will be a coaching system, so we do need to have some flexibility at the moment.

KENNEDY, DR: So in essence, the - I mean, if it were a more usual scenario where you were introducing a new helicopter into a system, that was a permanent fixture, and dah, dah, dah, dah, dah, the concept of it, and the trial, wouldn't be there. And that the way that you established a system like that would be through solid communication, "Here is the change, it will happen on this date".

BOSICH, MS: Correct.

KENNEDY, DR: "And this is the way that you do things". So why would you choose to do a trial about the implementation of $10 million of hardware in the first place?

BOSICH, MS: The actual implementation, the commission, is a hard start. It's, "Here's a change, here's your education, here's your things". The trial concept is really around understanding the activity benefits, understanding - it's the funding arrangements, it's about all those other components that - it's about - - -

KENNEDY, DR: So, is it to evaluate whether this is going to work?

BOSICH, MS: Well, it is an evaluation piece, there has to be an evaluation piece on the additional rotary-wing assets. And there is, you know - this isn't and IHPT, it's not just primary - - -

KENNEDY, DR: I mean, it's an extraordinarily odd way to approach the implementation of rotary-wing platforms. I am not aware of any jurisdiction, anywhere, that has done a trial to see if we need it. I mean, you do a needs assessment to see if you need it.

BOSICH, MS: Mm hm.

KENNEDY, DR: And then you find a solution and you implement it.
BOSICH, MS: Mm hm.

KENNEDY, DR: So, can you help me to understand the reason that - - -

BOSICH, MS: No, I don't know what the internals were behind the idea of a trial.

KENNEDY, DR: Okay.

BOSICH, MS: All I know is we were going to commission this, it's going to get on - - -

KENNEDY, DR: Like, I said, from my perspective, in terms of making recommendations, in terms of an aeromedical system, of the uncertainty of doing a trial, you know, what are the established fail points?

Are they determined?

BOSICH, MS: Not that I know.

KENNEDY, DR: Do we - you know, I mean, normally, if you do a clinical trial, you'll have an understanding of what you consider not good.

BOSICH, MS: Mm hm.

KENNEDY, DR: So "We're not going to continue with that trial". What are the decision points at the end of the trial that would determine whether the service continues or not? Do you we have a sense of that?

BOSICH, MS: There is an evaluation that's been - has been developed so that we can evaluate whether there has been - some of the assumptions that are made around the benefits to patients and door-to-doors, and all - - -

KENNEDY, DR: Okay.

BOSICH, MS: - - - there's an evaluation that says, you know, "Has this added value"?

KENNEDY, DR: Okay.

BOSICH, MS: And there is a missing piece in understanding activity. So, we know even, you know, we know that there are some patients who aren't having access to the ERHS, or decisions are being made so they're going via ambulance, but we haven't any view. So, this is starting to open up an opportunity to say, "How is this going to assist in patients"?

KENNEDY, DR: Can you make available to the Inquiry that evaluation protocol?

BOSICH, MS: Yes. Yes.

KENNEDY, DR: Thank you.

Are there any other gaps in terms of - I mean, this implementation has arisen - or the trial's arisen out of a perceived gap to clearly - or an alternative way of doing work, do you, as a key hub point in the system, see other areas of aeromedical gap that the Inquiry should be focussing on, that perhaps - if it's not already picked up in the consideration, or do you think that we've made a reasonable assessment of that to date?

YEUNG, DR: I think that the earlier presentation was through by the NETS service, so I think they've identified that there's a potential gap there.

KENNEDY, DR: Yes.

YEUNG, DR: I think it's about getting the - going back to it, getting the data piece about the needs analysis of where there may well be gaps, and I think some of the figures that I've seen through here, I'm not quite sure of the voracity of the numbers, but that probably is prefaced on what that needs analysis is. But I think there's probably a requirement up in the North West as well, be it rotary wing or fixed wing capacity, but - the third thing we say, mental health patient transfers also is another area which is challenging, as you know, and that's probably more around not just the aeromedical asset, but the police requirement and the escort requirement. So, they're probably the three areas that I'd identify.

BOSICH, MS: And as I raised yesterday, I still - having lived in the Pilbara for a long time, the challenges of trying to do medivacs in remote locations. It's sometimes not always raised up because it's not our core business, as normal, and it's probably the infrequency of some of those, but there is a gap around that space.

KENNEDY, DR: Okay. Yes, there has been additional data provided to the Inquiry since the Considerations Paper was circulated.

YEUNG, DR: All right.

KENNEDY, DR: And the picture of where the gaps appear to be are much clearer, and do map to your perceptions, largely, so that's helpful.

Just finally, I wanted to ask, given the broad church of your hub, which is really very inclusive and very kind of - inclusive in its thinking in terms of the way that you're approaching the system and the work that you're doing. At this stage, there are a few outliers in terms of, you know, obstetrics, you've mentioned, you have started to move in that space, which is good.

How do you see - or do you see a need for greater - or a stronger relationship between your area and the NETS, paediatrics and obstetrics outreach areas? And I don't mean, you know, take over the world, are there ways that the work of your area could help them in the work that they do, and to improve the aeromedical responses and use of resources, et cetera, that is required?

YEUNG, DR: That's a tricky area, isn't it?

BOSICH, MS: (Indistinct)10.05.45.

YEUNG, DR: I think one of the key areas for mine is around the prioritisation of the transfer.

KENNEDY, DR: Yes.

YEUNG, DR: And I think it's unclear from the conversations that I've been involved with, whether the fact that you're a neonate makes you an automatic, time-critical referral versus a more planned, just on the lower acuity referral. And I think having an - I won't say an umpire, but an independent assessment of that prioritisation is a key thing, I think, that we'll put into the system.

The other aspect that we're very keen to partner with PCH and NETS and any specialty really, is the ability to put eyes on that neonate.

KENNEDY, DR: Yes.

YEUNG, DR: And we've got the infrastructure, and we can link that in, and we've looked at rolling out various other video technology to assist that. And I do wonder, and this has no evidence behind it, but I do wonder whether that capability, and that linking capability, will, potentially, either make it very clear that this is a highly-critical, time-critical infant, sorry, neonate, that needs to go, versus something that can actually wait, that's something that we can add to the system to add value.

I think there's issues or areas working through the north of the State, versus south of State, and in the consideration paper, you've quite rightly identified that, you know, that relationship with the northern hub and Darwin and the Northern Territory about having that - not hub and spoke, but potentially, having a north of the country go through to Darwin, and I think that's something that the system's looking at now.

I think we need to develop the technical expertise, which is what we probably are lacking on at the moment, so we're not the experts in that area at this stage, so that's an area that we would have to collaborate with people to actually get the right overview of that piece there. But I think the prioritisation piece and the eyes on are the two biggest tick items, from my - - -

BOSICH, MS: And I think they eyes on, and what we've learnt from ETS, is you don't have to have an ED specialist, you can teach and hold and provide advice on the run.

KENNEDY, DR: On the run.

BOSICH, MS: So we have got nurses and midwives and the equipment at site that, through guidance from the neonatologist, or the, you know, the NICU nurse, they're actually able to continue to provide good care and do rounding, making sure that baby's well-cared for until that retrieval service arrives. And that's the same for any of our patients, getting good eyes on, get early treatment, while we're waiting for transfer.

KENNEDY, DR: So, if you're sharing technologies and systems at a - you know - - -

BOSICH, MS: Yes.

KENNEDY, DR: - - - I always have to keep saying aeromedical, because half of what I'm talking about is not purely aeromedical, but it's the nature of the overlap between aeromedical practice and everything else, particularly what you're doing.

But the concept that the aeromedical service needs to have better overarching governance, and to have those decision points, et cetera, in it, do you see that as sensibly extending to have a mantle over other outreach work, like the NETS obstetrics. And so, could there be a common governance system? Could there be common approaches to clinical improvement, to communications, to training, to all of those sorts of things? Would you see that happening within a mantle that everybody could comfortably work within?

YEUNG, DR: I think that would be great. I think that vision would be fantastic. I think the challenge is, obviously, going to be getting the individual parties to realise that.

KENNEDY, DR: Yes.

YEUNG, DR: But I think the vehicle is there, the frameworks there.

KENNEDY, DR: And everybody's special and different, I understand.

YEUNG, DR: Yes.

KENNEDY, DR: The whole world's full of special and different.

YEUNG, DR: Yes.

KENNEDY, DR: But once they've been in the tent for long enough, they appreciate the - - -

YEUNG, DR: I think so, yes.

BOSICH, MS: There's a bunch of commonality.

KENNEDY, DR: Yes.

BOSICH, MS: There's a - we're all doing the same thing, and there's a lot of commonality.

KENNEDY, DR: Yes.

And reinventing becomes two years, eventually.

BOSICH, MS: And why would we go outside of a system that can be - yes.

KENNEDY, DR: Okay.

YEUNG, DR: And it - - -

KENNEDY, DR: Is there anything else that you wanted to raise before we finish?

So I just wanted to wrap up by thanking you for your attendance today at the hearing.

The 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 need to return the transcript to us within 10 days of the date of the covering letter or email, otherwise it will be deemed to be correct. And while you can't amend your evidence, if you would like to explain particular points in more detail, or present further information, you can provide this as an additional component to your submission to the Inquiry when you return the transcript.

I would remind you that I've requested, formally, for that document about the evaluation of the current trial. We'll communicate that to you in writing as well, so it is a formal request from the Inquiry. Once again, thanks very much for your attendance and for your input. It's been a considered presentation and very helpful engagement. Thank you.

YEUNG, DR: Thank you.