Aeromedical Services WA Inquiry – Formal Hearing Transcription
Inquirer: Dr Marcus Kennedy
Organisation: WA Country Health Service – Mr J Moffet, Mr T McKimmie, Dr J Yeung, Ms K Bosich
Date: 10 February 2022, Time: 1017 - 1140

KENNEDY, DR: Thank you. I'd like to thank you for your interest in the Inquiry and for your appearance at today's hearing. The purpose of the hearing is to assist me in gathering evidence for the Inquiry into aeromedical services in Western Australia.

I'll begin by introducing myself, my name is Marcus Kennedy, and I have been appointed by the Chief Health Officer, to undertake the Inquiry. And beside me is Jonathan Clayson, the Inquiry's Project Director. Please be aware that the use of mobile phones and other recording devices is not permitted in this room, and please make sure that your phone is on silent or switched off.

The hearing is a formal procedure convened under part 15 of the Public Health Act 2016, and while you are not being asked to give your evidence under oath or affirmation, it's important that you understand that you must answer all questions and that there are penalties under the Act for knowingly providing a response or information that is false or misleading.

It's a public hearing and a transcript of your evidence will be made for the public record. If you wish to make confidential statements during today's proceedings, you should request that that part of your evidence may be taken in private. You've previously been provided with the Inquiry's terms of reference, the Inquiry's current state considerations paper, a focused list of relevant considerations and information on giving evidence to the Inquiry. Before we begin, do you have any questions about today's hearing and the way that it will be conducted?

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

MOFFET, MR: I'll start with me, Jeffrey - - -

KENNEDY, DR: Starting - - -

MOFFET, MR: - - - Moffet, Chief Executive, WA Country Health Service.

McKIMMIE, MR: Tim McKimmie, I'm the Director of Procurement and Contract Management for WA Country Health Service.

YEUNG, DR: Justin Yeung, Medical Director, WACHS Command Centre and Lead for Acute Patient Transfer Coordination.

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

KENNEDY, DR: Thank you.

You are now invited to address the focused considerations list that's been provided to you, and I would envisage that you may wish to speak to these for up to 45 to 60 minutes, which would leave us another 30 minutes for specific questions which I may ask, and then, any remaining time that's available, we may open for more general matters, if you have further to raise.
So over to you, and I'll try to interrupt you as little as possible for this initial period, where I'd encourage you to address the considerations paper and other matters, if you wish.

MOFFET, MR: Thank you.

So, I'll just maybe do some opening statements. I'm presuming you'll probably have questions for us - directed questions. We do have, I guess, a fair bit of commentary to work through. I'm not sure what format you'd like to do that, I will just start with an opening statement, perhaps, and we'll see where we go from there. So, thank you - first of all, thank you for the opportunity to appear. We did provide previous responses to the questions, which, I think, in part, have formed the considerations for the discussions amongst all the other submissions, no doubt, you received.

Just in general, so - I mean, WA - Western Australia is quite unique as a State. We talk about health in an aeromedical context in a number of ways. You know, we're obviously a third of the country's land mass. It's an enormous challenge for health service delivery. We have a very highly disbursed population and also a very centralised population in Perth, so our regional district and small centres are traditionally or typically, much more than the east coast of Australia - Queensland, New South Wales and Victoria, for example, a little more typical of South Australia, but obviously, on a much larger scale.

We have a lot of hospitals - 80 hospitals in country WA, 50 of those, small hospitals, scattered right through the State, from the Kimberley through to the Great Southern and the South West. Those hospitals vary in their capability, so we operate within a clinical services framework, as you would be familiar, which is a 1-6 scale, broadly, for a whole range of services.

And we, generally, in our regional centres - there are six regional centres that a provide a level 4 and sometimes 5 service, so essentially, secondary services - general surgical services, general medicine, psychiatry and those sorts of services. Our district hospitals provide a level 3 to 4 service, and our small hospitals are level 2 to 3 services. So, there's a scale of capability. And what that means is we end up doing a lot of transport. So, for any secondary care from small towns that's required, if it's not of a fairly low acuity nature or if it's surgical or obstetrics, for example, or mental health, it involves, at least, a regional transfer and sometimes, a metropolitan transfer. And I think you've seen the respective volumes of those, a lot of regional as well as metropolitan based transfers occurring.

Similarly, with our district hospitals and then, our regional hospitals, whilst we've got good clinical capability for tertiary and quaternary level care, there is a lot of transfer to Perth. So, they - and those - I guess, the services have evolved a lot. One of the features, I guess, that's quite prominent in WA is the services that have evolved and grown from the ground up. So the small hospitals - in fact, all of our hospitals were almost exclusively built by roads boards in the early days of settlement of the State, operated, really, by communities, and during the 1900s, progressively transferred to government for all sorts of reasons.

But there is - I guess the point around that is there's very significant community investment and ownership, and the journey's been very similar with transport - patient transport providers as well, perhaps even more so. So RFDS evolving out of the remote hospital environment and the St John Ambulance, out of local community need. And to this day, the road-based ambulance services through St John's have very strong community ownership and involvement through a very large volunteer system.

So I guess that context provides some of the - I think, the broader observations you've made as the Inquirer, in relation to the different entities, that we don't have a State-based health service provider or a State-based service that is patient transport specific, unlike significant other services in the jurisdictions, where the State is owning and running the service by direct employment.

We have our transport arrangements, primarily, through the Royal Flying Doctor Service, aeromedically, DFES also providing, as a State government, some rotary wing services, and with St John's supporting those rotary wing services clinically as well as road-based services. So, it's a very - it's different to many other jurisdictions. And there's significant benefits with that.

There's also, you know, significant issues around us having separateness as well of both health service providers and transport providers and making sure the coordination works well for patients. But there's - it's a very rich and deep history in WA about service provision that we're very proud of, very high-quality services, a lot of recent investment and growth.

Obviously, more investment as the Inquiry has observed, is required, and we would say, in road transport as well. We've developed an ambulance strategy - a Country Ambulance Strategy that very much centres on the need for some big things to happen around legislation, policy and I guess, some mandate around service provision - I'll talk to that a little later, but importantly, that, you know, volunteers and volunteerism in the State needs much more support and a lot more investment.

And we've seen some investment since the endorsement of that strategy by government. Two years ago, we've seen around $50 million in additional funding starting to flow through to country ambulance, and in fact, over the last couple of years, we've invested an additional - around $12 million in aeromedical services as well. And that's been complemented by significant investment by RFDS and their own assets through jets and more recently, through the purchase of some rotary assets as well. The environment, I suppose, is really relevant for healthcare, I think - hospitals as well as, you know, the patient transport and patient transfer scene. Increased demand has been a feature of our system, you know, like most of Australia, for a long time.

But the last two years, in particular, have seen an extraordinary increase in demand, as our borders have meant that holidaying inside the State has been the form of vocation, really, for families, and so we've seen a huge growth in - an unprecedented growth, really, in terms of hospital activity, particularly, emergency department activity and commensurate transport demand requirements from road ambulance as well as air ambulance. So the increase in demand has been very significant and remains, to this day - and obviously, we - you know, we're looking at probably further increased demand over the next few months.

Our increased technology capability, I think, is another factor that's changing our thinking and behaviour. As an organisation, WA Country Health has started a - I guess, over the last 10 years, we've been growing our virtual capability to support our clinicians in those remote hospitals. Many of those services are nurse led initially, particularly in terms of emergency care in those small hospitals, so we have used technology, and all that it offers us, to deliver virtual support in real time around emergency care, mental healthcare, in-patient care and just recently, obstetric care, which is a service we've just started.

That extends as well to transport providers, and it's obviously - I think it implores us, as well as the providers themselves, to optimise the use of capability and support staff in what is a very remote and lonely and challenging environment at times. So that's - and that's a big part of our patient transport coordination function and approach that we've just recently commenced, and which goes seven days a week as of tomorrow.

The other things, I think, that have affected us, in terms of trying to respond, so we've got increased standards coming from the Safety and Quality Commission and obviously, coming from our system manager. I think there is a - there is still some paucity of standards in relation to patient transport transfer, which probably need development in the Australian jurisdictional context, let alone the West Australian context. There are increased providers in this State, emerging, some of (indistinct) 10.26.04 road-based and air transport, and a lot of interest, I think, from rotary wing proponents all around the State. And there are increased platforms, obviously - different types of platforms.

So that environment's sort of quite complex. When you interface that with the size of our State, and the very long haul and complex transfer demands, it really means we can't stay operating as separate entities. And not having greater integration and coordination for those patients, we need to work together more, I think, is the conclusion. And from a St John Ambulance and RFDS perspective, I think they would agree, and we're seeing good cooperation with that.

So we would say greater coordination and integration is really required for the end to end service delivery for a patient being transferred from whichever site in this State to a metropolitan hospital or a regional hospital. So you know, some function needs to be responsible to make sure that that works in an effective and timely way and all the interregnums and unexpected issues that occur during the course of transport or awaiting transport or arriving are oversighted and managed really effectively, clinically.

And we would say, I guess, really importantly, whilst there's an aeromedical inquiry, the interface with the road ambulance system is completely critical.

It's obviously completely integral and the interface, in the same way with our hospital and clinic system, is critical. So we - for example, we're very focused now on providing St John Ambulance and RFDS and other providers, but primarily, St John's and RFDS, the status of our hospitals, where we have surgical capability, what's happening in real time, how demand's looking. So increasingly being very open with our capability in order to inform them and support us all to make the best decisions both at the time, but the best investment decisions over time as well, as we learn together.

So increased clinical oversight and governance of that transport journey's important. We have started on that, as I say, with the transport coordination service. But I think it's really important to state - and we - you can talk about this further, no doubt, that that happens in an environment where we've - we have driven our own strategy to the Country Ambulance Strategy, working through a transport collaborative initiative, formally, with St John's and RFDS, but a clear policy and plan and strategy for the State at a system level doesn't exist.

So that, at times, can be quite hampering, I think. And a level of sort of mandate and support for that, I think, is required. It certainly would be one of our recommendations that - planning a strategy around patient transport that enables and authorises the environment would be very important. You'll know one of the recommendations or one of the priority actions in the sustainable health review - which is really our strategic blueprint at the moment for the State, is that a State health operations centre, by whatever name - you know, an operations centre for the State, should be brought to bear, to operate, to coordinate all sorts of functions, but particularly, starting with country transport.

And so, the APTC is the embodiment of that, commencing with country transport. So, we do see that's the beginning of a much more federated and cooperative way of transporting patients between all the parties, where we all have a presence together over time. And I guess, in order to again, focus on - you know, really, that end to end journey, you know, not just the components in between. Because if you look at any typical journey, there are a lot of - when you add together the hospitals transport provision elements, there are a lot of points in between, a lot of gaps that need managing.

So that's whose - was - the APTC service was designed last year, collaboratively with St John's and RFDS, and it's just become operational two - three weeks ago - four weeks ago, and goes seven days a week from tomorrow, and will go 24 hours within a month or so, yes. So that has clinical elements and logistic elements and its a - it's very much a learning pieced together with St John's and RFDS and for ourselves and for our clinicians.

I think the - I mean, the main - it sits within our command centre at the moment - which I think you visited the other day, which is very much focused around direct clinical support to clinicians at any point time that they need it around the services that I talk to, but you know, primarily, emergency care, mental health, obstetrics and in-patient support, complementing whatever medical capability exists locally. And that varies, obviously, from place to place quite significantly.

I think the - I mean, the key thing to understand, I think, about that use of technology and the service, is the standardisation, the training and the relationships and the trust, is the key for that service to have been successful for us internally. It's not just the use of technology and it's not just point in time, it's built on a foundation of systemised ways of recording information, delivering drugs, you know, clinical procedures, staff training together and familiarity between sites. And that's - I think that's the really strong and potential benefit with us and Royal Flying Doctor Service and St John Ambulance in the future as well.

And for us, historically - or we - currently, we're in transition at the moment, and we're historically, a hundred different sites just for Country Health Service - so 80 hospitals and - in fact, more than that, 30 or so remote clinics, had to manage their own transport requests and requirements and juggle - when things become complex and the system's overwhelmed or a response is not going to be suitable for the patient needs, those sites have usually had to try and resolve, in their first instance, their issues. There are escalation pathways, but for - I'm sure you've heard from clinicians, that's a very difficult thing to do when you're caring for a patient, and particularly, when you have small teams.

So, the focus of the transport coordination is really on, you know, the patient journey possible in the context of the circumstances, and you know, really strong support for our clinicians trying to deliver care in, often, very challenging circumstances.

So the - that new system function really provides - is intending - and will grow in terms of real-time visibility and decision-making around transport plans for patients, particularly for the more complex retrievals, you know, coordinating fixed wing road rotary and hospitals as well, because bed finding is a very big issue. This position of bed flow is a big issue, so management of that hospital interface as well, is a very important part of that function. And we hope - you know, we hope to see that grow and extend over the next few months, particularly as we see demand rise in the next few months.

Country Health's also developing and modernising its contracts with both RFDS and St John Ambulance. So, St John Ambulance, currently, we have a level of contracting with them. The main body of the contract sits with the Department of Health currently, but they will transfer sometime in the next financial year to Country Health as part of the Country Ambulance Strategy to allow better integration of services. So that's a work in progress with the Department at the moment.

So that's - so the country component around St John Ambulance will move to us and we'll have much more visibility, I guess, influence and investment decisions and much more wisdom over time about how that service operates and what investment is required right across country WA.

Similarly, with RFDS, we're adopting more contemporary and emergent practices and standards in partnership with RFDS, so we'll - we are commencing and, in fact, have commenced our approach to a renewal of a 10-year contract with various terms in there. That is based on a more contemporary contract, so digitisation, information sharing and participation in the transport coordination functions et cetera.

The - there is also a trial at the moment, that we're entering with RFDS, of their rotary platform. RFDS proposed a rotary platform around a year ago, and that's getting close to - for commissioning. We're very keen to see the outcomes demonstrated by that, evaluate the benefits of the service, including, you know, receiving hospitals, sending hospitals and RFDS, St John's and any other players - DFES, for example, that are relevant to evaluating that trial. We think it's a really important thing to do, and will inform us for what we see as, you know, a necessary - at least, aeromedical plan and strategy, but particularly, a rotary wing plan and strategy for the State that we feel needs to emerge fairly quickly.

We do note that the inquirer has observed the underinvestment, relative to other states, in WA. Notwithstanding our geography, our rotary's a bit more challenging for us, but the reality is, we are underinvested by any measure, in terms of rotary wing capability. And to that end, there are emerging proposals all around the State over the last 12 or 18 months to multiple parties, again, just further telling us that a very clear strategy and plan from the State system - State Health is required to inform what should be designed and procured. We're very keen to be part of that.

We - just in terms of a couple of specific that you've touched on, we do believe that the current Emergency Rescue Helicopter Service should be clinically governed and tasked by within the State Health system - you know, obviously in partnership with St John's, but the clinical governance elements. It sits outside State Health and that makes us nervous, and we have had experiences from time to time, where we believe greater visibility and greater cooperation and coordination around investigating incidents and the clinical development of the service would be important.

Equally, I guess, our observation would be mixed crews make a lot of sense. We do have a sort of artificial separation of inter-hospital transfers and primary transfers in the rotary space for reasons of history, really. We don't really think that separation of primary and secondary rotary transfer is logical, and I think it probably dilutes the value available from each service, so we'd far rather see a more integrated platform and you know, use of the right type of crewing flexibly, you know, depending on the requirement and the need and that there wasn't some artificial distinction between primary and secondary transfers. But that is the situation at the

moment, but we do see, particularly in terms of this Inquiry, an opportunity to look at that issue and have a cogent way forward.

So, I guess, in - sort of in summary, in terms of opening from us, I mean, we believe a strategy will support greater investment and governance, oversight and operational coordination of critical services. We also see that, in time, legislation, you know, should be provided around air ambulance, road ambulance. We are one of the few jurisdictions that does not have legislation - that was part of the Country Ambulance Strategy, and supported by a strong policy position from the system manager, you know, around the direction and the standards that they see in relation to aeromedical services, that we can operate within.

We are very proud of the current services that we deliver in partnership with St John Ambulance and RFDS and other providers, for that matter, and some of our own services, and we want to work very closely with providers in the future.

Obviously, there are some - we purchase a lot of services, we purchase, you know, a couple of hundred million dollars' worth of services each year from private hospitals, radiology providers, Aboriginal medical services, St John's RFDS.

There's no service that's as sort of integrated and as complex as St John Ambulance and RFDS. It's a very partnered service, it's not something that we can - you know, we're not purchasing a product and it's different to radiology and it's different to purchasing volumes through a private hospital, so the partnering and the collaboration on the ground in particular, but at all levels within the organisation is just critical, and it's a complexity that's very important to address, you know, so - and that reflects the way in which we sort of contract manage and relate to both St John's and RFDS.

So that's probably it, from an opening strategy perspective, so - you know, just to get an - emphasising a strategy and a plan is, I think, a - significant early opportunities for this State to really provide a clear stamp on our direction around aeromedical service development and capability.

KENNEDY, DR: Thank you.

I'm happy for you to continue if you have got further specific statements that you wanted to make in terms of any of the considerations that have been raised or whether other members of your team need to contribute to that prior to asking you specific questions?

MOFFET, MR: Do you guys here want - if there's anything specifically - if you want to contribute before we go to questions?

BOSICH, MS: Probably just that coordination piece and oversight, how important that is, but it needs to be built in and developed and supported through that strategy, which - you know, you start with that strategy as a - you know, tip - the pinnacle of the enabler and getting it enabled and operationalised and then measured and developed and improved and it is a - it is the beginning of the journey we see from - particularly, from an APTC point of view.

KENNEDY, DR: Okay. Well, maybe to open, just in relation to that particular issue, what do you see is the pathway from an APTC to you know, a broader, central coordination system that is perhaps more encompassing than APTC at the moment? Is there a different shape for things in the future, or - how do you see that evolving, potentially?

MOFFET, MR: Well, it's - I guess, it's been referred to the SHOC - State Health Operations Centre - that's sort of the acronym that's been used. I think, as you observed, every HSP - RFDS, St John's, have got their own operations centre of whatever name, but there is nothing that joins those at all at the moment, beyond the patient transport coordination function we've just commenced.

So, I guess, I mean, I would see - patient transport, I think, is an obvious one. Country patient transport is the highest priority, and that's why SHR, presumably - the Sustainable Health Review Recommendation, presumably, address that as a priority.
Transport coordination in the metropolitan area is complex, and you know, all the issues around sort of access and ramping and flows et cetera, they are large, complex issues that other jurisdictions have much more system level visibility over. If we look at Kedron, in particular, which we visited a few years ago now, you know, it's a very live, real-time demand management system that has got predictive capability, it's well-linked directly into the health services operation centres.

So, I think that function of making sure we are very connected around situation awareness, risk and issues and we learn - and 24/7, we address demand and capacity issues. It doesn't exist, really, at a system level, so I think that's the first function to be defined, really. That can be a physical thing, like Kedron, where there's one room and everyone's in there from 000 call line through to metropolitan health service provider representatives, or some parts of it can be virtualised.

I guess our aspiration, really, for patients - particularly, for country patients, is that there is a - when I say - it's a federated system, so there is a presence from all the key players in that room, so RFDS, St John's, ourselves, metropolitan providers. And it needs to be proportionate and designed over time, but I guess, we see, in the end, a level of physical presence together is absolutely critical. I think it influences human behaviour and gets us on the same page quickly and gets us orientated around patients.

So, I think something physical needs to be designed. Obviously, it needs to start with a - at a system level, some sort of consensus or decision about what functions will be provided. And so that's the first point, I think, to sort through.

We have started with the obvious one, which is country patient transport. We'll build that capability, but obviously, we'll learn and grow. And that's - you know, it's not a - that's not an end point necessarily, but whether or not a State Health Operations Centres emerges in the short term or not, we think there are significant gains to be made with what we're developing together with St John's and RFDS.

KENNEDY, DR: So what you're referring to is obviously bigger than aeromedical per se, but aeromedical requires - for aeromedical to be effective, it requires a system that you've described, which is, essentially, a collaborative arrangement, where all of the system players work together in a common space, whether it's virtual or physical, to make this happen for the patient's journey.

The question arises in terms of governance of that system. So it's a nice concept to have a big room with everybody in there, working together, but something needs to sit above that to make that system work, it can't just be a pile of MOUs and we all want to do good for the patient, there needs to be some kind of governance around that.

Do you have a view on what that could or should look like?

MOFFET, MR: Look, I think - - -

KENNEDY, DR: Or is this SHOC - you know?

MOFFET, MR: Yes, I mean, I think - I don't know that - I mean, SHOC's just a word. I mean, I think the guts of it is, an operations centre that contains the key parties should exist - police run it, Qantas run it, Rio Tinto runs one. I mean, we're a $10 billion system with a lot of complexities and - - -

KENNEDY, DR: Yes.

MOFFET, MR: - - - we see gaps all of the time, and I think it's time for Health to realise that every other jurisdiction - - -

KENNEDY, DR: So - - -

MOFFET, MR: - - - is doing this.

KENNEDY, DR: - - - my point is that thinking - - -

MOFFET, MR: Yes.

KENNEDY, DR: - - - beyond a concept of a centre - which I really don't like in that name - - -

MOFFET, MR: Sure, yes.

KENNEDY, DR: - - - it's not up to me to like things, I know - - -

MOFFET, MR: Service.

KENNEDY, DR: - - - that, it's not a centre, it's a service.

MOFFET, MR: Yes.

KENNEDY, DR: It's a service that's being delivered, so a service needs to be managed - - -

MOFFET, MR: Yes.

KENNEDY, DR: - - - and it needs to have relationships and all - - -

MOFFET, MR: Yes.

KENNEDY, DR: - - - the rest of it.

MOFFET, MR: So - I mean, ultimately, there's got to be escalation of decision points, and I think that's part of the design issue. It's a - I mean, we'll have our opinion, but ultimately, we are one part of that system. This is a role, I think, for the system manager - and we're very happy to be very active in participating in the design and development, but really, the - you know, the system manager, via the DG, have the ultimate system authority, that's not

something that we possess, that's something the Director general has. My view would be, you know, you clearly want a 24/7 function, and someone needs to be in charge through a delegation arising from the system manager. That would be my view.

Now, that's - there's a lot of design work to do there, but you know, typically - I mean, there's so many examples I could provide, but I guess, a classic example would be a mental health transfer for us, if we just talk about a country sort of challenge, it's very common.

You know, mental health transfers are fraught with lots of complexities - a limited number of beds in the metropolitan area, there is a police presence required, you - obviously, you need aviation and ambulance capability that's appropriate. So, you've got to line a lot of ducks up in order to get a transfer to happen. And very often, we will see patients languish for days and days unnecessarily, because lining those ducks up is very difficult. And when you get four of them lined up, but this one isn't available anymore, so there's a lot of times - and there is no party in charge who can make a call or a decision on that from time to time.

So, we work through that in lots of ways. We've had a lot of - there's been a big focus, actually, between us and RFDS over the last few years, and we've seen a lot of improvement in the responsiveness around that. We've worked on an ED to ED transfer protocol with the metropolitan providers, so that if someone has an acute mental health condition and behavioural disturbance, they're not sitting in a very small hospital with, you know, two ED bays and three beds, they can sit in a very large teaching hospital with a dedicated mental health team and the appropriate capabilities.

So, we've done a lot to try and get some of the antecedents right, but ultimately, it's a very good example where a clear decision needs to be made at times. And it's hard to get those decisions, so I'll often negotiate directly with our Chief Executive or our Executive Directors. We'll negotiate a solution, we'll talk, obviously, with St John's and RFDS and police, but there is no dedicated function to do that, and that is a very frequent occurrence that's symptomatic of the design of that system that we've got. And I actually don't think it's too hard to sort through that. Someone needs to, ultimately, have a call about what happens for that patient.

KENNEDY, DR: Okay. Thank you.

Were there any other statements that you wish to make, or the team wish to make? And I guess, are there any of the considerations - bearing in mind that there are an enormous number of considerations that have been put in front of you - which is a reflection of the level of passion, in terms of the responses we had for our stakeholder consultation - and don't think for a minute that those are recommendations, they are considerations, but are there aspects of that which you otherwise would want to talk about, things that you perhaps vehemently disagree with of things which you wish to state a view on?

MOFFET, MR: I think - well, you'll - you're probably aware, there's also an upper house inquiry occurring in terms of ambulance services in the State as well, and I think the questions being asked and I think you've raised the question, I suppose, about the provider environment and the question ultimately, should the State be running these services - you know, that sorts of inferences, structurally. I guess, that's a - for us, we see that there's absolutely a need for greater integration and coordination between the parties, and improved accountability for all of us, including country health, but we're strongly supportive of the current transport providers.

We do see that more - sometimes, more choice needs to be available when you don't have a solution - whether that's road ambulance or air ambulance, but we are - we - you know, our primary provider will be RFDS now and for the future. That's - you know, we are very committed to that relationship.

KENNEDY, DR: Do you mean more choice or more capability? Do you see there's a fundamental difference there, one is if you had all of the capacity that you need, you wouldn't necessarily look for alternative provider? Is it a - or fundamentally, are you interested in having other providers because that alters the dynamic of the system from every perspective from contracts to performance to strategy?

MOFFET, MR: I mean, it's ultimate - I would guess it's, ultimately, a capacity issue, but you know, I think - road ambulance is probably the best example to use. You know, having - I think having metropolitan areas, you've got lots of choices around its use of road-based transfer. I think if there's sufficient volume, I think it does bring some diversity around choices and standards et cetera, but it is, ultimately, a capacity question.

And you know, we - I guess, we would say, there are times when we do run out of capacity in our aeromedical system. It's not a common - you know, we get peaks in demand, and also, you know, there are unforeseen issues for our air crews, and whatnot, the RFDS have to manage, so - no, we want capacity to respond.

We do agree that, obviously, we're moving - we've started with a very strong community grounding, there's a community services contract, the procurement - well, Tim can explain it better than me obviously, but the contracts with the NGO providers - if you like, right around the State, including RFDS and St John's, were very community-based and they've moved - the larger ones have moved to a more commercial base, they clearly need to move further. We all need to move further in that commercial direction, including us, as a contract owner.

But I would say, the main thing is that we do have surge capacity when we need it. And if that can work in a way that's commercially of good value, that's a good thing to do. I think both St John Ambulance and RFDS, in my engagements with them over the last few years, understand that there is a commercial element to the service, and demonstrating value is really important. So, I think so long as the State is deriving value and performance - which I think it is, then the provider environment needs to exist - needs to be commensurate of the volume and what's sustainable, really.

KENNEDY, DR: Okay. Just to clarify one point that you raised earlier on, you spoke about the contract development with St John's, and that the non-metro - the country component of that was coming out of the central contract, so there would, presumably, therefore, be two contracts - one between WACHS and St John's, and the other between Health and St John's to provide metro and country components, what happens at the interface and do you see any risk in that split contract arrangement in terms of actually achieving the - well, what's the rationale for the separation, first, and do you see any risks attached to that?

MOFFET, MR: Yes.

KENNEDY, DR: But this is not purely - it's not really aeromedical - I couldn't help myself from asking the question, but you know, from my point of view, every aeromedical transfer involves a road leg almost, and so it is important to understand. And often, one will be in the area that

you will govern in your contract, and then the other end will be in the area that's governed by metro, so - - -

MOFFET, MR: Sure.

KENNEDY, DR: - - - just - can you help me with that?

MOFFET, MR: Sure. I mean, probably, the easiest thing is - from our staff perspective and our organisational perspective, it's really the sort of - the outcome that has driven our interest in our ambulance service development and improvement in country WA.

We - our board and our executives spent a lot of time consulting with communities - you know, local governments, communities, whenever we travel regionally. The most common issue that is raised with us is the unsustainability and the underinvestment in the country ambulance system. That's been a pervasive theme for a long time, that there was excessive pressure on volunteers and investment is required. And so, our board endorsed the development of a strategy, which was independently run and delivered.

And a very central part of that is recognising that if you look at the report on government services, for example, we had the most underinvested, per capita, ambulance system in country WA in Australia, and we rely extraordinarily on volunteers. And in this day and age of you know, volunteerism, abilities for community support, all that's required - we believe that more support to volunteers is required, so training, you know, skills, articulation, debt management, assets, infrastructure - because the sub-centres actually also pay for their own consumables and we deal with them direct. So, it's very challenging for some sub-centres in remote parts of the State, where they have a high volunteer turnover.

So, our view was there needed to be a strategy for country communities around ambulance investment, so we developed that. A big part of that is, we've got a lot of skin in the game. If there's not an ambulance service in Laverton tonight, that becomes our issue, we end up putting nurses on ambulances. And it happens regularly. We partner very well with St John Ambulance, but you know, they've got a huge patch to cover as well, with 160 sub-centres. And we - you know, we've worked really collaboratively with Michelle Fyfe, the CEO, and St John's, to get an investment profile, so that there's more paramedics supporting volunteers.

So, I would say, with - you know, it's in desperate need of more investment. There's been good investment so far, we've had a good response to the strategy from government - $50 million over the last few years, but there is a long way to go to continue to support those volunteers. And we know that, we hear that all the time from sub-centres.

Now, why us - why split? Because the status quo wasn't okay, and it had been there for many years, and there'd been multiple reviews from the Joyce Inquiry.

In fact, before the Joyce Inquiry recommending Country Ambulance Strategy development investment, including from the OAG - the Office of the Auditor General, and that hadn't happened, so we took the destiny into our hands and developed a strategy, and we think it's the right one, it's absolutely the right direction and I think separation of contracts - we've got several contracts for - you know, many, many things across the State - radiology, hospital services et cetera, I don't see any interface issues at all.

And in the end, we and the Department will jointly oversee the contract arrangements. It's not - they're not - it's not going to be totally separate, there will still be an overarching head agreement guided by policy and conduct.

So - but it's a big step, because it's needed, because there is two standards to ambulance services in the State, you know? There's the paid services - which is mainly in metro, and volunteers in the bush, and they need a lot more support.

BOSICH, MS: I think a part of this, just to add to that, is around the service description. So it's not just about the contract management, it's about being able - - -

KENNEDY, DR: Yes.

BOSICH, MS: - - - to actually name the level of service and being very clear about what the level of service of ambulances we are - we need. It's data driven, it's risk profiled, it's - you know, looks at the holistic, what is the actual health service available, how does the transport service support that actual holistic service - health service delivery in that town or whatever.

So, I think part of it's been very much around describing what we need, looking to as to - I think to think differently about alternative workforces on how we might share or work together on delivering health services to that town. So not - it's not so much about the contract - that's certainly a part of it, but it's around - what we're trying to do is be able to describe the levels of service we need to be able to deliver country health services in partnership.

MOFFET, MR: Yes, one of the recommendations is, in fact, about the development of a clinical services framework relevant to transport. So, it might be regional specific, it could be place specific, but essentially, we don't define - so we don't have policy or statute, but we also don't define levels of service around patient transport. And we think that's an important thing to do around community expectations and us, you know, holding ourselves to account around a standard that we need to invest in.

So, a CSF equivalent specifying patient transport capability is something we think would be really useful as well. And that could apply equally to aeromedical, you know, it's not - it's really about ambulances - air ambulance or road ambulance.

The other thing probably to mention is, in terms of visibility - so you know, the contract in country for ambulance is around a term called, "Best endeavours", so there is no - there are no sort of metrics for the vast majority of the State around responsiveness or despatch times, that they're not required to be reported and measured, and so you don't know, from - at any point in time, what your capacity is.

So we're working closely with St John's in the same way that we want to inform people about our capacity on a continuous basis and what - we'd like to do the same with St John Ambulance, so we know which bases do have response capability. And over time, we'd learn from that and invest properly, strategically, in that service capability and I guess, continuity.

KENNEDY, DR: Thank you.

I might move onto some specific questions now, which some of them have been, in part, covered by - you've spoken to already, and some of them might be simplistic in their

presentation, and you may feel no need to say anything more than, "Yes", or, "No", but some of them may lead to discussions, so I'm happy to take that whichever way.

The first is, do you agree with the suggestion that an overarching service management body or organisation should exist - in terms of aeromedical services, and that such a body could potentially adopt a broader systems role than AMS, in isolation? For instance, bringing together things that are already partly brought together in your systems, such as patient transport functions, outreach support coordination and governance components?

MOFFET, MR: Yes, I think we agree that there should be a function that exists. I think the use of the term, "Body", just - I think the key to this is if we can create a part of the Department that owned all of this and had Country Health and the other metropolitan providers and all the - you know, RFDS and St John's, and all the other providers outside, being sort of tasked, but I think the secret to this - and certainly, what I've seen in terms of success overseas and interstate, is that the key partners need to be together, you know, to understand common language, same page, learn from each other. So, I would say it's a function - a federated function.

I absolutely agree with your point about someone's - well, I guess it's the point I made, that someone's got to be in charge, it does need to have a mandate and authority that does need to come from a system manager. But I'd probably describe it more as a federated function that should come together.

KENNEDY, DR: Yes, I understand that. The concept of a body or an organisation - - -

MOFFET, MR: Yes.

KENNEDY, DR: - - - is absolutely unnecessary, but the process and the system and the - - -

MOFFET, MR: Yes.

KENNEDY, DR: - - - authority - - -

MOFFET, MR: Not having a State Operations Centre - well, as I say, when you look at Rio, BHP - and, in fact, even, I think, if you look at RFDS and St John's, they have operations centres in their - at their entity level. The WA health system - even if you just look at our hospitals, the health system doesn't have one, they're all separate through the health service providers.

KENNEDY, DR: Okay. Do you agree with the need for the development of a State-wide strategic plan for aeromedical services and related structures or processes which defines the service model and the pathway to implementation?

MOFFET, MR: Yes (indistinct) 11.01.51.

BOSICH, MS: Yes, do not deny.

MOFFET, MR: Better check with my crew (indistinct) 11.01.53. Yes.

KENNEDY, DR: I'm not expecting a lot of, "Nos", to that one. Do you agree with the premise that for an aeromedical system to function optimally, it's desirable that all mission tasking and

coordination be managed centrally, whether by a core authority or body or by a process of collaboration - and as you've stated, federated activity?

MOFFET, MR: Yes, I certainly think you shouldn't have separate tasking - that's some part of the challenge that we've got, among all sorts of bodies, yes. So yes.

KENNEDY, DR: Okay. Is it fair to say that a contracted health system, not for profit provider, would be unlikely to invest a large amount of money in infrastructure without confidence of its acceptance into a system of care and a subsequent income stream?

MOFFET, MR: Yes, I think it's - sorry, could you just start the question again?

KENNEDY, DR: Is it fair to say that a - - -

MOFFET, MR: Yes.

KENNEDY, DR: - - - contracted health system, NFP, would be unlikely to invest a large amount of money in infrastructure without some confidence in its acceptance into the system of care?

MOFFET, MR: Yes, I agree with that, yes.

KENNEDY, DR: Do you have a view on what may have led RFDS to believe that purchase of two rotary wing aircraft would be followed by the State agreeing to fund the use of those within the State aeromedical system or health system?

MOFFET, MR: Do I have a view about why? Well, I think RFDS raised the notion of a rotary capability with us - because we're the contract manager, in late 2020 - so December 2020. So - and that wasn't just with us, it was also, I think, with the Minister for Health and the Director general certainly aware of it as well, in principle, all parties agreed that a trial of a rotary service, given the under rotary capability, was appropriate.

I mean, the trail is very much around doing some planning and probity and some modelling, and I guess all the things that the public sector does around - you know, trying to get the use case set out appropriately, and then take that to government. But yes, I - you know, the reason - I mean, they proceeded with the purchase of those aircraft, but we obviously had some awareness of their desire to trial a service, and we were supportive of that.

KENNEDY, DR: Okay. Seems a large investment for a trial. That's a comment, not a question. So just in more general terms, do you agree that the government and health relationships and contracts with all aeromedical service contractors should reflect contemporary commercial standards?

MOFFET, MR: Well, yes, I guess, I - finding contemporary commercial standards in aviation is probably a bit - or aeromedical services is a bit challenging, it's a developmental area. But I think there should be a reasonable commercial basis to that, you know, and you should understand your investment over time. It's a large investment, so in principle, yes, acknowledging the aeromedical standards and definitions in this country are probably still fairly developmental.

KENNEDY, DR: Okay. Thanks.

Do you have a view, in regard to those contracts, ensuring that a provider's other commercial activities or obligations create no conflict of interest or potential for operational compromise?

MOFFET, MR: Sorry, could you - I'll get you to ask that again, I got a bit lost in that one?

KENNEDY, DR: Do you have a view that such contracts with aeromedical service providers - in those contracts, that the providers' other commercial activities or obligations create no conflict of interest or potential for operational compromise? Should that be a component of a contract that you would have with an aeromedical provider?

MOFFET, MR: I think it's - so if you're referring to the - sort of, the Commonwealth purchasing primary services and the State purchasing - so a secondary or inter-hospital services, I think there's got to be a balance. I think, obviously, for us as a State, we want a provider - well, several providers, but in our instance, with aeromedical, the RFDS is the provider with scale, so - and in achieving scale, you do want to bundle volume, so probably 20 to 25 per cent of their work is Commonwealth type work, in terms of retrieval work, and 70 to 80 per cent, depending on the give and how you're measuring it, is the State.

So I think it would be very difficult to sustain the current level of service and capacity if you split those and if you want a complete separation. So I think there is a level of compromise from time to time you do have to accept, and that's - I think that's the importance around coordination, visibility, transparency - you know, agreement around transport plans and tasking, because often - you know, often, that's the challenge, I think, in us, as an organisation, perhaps understanding or trying to negotiate priorities, because we can't see, necessarily, the other challenges for other providers.

And it's the same for ambulance, quite frankly - road ambulance, so I just think, given the volumes, separating them completely and not expecting some balance and compromise is not realistic in this State. I think - but I think it's more about visibility and learning between the parties, and I guess, making sure we optimise decisions over time because even with our inter-hospital transfers, sometimes the demand will be so overwhelming we do have to make prioritisation choices.

And it's not optimal there either, you know, we have to hold patients longer than we'd like, even completely separate to the primary demand. So I just - I think, in principle, it would be really nice to say this is just an inter-hospital transport contract and that's all we're interested in, the reality is, we are interested in the total picture, and as an organisation, we support the public interest.

So we want - irrespective of whether we pay for a primary transfer or not, we want to see that transfer happening in a clinically appropriate way, and if that means we have to wait a little longer in an appropriate way, then I think that's completely reasonable. I think the secret is transparency and us working together to try and make the best decisions in real-time, in those circumstances.

BOSICH, MS: I think, even noticing in one of the comments from the Inquiry in the papers, or one of the statements within that, is around there's no other jurisdiction that's really split out, they had just IHPT or - you know, or split the primaries and the IHPTs, because it doesn't make good use of assets, it doesn't have oversight. But the problem - the issue actually is

about having oversight and decision-making, so - and transparency and how funds and activity and all the rest of it's actually done.

So the patients end up being ours and we still have all of that need to be able to see when patients are coming and moving, so I think it doesn't make sense to completely have a dedication IHPT kind of approach, when we've got one State and one - you know, one provider - or one hospital service that's - - -

MOFFET, MR: Yes.

BOSICH, MS: - - - being provided.

MOFFET, MR: I think, especially as you get to regions, like in the - you know, Goldfields, Kimberley, Pilbara, you know, you do want scale as much as you can get it, because that's the challenges, demand in those environments is a continuous challenge for St John's, us, and RFDS. You know, it is a balance, and hopefully, we've answered that question reasonably?

KENNEDY, DR: I understand your response, and I'm inclined to agree with it, which is - it doesn't mean I absolutely agree with it, I see the merit of the discussion and the argument. There are other systems where there is a divide between these kinds of services. That was not really the core of the question. The core of the question was about conflict of interest and operational compromise.

So I think if we take that back, and maybe if I ask it in another way, you know, whether a system is, essentially, as structured now, which makes a lot of sense, in terms of a heterogeneous system that has lots of different roles in terms of the service provider's responsibilities, is it important, from a State aeromedical service perspective, that there is not significant conflict of interest or compromise of clinical services in that space as a result of those other obligations of the provider?

MOFFET, MR: Yes, in short, I think, yes, and we - I mean, interest - every organisation, every entity has interests, where there is conflict, we - absolutely, we would expect conflict to be declared, managed, you know, to be transparent, as a general statement.

In terms of clinical compromise, we'd know - we wouldn't - I guess, we wouldn't expect clinical compromise. I mean, it depends to the scale, I mean, anyone that has to wait for - wait a bit longer for a transfer, for example, you could argue risks, clinical compromise, but I think that's the importance of actually monitoring the clinical performance of the contract, and that's why we have a clinical subcommittee that talks about problem transfers or issues raised from either end.

If it's systemic, absolutely, that's not acceptable. It's not acceptable on our part or no doubt, from RFDS's. No one wants to see that. So - or from - you know, no doubt, it's probably the same for DFES as well - we don't have those conversations with them, but I don't think any of them would expect unreasonable clinical compromise.

KENNEDY, DR: Okay. Thank you. Would you support the view that all aeromedical service contracts must specify, clearly and unequivocally, the aviation and service or clinical standards required to be delivered?

MOFFET, MR: Yes, and that's part of our development of the standards that we're going to sit down and discuss and negotiation within a contract with RFDS.

KENNEDY, DR: Okay. In some of the considerations, some respondents expressed views around the movement of EHRS, which you've spoken to, to a degree, do you have a view - or can you restate your view in regard to the suggested realignment of EHRS, which is, essentially, an ambulance service, to sit within a health structure - I don't mean the Health Department, I mean within a health environment?

MOFFET, MR: Yes. Clinically, yes. And you know, tasking and oversight, yes, we absolutely think it should be inside of health. Another good example as to why that should be the case, we all need visibility, in real-time, of the use of assets and employment and clinical decisions around deployment. I think DFES are a very good aviation manager, so you know - - -

KENNEDY, DR: Yes.

MOFFET, MR: - - - whether - you know, I think the whole aviation management, DFES do a very good job of, they have a lot of fleet, you know, leasing arrangements right around the State, so not so much on that side. I think we're a bit agnostic about that, in fact, we're probably, you know, we respect the fact that they do have a lot of aviation capability that we don't have. But on the clinical front, we absolutely think that should be the case.

And I've - in our discussions with DFES - I mean, they have acknowledged that, you know, tasking and oversight - clinical oversight should really probably sit with Health, that's - we've had a number of discussions about that. So - where that's - we have a fairly strong view about that, because I guess some of the issues and incidents that do get reported that we - that don't go through a normal clinical governance process.

KENNEDY, DR: Okay. Do you have a view on the development of specialist fixed wing contracts to introduce - potentially introduce new service providers or service provider options for Health to access, which may create a stronger commercial atmosphere in WA aeromedical services and provide for specific needs such as NETS, mental health, repatriation, interstate transfer, reserve or surge capacity?

MOFFET, MR: I think it's a difficult question, really. I think when we do see that - I think, in the first instance, you know, getting much more transparent, real-time information and understanding from the parties - because I'm referring to NETS specifically, is really important.

I - you know, I view it, be that - I understand there are frustrations from time to time from NETS, but this a very large State, where retrieval times are sometimes five, six or seven hours, even with the best in class response, so I think the issue that's been raised around that is a symptom of - actually, a lack of connection of the parties. I - you know, I'm sure there are times when we can do retrievals better, but equally, in the NETS service response, we've had discussions with CAHS and PCH.

It's the whole patient transfer thing, not just the actual transport, you know, that needs to be looked at. So as soon as - for example, when we have a neonate that does need, you know, critical care and support, that that's available through telehealth technology and immediately, for example, whether it's through our ETS or through CAHS and the sorts of things that we see around trying to get good outcomes from neonatal transfers often relate to that front-end management, you know, before the aircraft arrives.

So we think the parties getting together more, planning more around neonatal retrievals, as a particular example, makes a lot of sense, and including have real-time visibility when transfer cases come up, so the patient transport coordination service should shed a lot of light on how well we're responding and I guess, you know, optimising the responses each and every time, depending on aircraft and you know, medical availability.

In terms of the broader - well, I think so long as government's getting good value and appropriate response from RFDS, you know, I don't - I think there should be an intentional move to introduce more fixed wing capability, but I think that issue of surge capacity is a really important one. You know, we currently do ask RFDS, from time to time - or task ourselves from time to time, CareFlight or Medical Air, when there is a capacity issue, and it almost always goes through RFDS when they've got them - when they are genuinely deployed right around the State and they were past capacity.

So, it's a really tricky question, isn't it, about what the right response is, but - - -

KENNEDY, DR: You can say, "Maybe".

MOFFET, MR: Maybe. Yes, but I think there is an issue around surge response that we do honestly - and again, the patient transport coordination function, I think, is the best way for the parties to learn from those things, about what we can and should do differently. There are times - and it will change the way we do business - and I've talked to Rebecca about this.

You know, there are times when we might want a different destination for a patient that is planned, for example, I guess the way in which we optimise use of both our hospital assets and the aviation and road-based assets is something that we want to learn about together.

So, I think we can probably get more out of the existing capacity by the parties being together, I guess is what I'm saying.

KENNEDY, DR: Yes. Certainly, in a lot of our consultation, the messaging was very clear about, you know, accessing the system, in terms of neonatal care and also mental health, and I think there are very, very strong messages from the referring end, in particular - - -

MOFFET, MR: Yes.

KENNEDY, DR: - - - that the timeframes, at the moment, are a real challenge for them. And I think the work that is going on, in terms of outreach systems, is superb, and it's, you know, world-leading, really. However, I don't believe that that gives you, therefore, an option to not have the most rapid response capable, because when you think of combining both fantastic outreach and fantastic responsiveness, you really cut that window and the service gap for that, you know, 30-week baby in the middle of nowhere, down to, you know, the smallest gap that you can possibly achieve, short of having a Tardis or something.

MOFFET, MR: Yes.

KENNEDY, DR: So, it's not really an either or, it's a complex question, but thank you.

BOSICH, MS: Can I add just a piece to that, because what we've really observed is that we say NETS and we say mental health, but we actually forget that there's a clinical urgency on each of those. So not all NETS are clinically, massively urgent and - - -

KENNEDY, DR: No, I - - -

BOSICH, MS: - - - mental health, not clinically urgent, and I think some of the responses we might've heard is because that clinical urgency hasn't been defined, and we just expect - - -

KENNEDY, DR: Yes.

BOSICH, MS: - - - our service to be rapid, to be run on the (indistinct) 11.19.56, so I think - - -

KENNEDY, DR: Yes.

BOSICH, MS: - - - developing clear understanding of clinical urgency measures is really important for that.

KENNEDY, DR: I think that's extremely - it's extremely important, and it needs to be at a patient level, not - - -

BOSICH, MS: Yes.

KENNEDY, DR: - - - at a label level.

BOSICH, MS: Correct.

KENNEDY, DR: So just because - your mental health doesn't make you that - or that level of urgency - just because you're in a hospital, doesn't make you that level or that level of urgency. It needs to be patient focused, obviously.

Thank you.

MOFFET, MR: Yes, and I think the NETS and the mental health are the often complex transfers, and while you don't have coordination of a complex system, both receiving hospitals, sending hospitals and all points in between, patients can fall through cracks, and so - and escalation pathways aren't as reliable as they should be - - -

KENNEDY, DR: Yes.

MOFFET, MR: - - - for - in both instances in WA, and that is absolutely what we're trying to respond to - - -

KENNEDY, DR: So - - -

MOFFET, MR: - - - by getting the parties together.

KENNEDY, DR: - - - that collaborative coordination environment - - -

MOFFET, MR: Yes.

KENNEDY, DR: - - - really helps you to solve - - -

MOFFET, MR: Visibility.

KENNEDY, DR: - - - those issues?

MOFFET, MR: Yes, and - - -

KENNEDY, DR: I think repatriation comes into that equation as well - - -

MOFFET, MR: Potentially, yes.

KENNEDY, DR: - - - because, on the face of it, not many people think of repatriation as being particularly urgent, but from the point of view of the people in the queue waiting for elective surgery, it's extremely important - - -

MOFFET, MR: Yes.

KENNEDY, DR: - - - and it chews up an enormous amount of resource for our health - - -

MOFFET, MR: Yes.

KENNEDY, DR: - - - systems, so - thank you. I think you've answered the next question.

The next question I've got is, do you support, in principle, an expanded hub and spoke structure for core aeromedical services and systems? These could include things like co-located fixed wing rotary bases at different places in the State, aeromedical staff centres, the development of closer local WACHS operational links between RFDS and local health services from the point of view of shared staffing models et cetera, are those types of principles, in a broadly hub and spoke shape, of interest?

MOFFET, MR: Yes, definitely. Sort of how we operate at the moment, I guess the - you know, the - Jandakot's the primary base in terms of RFDS, but Broome's taking on a - I guess, a lot of capability over the last few years as well, and we have spent a bit of time during COVID trying to - cross-credential and cross skilled staff to support both RFDS and for RFDS to support us. We probably haven't drawn on it in, you know, in anger yet, in terms of a real-fire situation, but you know, that's probably coming in the next few months.

So - and we'd like to do a lot more of that, and I guess, with - we also, just from a collaborative perspective around, you know, research, you know, teaching and training, there's a rural generalist pathway that we're coordinating and developing in this State, but we want to see RFDS and St John's and AMS sector all be part of that, because that's an amazing experience, I think, for young doctors that are really wanting to choose rural practice, and for that matter, I think (indistinct) 11.22.58 in allied health exposure as well.

So, we are very keen, in our partnership with RFDS and St John's, to really look at what we can offer as a set of country service providers, in terms of experience and skills development and value and return for them as professionals. And I think we've got a lot to offer between us, so those hubs could definitely support that more. You know, places like Kalgoorlie and Broome, Port Hedland, we are very keen to explore, I guess, in our next - well, it's not really the contract, but the contract needs to reflect it better in our next partnership journey over the

next 10 years, is getting into that workforce collaboration together and research trials together with Curtin University, where we've got an alliance.

So, trying to - you know, trying to optimise and modernise what we do and be very proud of what country can offer, as an experience, because it's unique, it's amazing for practitioners.

KENNEDY, DR: Indeed. Okay.

I guess, just as a final question, here, which is not absolutely key to the services you provide - although you intercept, obviously, with the EHRS at times, there is a general contention that in aeromedical circumstances, whether it's primary response or inter-hospital transfer, that rotary platforms should have a base crewing of two flight crew and two clinical crew, do you have a view on that?

MOFFET, MR: Well, I defer to Justin on this one. I'm no expert on this, sorry.

YEUNG, DR: I think the inner jurisdictional evidence would suggest that there should be a dual clinician model of the rotary, so we would support that.

KENNEDY, DR: Would you have a view about flight crew?

YEUNG, DR: I guess it depends on where the rotary wing's based, doesn't it? So if we're looking at - again, I guess, the inner jurisdiction visits that we've had, and being a member of the Australasian Aeromedical Retrieval Directors forum, is that the mix and match for the rotary wing between doctor and paramedic is probably - I guess, depending on the case and the priority and the natural clinical urgency, would be one of the options. Whether it's paramedic, paramedic, paramedic, doctor - but I think that would be, generally, the mix that I'd be looking at.

BOSICH, MS: I know the different flight kind of arrangements in different areas with sometimes the clinician being a dual flight kind of approach, being the eyes on the other side of the plane, being - or the helicopter, on that flight kind of engineering. It's different everywhere, and I'm - the hybrid model we've got here seems to be working, but I just don't know what the contemporary standards are.

YEUNG, DR: Just to clarify as well, I guess it depends on whether it's a primary mission or whether it's an inter-hospital patient transfer mission, so you know, if it's an IHPT and it's a doctor flight, a nurse would be a reasonable - I guess, it depends on where there's a colocation of those clinical services.

KENNEDY, DR: Okay. So, if we assume that we're talking to clinicians, in terms of patient care - two qualified clinicians, do you have a view in regard to the aircraft crew or the aviation crew in terms of pilot and crew?

YEUNG, DR: I couldn't - - -

KENNEDY, DR: Okay.

YEUNG, DR: - - - give you an answer on that one.

KENNEDY, DR: Thanks.

Have you got any other matters that you wanted to bring before the Inquiry or suggestions for the Inquiry to look in other directions or investigate other matters that haven't appeared so far in the considerations?

MOFFET, MR: Not in broad terms, I mean, I think you've floated lots of stuff up, you know? There's - - -

KENNEDY, DR: Yes - - -

MOFFET, MR: - - - plenty of information there.

KENNEDY, DR: - - - there's a lot of stuff floating - - -

MOFFET, MR: Yes.

KENNEDY, DR: - - - that's a good - - -

MOFFET, MR: There is.

KENNEDY, DR: - - - way to describe it.

MOFFET, MR: Yes, so - but it's - and I think it's good, I think the - I hadn't really seen a considerations document before, and a lot of it, you know, is contradictory and I guess, attributed, but I think it's - there's a lot there, so I think the core - I really, you know, believe some of your comments, I guess, that we've comment, I support.

I absolutely think that we need better coordination. We're a massive system, we need to be better coordinated for the interest of patients in this State, and I think it can happen in a way that's good for all parties. I don't think there have to be winners and losers in all of that.

We - I mean, as you can tell, we are very supportive of our primary providers, and we want to continue to have long-term arrangements with them, we're not seeking to have the State take-over, you know, big chunks of transport, that's not our position. I think it can work even better in the future.

So I guess I would just emphasise again that it - that the lack of a legislative policy and strategic environment makes it very difficult for us to proceed with things at times, which we pointed out through the ambulance inquiry, and we would reiterate that. We would really like to see the system manager work with us and as I say, we're happy to be as involved as necessary around trying to create some of that framework, so it's clearer for all parties, particularly in the investment plan for government.

And many of the issues that you've touched on today are much more informed by (indistinct) 11.28.29 and I guess, the key priorities for the State.

BOSICH, MS: And it extends into - well, one of the things that hasn't really - or it doesn't always service, it does sit, you know, out of zone, is that offshore retrieval and the remote retrieval kind of stuff - - -

MOFFET, MR: Yes.

BOSICH, MS: - - - that WACHS ends up, you know, having to manage and support. It's around including that that component is considered in that funding and in that State strategic plan.

MOFFET, MR: Yes, that is - I would be interested in your views on that, I guess, through the course of the Inquiry, because it is a - I wouldn't say regular, but it's not an infrequent challenge when there are offshore issues, particularly in the north, where it's very unclear, jurisdictionally, about what should happen. We worked well with RFDS around the COVID response stuff last year and the year before, but it is unclear, and I think there was an outstanding coroner's recommendation in relation to arrangements around offshore retrievals that should be clarified.

So, we - you know, we're happy to support arrangements, I think just a lack of jurisdictional clarity is a bit of a problem at the moment.

KENNEDY, DR: I guess the only - I mean, the only other area like that, really, is the interface - is the road retrieval space, which we haven't spent any time talking about here today, because it's just, theoretically, aeromedical, but it is - I'm interested in your views on this, it is very difficult to conceptually construct an aeromedical system and a road retrieval system sensibly, because you're constructing two - if you want to construct two completely separate systems, then, the waste involved in that is enormous. The overlap in purpose is, really, a hundred per cent, it's about moving a patient from here to here. And there is always the scenario where an aeromedical service fails, as in weather related or platform related or whatever, and the plan B will always be a road transfer.

Did you have any views which you wish to state in terms of the role of road retrieval related to aeromedical services or otherwise?

MOFFET, MR: I mean, Justin and Kylie might have some comments here in a second, because it goes to the heart of what we're trying to achieve through the patient transport coordination, which is very much dealing with that plan B, C, D that you referred to.

Look, we - it's absolutely integral, you know. We can see - we're going through the planning at the moment with RFDS, as I said, around their rotary capability, and as you go through that, it's very clear that the ambulance is an integral part of that, along with the hospitals and helicopters. So, I think that issue about, you know, visibility, transparency, you know, coordination, applies as much - - -

KENNEDY, DR: Yes.

MOFFET, MR: - - - to road transport, and I would say, to hospitals as well. I think, probably, we haven't talked enough about hospital transparency and information for providers about where hospitals are at, because I think it's easier just to look at the transport bit. We've got a very big part to do of sending and receiving.

KENNEDY, DR: Capacity wise (indistinct) 11.31.31 - - -

MOFFET, MR: Yes, and also - - -

KENNEDY, DR: - - - and capability?

MOFFET, MR: - - - just visibility and us complying, you know, if we're going to do a mental health transfer, that we've done the right thing and got everything in order prior to that happening, that we communicate clearly between our departments and St John's and RFDS and you know, we're collaborative and cooperative around the way in which we hand over patients. I mean, there's a lot that happens at hospital level that's really important for us to - - -

KENNEDY, DR: Yes.

MOFFET, MR: - - - be held to account for as well.

So, I think on your initial question, Justin and Kylie could - - -

YEUNG, DR: Yes, I think - - -

MOFFET, MR: - - - have some views.

YEUNG, DR: - - - that's absolutely right. So, the vast majority of our inter-hospital patient transfers are actually done via road, and I think the tricky thing is that interface point, where there might be variable capacity from near a medical or road point of view.

And we've - and I guess, it's part of tomorrow's session, but a - come up with this term of the, "Transport vortex zone". In other words, you go around the rim a couple of times until you can't, and then you have to have a decision at the end. And we've had a couple of cases in the last two weekends where that's been demonstrated, where a patient has turned up to a hospital with no airstrip, had a - what we thought was time urgent as opposed to time critical condition, and looked at the resourcing in terms of rotary wing and air - sorry, rotary wing and road response, and I think that interface is also with that hospital capacity point of view.

So have we got the right, for example, nurse, from one of our facilities, to go on a road transfer, if that level is required, so that the system actually proves itself from an APTC point of view, where we could actually - saw what was going on in terms of rotary wing availability. We went through the vortex options and went, look, you know, the best way to go is actually by road, running with a nurse from our facility.

So absolutely, all stakeholders come under one roof, and it's around having that visibility and oversight, but also having the authority to push, "Go". So, we actually had two plans running simultaneously, because we suspected that the - one of the plans would actually fail. And it did. So - but we actually had a response that was timely. So that interface point is, to me, a no brainer, actually.

KENNEDY, DR: Okay.

MOFFET, MR: And I think we know, in the past, we've had experiences where we haven't done well because of the lack of sort of real-time decision-making visibility where the outcomes have been exceptionally poor in those circumstances, so you know, they can make a massive difference to the patient outcome.

KENNEDY, DR: Thank you.

There's, potentially, 10 minutes left. If you have any further statements or anything else that you wish to raise, otherwise we will conclude?

MOFFET, MR: No, I think we've probably covered a lot of things.

I did note the comments around airstrips and helipads and responsibility. I think it's a complex area and I don't know what the Department of Transport or the local government position would be on that, so we haven't particularly ventured a view, except to say there are - we probably feel, as an organisation, we need to have a stronger view about - where airstrip capabilities a chronic issue.

In fact, I - we - I travelled with the CEOs of RFDS and St John's and Silver Chain out to Eucla recently and there was an example of where the strip there is really not up to scratch, and that's something that's pretty important for that community, so I don't know - I probably - there was some, I guess, comments about whether that should come to Health.

I don't - I think airstrips are multipurpose use and I think there were probably others with better comment to make than us, but we do note that it can be an issue and we probably, as a - I guess, as provider that relies on those strips, we need to be more situationally aware in the future of constraints for RFDS or others and try support resolution. That's probably the broad comment I would make about that, probably not looking to manage them, but - - -

KENNEDY, DR: Yes, it's a - I mean, it's an interesting one from the point of view of rotary wing services and now, with the - you know, with the trial that you've got going on in terms of inter-hospital transfer. It's about as essential as having an ambulance bay, really, you know, having - - -

MOFFET, MR: Absolutely.

KENNEDY, DR: - - - a local helipad - - -

MOFFET, MR: Yes.

KENNEDY, DR: - - - in terms of getting the most out of that system, otherwise you, obviously, have multiple road transfers at either end, and suboptimal arrangements.

So yes, we haven't - I mean, it's not absolutely clear where that sits, however, you're most often talking about hospital campuses, aren't you, in terms of where you could most optimally put a helipad. Even having it a hundred metres away on an oval is not a great solution, because that's going to require some other vehicle to get you from here to there.

So that is an important thing, but the system's - - -

MOFFET, MR: Yes.

KENNEDY, DR: - - - going to have to think about more as you develop that rotary capability.

MOFFET, MR: Capacity, yes. That's a very good point, actually, you make. We've only got four helipads in the south of the State, a couple in the north, and they're great to have. We are planning - as we're doing new developments, planning to incorporate those and particularly, into Bunbury, where we - that's going to take some time, but that's going to take some time, but that's a, you know, busy hospital that desperately needs one. But I guess that's one of the - I think one of the challenges for us is that there's clearly a patient transport

strategy - and you could say legislation and other things, but some of those things take a long period of time.
I guess an issue I might raise, really, I suppose, is there is some urgency around rotary planning, whether it's helipads or you know, bases or, you know, primary versus secondary separation. If there's anything I think that's needed fairly urgently as a subset, it would be a rotary plan for the State, rather than that have to wait before three components get done for several years, so that's probably just a comment that I think might be helpful for all of us in trying to make some decisions fairly quickly.

KENNEDY, DR: Yes. Thank you.

Well, thank you for your attendance at the - today's meeting for - - -

MOFFET, MR: Thank you.

KENNEDY, DR: - - - being here and for your input and answering all our questions.

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So once again, thank you very much for - - -

MOFFET, MR: Yes, thank you.

KENNEDY, DR: - - - talking with us and thank you to the rest of your team as well.

MOFFET, MR: Okay. Thank you - - -

KENNEDY, DR: Thank you.

MOFFET, MR: - - - very much.

YEUNG, MR: Thank you.