Aeromedical Services WA Inquiry – Formal Hearing Transcription
Inquirer: Dr Marcus Kennedy
Organisation: Clinical Excellence Division, Department of Health WA – Dr DJ Williamson
Date: 10 February 2022, Time: 1535 – 1604

KENNEDY, DR: Good afternoon.

WILLIAMSON, DR: Good afternoon.

KENNEDY, DR: You're settled?

WILLIAMSON, DR: Sorry?

KENNEDY, DR: You're settled?

WILLIAMSON, DR: I am. I am and I'm alone, my colleague was called to another meeting.

KENNEDY, DR: You're amongst friends. So, I'd just like to start by my thanking you for your interest in the inquiry and for your appearance at the hearing this afternoon. The purpose of the hearing 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. I've been appointed by the Chief Health Officer to undertake the inquiry. Beside me here is Jonathan Clayson who's the Inquiry's Project Director.

I just need you to be aware that the use of mobile phones and other recording devices is not permitted in this room and we'd ask you just to make sure that your phone's silent or switched off. The hearing is a formal procedure convened under part 15 of the Public Health Act 2016 and so although you are not 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 is false or misleading.

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

WILLIAMSON, DR: No, I think it's quite clear, thank you very much.

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

WILLIAMSON, DR: I'm Dr Duncan James Williamson, I'm the Assistant Director General in the Clinical Excellence Division of the Department of Health.

KENNEDY, DR: Thank you. So, I'll now invite you to address the focus considerations or other matters relevant to the inquiry from the document that's been provided to you or otherwise. It would be good if you could speak for up to 15 to 20 minutes. That can be in any format that you like in terms of - - -

WILLIAMSON, DR: Yes.

KENNEDY, DR: - - - addressing those issues. I'll try to let you speak without interruption, however, there may be things that I need to clarify that I don't understand. And then after you address I may ask additional questions depending on where we get to, so - - -

WILLIAMSON, DR: Sure.

KENNEDY, DR: - - - over to you.

WILLIAMSON, DR: Thank you very much for the opportunity to attend and present to the inquiry.

My focus is predominantly going to be on clinical issues and in particular patient safety and clinical quality. I thought I might start by just discussing the sort of patient journey that might be encountered and highlight some of the issues which can arise, which hopefully the 'future state' might address.

So obviously the patient journey for someone undergoing aeromedical retrieval can be extremely complex with multiple agencies involved. Each of which we are told has its own clinical governance and assurance mechanisms, but which are not necessarily transparent to the Department of Health, that's the entity contracting those services. We don't really have a mechanism of oversight of that, although there are some contractual obligations on the service to report and I'll come to that later on.

From our other work on clinical safety we're aware that the transfer of care is a particularly hazardous period whether that be, you know, from a hospital to a general practitioner or even within a hospital from one service to another. You can imagine with all of those individual transfers of care the overall risk rises exponentially in aeromedical retrieval - and the sort of patients who are being transferred are often particularly vulnerable. You know, they might have been in a road traffic accident or they might have been a mental health patient whose condition is deteriorating, though there are any number of scenarios that one might envisage.

Some of the issues which arise during the transfer of that patient include delays and in our systematic reviews of incidents which have arisen, in which you know, medical transport has featured, delays have been one of the contributing factors to adverse outcomes. The delays might be due to the availability or lack of availability of assets, planes, helicopters, whatever it happens to be, or it might be due to the lack of availability of beds. Those would be the common things.

In terms of the assets there are often competing priorities, and one of the issues the clinicians are concerned about is: who is setting those priorities and under what circumstances might those priorities be changed; and how would that change and priority be communicated. Another large area where, you know, bad things happen for want of a better phrase is when somebody deteriorates under clinical care, and the ability to recognise and response to acute deterioration is really one of the very important features of a functioning health system.

We have several examples where there's been a failure to recognise deterioration, a failure to escalate the priority, or to recognise that in the absence of the traditional asset, if that be a plane, then other mechanisms of transport might be engaged. We've had a particularly unfortunate incident where somebody could easily have been transferred by road from Bunbury but was awaiting a plane and waited too long. So that coordination, not just between the air carriers, but between the air and road transport providers, is absolutely critical, as you're obviously aware.

We have had incidents where the priority has been de-escalated, perhaps by RFDS, without that being communicated to the clinicians. Sometimes there's a suspicion this might be due to the availability of assets. By setting KPIs based on priorities and the ability to respond within set time frames, you can often get behaviours that are not necessarily patient-focused in order to meet those KPIs; so that's something that we are really conscious about.

We have several examples where, because of delays, a patient's mental health condition has deteriorated to the extent that their behaviour becomes unmanageable, in which case they have to be sedated, sometimes even anaesthetised and intubated, in order to facilitate transfer in a safe manner. I even have been told of an example where a patient had to be anaesthetised, was transferred to the metropolitan hospital, had to go directly to ICU, and was subsequently extubated and returned to the regional hospital without seeing the psychiatrist. So there are lots of opportunities to get things wrong, I think, in this scenario.

It might not be sedation, it might not be that severe, but there are quite often situations where delays precipitate aggressive, violent behaviour and physical restraint is required, which otherwise might not have been necessary. But I think all of this reflects that there's no clear line of sight. There's no common view or consistent view of where a patient is in that journey, although I think it has to be said that the individual services themselves have good command and control structures and often have got good situational awareness of their own particular patch.

Another aspect is inefficiencies that can arise. We often are reliant on police officers to assist with transfer of mental health patients where transport officers would suffice. So, there would be an opportunity to make that a much more efficient process and allow the police to get on with their job.
Inefficiencies in the use of doctors' time arise frequently. Doctors are very concerned that instead of the situation in South Australia, for instance, (where really there's a one-stop-shop that then takes responsibility for liaising and coordinating the transfer) our doctors, who are at the same time trying to facilitate the clinical care of a patient, are being pulled in three different directions to perhaps communicate with police, RFDS, and the distant metropolitan site, where they might get a junior doctor rather than somebody senior who can make a decision.

If delays are encountered, then often the patient might arise - might, sorry, arrive at their destination to find that that bed was no longer available. Or alternatively it's been the case that the destination has been changed on-route without the clinical staff being overtly aware of it. So, there are lots of issues around communication and that inability to actually see where the patient is at any given time.

Now, occasionally problems arise. We contractually require that our providers report the SAC 1 incidents, and they would be subject to a multi-site investigation. We do have guidelines on that. Generally, where that arises there's good cooperation from the different groups. There are sometimes issues about the availability of data, there's sometimes issues about the confidentiality of patient information, but generally speaking those investigations are done in the spirit of, you know, getting the best information.

But there are some issues around data, and in particular in WA where we do not have privacy and responsible data sharing legislation, and I think it would be useful just to clarify some of those grey areas.

Throughout all of this there's quite an emphasis on contract management rather than with a clinical view, and the contract managers, although they might be skilled in the particular area that they're required to address, don't have the clinical skill set to manage issues of clinical safety and clinical governance et cetera. The problem is there needs to be a broader of view of how that might be managed, and there certainly needs to be an assurance function to ensure that the relevant internal systems are present in the contracted organisations.

An overarching governance framework, whether or not you go for an external authority to provide that assurance function, is really what one would be looking for; and with a focus on the patient at the forefront of what you're trying to do and transparency about the data that you're analysing.

There are a few other issues with respect to patient safety that I'm aware of. You would have already heard from the Child and Adolescent Health Service, I think, and they have some specific areas around the neonatal emergency transfer service. There can be problems with compatibility of equipment, but I would let them speak in more detail about that.

I think I might pause there and allow you to ask me questions on any of the areas that have cropped up from your considerations.

KENNEDY, DR: Thank you very much. The issue around I suppose administration of contracts where it starts, which you spoke to, where there is a need for clinical assurance or verification of systems as opposed to eyeballing of indicators.

WILLIAMSON, DR: Yes.

KENNEDY, DR: How do you see that as working? Because at the moment the contracted administration system seems to be largely administrative as opposed to a clinical governance - - -

WILLIAMSON, DR: Yes.

KENNEDY, DR: - - - function.

WILLIAMSON, DR: Yes.

KENNEDY, DR: Which again, as you said, doesn't necessarily have the perspective that's required to really ensure that the things that matter from a patient safety and quality perspective are delivered.

WILLIAMSON, DR: Yes.

KENNEDY, DR: The matrices are fairly straightforward, response times are easy.

WILLIAMSON, DR: Yes.

KENNEDY, DR: But the rest of it.

WILLIAMSON, DR: Yes.

KENNEDY, DR: And how do you see that space as moving forward giving the - when you actually look at the contracts that are sitting in place at the moment that describe these functions, they're quite old.

WILLIAMSON, DR: Yes.

KENNEDY, DR: They are pre a lot of our new thinking about system safety and - - -

WILLIAMSON, DR: Yes.

KENNEDY, DR: - - - so on. How do you see that movement occurring and within what kind of structure of framework?

WILLIAMSON, DR: Yes, you know, internally within health we have our own clinical governance framework and that's broadly applicable, it's based on national guidelines. And I note that some of the organisations, I think it was RFDS, have actually begun to be accredited according to the national safety and quality guidelines, none of which are particularly well developed for Aeromedical Services it has to be said.

KENNEDY, DR: Correct.

WILLIAMSON, DR: And I think there is some work that could be done by the Commission, as an example, to develop another suite of standards around aeromedical retrieval. I'm sure they get bombarded with requests for the development standards for this group or that group. But a start has been made in Queensland. I think you would probably know - - -

KENNEDY, DR: Yes.

WILLIAMSON, DR: - - - more about it than I would.

In terms of how it would be managed, as I say, when we have our performance review meetings as System Manager with our HSPs, with which we have service agreements, there's equal weighting given to some of the performance and financial metrics as there is to the safety and quality metrics. What we have tried to do though is have more of a focus on using safety and quality KPIs and other sources of data for improvement rather than necessarily for assurance. I mean our real focus is on making things better and there are sometimes where it's better to have that honest discussion rather than a 'thou shalt do this' sort of approach to things.

I think there are a number of different models that could be trialled. I'm not very sure what's used in some of the other jurisdictions, which have been mentioned in your draft report here. I think you mentioned one in Canada, it was Ontario perhaps, or Queensland as well. So, I would have to have a look at what systems they've got in place, but I think our own clinical governance framework is a good start. And there are external accrediting bodies. Then I think with the agreement to actually share data and have a common view of the system, which I'm sure my colleague Robyn Lawrence will talk about, we could get at least 80 per cent or 90 per cent - - -

KENNEDY, DR: Yes.

WILLIAMSON, DR: - - - of the way to achieving that.

KENNEDY, DR: Yes. As you said, a considerable part of the challenge is the ability to have a process within the system that allows for monitoring of the patient journey really from beginning to end.

WILLIAMSON, DR: Yes.

KENNEDY, DR: And by journey, I mean the bits that happen before they actually move as well.

WILLIAMSON, DR: Yes.

KENNEDY, DR: What's been proposed in different ways in the considerations paper is some form of body which is, you know, a central coordinating collaborative space where the relevant providers or facilitators of that journey work together - - -

WILLIAMSON, DR: Yes.

KENNEDY, DR: - - - share knowledge and streamline decision making. Do you have any particular feeling in terms of how that could look, where it could sit on its relationships to the system might be?

WILLIAMSON, DR: I don't think - well, its geographic location is more or less not important. In terms of how it would organisationally sit, then there has been discussion about having external groups. I think this could be organised at a contractual level. As the funder of the service I think WA Health should actually have the lead role in this.

KENNEDY, DR: Yes.

WILLIAMSON, DR: I am aware that some of the other groups have got other priorities; they have other contracts with other providers as well, and sometimes that can be a conflict. But it would seem to me that when we're talking about patients who are being transferred to and from our facilities essentially, I think WA Health should have the lead in that. We're not the experts, that is the WA Health system is not the expert in, the pre-hospital aspects of this.

KENNEDY, DR: Sure.

WILLIAMSON, DR: So, it's not as if we want to necessarily take over all of that decision making. But I think anything that would add to the communication and particularly changes in prioritisation and actually knowing where the patient is, and where the assets are in relationship to that patient. Sometimes decisions are made by one body which are uninformed by really good advice that could be shared by the other so, yes.

KENNEDY, DR: Yes. Yes, so although health is not, as you say, the expert body in terms of the aeromedical system is the expert and the responsible body in terms of systems management for patient care, so - - -

WILLIAMSON, DR: Yes.

KENNEDY, DR: - - - that connection makes sense obviously. From the point of view guidelines and standards within aeromedical systems did you have any particular thoughts

beyond what has been included? We obviously have referenced that within the considerations paper and many people have spoken to the need for commonality.

WILLIAMSON, DR: Yes.

KENNEDY, DR: Particularly with multiple service providers and multiple regions with different geographical and infrastructure challenges.

WILLIAMSON, DR: Yes.

KENNEDY, DR: Did you have - - -

WILLIAMSON, DR: Well, to be honest I haven't gone to look at other jurisdictions and what they have in place, and I would have thought that the Commission, essentially being responsible for setting up the standards, would be the natural place for this to sit, but they would presumably contract that to relevant expertise. There are a number of standards which would fit - and I'm talking particularly about the clinical standards here, not so much about those which you'd have to have through CASA or some other organisation.

KENNEDY, DR: Aviation standards I think - - -

WILLIAMSON, DR: Yes.

KENNEDY, DR: - - - are covered pretty comprehensively.

WILLIAMSON, DR: Yes, yes. So that would be where I would look in the first instance. And, as I say, when I look through the national standards as they apply to hospitals, you know, you've got clinical governance, you've got infection prevention control, medication management, communication, blood management, recognising and responding to clinical deterioration and that overarching comprehensive care one, which actually takes in the whole patient journey and transfers of care. That's a very good starting point. There will be other elements that you might like to specifically tease out, which relate to aeromedical retrievals, but that would be the way I would be looking at it.

KENNEDY, DR: Yes.

WILLIAMSON, DR: You know, you might look at joint prioritisation or, you know, how the organisations work together and putting some metrics around that.

KENNEDY, DR: Yes, I think the headings are correct, it's the subheadings that - - -

WILLIAMSON, DR: Yes, yes.

KENNEDY, DR: - - - require work and it is a challenge - - -

WILLIAMSON, DR: Yes.

KENNEDY, DR: - - - which, you know, I am aware that there's been some lobbying of the Commission at different times but, as you say, you know, whether it's day hospitals, endoscopy services, whatever it might be - - -

WILLIAMSON, DR: Yes.

KENNEDY, DR: - - - everybody wants their own set of standards. But I think the environment in the aeromedical setting is quite peculiar and - - -

WILLIAMSON, DR: Yes.

KENNEDY, DR: - - - the emphasis is different. And that doesn't mean that you would need necessarily new or more standards but, for instance, the emphasis on communication is absolutely number 1 really.

WILLIAMSON, DR: Yes. Well, communications become a lot easier these days, you know, and I think you're right in saying, look, if anywhere needs these to be put in place it's Australia with its geographic challenges and remote areas.

KENNEDY, DR: I was impressed by your considered discussion of the issues and problems in terms of delay and prioritisation and I think that shows that clearly, you've given great thought to and have some good understanding of this whole space. Are there any other particular issues that you think, particularly, you know, from a clinical excellence or systems, quality and safety perspective we should be keeping in mind?

WILLIAMSON, DR: Yes, well, I suppose one of the other pillars of clinical governance is the ability to partner with your consumers. We do get consumer feedback, complaints management is often what's referred to, but really we should be looking at co-designing some of our systems as well, so when we do think about what is required we should be working with the communities and understanding what their needs are. Often the best outcome is not to transfer.

KENNEDY, DR: Can be.

WILLIAMSON, DR: Often the best outcome is to actually repatriate someone from one of the metropolitan hospitals to the local community at an early stage and yet those are the ones that tend to be prioritised last. So, I think having that sort of consumer focus in what we subsequently design would be really important.

KENNEDY, DR: Yes. I think the other consideration in that space is to look on the referring practitioner as a consumer quite often rather than a colleague. Essentially, they are trying to articulate with your service to receive a service.

WILLIAMSON, DR: Yes.

KENNEDY, DR: And the importance of how well that works, well, this is very fundamental. One of the areas which has been a mainstay of mature aeromedical practices is clinical audit in terms of the ability, particularly in quite regimented settings where local data capture is often quite good to then be able to critically analyse a series or thematic clinical issues. Is that something that your area has particular oversight on and provides guidance for WA?

WILLIAMSON, DR: Yes. So, we conduct a number of routine audits and are involved in oversight in those routine audits, and we will commission specific audits where a particular problem arises.

You know, it might be to do with sepsis. Probably one of the most well-known initiatives that we have here is our surgical audit, which James Aitken introduced and which is now being taken up more broadly across Australia, where surgeons investigate the deaths associated with surgical practice. As a result of that methodical approach over a number of years we've seen significant improvements in surgical practice and seen significant reductions in complications and deaths. So, yes, we're very much involved in that.

And, of course, there's the State Trauma Committee as well, which - - -

KENNEDY, DR: Yes.

WILLIAMSON, DR: - - - has a particular focus on trauma and auditing trauma outcomes.

KENNEDY, DR: The greatest value I think in audit and case review is in the sharing of the knowledge that comes from that. How do you or how does your system facilitate that and how could that work in the scenario of the Aeromedical - - -

WILLIAMSON, DR: Right.

KENNEDY, DR: - - - Service where you've got multiple providers?

WILLIAMSON, DR: Yes.

KENNEDY, DR: Sometimes some touchiness around the borders, sometimes some reluctance about - - -

WILLIAMSON, DR: Yes.

KENNEDY, DR: - - - the dirtiness of your own linen in public places. You know, people are very sensitive about these kinds of conversations in a - - -

WILLIAMSON, DR: Yes.

KENNEDY, DR: - - - competitive and a contractual environment. How can you facilitate that?

WILLIAMSON, DR: Yes, so there are a couple of comments I'd make about that. The first going back to the surgical audit; I mean the way that that's done is the individual surgeon's outcomes are fed back to him. In other words, all of the data is provided, and that individual surgeon's performance is actually highlighted to the individual, but not to everybody else, so they can see where they rank against their colleagues. Applicable also in terms of surgical site infections, re-operation rates or in the case of death what the contributory factors were to that death.

So that would be the sort of traditional way. Similarly, in orthopaedic practice where joint replacements are done, there's feedback to individual surgeons where their performance is identified in relationship to their peers, but obviously they don't identify all the peers. The other example would be the health round table, which is a suite of indicators, which each of our HSPs subscribes to, and in that situation the hospitals are - well, certainly in the initial stages - deidentified: they were given a code, which the hospital would know but not everybody else. But, of course, everybody became aware of what the codes were.

KENNEDY, DR: Yes.

WILLIAMSON, DR: And what's happened now is that almost all of the hospitals have asked to be identified as there's much more openness in the - - -

KENNEDY, DR: Yes.

WILLIAMSON, DR: - - - sharing of that information. And then finally, WACHS is trialling some software that's being used quite widely in the NHS, which not only facilitates clinical audit but allows the sharing of those learnings between different units within WACHS, but it could potentially be within different areas across a broader - - -

KENNEDY, DR: Okay.

WILLIAMSON, DR: a broader group of organisations.

KENNEDY, DR: Thank you. I think we're drawing to the end of our time, so I would like to thank you for your considered preparation for today, you've clearly turned your mind to it, and it's been a very helpful contribution, so thank you for that.

The transcript of this 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 the transcript to us within 10 works days of the date of the covering letter or email otherwise we will assume that it's correct.

And while you cannot amend your evidence, if you would like to explain particular points in any more detail or present further information, you would be quite welcome to do that and provide it as an addition to the submission. We're always happy to receive more information. So that draws to an end this part of the hearing and again, thank you very much for your assistance and we'll let you get back to your very busy day job I'm sure.

WILLIAMSON, DR: Thanks very much.

KENNEDY, DR: Thank you.