Aeromedical Services WA Inquiry – Formal Hearing Transcription
Inquirer: Dr Marcus Kennedy
Organisation: East Metropolitan Health Service – Ms E MacLeod,
Dr D McCoubrie, Dr G Waterer
Date: 10 February 2022, Time: 1340 - 1408

KENNEDY, DR: Thank you for your interest in the inquiry and for your appearance at today's hearing and I'm sure it's a busy week for you.

The purpose of the hearing is to assist me in gathering evidence in 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 this inquiry. Beside me is Jonathan Clayson who's the Inquiry's Project Director.

We need to make you aware that the use of mobile phones and other recording devices is not permitted in this room and we ask that you 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 and 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. So far that hasn't happened.

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 proceedings today, 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, a focus list of relevant considerations and information on giving evidence to the inquiry. Before we begin do you have any questions about the procedure this afternoon?

MacLEOD, MS: I don't.

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

MacLEOD, MS: Elizabeth MacLeod, Chief Executive Officer East Metropolitan Health Service.

McCOUBRIE, DR: David McCoubrie, Director of Emergency Medicine at Royal Perth Hospital.

WATERER, DR: Grant Waterer, Director of Clinical Services East Metropolitan Health Service and Royal Perth Bentley Group.

KENNEDY, DR: Thank you. We'll now invite you to address the focus considerations list that's been provided to you in whatever format you choose and you may speak to these matters for up to 15 to 20 minutes and then after your address I may ask additional questions depending on where we get to. But I will try not to interrupt you during that presentation unless there's issues that I don't understand. Thank you.

MacLEOD, MS: Thank you. So just by way of starting we would agree that there is a lack of an integrated State-wide system and policy and framework around the management of Aeromedical Services and associated with that probably a lack of clarity as to the governance structures that would be in place to support that. I think from an East Metropolitan Health Service perspective our primary role in the Aeromedical Services is the receipt of patients

coming into Royal Perth Hospital. And I think our - so our evidence would be limited in terms of - and comments would be limited really into that - our roles to date.

So, I think from obviously having some level of plan from an Aeromedical Services perspective with an articulation of governance and associated matrix would be of benefit to the State and to the services. I think the other bit we would just like to comment on is around - probably around the reference to an operation centre being used as one of those supporting infrastructure mechanisms.
Whilst acknowledging the need to have some level of coordination we would have concerns around a scope of an operation centre and perhaps some of the negative consequences that that might have from the Metropolitan Health Services and the broader health services that we deliver.

Obviously, the Aeromedical Services in our world is a relatively small component of our day to day business. The majority of the business that we manage is obviously involving a lot of patient logistics, interaction and movement. Having an external to our health service operation centre, if it weren't worked through really diligently, and with a lot of consideration it may, in fact, have a negative impact on the bulk of our business, so we'd just exercise some caution into that space.

I'll ask my colleagues perhaps from their perspective to give any other comments.

WATERER, DR: So again, I think with - and it's particularly I guess with regard to item 86 in terms of a centralised system as someone who's been a senior medical executive for going on nine years one week in eight where I perform the role of the State Ambulance Distribution Coordinator and all of our medical executives, senior medical executives do that. It is a normal state of affairs now to have no intensive care beds available in Perth and to have no beds available. And what I would say is that it's true that 90 per cent of the time patients do flow through normal mechanisms well but the anecdotes of - are having difficulty are clearly true.

However, a centralised system won't solve that because the issue is that when you have no intensive care beds ultimately it gets escalated to someone like me and it becomes a case of which key surgery do we cancel, who do we take out of intensive care, and allow a much higher risk for that person in order to fit someone else in. Where can we shuffle patients between intensive care units, which then requires at my level a lot of negotiation with the equivalence in my hospitals. There's no way that someone without my level of authority and experience can make those decisions otherwise what happens is you'll have a patient turn up into an already overloaded system and dramatically increase risk for everybody else who need those resources.

So while we would certainly support, as Liz has said, you know, a coordinated system in terms of who does the retrieval and all of that, the idea that some centralised process can arbitrarily just solve the problem by going this patient's going to Sir Charles Gairdner or this patient is going to Royal Perth. The reality is it takes someone like me sometimes a couple of hours to sort through that and people like me are not going to staff a centre like that for something that happens two times a week.

So, there is already a mechanism in place, it's called the State Ambulance Distribution Coordinator. And so perhaps it's more around visibility or notification of when there is a problem, so that it can be escalated to someone like me faster rather than trying to create

another mechanism that frankly can't work because it does not have and will not have the ability to solve our lack of bed problem.

McCOUBRIE, DR: Thank you. Just a couple of remarks from the perspective of an emergency department tertiary hospital. I think over time it has been confusing for frontline staff to watch the way the system has sort of been evolving and I say "Confusing" because we're unclear as to what the actual overall vision for Aeromedical Services in Western Australia is and so we actually welcome the inquiry for that reason.
Over the years we've seen the introduction of helicopter services and the interesting decision around medical staff of secondaries versus not for primaries and then the advent now of additional helicopters hitting the system through the Royal Flying Doctor Service. So, I guess from an end user perspective navigating that and understanding the vision or the strategic priorities there ought to be planning to integrate those. For us, you know, it would be great value to have that in place.

I think there's another issue too about - and certainly retrieval medicine is a branch of emergency medicine in many states and jurisdictions and intensive care within that domain we are aware that we've lost numerous consultants over the years who wanted to specialise in specifically in aeromedical retrieval involved both integrated service and fixed wing and we've watched them move interstate because of that unclear vision of where this State is headed in terms of the development of its service. So, thank you.

MacLEOD, MS: So, some of the other points probably just in terms of consideration. The considerations raise the issue around the repatriation, so I think certainly that is an issue from the Metropolitan Health Service perspective about getting patients back. And I think, as you've quite rightly noted in your paper there, the siloed arrangements can make that very difficult in terms of a timely transfer back, which is again making the capacity available.

I think the other just from a probably supporting infrastructure perspective the sharing of information and those - and the ability to have those handovers infrastructure and all of those things that would come I think if there was a stronger governance and clarity of roles between the different organisations that probably would assist as we've found in a lot of other things. You need often the supporting infrastructure as well.

And the last one is really just around raising mental health and probably the intricacies associated with the transfer of mental health consumers, which I'm sure you're going to pick up as well. But anecdotally we certainly hear that that's even more complex than the other transfers.

KENNEDY, DR: Thank you. Major trauma did you have anything that you wish to address or speak about from an aeromedical perspective?

WATERER, DR: Actually, I think relationships are very good between the State Trauma Service and aeromedical retrieval, they do a lot of joint exercises. It works well, so I don't think with respect to that we have any concerns at all.

MacLEOD, MS: And I suppose just perhaps as part of this and as we always look to improve some things making sure there are no unintended consequences on the things that are actually working well. I think the State Trauma Service actually in association with DFES provides a really good service and we would want to ensure that isn't impacted negatively in any way.

MacLEOD, MS: Correct.

KENNEDY, DR: So, with respect it's an interesting thing the concept of unintended consequences. It's a phrase which I barely understood until I came to Western Australia, but it's raised in every second conversation that I've had involved in this. What do you mean by "Unintended consequences"?

Because to me that's a term that - can you explain what you think could happen?

MacLEOD, MS: If we put in place governance structures that might change the way DFES worked say and had then meant that there was different processes and additional steps that might be put in place as part of this a broader aeromedical service but actually elongated the transfer time for our trauma patients that are actually arriving. So, things work well and so I wouldn't want to have processes that then made things not work as well as they currently do. I think we would say we provide a high-quality trauma service that we would want to maintain.

KENNEDY, DR: So specifically, are there any issues within the consideration papers that have come up that may suggest to you that we would be at risk of these unintended or unseen or unforeseen consequences?

WATERER, DR: So I think the concept of an operation centre that might dictate to the hospitals that you will take this patient without the kind of due consideration that ultimately leads - means to someone to me about how you balance the risk. You could end up with more harm from all the other patients who also need access to intensive care because this frankly is a daily issue for us of how we balance our need. These patients are important but there are other important patients as well and in trying to decide which hospital should take those patients there's a very high level of discussion and consideration and balance of risk. Creating another system that would attempt to bypass that could have quite significant unintended consequences to other people who need to access those services.

KENNEDY, DR: So the likelihood of your unintended consequences is based on your implicit assumption and that is that any coordination centre would bypass existing safety valves and I think that's something that obviously in the spirit of systems improvement you would obviously try to avoid. The issue of coordination, if I can ask you a question that is outside of the absolutely critical scenario that you're talking about, which is an uncommon event twice a week, as you've said, and think of it in terms of the referring clinician who typically will spend two hours trying to find a bed for a patient whilst they're the only care provider in a remote and austere environment.

It's a different story I think you'll agree in terms of what a coordination centre can offer that clinician and that patient as opposed to the occasional episode that you've referred to. Is that fair?

WATERER, DR: I think it's in part fair it is difficult for clinicians. Having said that our own clinicians face the same barrier trying to get patients into our hospitals when we have no beds, so it would not be unusual for my clinicians in my hospital to spend a number of hours trying to negotiate how to get patients in. I think again, it is reasonable to want to have a process whereby perhaps some of all that negotiating is taken out of the clinician's hands but equally to make sensible decisions.

Ultimately, you do need a level of clinical information that can only come from that clinician, so there will have to be a number of two-way conversations to try and really determine what is that patient's need against potentially the other five or six patients that everyone's also trying to get in.

So there is no what that you will be able to divorce the clinician from part of the process because there's got to be two-way clinical handover between clinicians to be able to make those kind of decisions about where should the patient go.

McCOUBRIE, DR: I couldn't agree with you more.

MacLEOD, MS: And I don't think we would disagree about improving the coordination from the sending site and we hear and, you know, we have a lot of sympathy for our colleagues and obviously from a patient outcome perspective. But it's just being careful I suppose around that level of coordination and the extent of it into the rest of our business.

KENNEDY, DR: Absolutely.

McCOUBRIE, DR: Maybe if I can make a comment on that as well and having worked, well, I do work at WACHS sites I've experienced - the experience of referring both my own hospital and other tertiary hospitals in Perth. I think the WACHS Linkages Project did define those pathways quite well for us when working in regional Western Australia. I guess the issue is or pointing out the anecdote refers to the circumstance where for whatever reason beds are not available. And I think there are operational processes through which both managerial and clinical staff ought to set reasonable boundaries for determination of that. And certainly, in the context of trauma, like we mentioned before, we don't block the flow of trauma, that does not occur. And so there are - I'm sure there are managerial principles that could be put in place to limit that unfortunate example of people waiting multiple hours and multiple phone calls to get multiple, you know, looking for a bed, for example.

WATERER, DR: When you try to put things into perspective, just yesterday I had 17 patients awaiting transfer into Royal Perth Hospital from other hospitals, including the country, that we couldn't find beds for. That is a normal day for us.

KENNEDY, DR: Yes, no, I understand. And I don't think that any system around aeromedical coordination can even aspire to be involved in that space. You know, I think there's clearly a degree of standard transfer mechanisms which exist work as well as they can, given everybody's limited resources. And which have got, you know, an organic flavour and you've got a history of pre-existing systems and policies around them, which continue.

However, I think there is when you look at the aeromedical environment a particular challenge in terms of managing the combination of events that go to be a case from the austere environment in which the patient is, the limited resources available to clinicians, the complexity of queuing and logistics around the response, you know, a plane may be available now but not available in six hours, all of those sorts of things have to get factored into it. And then in as much as the aeromedical system can't have stresses in your system you cannot be aware of the stresses in that system.

So the concept of the coordination is really collaboration and in as much as it's around the aeromedical process, so collaboration between the various providers and St Johns and

WACHS et cetera collaboration across the interface between that movement and the receiving hospitals is also the kind of concept that we're talking about in terms of how that could function.

WATERER, DR: I would agree with that. I just would say that I think that the administrative processes tend to just become ingrained and often, you know, if the clinician talks to someone like me directly and I can understand the clinical scenario on the ground, then we make decisions much faster. I mean and usually I think it is about a process of when there is bed block how do you get to someone like me who can then solve the problem, that is what's needed. Because if I can talk to a clinician directly and understand them and then if, you know, the decision is, well, I don't want your patient right now and this is why at least I can explain why. And it's all about relative balance.

McCOUBRIE, DR: If I could just make a comment as well. I think when you make a referral from a remote site at the moment I think it's very, very clear that already in terms of transparency around why RFDS is not available to pick your patient up because it's critical for service delivery at your regional sites to determine timing of such transfers. And more commonly rather than bed availability I think the more common scenario is, in fact, plane availability and those logistics. And you could get representations I'm certain from WACHS to give you some data on that.

And I guess the point being that in an overall governance structure determining resourcing to ensure those response times are as optimal as possible would be good and advantageous.

KENNEDY, DR: Okay. Any other thoughts or questions?

MacLEOD, MS: Well, I think just in summary I think there is a lot of coordination needed between the parties and, you know, I think we would support that in terms of the commentary that you made. So the discussion on our end around the coordination centre and what that looks like from the Metropolitan end we've obviously got some concerns but from the patient end up to when they arrive I absolutely think having some coordination, clarity, good governance I think would be very beneficial. Good governance across them all. I think they've all got good governance within but governance across the whole service.

KENNEDY, DR: Yes.

MacLEOD, MS: Yes.

KENNEDY, DR: And the lot of interfaces there where good governance gets tested.

MacLEOD, MS: Yes.

KENNEDY, DR: And sometimes things aren't seen. I guess just from an operations centre perspective I don't want to kind of try and talk you into a particular way of thinking or a particular view but you would be aware that in every State in Australia there is to one degree or other a coordination centre for aeromedical and like services. So I think some of - I guess what I would like to reassure you about is that I think some of the fears that you have expressed, which are partly about, you know, controlling the system and partly about managing the system as well as you, you know, are committed to manage it.

There are multiple examples across many jurisdictions where this space has been moved along and as long as what goes into that space of a coordination centre adds value to the equation and to the patient journey, then it's not necessarily something to be feared.

MacLEOD, MS: I appreciate that. I think just from - I'm not sure if you're aware, the State Health Operation Centre the SHOC has been spoken about.

KENNEDY, DR: Yes, yes.

MacLEOD, MS: And the current scope or a recent scope was much broader than what you're talking around in the context. So, I think our concerns are raised from a scope that wasn't what we'd agreed to.

KENNEDY, DR: Yes.

MacLEOD, MS: Yes, so I think we come with probably a little bit of concern around something that's been proposed before, not by - not in relation to this issue. So, it would be - yes, so I appreciate if we probably came in with a clean slate about it we might be having a different conversation.

KENNEDY, DR: You've been tainted by SHOC.

MacLEOD, MS: We have. We are SHOCed.

KENNEDY, DR: You have a view on it. I think the - you know, that's fair and it's good for me to appreciate that that's - - -

MacLEOD, MS: Yes.

KENNEDY, DR: - - - where your perspective is from. Because I think the - you know, clearly what, you know, SHOC may or may not be part of equation that relates to Aeromedical Services and how the coordination of that happens. However, there is a sensibility, if you're going to have a coordination centre, which is basically a collaborative space where all of the service providers make things happen in the smoothest possible way, you know, it's going to be beyond just Aeromedical Services because there's road links to the end of every case, there's the outreach components to it, and then there's the destination planning, which is where it starts to get into your SHOC concerns I think.

MacLEOD, MS: And I suppose then it becomes the question of is it just for country patients or is then for all metropolitan patients as well.

KENNEDY, DR: Yes, well - - -

MacLEOD, MS: And it becomes - - -

KENNEDY, DR: - - - from an aeromedical point of view the - - -

MacLEOD, MS: Yes.

KENNEDY, DR: - - - the city patients are not of much interest.

WATERER, DR: I would just also - - -

KENNEDY, DR: There will be the odd few I'm sure but - - -

MacLEOD, MS: No, but that's I think where the scope - - -

KENNEDY, DR: Yes.

MacLEOD, MS: - - - of it can become - - -

KENNEDY, DR: Of course.

MacLEOD, MS: Yes, that not just a creep I would think a fairly rapid race in terms of scope.

KENNEDY, DR: And that's certainly not - - -

MacLEOD, MS: Yes.

KENNEDY, DR: - - - the kind of thinking that is part of this.

MacLEOD, MS: Yes.

KENNEDY, DR: And I'm thinking from an aeromedical systems perspective, that's not Aeromedical Services, that's - - -

MacLEOD, MS: Yes.

KENNEDY, DR: - - - a different beast. And, yes, I will share some of your concerns about how that can be made to work. It's very, very difficult.

WATERER, DR: And just to reiterate something that Liz said before, that there has to be equal priority on getting patients back.

KENNEDY, DR: Absolutely.

WATERER, DR: Every patient that we keep for a few extra days is patients we can't get in who need our care. And at the moment it is very clear that it is not prioritised the same as coming in.

KENNEDY, DR: Yes, I think there are very different perspectives around urgency and the urgency for back transfer to me is all about the next elective patient that's not going to get their procedure done.

MacLEOD, MS: Correct.

KENNEDY, DR: And who may have a fall in the meantime and end up dead, you know, who knows. The response time for mental health patients is often not seen in the same triage priority as it is for, you know, more organic type of issues but we know that delays mean bad outcomes.

MacLEOD, MS: I think the extra challenge with mental health, if I can, is that we've probably got a really quite significant shortage of beds.

KENNEDY, DR: Yes.

MacLEOD, MS: So, we would have people waiting in our emergency departments.

KENNEDY, DR: Yes.

MacLEOD, MS: It would not be uncommon unfortunately for people to be in our emergency departments for over 24 hours and there have been longer waiting for a bed. So, I think there are more other compounding issues in terms of the mental health transport of patients.

KENNEDY, DR: Yes.

MacLEOD, MS: Yes, so we have come to an agreement with WACHS for a cohort of patients that come in ready or not. So we've agreed just to accept those ones that they really can't care for and we will make sure if they're even in our - no disrespect, David, but even in our EDs rather than our mental health units they're receiving the right level of care. But you're right, the level of - the ability for us to be able to respond appropriately with getting a mental health bed is something that would be of concern. Yes, absolutely.

KENNEDY, DR: It would be lovely if you could just have the extra beds that were necessary for that cohort of patients. But, yes, you're right, in an aeromedical sense you're getting back to the question of, you know, is it better to sedate and/or even intubate a patient for transfer in that scenario and bring them to somewhere which really doesn't have the capacity to deal with them. Or would it be better to have what's second best, so you haven't got a bed but what's second best might be the better delivery of outreach care of a different shape that we haven't invented yet. That's probably beyond aeromedicine although aeromedicine's very tied up to that outreach concept and every aeromedical transfer has an outreach component where there's a period of time before you get there.

Okay, I think I have - I'm not meant to talk, I'm meant to listen, so sorry. But at this time of the afternoon sometimes you just have to engage a bit more. Is there anything else finally that you wanted to raise? Okay, in that case I'll just finish by thanking you for your attendance at today's meeting. There will be a transcript of the hearing 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 within 10 works days of the date of the covering letter or email otherwise it will be deemed to be correct.

While you cannot amend your evidence, if you would like to explain particular points in any more detail or present further information you can provide that as an addition to your submission to the inquiry when you return the transcript.

So that's the end of the proceedings and I'd just like to thank you again for coming in in a busy week and providing that information and your perspectives, so thank you very much.

MacLEOD, MS: Thank you for the opportunity. Thank you.

WATERER, DR: Thank you.